INTERPERSONAL PROCESS, THERAPISTS' SUPPORTIVE AND INTERPRETIVE INTERVENTIONS, AND INTRAPSYCHIC CHANGE IN PSYCHODYNAMIC PSYCHOTHERAPY

BY

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

DOCTOR OF PHILOSOPHY

Department of Psychology
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Abstract

This study examined the relative contributions of the therapist-client relationship and therapist interventions to psychotherapy outcome, especially to changes in how clients perceive and relate to themselves. Fifty-nine therapist-client dyads drawn from the Vanderbilt Psychotherapy Project II on time-limited dynamic therapy served as participants in this study. The therapeutic relationship was operationalized in terms of independent observer ratings of therapists' and clients' moment-to-moment interpersonal behaviours in the 3rd session using Benjamin's (1974) Structural Analysis of Social Behavior model (SASB). Likewise, therapists' interventions in the 3rd session were categorized as either interpretive or supportive by independent raters using Gaston's (1988) Inventory of Therapeutic Strategies (ITS). Changes in clients' self-perceptions and self-directed behaviours were measured by the INTREX Introject Questionnaire (Benjamin, 1988), administered at the beginning and end of therapy. A second measure of outcome was obtained by combining clients' pre- and post-therapy scores on the Symptom Checklist-90 Revised (SCL-90-R; Derogatis 1983), and the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976). The results of hierarchical, multiple regressions indicated that SASB-ratings of clients', but not therapists', interpersonal behaviour predicted residual-change on the combined outcome measure. Contrary to hypotheses, therapists' and clients' SASB ratings and therapists' supportive and interpretive interventions did not interact to predict outcome on either measure. Also contrary to predictions, therapists' interpretations that focused particularly on clients' experiences in the

therapeutic relationship were not associated with positive intrapsychic change. The study's limitations and its theoretical, empirical, and practical implications are discussed.

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Contents

List of Figures and Tables

Table

Interpersonal Process, Therapists' Supportive and Interpretive Interventions, and Intrapsychic Change in Psychodynamic Psychotherapy

Over the years, the client-therapist relationship has emerged as a crucial factor in the successful outcome of psychotherapy. Contemporary psychodynamic and interpersonal theory argues that the relationship between therapists and clients has a direct, ameliorative effect when it disconfirms the negative interpersonal experiences that clients encountered in the past and when it offers an experiential base for improving clients' internalized manner of relating to the self, formally called the introject (Henry & Strupp, 1994).

Therapists' techniques also play an important role in the successful therapeutic endeavour, according to psychodynamic theory. In particular, therapists' interpretation of clients' problematic behaviours, thoughts, and expectations are said to facilitate improvements in therapy (Bibring, 1954; Malan, 1979). Such interventions, it is argued, increase clients' awareness of their current manner of perceiving and relating and provide the necessary incentive for change (Blatt & Behrends, 1987; Meissner, 1981; Strachey, 1934). This change includes the way in which clients perceive and relate to themselves as well as changes in symptoms, interpersonal relationships, and clients' overall adjustment.

To the extent that therapists' interpretations create a certain amount of anxiety in clients, their effectiveness may depend on the state of the client-therapist relationship. Some psychodynamic theorists argue that a positive

therapeutic relationship enables clients to tolerate the stress that is introduced by their therapists' interpretations, and that, in the absence of such a relationship, interpretations can have countertherapeutic effects (Blatt & Behrends, 1987). Furthermore, it is argued that in situations where clients have difficulty engaging in the therapeutic relationship, better outcomes will be obtained when therapists use supportive, rather than interpretive, interventions (Zetzel, 1956).

In what follows, psychodynamic theory and research on the respective roles of the client-therapist relationship and therapists' interventions in psychotherapy will be more thoroughly considered. Within this discussion, a recent formulation of the relationship in terms of the ongoing interpersonal process of therapy will be presented that calls for fine-grained analyses of therapists' and clients' moment-by-moment interactions. Following this, the psychodynamic concept of introjection will be presented as an important facilitator of psychotherapeutic change. This concept is defined as the experiential learning process whereby individuals form images of themselves and learn to interact with themselves as they have been treated by others. Finally, an empirical study will be presented wherein the contributions of the interpersonal process of therapy and therapists' interpretive and supportive interventions to positive therapeutic outcomes were examined. The study was based on 59 client-therapist dyads who participated in the NIMH funded Vanderbilt Psychotherapy Project II on time-limited dynamic therapy. Independent raters' assessments of therapists' and clients' interpersonal behaviours and therapists' interventions in the third session were obtained as

well as measures of clients' functioning before and after therapy. Statistical analyses consisted of hierarchical multiple regressions and determined the independent contributions of each of the rated variables and their interaction terms to changes in clients' introjects and their general functioning over the course of therapy. Hierarchical rather than simultaneous regressions were used for the main analyses because this permited the partitioning of the variance in the outcome measures accounted for by therapists' supportive and interpretive interventions (and/or the interaction between therapists' interventions and the interpersonal process of therapy) from the variance attributed to the interpersonal process alone (Cohen & Cohen, 1983). The theoretical and practical implications of the study will be discussed throughout.

The Therapeutic Relationship and Psychotherapeutic Change

Psychodynamic Formulations

The client-therapist relationship has been an important, and at times controversial, focus of discussion in most theories of psychotherapy. The psychoanalytic/psychodynamic perspective, in particular, has played an important role in clarifying the nature of this relationship and its contribution to the therapeutic endeavour. Freud, himself, offered different views on the relationship as his career unfolded (Horvath, Gaston, & Luborsky, 1993; Horvath & Luborsky, 1993). In his earliest writings, Freud (1912/1966; 1913/1958) described the collaboration between patients and analysts in terms of positive transference. He maintained that patients form an attachment to their analyst when they perceive the latter's supportive interpersonal stance and

unconsciously identify him or her with supportive individuals in their past. Freud went on to argue that patients' transference associations are an important factor in enabling patients to accept as authoritative the analyst's interpretations. Later in his writings, Freud (1940/1949) seemed to admit a reality-based component to his description of the patient-analyst interaction. He depicted the analytic situation in terms of a "banding together" of the analyst and the patient's weakened ego in the "real external world" (p. 63). Although Freud (1940/1949) continued to emphasize therapists' interpretations of the transference neurosis as central to the work of therapy, he implied that a crucial factor in the healing process is the client's ability to form a pact between her or his reasonable self and the real person of the therapist (Horvath, Gaston, & Luborsky, 1993).

Sterba (1934) and Zetzel (1956) were among several theorists to elaborate on Freud's idea that a rational collaboration between clients and therapists is critical to the analytic endeavour. Sterba (1934) used the term "ego alliance[1]" and Zetzel (1956) the term "therapeutic alliance" to describe the alignment of the reality-based portion of the patient's ego with the therapist's

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[1] The terms "therapeutic alliance," "working alliance," or simply, "alliance" will be used interchangeably in this manuscript. It is nevertheless acknowledged that these terms have been used differentially by authors in the past to refer to different aspects of the alliance or to clarify theoretical points that are not directly relevant to the current discussion.

analyzing activities. Both argued that the alliance enables patients to oscillate between subjectively experiencing and objectively observing their transference reactions in the analytic situation. In that way, Sterba (1934) suggested, the alliance contributes to patients' active participation in the work of therapy.

Finally, Greenson (1965, 1967) proposed a model of the therapeutic relationship that consists of three interrelated components: the working alliance, the transference relationship, and the real relationship. Similar to the theorists cited above, Greenson (1965) defined the working alliance as the "non-neurotic, rational rapport which the patient has with his analyst" (p. 157). The working alliance, he argued, is distinct from the transference relationship. The transference relationship, in Greenson's view, referred to interactions between patients and therapists that are unconscious repetitions of patients' past interpersonal conflicts. According to Greenson (1965), the working alliance permits patients to experience the full impact and emotional challenge of their transference reactions and, at the same time, remain in therapy to continue working with the therapist's interpretations. Greenson (1965), like the previous authors, claimed that patients must have the capacity to engage in both kinds of relationships in order to benefit from analysis. Lastly, Greenson (1971) defined the "real" relationship as patients' and therapists' undistorted perceptions and genuine responses to each other. Greenson (1971) argued that the core of the working alliance is found in the real relationship, and that patients must have the ability to appreciate, at some level, the realistic qualities of their therapists in order to work with them effectively. Ultimately, Greenson (1971) argued, positive

therapeutic outcomes depend "to a great extent on the transference neurosis being replaced by a real relationship" (p. 439).

Psychoanalytic formulations of the therapeutic relationship have continued to evolve. The therapeutic or working alliance, in particular, has become a central construct within psychodynamic theory (Gaston, 1990; Henry, Strupp, Schacht, & Gaston, 1994; Horvath and Luborsky, 1993). This despite the fact that more classical analytic authors have questioned whether the alliance is truly a distinct concept from the transference relationship and whether focusing on the alliance is not a dangerous departure from more traditional analytic techniques (Brenner, 1979; Curtis, 1979). Among the theorists supporting the validity and utility of the alliance construct, Bordin (1979, 1993) was one of the first to offer a definition that could be applied to therapies outside of the analytic perspective. Building on the work of Greenson (1967), Bordin (1979) maintained that a strong working alliance is key to any interpersonal change process, including those that occur in contexts outside of therapy. Furthermore, Bordin (1979, 1983) identified three essential elements in the alliance: goals, tasks, and bonds. The first of these elements, he argued, encompasses therapists' and clients' mutual agreement on what aspects of the client's functioning should be targeted for change. The second element, the assignment of tasks, in Bordin's view refers to therapists' and clients' more or less explicit understanding of how each will contribute to the work of therapy and how the desired changes will be brought into effect. Finally, Bordin explained that the bonds of therapy refer to therapists' and clients' positive emotional involvement and to their trust of one another.

Overall, Bordin (1979) argued that each of the three elements must be present for a strong working alliance to develop in any psychotherapy, but their precise manifestation will vary depending on the therapist's theoretical orientation.

Other definitions of the alliance have been proposed by more recent psychodynamic theorists (e.g., Frieswyk et al., 1986; Horvath & Greenberg, 1989; Marmar, Weiss, & Gaston, 1989). In fact, more than 11 rating scales of the alliance construct have been developed, each with their own operational definition (Horvath & Luborsky, 1993). Despite considerable variability in these definitions, Horvath and Symonds (1991) argue that a general consensus exists among them that the alliance represents the joint contribution of therapists and clients to the therapeutic relationship and takes into account both of their abilities to negotiate an appropriate contract for therapy. This idea, that the therapeutic relationship is jointly created by therapists and clients, appears unique to the psychodynamic perspective and sets the alliance concept apart from formulations of the relationship offered by theorists from other theoretical orientations. The humanistic (Rogers, 1957) and social-influence (Strong, 1968; LaCrosse, 1980) conceptualizations, in particular, have had considerable influence on current understandings of the therapeutic relationship. Both of these perspectives emphasize the relationship as crucial to the outcome of therapy and they regard similar therapist characteristics (empathy, genuineness, unconditional positive regard, or expertness, attractiveness, trustworthiness) as important to the therapeutic process. However, these perspectives offer a more limited view than psychodynamic formulations of how the client contributes to the

therapeutic relationship and to her or his progress in therapy (Horvath & Greenberg, 1986; Horvath & Luborsky, 1993).

Therapeutic Alliance as Interpersonal Process: The SASB Model

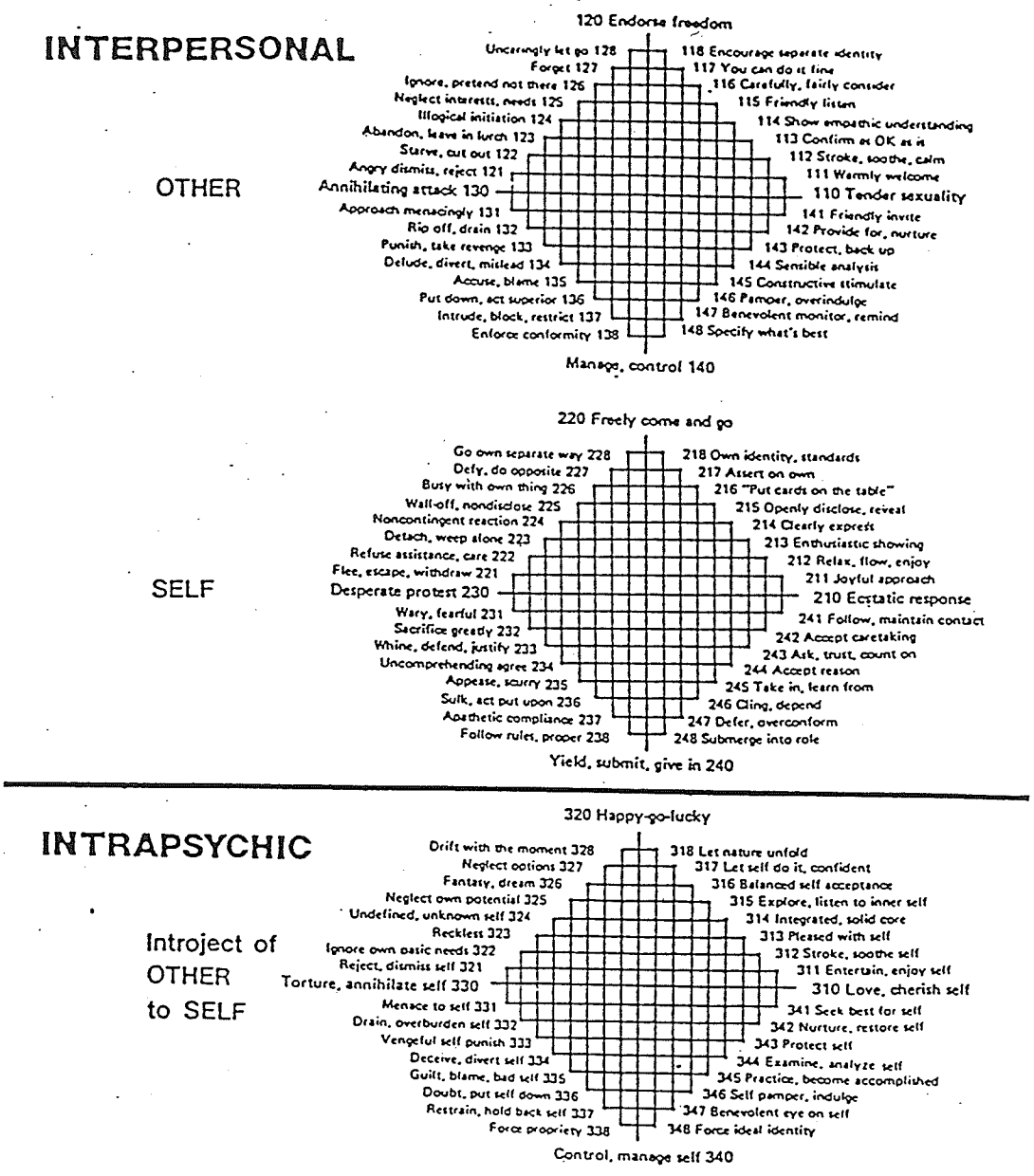
The definitions and formulations of the alliance that have been described thus far are relatively global in nature. For the most part, they focus on the basic constitution of the alliance or on the manner in which it manifests itself in the general content and emotional climate of psychotherapy. According to Henry and his colleagues (Henry, Schacht, & Strupp, 1990; Henry & Strupp, 1994), definitions such as these have played an important role in helping theorists and researchers to make basic distinctions between good and poor therapeutic interactions and to design empirical studies that demonstrate a significant association between positive client-therapist relationships and psychotherapeutic change (see reviews by Gaston, 1990; Henry, Strupp, Schacht, & Gaston, 1994; Horvath & Symonds, 1991). Henry et al. (1994) maintain that, having established a consistent link between the strength of the alliance and positive therapeutic outcomes, theorists and researchers now need to adopt a more precise formulation of the alliance. This formulation, they argue, should permit a clearer understanding of what therapists and clients actually do to establish and maintain a good working alliance, and it should lend itself to theory-specific explanations of how exactly the alliance contributes to change. In line with these recommendations, Henry and his colleagues re-conceptualize the alliance construct in terms of the moment-to-moment interpersonal process that transpires between clients and therapists in individual therapy sessions (Henry,

Schacht, & Strupp, 1986, 1990; Henry & Strupp, 1994).

Henry and Strupp's (1994) formulation of the alliance as interpersonal process is compatible with the idea that the alliance is jointly created by therapists and clients. In fact, it is heavily influenced by Sullivan's (1953) interpersonal theory which argues that all human relationships, including the therapeutic relationship, are "circular" in nature, with the behaviour of one individual influencing that of the other and vice versa in a continuously evolving process (Kiesler, 1982a). Therapists, from this perspective, are regarded as "participant observers" with specialized knowledge that enables them to recognize their own and their clients' contributions to the therapeutic interaction and to identify the meanings and implications that these contributions have for clients' problems in living and their learning experiences in therapy (see below for further discussion of interpersonal theory).

Building on their interpersonal leanings, Henry and Strupp (1994) provide an operational definition of the momentary interpersonal process of therapy by invoking Benjamin's (1974, 1984) Structural Analysis of Social Behaviour model. This model is one of several circumplex representations of interpersonal behaviour that have evolved out of interpersonal theory and is a direct extension of Schaefer's (1965) representation of parent-child interaction and Leary's (1957) Interpersonal Circle model of more general social behaviour. A graphic summary of the SASB model is presented in Figure 1.

Figure 1. The Full SASB Model



Note. From "Structural Analysis of Social Behavior: Coding manual for psychotherapy research" by M. Grawe-Gerber & L. S. Benjamin, 1989, . Unpublished manuscript, Department of Psychology, University of Bern, Bern, Switzerland.

In its current form, the SASB model uses three fundamental dimensions to describe interpersonal behaviour: Focus, Affiliation, and Interdependence. The "Focus" of behaviour, according to Benjamin (1974), pertains to the person or persons to whom the behaviour is directed. In Figure 1, this dimension is depicted in terms of the three interrelated planes or surfaces, respectively labelled "Other," "Self," and "Intrapsychic." The "Other" surface portrays active or transitive behaviours of the individual that are directed toward another person (e.g., "annihilating attack"). The "Self" surface depicts reactive or intransitive behaviours of the individual that show what is done to or for the self (e.g., "desperate protest"). Finally, the "Intrapsychic" surface describes how individuals relate to themselves. It portrays active behaviours of another that have been introjected or turned inward on the self (e.g., "torture, annihilate self").

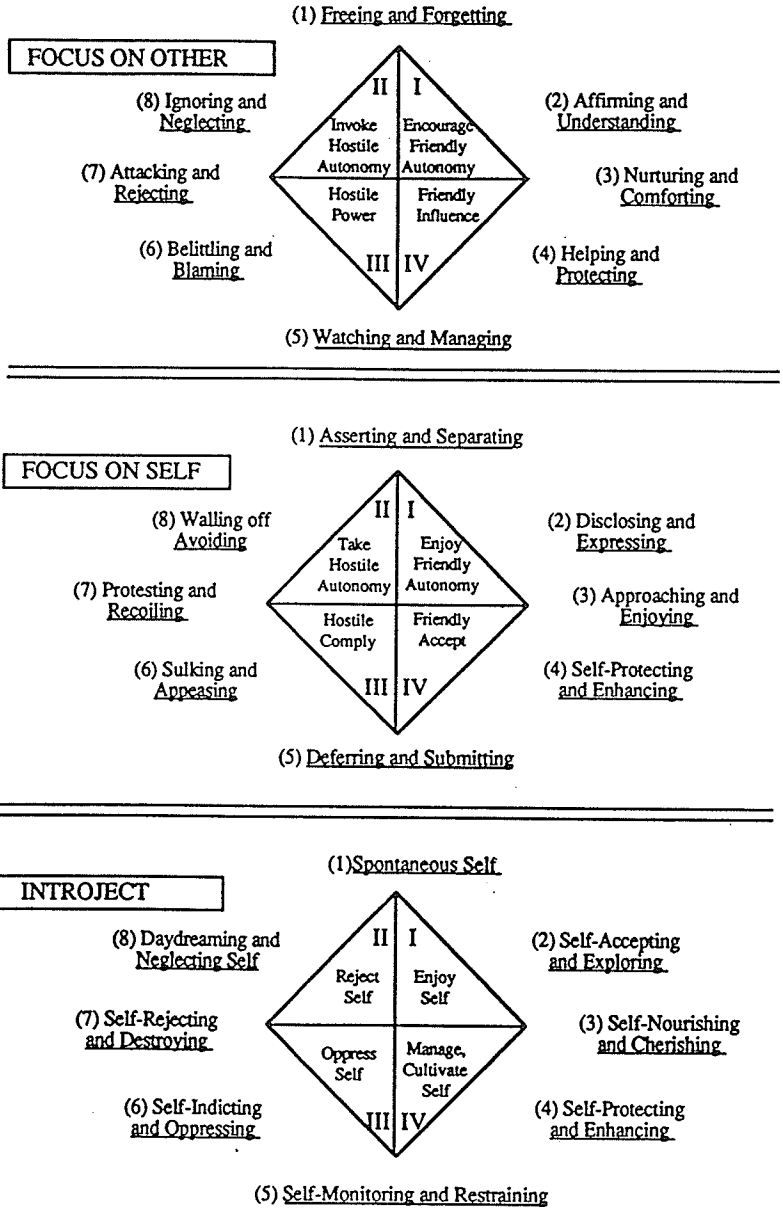
Affiliation and interdependence are, according to Benjamin (1986), basic social orientations that have evolved in humans as a result of natural selection and other biological processes. In Figure 1, affiliation and interdependence are respectively depicted in terms of the horizontal and vertical axes that intersect each of the three surfaces. The affiliation axis (i.e., the horizontal axis) on each surface is anchored at one end by maximally affiliative behaviours (e.g., tender sexuality) and on the other end by maximally disaffiliative behaviours (e.g., murderous attack). Likewise, the interdependence axis (i.e., the vertical axis) for each surface is rooted at one end by behaviours that encourage or demand maximum autonomy (e.g., endorse freedom, or freely come and go) and on the other end by behaviours that maintain or elicit maximum control (e.g., manage,

control, or yield submit). Once the object of the action is identified (the surface of Other, Self, or Introject), then any interpersonal behaviour is further identified by its affiliation and interdependence coordinates on the horizontal and vertical axes. A behaviour reflecting high affiliation and minimum autonomy, for example, would occur in the bottom, right-hand portion of the model. Alternatively, a behaviour reflecting relative hostility and maximum autonomy would occur in the top, left-hand portion of the model. In general, the model is constructed in such a way that correlated behaviours are situated closer together and unrelated behaviours are situated further apart. On each surface, behaviours that are most negatively correlated are considered "opposites" and are separated by 180°. Behaviours that occur in the same position but on different surfaces of the model are considered "complements."

In the full SASB model, as shown in Figure 1, each surface contains 36 behaviours that represent different combinations of the affiliative and interdependent dimensions. These behaviours are mathematically situated in the model according to their relation to the affiliation and interdependence axes. The 36 behaviours on each surface can be grouped into eight empirically validated clusters or four quadrants as seen in Figure 2 (Benjamin, 1974). As will be noted below, empirical studies that use the SASB model to measure the interpersonal process of therapy primarily use the cluster and quadrant versions of the model.

Henry and Strupp's (1994) operationalization of the interpersonal process

Figure 2. The Cluster and Quadrant Version of the SASB Model.



Note. From "Patient and Therapist Introject, Interpersonal Process, and Differential Psychotherapy Outcome" by W.P. Henry, T.E. Schacht, H.H. Strupp (1990). Journal of Consulting and Clinical Psychology, 58, 768-774.

of therapy in terms of the SASB model focuses on the observable behaviours and communications that transpire between therapists and clients. For this reason, information pertaining to the client's unconscious conflicts that is necessary for discrimination between the real, transference, or working alliance aspects of the therapeutic relationship is not available. Henry and Strupp, in fact, use the terms "therapeutic relationship" and "therapeutic alliance" interchangeably and they emphasize that their interest is not so much to explain the etiological origins of the relationship components as it is to describe and understand the actual interpersonal process of therapy as it unfolds in a given session. In their view, the interpersonal process of therapy, regardless of its etiology, is what does or does not contribute to positive therapeutic outcomes.

With regard to earlier definitions of the alliance that refer to the bonds, tasks, and goals of therapy (c.f., Bordin, 1979, 1993), Henry and Strupp (1994) suggest that these are higher order concepts that emerge out of and contribute to the underlying interpersonal process. They argue, for example, that, over time, complementary exchanges between therapists and clients on the affiliation axis of the SASB model accumulate to define the bond component of the therapeutic relationship. If the client-therapist exchange occurs primarily on the hostile end of the axis (e.g., the therapist belittles and blames the client; the client sulks and appeases the therapist), it is argued that a negative affective bond will develop that will interfere with establishing relevant goals and performing the tasks of therapy. On the other hand, if the client-therapist exchange occurs mainly on the affiliative end of the horizontal axis (e.g., the

therapist affirms and understands the client; the client discloses and expresses him/herself to the therapist), a positive affective bond is expected to develop that will facilitate the identification of goals and the completion of therapeutic tasks. Henry and Strupp suggest further that an affiliative therapeutic bond and consensus on goals and tasks work together to ensure that a benign interpersonal process will continue and to maintain patients' involvement in therapy despite momentary lapses in the process or occasional misguided interventions.

In general, Henry and Strupp's (1994) definition of the alliance as interpersonal process is an extension of, rather than a substitution for, definitions of the alliance that were cited earlier. In many ways it represents a broadening of the alliance concept by de-emphasizing the traditional psychoanalytic distinctions that were made between it and other components of the therapeutic relationship. In other ways, however, their definition narrows the concept by equating it with very specific, momentary therapist and client behaviours. Together with Freud and other theorists, Henry and Strupp (1994) continue with the overall assumption that the alliance, in whatever way it is conceived, is a crucial ingredient in the therapeutic endeavour. A discussion of exactly how the alliance as interpersonal process contributes to positive therapeutic outcomes follows.

The Interpersonal Process of Therapy: Direct Change Mechanisms

Psychotherapeutic change, according to Henry and Strupp (1994), is synonymous with experiential, interpersonal learning. This learning, they argue,

is characterized by many of the same developmental processes that underlie the emotional and cognitive growth of children as they interact with their parents. The developmental process that Henry and Strupp (1994) regard as especially important for bringing about change in psychotherapy in the context of the therapeutic relationship is called introjection.

Originating with Freud, introjection has been defined in many different ways by many different theorists (Greenberg & Mitchell, 1983; Orlinksy & Geller, 1994). Within the psychoanalytic perspective, introjection is generally viewed as a developmental process whereby individuals transform the characteristics and behaviours of significant others into enduring aspects of their own personality (Meissner, 1981; Schafer, 1968). The hypothesized personality structure that is presumed to arise out of this process is called the "introject" and is described as an "inner felt presence" that regulates behaviour and influences emotions in the same way that external others did for individuals in the past. Theorists from the cognitive-developmental perspective, on the other hand, regard introjection as a representational process whereby individuals form mental images of their interactions with significant others that act as inner templates for subsequent feeling and behaviour (Geller & Farber, 1993; Orlinsky & Geller, 1994). These templates are called "schemas" and represent a conglomerate of significant interpersonal experiences rather than the isolated activities of any one person. Finally, from an ethological standpoint, Bowlby (1988) describes introjection as a process whereby individuals build "working models" of relationships based on their day-to-day interactions with important others. These working models,

according to Bowlby (1988), play a determining role in how individuals feel about themselves and how they expect others to treat them. They also influence how individuals organize their behaviour to maintain relatedness to others.

The concept of introjection espoused by Henry and Strupp (1994) proceeds out of interpersonal theory (Sullivan, 1953) which was heavily influenced by Cooley's (1956) idea of the "looking glass self." Introjection, from this perspective, is defined as a developmental process whereby individuals form concepts of themselves based on the reflected appraisals they receive from the people around them, and learn to treat themselves as they have been treated by others. The "introject" is said to comprise "a relatively stable conscious and unconscious repertoire of ways of treating the self" (Henry et al., 1990, p. 769) and to correlate more or less directly with individuals' level of psychological health or psychological disturbance.

According to most introject theorists, the basic substrates of the introject are laid down relatively early in life and reflect the kinds of interactions that individuals experienced with their primary caretakers (Greenberg & Mitchell, 1983; Henry & Strupp, 1994). For example, individuals whose introjects are relatively friendly and self-accepting are presumed to have been raised in a generally caring and responsive environment. Conversely, individuals whose introjects are largely hostile and self-rejecting are presumed to have been reared in more antagonistic surroundings. In general, it is argued that individuals with basically positive caretaking experiences will develop affiliative introjects to reflect those experiences and will grow up to exhibit psychological health,

including feelings of well-being and appropriate interpersonal behaviour. Individuals, on the other hand, whose caretaking experiences are mostly negative are expected to develop more hostile introjects and to exhibit signs of psychological maladjustment, including feelings of depression and/or anxiety and a generally maladjusted style of relating to others. Theoretically, individuals with introjects in the latter category are considered the more likely candidates to seek out or be referred for psychotherapy.

Like the parent-child relationship, the relationship between therapists and clients is said to be emotionally significant to clients and is argued to have an important influence on clients' introject formations. In fact, to the extent that introjection of negative caretaking experiences plays a vital role in creating a client's pathology, Henry and Strupp (1994) propose that introjection of affiliative interpersonal process in therapy is central to the client's recovery. Drawing again from interpersonal theory (see especially Cashdan, 1982; Kiesler, 1982b; Safran, 1990a, 1990b), Henry et al. (1990) explain that most individuals who come for therapy have become entrenched in a rigid pattern of relating to the self and other in a maladaptive manner that is congruent with the negative state of their introjects. This pattern of behaviour, they argue, consistently pulls for negative responses from others in a way that confirms for clients the negative relationship experiences that they encountered in the past. One way or another, Henry et al. propose that clients' negative pattern of behaviour works itself into the therapeutic situation. It is argued that therapists who consistently counter their clients' negative evoking style with affiliative interpersonal process effectively

break the negative relationship pattern to which clients have become accustomed and offer them a new experiential base on which to build an image of themselves and orient their self-directed behaviours.

To elaborate on the therapist-offered interpersonal process that facilitates change in clients' introjects, Henry and Strupp (1994) argue that this is more or less synonymous with the "facilitating qualities of a good parent" (p. 68). They suggest that this process should include "communications that are straightforward, not complex and contradictory, and create a positive reflective appraisal" (Henry & Strupp, 1994, p. 68). Henry and Strupp explain further that therapists' affiliative behaviours are most influential when they occur in the context of an established power base, similar to the one that exists in parent-child interactions. This power base, it is argued, increases the importance of therapists' behaviours in the eyes of clients, and enhances the probability that clients will internalize these behaviours to become a part of their introject structures. In terms of the SASB model, Henry et al. (1986; 1990) predict that optimal therapist behaviours would be focused mostly on the "Other" (i.e., directed at the client; see Surface 1 in the SASB model, figure 1) and oriented toward affiliative interaction (i.e., see behaviours in Quadrants I & III). In terms of SASB clusters (see Figure 2), therapist behaviours that are "affirming and understanding" (Cluster 2), "nurturing and comforting" (Cluster 3), and/or "helping and protecting" (Cluster 4) are considered important.

Henry and Strupp's (1994) emphasis on the therapist's contribution to the therapeutic relationship does not imply that the client's contribution is

unimportant. To the contrary, it is argued that the success of therapy depends fundamentally on the client's ability to form positive emotional attachments with others and to participate in the positive interpersonal process. At the same time, Henry and Strupp suggest that only very few clients are completely incapable of bonding with another individual and that it is largely incumbent on the therapist to manage the relationship in such a way that a client's bonding capacity can emerge. As a result, Henry and Strupp imply that a client's optimal contribution to the therapeutic interaction would consist of some disaffiliative behaviours to reflect her or his negative evoking style, especially during the earlier stages of therapy, but would include mostly affiliative interpersonal interactions to reflect her or his acceptance of the therapist's communications and her or his positive participation in the therapy. In terms of the SASB model, therefore, Henry et al. (1986; 1990) predict that optimal client behaviours would be focused mostly on the "Self" (Surface 2) and may express some hostility (Quadrants I & IV), but comparably more affiliation (Quadrants II & III). In the cluster version of the model, optimal client behaviours would be expected to fall mostly in the "disclosing and expressing" category (Cluster 2), the "approaching and enjoying" category (Cluster 3), and/or the "trusting and relying" category (Cluster 4). Finally, Henry et al. predict that positive changes in clients' introjects would be reflected by a greater representation of "self-accepting" (SASB Surface 3, cluster 2), "self-nourishing" (Surface 3, cluster 3), and "self-protecting" (Surface 3, cluster 4) behaviours from the beginning to the end of therapy.

In summary, Henry and Strupp maintain that the interpersonal process of

therapy contributes directly to psychotherapeutic change when the therapist provides a positive relationship for the client that disconfirms clients' negative relationship experiences of the past and provides them with an experiential base on which to change their introjected image of themselves. Henry and Strupp suggest that therapists' management of the relationship is central to the overall change process but that clients' contributions to the interpersonal process of therapy are also important in so far as they reflect clients' willingness and ability to engage in the relationship that their therapists are offering. It is important to remember that Henry and Strupp's formulation of how the therapeutic relationship contributes to positive therapeutic outcomes evolves directly out of the interpersonal perspective and has many features in common with contemporary interpersonal theorists (e.g., Cashdan, 1982, Kiesler, 1982a, Safran, 1990a, 1990b). Henry and Strupp emphasize, however, that their aim is not to exemplify the merits of one theoretical perspective over those of another. Rather, they imply that their intention is to use the interpersonal perspective as a springboard for identifying "common factors or processes that operate in all therapies" (p. 51). To that end, Henry and Strupp maintain that introjection of ameliorative interpersonal process is such a factor, and that it is worthy of theoretical and empirical consideration in any therapeutic endeavour, regardless of the therapist's or researcher's particular orientation.

Therapist Interventions and Psychotherapeutic Change

Despite their emphasis on the interpersonal process of therapy and its potential contribution to positive changes in clients' introjects, Henry and Strupp

do not maintain that the therapeutic relationship is the only contributor to positive therapeutic outcomes. Rather, they suggest, as do most theorists in the psychotherapy literature, that several factors combine to make up the successful therapeutic endeavour; many of these factors fall under the traditional rubric of technique. It is interesting that Henry and Strupp regard the therapeutic relationship, or more precisely, therapists' management of the relationship, as a technical intervention in and of itself. Again, however, they suggest that the relationship is only one technique among many that makes for a successful approach to therapy. In what follows, psychoanalytic/psychodynamic formulations of two additional interventions, therapists' interpretations and therapist support, will be examined. These interventions will be considered with regard to their hypothesized contributions to positive therapeutic outcomes, and specifically, their contributions to positive changes in clients' intrapsychic state.

Therapist Interpretations and Introject Change

From Freud onwards, considerable emphasis has been placed in the psychoanalytic/psychodynamic literature on therapist interventions that promote insight into the origin of patients' difficulties and heighten patients' awareness of the psychological and behavioural mechanisms that maintain them. In classical analytic theory, these interventions were defined as interpretations and were said to focus almost exclusively on explaining patient difficulties in terms of conflicts and repressed memories that exist in the unconscious (Bibring, 1954; Freud, 1937/1964, 1940/1949). More recent formulations of interpretations define their focus more broadly, allowing them to elaborate on conscious and preconscious

material so long as this material, in some way, provides a new frame of reference for the client (Clark, 1995). For both groups of theorists, interpretations are said to follow out of an exploratory process wherein therapists listen to patients' communications of their thoughts, feelings, and experiences and observe patients' reactions and behaviours in the analytic situation, especially in relation to the therapists themselves. The therapist then assigns meaning to the patient's reactions and draws connections between the client's manner of relating in the therapeutic relationship, the client's experiences with significant others in the past, and the current interpersonal difficulties she or he is encountering in extra-therapeutic situations (Malan, 1979). Ultimately, the insight gained from therapists' interpretive interventions is said to re-educate or re-orient the rational portion of the patient's personality (i.e., the ego) and to initiate a fundamental change in the patient's experience of the self (Freud, 1937/1964; 1940/1949).

Freud did not relate directly therapists' interpretations to the process of introjection in psychoanalysis. A number of his followers, however, made a definite link between interpretive interventions and the introjective process and have argued that both are fundamental to facilitating lasting structural change. Among these, Strachey (1934) argued that therapists' interpretations "clear the way" for introjection to happen by helping patients become aware of the distortions that exist in their perceptions of the people around them. In a manner that parallels the views of Henry and Strupp (1994) cited earlier, Strachey explained that individuals come to therapy with a pre-conceived notion of how

others will treat them based on having already introjected previous relationship experiences and based on a tendency to project their own conflicts onto others and then to introject these conflicts back onto themselves. Strachey argued that until they become aware of the biases that exist in their perceptions of others, patients have only a limited capacity to appreciate the real qualities of their therapists or to recognize their therapists' benevolent and nurturing behaviours as a new model for how to interact with themselves. Strachey maintained, therefore, that therapists' interpretations have the primary function of helping patients gain insight into their intrapsychic conflicts and helping them to distinguish between their experiences in previous relationships and their current involvements in therapy. The end result, according to Strachey, is that therapists' interpretations strengthen patients' contact with reality and increase their capacity to learn about themselves from their therapeutic interactions and from more general involvements with others.

Meissner (1981) is a more recent author to stress the importance of interpretation in the introjective process. Similarly to Strachey (1934), Meissner argues that patients need to become aware of the distortions that exist in their perceptions of others, especially in their perceptions of the therapist, before they will be capable of recognizing the true nature of the therapeutic interaction and of using this interaction to change how they relate to themselves. Adding to this argument, Meissner maintains that therapists' interpretations, in order to facilitate changes in the introject, should include a direct exploration of the etiological origins of patients' current introject structures and of the motivational factors that

continue to maintain them. This exploration, according to Meissner, helps patients to give up the debilitating aspects of their old introjects and to incorporate the beneficial aspects of the new.

Finally, Blatt and Behrends (1987) argue, from a different angle than the previous psychoanalytic authors, that interpretations play a crucial role in facilitating patients' introjection of their therapists' interactions. According to Blatt and Behrends (1987; Behrends & Blatt, 1985), introjection in any relationship has two major prerequisites: the gratification and minor deprivation of needs. Interpretations, it is argued, are a form of minor deprivation in the therapeutic relationship to the extent that they challenge, rather than support, patients' perceptions of reality, and question, rather than encourage, their current manner of relating. Blatt and Behrends contend that interpretations create feelings of loss and incompatibility in patients when they disrupt an otherwise gratifying flow of empathic and generally supportive interventions and when they force patients to recognize the limits of the therapeutic relationship. In order to deal with this loss and resolve the incompatibility, it is argued that patients begin to identify what was gratifying about their therapists' previous communications and they recover these gratifications by introjecting them as a permanent part of how they interact with themselves. Thus, according to Blatt and Behrends, interpretations are crucial in the therapeutic endeavour not just to promote insight and more accurate perceptions but to motivate patients to begin fending for themselves.

The views presented by each of the preceding authors, despite some points of variability, have a number of assumptions in common. Of these, the

most important assumption appears to be that the mere presentation of a benevolent interpersonal process is not enough to ensure that patients will recognize this process for what it is or that they will be motivated to introject this process and make it a part of their own experience and behaviour. Two of these authors, for example, suggest that patients come to therapy having already introjected a diversity of interpersonal experiences, positive and negative. These authors claim that patients' introjects often cloud patients' perceptions of subsequent relationships, sometimes to the point that they are unable to differentiate a benign interpersonal process from the more hostile interactions that they may have experienced in the past. In addition to this, Blatt and Behrends (1987) seem to argue that without some kind of challenge to patients' basic self-representations, patients may simply form an attachment to their therapists and see no reason to incorporate their therapists' benevolent behaviours into their own repertoire of ways of seeing and relating to the self. It is interesting that interpersonal theorists also acknowledge the importance of therapists' interpretive interventions. Sullivan (1953), for example, emphasized that therapists should use their personal reactions to patients as an indicator of the problems that exist in patients' social behaviours. Sullivan argued that once therapists have identified their patients' negative interpersonal styles, they must work to counter these styles with benevolent behaviours of their own, and they must explore with patients the cognitions and perceptions that underlie their behaviours so that patients will see a need and strategy for change. More recent interpersonal theorists seem to agree with this approach to intervention (e.g.,

Kiesler, 1982, 1988; Safran, 1990a, 1990b; Strupp & Binder, 1984), as do a number of other theorists from the object relations and attachment theory perspectives (e.g., Bowlby, 1988; Kohut, 1971).

Another assumption that is implied in the writings of the previous authors is that interpretive interventions are most effective in initiating introject change when they focus directly on clients' reactions to and perceptions of the therapeutic relationship. The rationale for this assumption is that interpretations based on clients' experiences in therapy have greater emotional immediacy for clients than do interpretations that are based on clients' reactions in more remote situations and relationships (Strachey, 1934). It is argued that clients respond to their therapists in a similar way that they respond to other significant individuals. By focusing their interpretations on the therapeutic situation where the object of clients' reactions is immediately present, it is argued that therapists have the opportunity to access in a very immediate way the most salient aspects of their clients' introjects and the perceptions and expectations that maintain them (Strachey, 1934). To the extent that clients' difficulties are said to originate in their formative experiences with significant others, theorists also argue that therapists' interpretations of client reactions to early relationships that clients have transferred onto the therapeutic situation are effective in facilitating change because they promote insight into the root cause of clients' problems (Blatt & Behrends, 1987).

Therapist Support and Introject Change

For many psychoanalytic and psychodynamic theorists, therapists'

interpretations represent the core technique in the analytic endeavour. Freud (1937/1964, 1940/1949) regarded interpretations as the hallmark of his therapeutic approach. Likewise, Strachey (1934) viewed interpretations as the "main weapon in the analyst's armoury" (p. 140). Strachey, in fact, contrasted the therapeutic effect of interpretations with the effect of therapists' "reassurance." Although he acknowledged that the latter category of interventions can do much to lower a patient's anxiety, he stated that this is not always a desirable effect. Strachey argued that the anxiety brought on by therapists' interpretations is often a reliable indicator that the therapist is addressing important sources of conflict and perceptual distortion. Thus, he maintained that interpretations, not reassurance, are the interventions that will bring about lasting, structural change.

Somewhat differently, Bibring (1954) contrasted therapists' interpretations to therapists' clarifications. Clarifications, according to Bibring, involve therapists' restatement of patients' feelings in a more precise form than patients themselves have been able to articulate. He argued that clarifications help patients gain a clearer and more objective understanding of the self. Bibring explained further that clarifications, by definition, do not go beyond the client's phenomenological experience and do not broach subjects outside of the client's conscious and/or preconscious awareness. As such, Bibring hypothesized that clarifications rarely meet with client resistance and that they do not initiate actual changes in clients' psychological structures. Although Bibring argued that clarifications can do much to heighten clients' self-awareness, he seemed to agree with Strachey that

interpretations are the more essential interventions in achieving lasting therapeutic gains.

Despite the fundamental importance attributed to interpretive interventions by many theorists, there are authors who caution against the use of interpretations in some situations. Zetzel (1956), for example, argued that interpretations are only conducive to positive change when they are given in the context of a strong therapeutic alliance. She argued that some patients enter therapy with only a limited ability to form attachments with others because of insufficient ego development. For these individuals, Zetzel argued that interpretive interventions that present a further challenge to the ego would be inappropriate and possibly even dangerous. She recommended instead, for traditional analytic techniques to be modified, at least for a time, and for therapists to focus on more supportive interventions until the patient's ego has had opportunity to mature. More recently, Malan (1979) argued similarly that patients who are severely disturbed may not be suitable for strictly interpretive psychotherapy. For these patients, Malan (1979) recommended a cautious and gradual approach to offering interpretations that is balanced with an appropriate level of support.

Blatt and Behrends (1987) also maintain that interpretations are not the appropriate intervention for all individuals at all times. They emphasize, as did Zetzel, that the therapeutic effectiveness of interpretations is fundamentally dependent on the status of the therapeutic relationship. They argue that interpretations, especially because of their depriving and anxiety-promoting

characteristics, must be offered within a caring and compassionate environment. Otherwise, they maintain, patients will be prone to introjecting a relatively harsh image of the analyst and they will deteriorate rather than improve as a result of their involvement in therapy. Blatt and Behrends stress that even the most insightful of interpretations will have no beneficial effect if they are not offered in a tactful manner and with an appropriate emotional tone. Blatt and Behrends, in fact, argue that the effect of interpretations is so intertwined with the status of the therapeutic relationship that the former cannot really be considered without reference to the latter.

Somewhat differently from Zetzel, Blatt and Behrends maintain that supportive interventions, or interventions that uphold and reinforce a client's sense of self, are not just an adjunctive or preliminary technique to be used only with clients who have difficulty attaching. Their view seems to be that all clients will have difficulty engaging in the therapeutic relationship at one time or another and that all clients need their therapists to be supportive when these difficulties arise. In fact, Blatt and Behrends contend that psychological growth is an evolving process, one that requires therapists to be at times challenging and at other times supportive. As was indicated above, Blatt and Behrends argue that therapists' supportive communications are important for introjection to occur because they provide a source of gratification to clients. This experience of gratification, it is argued, is what clients aim to preserve when they introject their therapists' behaviours.

It is important to point out that Blatt and Behrends' views on the role of

therapist support are not completely incompatible with those of Zetzel. Their discussion leaves room for the possibility that some clients, namely those with especially difficult relationship histories, require very high levels of support in order to take part in the therapeutic relationship. Blatt and Behrends would perhaps argue that clients in this category would feel sufficiently challenged simply by becoming involved in an interpersonal relationship and that they would not need the added challenge of interpretive interventions in order for their introjects to change. For these clients, therapists' offer of support may, in fact, represent clients' first experience of support in an interpersonal context and provide them with the first concrete example of how to be supportive of themselves. On the other end of the spectrum, Blatt and Behrends might also propose that higher-functioning clients who are more accustomed to interacting with others and who know, to some extent, what it is to be supported by another, would feel underchallenged by the therapist's supportive interventions and would need a higher rate of interpretation in order for their introjects to change.

Overall, there seems to be theoretical support for the importance of both interpretive and supportive interventions in bringing about positive therapeutic outcomes and, in particular, positive changes in clients' introjects. Interpretive interventions, one could hypothesize, would be most effective in producing change when clients and therapists are both engaged in primarily affiliative interactions. Supportive interventions, on the other hand, may be more important when clients show difficulty accepting their therapists' affiliative gestures and when they have difficulty engaging in affiliative behaviour

themselves. Although most clients can be expected to exhibit these difficulties at some point in therapy, it seems likely that some clients would have greater difficulty in this area than others and for longer periods of time. These clients, one could hypothesize, would feel overwhelmed by the challenging aspects of therapists' interpretations and would profit more from a mainly supportive approach.

At this point it is important to clarify that both supportive and interpretive interventions can be offered by therapists in a disaffiliative manner. With regard to the former, a therapist could, for example, resonate with a client's sense that she or he is incapable of meeting the demands of her or his situation and thereby support the client's sense of self. The therapist may do so, however, in a patronizing, rather than empathic, manner and in a tone that precludes the client from considering alternative ways of thinking. In comparison to supportive interventions, however, therapists' interpretations may be especially vulnerable to being offered in a disaffiliative manner because of their inherently challenging nature. In an effort to help a client recognize her or his contribution to a problem situation, a therapist may, for example, inadvertently accuse the client and blame her or him for not acting sooner. Wiles (1984) has argued that therapists working from a psychoanalytic perspective, because of their emphasis on interpretive interventions, need to take special caution that their interventions do not inflict unnecessary harm.

As a general rule, then, it seems that therapists need to be keenly aware of their clients' style of interacting when they choose their interventions and they

need to offer their interventions in a strictly affiliative manner. It seems that interpretive *and* supportive interventions, when offered in a disaffiliative manner by therapists, would only serve to confirm the negative experiences that clients encountered with others in the past and would probably lead to disappointing, or even detrimental, results. It seems possible that clients who enter therapy with introjects that are already fairly positive would not be as vulnerable to therapists' disaffiliative communications as clients whose introjects are primarily negative. At the same time, it seems likely that even clients with relatively positive introjects, if they remain in therapy with disaffiliative therapists for an extended period of time, would eventually succumb to the negative effects of their therapists' communications and end up with less than positive results.

Research on the Interpersonal Process of Therapy and on the Role of Therapists' Interpretive and Supportive Interventions

It has been argued that the therapeutic relationship, operationalized as the momentary, interpersonal process of therapy, and therapists' interventions both play an important role in determining the outcome of therapy and in determining the amount and type of change that will occur in clients' introjects. With regard to the relationship component of the therapeutic endeavour in particular, a review of the literature indicates that a number of recent studies have used the SASB model to operationalize the interpersonal process of therapy and to determine how this process relates to positive therapeutic outcomes, including positive introject change. A summary of these

investigations is presented in Table 1. A number of studies have also considered the additional contribution of therapists' interpretive and/or supportive interventions and the manner in which these interventions interact with the therapeutic relationship to facilitate positive therapeutic gains. In fact, a review of the literature suggests that six studies have examined the joint contribution of the relationship and interpretive/supportive interventions to the outcome of psychotherapy. A summary of these studies is presented in Table 2. In what follows, the empirical results presented in Tables 1 and 2 will be examined more closely and their implications for future investigations will be considered.

Tables 1 and 2 include information about the client population and type of therapy that were investigated in each study, the rater perspectives from which the therapeutic relationship and/or therapists' interventions were assessed, and the perspective and criteria that were used to measure changes in client functioning or the outcome of therapy. The last column in each table summarizes the findings in each study. Positive and negative associations between the relationship/intervention variables and outcome are represented, respectively, by "+" and "-" signs. Nonsignificant associations between the process and outcome variables are represented by the integer, "0." For several studies listed in the two tables, the association between the process and outcome variables was assessed at several different points in treatment. For these studies, findings are reported separately for each point in treatment at which the association was assessed. For example, in Table 1, Coady (1991a)

Table 1

Summary of Psychotherapy Outcome Studies using SASB Interpersonal Process Ratings as a Measure of the Therapeutic Relationship

Reference	Client Population (n) & Type of Therapy	SASB Process Rater Perspective & Time of Assessment [a]	Outcome Perspective & Criteria for Evaluation	Finding [b]
Coady (1991a)	outpatients (9) seen at a university clinic for psychodynamic therapy	I rating T after 3rd, 5th, & 15th session	S-symptom reduction S-reduction in depression CE-improved social adjustment (ratings combined into one outcome score for analyses)	+ session 3 + session 5 + session 15 + overall
		I rating C after 3rd, 5th, & 15th session	S-symptom reduction S-reduction in depression CE-improved social adjustment (ratings combined into one outcome score for analyses)	+ session 3 + session 5 0 session 15 + overall
Harrist, Quintana, Strupp, & Henry (1994)	outpatients (70) seen at a university clinic for short-term, psychodynamic therapy	C rating self and T after 3rd session; T rating self and C after 3rd session; C & T ratings then compared to C rating of self on intrapsychic surface before and after therapy to calculate index of "internalization" [c]	S- symptom reduction CE-increase in adaptive functioning	+ [d] + [d]
Henry, Schacht, & Strupp (1986)	male outpatients (8) seen at a university clinic for short-term therapy, theoretical orientation not specified	I rating T in 3rd session	S- symptom reduction T- post-therapy evaluation T- global outcome C- global outcome CE-global outcome (ratings combined into one outcome score for analyses)	+
		I rating C in 3rd session	S- symptom reduction T- post-therapy evaluation T- global outcome C- global outcome CE-global outcome (ratings combined into one outcome score for analyses)	+

Table 1 (continued)

Reference	Client Population (n) & Type of Therapy	SASB Process Rater Perspective & Time of Assessment [a]	Outcome Perspective & Criteria for Evaluation	Finding [b]
		I ratings of T and C used to calculate "Index of Positive Complementarity" [e]	S- symptom reduction T- post-therapy evaluation T- global outcome C- global outcome CE-global outcome (ratings combined into one outcome score for analyses)	+ [f]
Henry et al. (1986) -continued-		I ratings of T and C used to calculate "Index of Negative Complementarity" [e]	S- symptom reduction T- post-therapy evaluation T- global outcome C- global outcome CE-global outcome (ratings combined into one outcome score for analyses)	+ [g]
		I ratings of T and C used to calculate "Index of Total Complementarity [e]	S- symptom reduction T- post-therapy evaluation T- global outcome C- global outcome CE-global outcome (ratings combined into one outcome score for analyses)	+ [h]
Henry, Schacht, & Strupp (1990)	outpatients (14) seen at a university clinic for short-term, psychodynamic therapy	I rating C in 3rd session	S- positive change in client introject	+
		I rating T in 3rd session	S- positive change in client introject	+
Najavits & Strupp (1994)	outpatients (70) seen at a university clinic for short-term, psychodynamic therapy	C rating T after sessions 3, 8, 16, 22 (average rating used in analyses)	S- symptom reduction T- post-therapy evaluation T- global outcome C- global outcome CE-global outcome [i]	+ [j]
		T rating self after sessions 3, 8, 16, 22 (average rating used in analyses)	S- symptom reduction T- post-therapy evaluation T- global outcome C- global outcome CE-global outcome [i]	+ [k]
Rudy, McLemore, & Gorsuch (1985)	outpatients (42) seen at two psychotherapy clinics, therapy orientation was eclectic	C rating T after mean of 30 sessions	S- symptom reduction C- progress to date T- progress to date T- global success	0 [l] + [l] 0 [l] 0 [l]

Table 1 (continued)

Reference	Client Population (n) & Type of Therapy	SASB Process Rater Perspective & Time of Assessment [a]	Outcome Perspective & Criteria for Evaluation	Finding [b]
		T rating C after mean of 30 sessions	S- symptom reduction C- progress to date T- progress to date T- global success	+[l] 0[l] +[l] +[l]
		sum of T & C's ratings of each other	S- symptom reduction C- progress to date T- progress to date T- global success	+[l] +[l] +[l] +[l]
Svartberg & Stiles (1992)	outpatients (15) seen at a number of clinics for short-term, anxiety-provoking therapy	I rating C and T in session 4; SASB process ratings then used to calculate "Index of Positive Complementarity" [e & m]	S- symptom reduction CE-improved social adjustment S- improved thinking patterns	+[n] at 0[n] mid-point +[n] in treatment
			S- symptom reduction CE-improved social adjustment S- improved thinking patterns	0[n] at 0[n] termination 0[n]
Tasca & McMullen (1992)	male outpatients (8) seen at a university clinic for short-term therapy, theoretical orientation not specified	I rating C & T after early, middle, and late session; SASB process ratings then used to calculate "Index of Positive Complementarity" [e] for each stage of therapy	S- symptom reduction T- global change C- global change CE-global change (ratings combined into one outcome score for analyses)	+ early session [p] 0 middle session + late session [p]
		I rating C & T after early, middle, and late session; SASB process ratings then used to calculate "Index of Negative Complementarity" [e] for each stage of therapy	S- symptom reduction T- global change C- global change CE-global change (ratings combined into one outcome score for analyses)	+ early session [q] 0 middle session + late session [q]

Note. I = Independent Observer; C = Client; T = Therapist; CE = Clinical evaluator; S = Objective Indice or Test.

[a] Unless otherwise specified, process ratings made by clients reflect global assessments of therapist behaviours across entire session. Process ratings made by therapists reflect global assessments of client behaviours across entire session. Process ratings made by independent observer reflect moment-to-moment assessments of client and/or therapist behaviours in first 15 minutes of session indicated.

[b] Unless otherwise specified, findings reported as "+" (client group with good outcomes showed a significantly higher degree of affiliation and/or a significantly lower degree of disaffiliation than client group with poor outcomes), "0" (no significant difference in process ratings for good and poor outcome groups).

[c] "Index of Internalization" compared clients' and therapists' ratings of the interpersonal process to clients' pre- and post-therapy ratings of their intrapsychic behaviours. This index was calculated by summing the difference between cluster scores on the SASB Interpersonal Surfaces 1 or 2 (as rated by clients and therapists after the third session) and each corresponding cluster on the SASB Intrapsychic Surface 3 (as rated by clients before and after therapy). If the difference scores were significantly smaller at the end of therapy than they were at the beginning, this was taken as evidence that clients had internalized the interpersonal process of therapy.

[d] Regression analyses indicated that the "Index of Internalization" was a significant predictor of positive change on both

Table 1 (continued)

outcome measures.
[e] Degree of complementarity calculated for each client-therapist exchange by assigning 1 point for therapist and client behaviours that occurred on different SASB Surfaces, 1 point for behaviours that were matched on affiliation, 1 point for behaviours that were matched on interdependence. Index of positive complementarity calculated by summing the number of complementary exchanges in which both participants were behaving in an affiliative manner.
Index of negative complementarity calculated by summing the number of complementary exchanges in which one or both participants were behaving in a disaffiliative manner. Total complementarity was calculated by summing the number of negative and positive complementary exchanges.
[f&g&h] Good outcome group showed significantly higher positive complementarity, significantly lower negative complementarity, and significantly higher total complementarity than poor outcome group.
[i] Scores on outcome measures combined into one "Outcome" score for each client. Therapists were then identified as "more" or "less" effective based on their clients' outcome scores relative to the rest of the client sample, the number of clients in their caseload with negative outcomes, and the number of clients who terminated therapy before session 16.
[j&k] Results based on comparison of "more" and "less" effective therapists on SASB clusters. "More" effective therapists rated by clients as more affirming and understanding (cluster 2) than "less" effective therapists. "More" effective therapists rated themselves as more affirming and understanding (cluster 2), less watching and controlling (cluster 5), and less belittling and blaming (cluster 6), than did "less" effective therapists.
[l] Findings reported as, "+" (higher overall affiliation and autonomy, higher scores on affiliative SASB Quadrants and Clusters, and lower scores on disaffiliative Quadrants and Clusters predicted positive outcomes in regression analyses), "0" (overall affiliation and autonomy and SASB Quadrant and Cluster scores did not predict outcomes).
[m] Index of Negative Complementarity was subtracted from Index of Positive complementarity to yield "Index of Net Positive Complementarity."
[n] Findings reported as, + (net positive complementarity contributed significantly to prediction of outcome using regression analysis), 0 (net positive complementarity did not contribute significantly to prediction of outcome).
[p&q] Good outcome group showed significantly higher positive complementarity and significantly lower negative complementarity than poor outcome group.

Table 2

Summary of Research examining contribution of Therapeutic Alliance and Therapist Interventions to Psychotherapy Outcome

Reference	Client Population (n) & Type of Therapy	Therapeutic Alliance Rater Perspective & Time of Assessment	Therapist Interventions Rater Perspective & Time of Assessment	Outcome Perspective & Criteria for Evaluation	Finding [a]
Coady (1991b)	outpatients (9) seen at a university clinic for psychodynamic therapy	I rating T in 3rd session	I rating T in 3rd session	S- symptom reduction S- reduction in depression CE- improved social adjustment (ratings combined into one outcome score for analyses)	+ A [b] 0 TRM [c] + A x TRM [d]
Crits-Christoph, Cooper, & Luborsky (1988)	outpatients (43) seen at hospital or private clinic for psychodynamic therapy	I- two early sessions (ratings combined for analyses)	I- two early sessions (ratings combined for analyses)	C & CE- residual gain in general adjustment (ratings combined for analyses)	+ Int + A 0 Int x A
				T & C - rated benefits (ratings combined for analyses)	+ Int + A 0 Int x A
Gaston & Ring (1992)	elderly, depressed outpatients (10) seen at unspecified clinic for psychodynamic therapy	I- sessions 5, 10, & 15 (average ratings used in analyses)	I- sessions 5, 10, & 15 (average ratings used in analyses)	S- scores from two depression inventories combined into one outcome rating [e]	- Int [f] 0 Sup + Int x A [g]
Gaston, Piper, Debanne, Bienvenu, & Garant (1994)	outpatients (32) seen at unspecified clinic for short-term (ST; n= 17) and long-term (LT; n=15) psychodynamic therapy	I- early, middle, & late sessions in ST and LT modalities (average ratings used in analyses)	I- early, middle, & late sessions in ST and LT modalities (average ratings used in analyses)	S- reduction in symptoms	ST modality: 0 Int 0 Sup + A 0 Int x A 0 Sup x A
				S- improved interpersonal functioning	ST modality: 0 Int 0 Sup 0 A 0 Int x A 0 Int x Sup

Table 2 (continued)

Reference	Client Population (n) & Type of Therapy	Therapeutic Alliance Rater Perspective & Time of Assessment	Therapist Interventions Rater Perspective & Time of Assessment	Outcome Perspective & Criteria for Evaluation	Finding [a]
Gaston et al. (1994) -continued-				S- reduction in symptoms	LT modality: 0 Int 0 Sup 0 A + Int x A + Sup x A
				S- improved interpersonal functioning	LT modality: 0 Int 0 Sup + A + Int x A + Sup x A
Gaston, Thompson, Gallagher, Cournoyer, & Gagnon (1998)	elderly, depressed outpatients seen at unspecified clinic for short-term Behaviour Therapy (BT; n=30), Cognitive Therapy (CT; n=31), or Brief Dynamic Therapy (BDT; n=30).	I- sessions 5, 10, & 15	I- sessions 5, 10, & 15	S- reduction in depressive symptoms	BT Group (sessions collapsed): 0 Int 0 Sup 0 A 0 Int x A 0 Sup x A
					CT Group (sessions collapsed): + Int 0 Sup + A 0 Int x A 0 Sup x A
					BDT Group (sessions collapsed): 0 Int 0 Sup 0 A 0 Int x A 0 Sup x A
					At Session 5: 0 Int 0 Sup + A (all groups collapsed; BT & CT groups) 0 Int x A 0 Sup x A

Table 2 (continued)

Reference	Client Population (n) & Type of Therapy	Therapeutic Alliance Rater Perspective & Time of Assessment	Therapist Interventions Rater Perspective & Time of Assessment	Outcome Perspective & Criteria for Evaluation	Finding [a]
					At Session 10: + Int (BDT group) 0 Sup + A (BT & CT groups) + Int x A (BDT group) - Int x A (CT & BT groups) 0 Sup x A
Gaston et al. (1998) -continued-					At Session 15: 0 Int 0 Sup +A (CT & BT groups) 0 Int x A + Sup x A (BDT group)
					All Sessions & Groups collapsed: 0 Int 0 Sup + A 0 Int x A 0 Sup x A
Svartberg & Stiles (1994)	outpatients (13) seen at unspecified clinic for short-term, anxiety-provoking psychotherapy (STAPP)	C -after 7th session	I- session 4	S - reduction in symptoms	0 A + TC[b] 0 A x TC
					0 TC + A 0 A x TC
				S - increase in functional attitudes	0 A 0 TC 0 A x TC
					0 TC 0 A 0 A x TC

Note. T = Therapist; C = Client; I = Independent observer; CE = Clinical evaluator; S = Objective indice or test; Int = Interpretive interventions; Sup = Supportive interventions; A = Alliance; Int x A = Interaction between interpretive interventions and Alliance; Sup x A = Interaction between supportive interventions and alliance; TRM = Therapist interventions measured in terms of therapist response modes; A x TRM = Interaction between alliance and therapist response modes; A = Alliance; TC = Therapists' technical competence; A x TC = Interaction between therapists' technical competence and Alliance..

[a] Unless specified otherwise, findings reported as "+" (therapist intervention or alliance made significant positive contribution to prediction of outcome using regression analyses), "0" (therapist intervention or alliance did not contribute significantly to prediction of outcome), "-" (therapist intervention or alliance made significant, negative contribution to

Table 2 (continued)

prediction of outcome).
[b] Therapists for positive outcome group showed higher level of affiliation than therapists for poor outcome group
[c] No significant difference between therapists for good and poor outcome group in response modes used.
[d] Therapists in poor outcome group offered disaffiliative interpretations significantly more often than therapists in good outcome group.
[e] Clients categorized into "improved" and "unimproved" groups based on average, combined scores on outcome measures.
[f] Therapists of clients in unimproved group used interpretive interventions significantly more than therapists of clients in improved group.
[g] Therapists of clients in the improved group used interpretive interventions significantly more when a strong therapeutic alliance had been established.
[h] Greater technical competence on the part of therapists predicted greater improvements in client symptomatology.

examined the association between therapists' and clients' interpersonal interactions and a combined outcome measure after the 3rd, 5th, and 15th sessions. He also collapsed the process and outcome variables across sessions into one score to represent the general status of these variables in therapy overall. The last column in Table 1 therefore indicates the direction and significance of the association that was observed by Coady (1991a) between the process and outcome variables at each point in therapy that the association was assessed (i.e., the 3rd, 5thand 15th sessions). It also presents Coady's (1991a) findings for when the process and outcome variables were collapsed to represent therapy overall.

A number of studies in Table 2 also examined the significance and direction of association between measures of the therapeutic relationship, therapists' interventions, and outcome in different therapy modalities. Again, for these studies, findings are reported in Table 2 for each treatment modality in which the association was assessed. For example, Gaston et al. (1994) examined the association between the therapeutic alliance, therapists' interventions, and outcome in the context of long- and short-term psychodynamic treatments. The last column in Table 2 therefore presents separately Gaston et al.'s (1994) findings for each treatment modality.

To focus on Table 1, then, herein are presented 43 findings derived from 8 studies that examined the association between SASB ratings of therapist and client interpersonal process and therapeutic outcome. Thirty-two of these findings are positive, indicating that affiliative therapist-client interactions are

associated with positive therapeutic outcomes and that disaffiliative therapist-client interactions are associated with negative therapeutic results. The positive findings in Table 1 were obtained across a variety of outcome measures. Eleven findings in Table 1, on the other hand, are nonsignificant, indicating a lack of association between the quality of the client-therapist interaction and client change. Again, the nonsignificant findings were obtained across a range of outcome criteria. None of the findings in Table 1 is negative, suggesting that positive client-therapist interactions are not associated with poor therapeutic results, and negative client-therapist interactions are not associated with positive therapeutic results.

SASB ratings of the interpersonal process were made from three rater perspectives in the studies presented in Table 1 - independent observers, therapists, and clients. In the SASB system, the independent observer rating method is the most complex and follows a very rigorous procedure. According to this procedure, two or three trained raters observe audio- or video-taped segments of individual therapy sessions and code each and every therapist or client behaviour according to its relative position in the SASB model (Benjamin, Giat, & Estroff, 1981; Grawe-Gerber & Benjamin, 1989; see below for a more detailed description of the SASB observer rating method). Five studies in Table 1 used this method to assess the quality of the therapeutic interaction. Out of the 27 findings reported for these studies, 20 are positive.

Compared to the SASB process ratings made by independent observers, those made by therapists and clients are obtained more simply. This method

involves administering a series of closed-choice questionnaires to clients and therapists that require them to give global, retrospective descriptions of their own and/or each other's behaviours across an entire session (Benjamin, 1995). In Table 1, three studies used clients and therapists to rate the interpersonal process of therapy. Of the 16 findings reported for these studies, 12 are positive. If one considers ratings made by therapists and clients separately, Table 1 indicates that therapists' ratings of their clients' behaviours were positively associated with outcome in 3 out of 4 findings. The direct association between therapists' ratings of their own behaviours and outcome was examined in only one study and was positive (Najavits & Strupp, 1994). Clients' ratings of therapists' behaviours were positively associated with outcome in 2 out of 5 findings. Finally, clients' and therapists' ratings of themselves and each other were summarized in two studies. In the study conducted by Rudy et al. (1985), clients' ratings of their therapists' Surface 1 behaviours and therapists' ratings of their clients' Surface 2 behaviours were added together as a composite index of the interpersonal process of therapy. In the study conducted by Harrist et al. (1994), clients' and therapists' ratings of themselves and each other were compared to clients' ratings of their intrapsychic behaviours to determine the extent to which clients had introjected the interpersonal process of therapy and whether this was related to outcome (see below for further detail). Of the 6 analyses performed on the combined ratings in these two studies, all yielded positive results.

A comparison of the findings that were obtained using the two rating

methods, then, indicates that the proportion of positive results was not significantly different whether independent observers rated the interpersonal process of therapy or whether it was rated by therapists and clients ($\underline{Z}$ = 1.15, ns). The similarity in proportions may attest to the concurrent validity of the two rating methods. It is important to note, however, that both methods were designed to assess constructs that have been defined in the SASB model (e.g., affiliation, autonomy, interpersonal focus) but that only the independent observer method yields a moment-by-moment description of these constructs as they occur in ongoing therapy sessions. For this reason, ratings of the interpersonal process made by independent observers seem to offer a more detailed and more satisfactory assessment of the therapeutic relationship than those made by the therapy participants themselves. Indeed, the fact that 74% of the findings pertaining to the association between the observer-rated process and therapy outcome were positive lends considerable support to the idea that the ongoing, momentary process of therapy is an important predictor of therapeutic change.

The point in therapy at which the quality of patient-therapist interactions was assessed seemed to have an impact on the proportion of positive findings in Table 1. In fact, a significantly higher proportion of positive findings was obtained when therapist and client behaviours were rated early in therapy than when they were rated later on ($\underline{Z}$ = 30.72, $\underline{p}$ < .001). Specifically, 15 out of 15 findings were positive when the interpersonal process was assessed on or before the 5th session. By contrast, 5 out of 12 findings were positive when therapist-client interactions were assessed at therapy midpoint or beyond (16

findings in Table 1 were based on process ratings that were averaged across a number of sessions). It is difficult to speculate on the reasons for these differential results without empirical clarification. Nevertheless, the findings may indicate, as was suggested by Henry and Strupp (1994), that the early phase of therapy is especially important for alliance development. In addition, the findings are in many ways consistent with previous research which has shown that global ratings of the alliance made early on in therapy are predictive of therapy outcome (Suh, O'Malley, & Strupp, 1986).

With regard to the individual results presented in Table 1, those reported by Henry et al. (1990) and Harrist et al. (1994) are noteworthy because they pertain specifically to the association that does or does not exist between the interpersonal process of therapy and clients' intrapsychic state. The first of these studies was based on a sample of 14 therapeutic dyads (Henry et al., 1990). Pre- and post-therapy questionnaire data were used to categorize clients into good and poor outcome groups according to the amount and type of change that had occurred in their introjects from beginning to end of therapy. The interpersonal process that transpired between clients and therapists was assessed by independent observers in the third session. The results indicated that clients and therapists in the poor outcome group showed significantly higher levels of disaffiliative behaviours than did those in the good outcome group and exhibited higher levels of mixed communications (defined as statements that express two or more conflicting interpersonal messages at the same time; e.g., acceptance and rejection). The authors also reported that clients in the poor

outcome group spoke significantly less, relative to their therapists, than did clients who manifested more positive change, and that the number of hostile and controlling therapist statements correlated strongly with the number of critical and self-blaming statements made by clients. In general, therefore, this study provides a fairly detailed description of the momentary process in therapy that goes with positive or negative introject change and it lends relatively strong support to the idea that clients' interactions with their therapists have an impact on how they interact with themselves.

The study conducted by Harrist et al. (1994) was based on a larger sample of clients (n=70) taken from the same dataset as the clients in Henry et al.'s (1990) study. This study used therapists' and clients' retrospective questionnaire responses, rather than the direct observations of independent raters, to assess therapists' and clients' contributions to the interpersonal process of therapy. Therapists' and clients' ratings of the interpersonal process were made after the third session. As in the previous study, clients rated their introjects on SASB questionnaires at intake and after therapy was completed. The results showed that clients' post-therapy ratings of how they treated themselves (i.e., their introjects) were significantly more similar to their ratings of the interpersonal process of therapy and their therapists' ratings of the interpersonal process than were clients' pre-therapy ratings of how they treated themselves. The results also showed that clients' treatment of themselves had become significantly more affiliative from the beginning to end of therapy. Finally, it was found that, by therapy termination, the extent to which clients'

introjects had changed in a positive direction to become more similar to clients' and therapists' positive ratings of the interpersonal process was a significant predictor of clients' symptomatic improvement and improved functioning overall. The results of this study, similar to the ones cited above, are therefore consistent with the idea that clients introject their experiences in therapy and that their introjection of affiliative interpersonal process, in particular, coincides with other aspects of positive change.

Considered overall, then, the positive findings presented in Table 1, particularly the findings reported by Harrist et al. (1994) and Henry et al. (1990), give tangible support to the hypothesis that affiliative interpersonal process, especially when it is assessed early in therapy, is associated with positive therapeutic outcomes and to positive changes in clients' introjects. They also demonstrate the utility of conceptualizing and operationalizing the therapeutic relationship in terms of the SASB model. The fact that eleven of the findings in Table 1 did not come out as significant suggests that support for the above-stated hypotheses and for researchers' implementation of the SASB model is not unequivocal, however. At the very least, these findings suggest that psychotherapy is complex and that a multitude of variables interact to produce positive or negative results.

Turning to Table 2, herein are presented 80 findings derived from 6 studies that examined the contribution of the therapeutic relationship and therapists' interpretive and/or supportive interventions to various indices of psychotherapy outcome. Only one study in the table used SASB process ratings

as a measure of the therapeutic relationship (Coady, 1991b). This study was based on nine therapeutic dyads that were divided into good (n=5) and poor (n=4) outcome cases according to the amount of positive change that clients reported from beginning to end of treatment on measures of symptomatology, depression, and social adjustment. SASB ratings of therapists' interpersonal behaviours were made in the third session by independent observers, as were ratings of therapists' interventions. The latter variable was operationalized in terms of eight mutually exclusive response mode categories that included interpretations, approval-reassurance, minimal encouragers, questions, self-disclosures, paraphrases, directives, and miscellaneous responses. The results indicated that therapists in the poor outcome group showed significantly higher levels of disaffiliation than did therapists in the good outcome group. The two groups of clients could not be differentiated on the basis of therapists' interventions alone. However, the interaction between therapists' interventions and therapist-offered interpersonal process did come out as significant, but only for one response mode category. Therapists in the poor outcome group were more likely to offer interpretations in a disaffiliative manner than therapists of clients with more positive outcomes. The latter finding held true only for interpretations that did not focus on clients' reactions in the therapeutic relationship or on clients' affective state. The significant findings in this study must be tempered with the fact that the analyses consisted of a series of t-tests and therefore inflated the Type-I error rate above the traditional .05 level.

The study by Crits-Christoph et al. (1988) examined the contribution of

therapists' interpretations to therapy outcome, alone and in interaction with the therapeutic alliance. Therapists' interpretations were defined as statements that "explained possible reasons for a patient's thoughts, feelings, or behavior" and/or "alluded to similarities between the patient's present circumstances and other life experiences" (Crits-Christoph et al., 1988, p. 491). Independent raters examined therapy transcripts of two early sessions for 43 clients to identify the number of interpretations that were made. Following this, each interpretation was rated according to accuracy based on how well it corresponded with the relationship themes that emerged out of clients' in-session discussions. The therapeutic relationship was assessed in this study by another set of independent raters using the "counting signs method." This method required raters to scan two early transcripts to identify every client statement that was suggestive of either a positive or negative alliance. The results showed that therapists' interpretations, or more precisely, the accuracy of therapists' interpretations was a significant predictor of therapeutic gain. Likewise, the therapeutic alliance was also a significant predictor of psychotherapy outcome. Somewhat surprisingly, and contrary to Coady's (1991b) findings, the interaction between the alliance and the accuracy of therapists' interpretations did not add further to the outcome predictions.

Svartberg and Stiles (1994) also did not report a significant interaction between the therapeutic alliance and therapists' technical interventions. In this study, the therapeutic alliance was assessed by clients ($\underline{n}$ = 13) after the 7th session using a self-report measure called the Facilitative Alliance Inventory.

This measure assessed clients' perceptions of their therapists' helpfulness, understanding, and active participation, and therapists' success in facilitating clients' self-disclosure. An independent clinician rated the competence of therapists' technical interventions using the Therapist Competence Rating Form (TCRF). Svartberg and Stiles (1994) provided only limited information about the types of interventions that were rated by the clinician; however, the examples they give and the context of their discussion suggests that the interventions were probably different varieties of interpretations. The competence of each intervention was rated on a 5-point, Likert scale, and the mean overall score for each therapist was entered into analyses. Two types of hierarchical regressions were conducted in which either the alliance ratings were entered in the first step and the Competency ratings were entered in the second step, or vice versa. In both regressions, the interaction between the Alliance and Competency ratings was entered in the third step. The results of the study showed that both the alliance and the competency ratings predicted reductions in clients' symptoms independently when they were entered in the second step of the hierarchical regressions. Neither variable predicted outcome when it was entered in the first step of the regression analyses, or when it was combined with the other variable in the interaction term. The alliance, therapists' competency ratings, and their interaction terms also did not predict outcome when this was assessed in terms of improvements in clients' functional attitudes.

Finally, the studies reported by Gaston and her colleagues (Gaston & Ring, 1992; Gaston et al., 1994; Gaston et al., 1995) account for the majority of

findings presented in Table 2. In these studies, therapists' interventions in early, middle, and late sessions of psychodynamic (Gaston & Ring, 1992; Gaston et al., 1994), and psychodynamic, cognitive, and behaviour therapy (Gaston et al., 1998) were categorized by independent raters as either Exploratory or Supportive depending on their content and intent. Exploratory interventions were defined as any therapist statement that aimed to challenge a client's basic sense of self. Most often, they occurred in the form of interpretations or confrontations[2]. Supportive interventions, on the other hand, were defined as statements that aimed to reinforce and strengthen a client's concept of the self. They occurred in a variety of forms, including empathic statements, statements of reassurance, or the provision of direct help. The therapeutic alliance was also rated by independent observers on a standardized scale in the same early, middle, and late sessions. In each study, the ratings of therapists' interventions and of the therapeutic alliance were collapsed across sessions into total scores for analyses. One study also examined the contributions of the alliance and therapists' interventions separately for the early, middle, and late sessions (Gaston et al., 1998).

The results of the Gaston et al. studies indicate that therapists' Supportive

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[2] From this point on in this manuscript, the terms "Exploratory" and "Interpretive," when referring to therapists' interventions, will be used interchangeably.

interventions did not make an independent contribution to the prediction to outcome in any of the 12 analyses that were conducted. Exploratory interventions, on the other hand, made an independent contribution to the prediction of outcome in three analyses. Contrary to what was observed by Crits-Christoph et al. (1988) and Svartberg and Stiles (1994), one of these findings was negative, indicating that therapists of clients who exhibited poor outcomes used Exploratory interventions more often than did therapists of clients with good outcomes. The other two findings were positive and indicated that therapists' use of Exploratory interventions predicted positive results.

The therapeutic alliance made its own, positive contribution to the prediction of outcome in 7 out of the 11 analyses that included the alliance as an independent variable of interest. The positive associations indicated that better outcomes were obtained for cases where a better alliance had been established. Again, these findings are consistent with those reported by Coady (1991b) and Crits-Christoph et al. (1988).

The interaction between therapists' Exploratory interventions and ratings of the alliance was significant in 5 out of 12 analyses in Table 2. One of these findings was in the opposite direction that was hypothesized and indicated that, in Behaviour and Cognitive therapy, fewer interpretive interventions offered in the context of better alliances, and more frequent interpretations offered in the context of poorer alliances were predictive of greater reductions in depressive symptoms by the end of therapy. On the other hand, within brief psychodyamic therapy, the findings were consistent with predictions and indicated that better

outcomes were observed when therapists used a greater number of interpretations in the context of stronger alliances, and when they used fewer interpretations in the context of an alliance that was weak. All of these interactions were observed in the 10th session of therapy.

Finally, the interaction between therapists' use of Supportive interventions and the therapeutic alliance was significant in one analysis. At the 15th session in brief psychodynamic therapy, therapists' use of higher levels of support in the context of weaker alliances predicted more positive therapeutic results.

Taken together, the findings reported in Table 2 lend tentative support to the idea that the therapeutic relationship and therapists' interventions both play a role in determining the outcome of psychotherapy. In particular, there is strong support for Henry and Strupp's (1994) idea that the therapeutic relationship has a direct and independent influence on therapeutic outcomes. The precise workings of this influence were not examined in the studies listed in Table 2. However, in light of the findings reported by Henry et al. (1990) and Harrist et al. (1994) above, it seems possible that the therapeutic relationship contributed to positive outcomes by impacting on clients' intrapsychic state. In line with Zetzel's (1956) and Blatt and Behrends' (1987) ideas, the findings in Table 2 do not indicate very strongly that therapists' interventions also make an independent contribution to therapy outcome. Instead, they suggest that the effectiveness of therapists' interventions depends on the relationship context in which they are offered. The studies conducted by Gaston and her colleagues (Gaston & Ring, 1992; Gaston et al., 1994; Gaston et al., 1994) are especially noteworthy in this

regard, suggesting that interpretive interventions, at least in long-term, dynamic therapy, are most effective when they are offered in the context of a solid therapeutic relationship, and that supportive interventions are more effective when a positive relationship is proving difficult to maintain.

It has already been noted that SASB process ratings were used to assess the therapeutic relationship in only one investigation in Table 2 (Coady, 1991b). The remaining studies used more global measures of the relationship that provided a less detailed description of the therapeutic interaction. Ten out of 17 findings in the latter studies indicated that the alliance contributes independently to the prediction of outcome. Eight out of 30 findings indicated that the alliance interacts with the therapist's interventions to predict therapeutic gains. The findings reported by Coady (1991b) also indicate an interaction in so far as the SASB measure of the therapeutic relationship was a significant predictor of outcome and interacted with one type of intervention (therapists' interpretations) to predict therapeutic success. However, Coady's (1991) study provided detailed, SASB ratings of only the therapist's contribution to the interpersonal process of therapy and not the client's. For this reason, it was not possible to determine whether clients' manner of participating in the relationship had any impact on the effectiveness of therapists' interventions or on the outcome of psychotherapy.

The manner in which therapists' interventions were assessed in Coady's (1991b) study was also problematic. Previous research has shown that operationalizing therapist interventions in terms of response modes rarely leads

to significant results (Elliott et al., 1987; Hill et al., 1988). In this regard, it is interesting that Crits-Christoph et al. (1988) and Svartberg and Stiles (1994), by evaluating the accuracy of therapists' interpretations or therapists' competence in using them, obtained positive results, even for the independent contribution of interpretations to outcome. It is unfortunate, however, that Crits-Christoph et al. (1988) did not operationalize or consider the specific impact of any other interventions, and that Svartberg and Stiles (1994) did not specify more clearly the types of interventions that were rated.

Of the three rating systems for therapists' interventions, the one used by Gaston et al. (1994; Gaston & Ring, 1992), called the Inventory of Therapeutic Strategies (ITS), seems most appropriate for addressing the questions currently being considered regarding the relative contributions of the therapeutic relationship and therapists' interventions to psychotherapy outcome. Indeed, the ITS method of classifying interventions in terms of the degree of challenge they present to clients' basic sense of self seems especially appropriate for investigating the factors that contribute to improvements in clients' introjects. It will be recalled that Blatt and Behrends (1987) regarded the oscillation of challenge and support as central to initiating positive introject change. Given the appropriateness of the Gaston measure, then, it seems that a logical step in the investigation of effective psychotherapy, should involve combining the ITS method of assessing therapeutic interventions and the SASB method of defining the therapeutic relationship in a study that examines each of their independent and interacting contributions to client introject change.

Summary

The therapeutic relationship and its contribution to positive therapeutic outcomes have been discussed. In particular, psychoanalytic and interpersonal formulations of the therapeutic or working alliance have been presented that emphasize the affiliative collaboration that takes place between therapists and clients in defining the goals of therapy and carrying out the requisite tasks. As compared to more global ratings of the alliance provided by earlier writers, Henry and Strupp's (1994) conceptualization of the alliance in terms of the moment-to-moment interpersonal process of therapy has been presented as an especially innovative approach to the therapeutic relationship. This approach allows for a detailed examination of clients' and therapists' actual behaviours in therapy and their relative contributions to therapy outcome overall. An operational definition of the interpersonal process of therapy has been presented in terms of Benjamin's (1974) Structural Analysis of Social Behavior Model (SASB). This model categorizes interpersonal behaviour according to its focus, and its degree of affiliation, and interdependence.

Also drawing from psychoanalytic and interpersonal theory, it has been suggested that the interpersonal process of therapy contributes directly to positive therapeutic outcomes by fostering change at the level of clients' introjects. The introject has been defined as a hypothesized personality structure that represents clients' main ways of treating the self. It is said to correlate more or less directly with clients' emotional health or illness, and with their manner of relating to others. It has been argued that affiliative therapist-

client interactions have a disconfirming effect on negative relationship experiences that clients encountered in the past and provide clients with a model for how to improve their interactions with themselves.

The impact of therapists' interpretations has also been discussed as an important component of the therapeutic endeavour. It has been argued that interpretive interventions provide an emotional challenge to clients that helps them recognize the distortions that exist in their perceptions of others. It has also been argued that interpretations motivate clients to identify the gratifying aspects of their interactions with therapists and to transfer these gratifications to their own experience and behaviour. The effectiveness of therapists' interpretations in facilitating change, however, is said to depend on the relationship context in which they are offered. Especially regarding situations where clients show difficulty engaging in an affiliative interaction with their therapists (or therapists with their clients), it has been argued that clients might feel overwhelmed by the challenges inherent in therapists' interpretations and they might profit from more supportive interventions.

Finally, empirical research pertaining to the respective contributions of the therapeutic relationship and therapists' interpretive and supportive interventions to psychotherapy outcome was examined. Several studies have looked at the interpersonal process of therapy and compared it to psychotherapy outcome. Many of these studies found that affiliative client-therapist interactions are associated with positive therapeutic results, including positive changes in clients' intrapsychic behaviours. Relatively few studies have examined the contribution

of both the relationship and therapists' interventions, however. Of the studies that have considered the contribution of both variables, only one has operationalized the relationship in terms of momentary interpersonal process. In addition, none have examined the contribution of relationship and technical factors, particularly therapists' supportive and interpretive interventions, to specific changes in clients' intrapsychic states.

The Present Study

The current study was designed to build upon existing research that investigated the relative contributions of the therapeutic relationship and therapists' technical interventions to psychotherapy outcomes. This study was based on actual therapeutic dyads involved in short-term, individual, psychodynamic therapy. The therapeutic relationship was operationalized in terms of independent observer ratings of therapists' and clients' interpersonal behaviours in the third session using the SASB model. Therapists' interventions in this session were categorized by independent raters as either interpretive or supportive. The content of therapists' interventions were subject to further categorization in order to identify interpretations that focused on clients' reactions in the therapeutic relationship as compared to those that did not. Finally, psychotherapy outcomes were operationalized in terms of pre-post therapy comparisons of clients' symptomatic functioning, general adjustment, and intrapsychic behaviours.

Hierarchical, multiple regression analyses were conducted to assess whether the interpersonal process of therapy and therapists' exploratory and

supportive interventions predict psychotherapy outcome, alone or in combination with each other. Protected t tests and comparisons of the adjusted R^2 values from the regression analyses indicated: 1) the extent to which ratings of affiliation in the interpersonal process contributed to the prediction of outcome; 2) the extent to which ratings of therapists' interpretive or supportive interventions contributed to the prediction of outcome over and above the contribution of the interpersonal; and 3) the extent to which the interaction between therapists' interventions and the interpersonal process of therapy contributed to the prediction of outcome over and above the independent contribution of the interpersonal process and therapists' interventions. Finally, hierarchical regression analyses tested whether improvements in client functioning were predicted by interpretations that focused specifically on the therapeutic relationship.

Hypotheses

1. Having controlled for the level of affiliation in clients' and therapists' behaviours, therapists' interpretive and supportive interventions will interact with therapist and client affiliation to predict outcome as follows:

    a) For dyads in which therapists and clients both show high levels of affiliation, greater improvements in clients' intrapsychic functioning and general adjustment will be observed when therapists employ more interpretive and fewer supportive interventions.

b) For dyads in which therapists show high levels of affiliation and clients show high levels of disaffiliation, greater improvements in clients' intrapsychic functioning and general adjustment will be observed when therapists employ more supportive and fewer interpretive interventions.

c) For dyads in which therapists show high levels of disaffiliation, interpretive and supportive interventions will both predict negative change in clients' intrapsychic functioning and general adjustment for affiliative and disaffiliative clients. Clients who show high levels of affiliation will show less negative change than clients who show high levels of disaffiliation.

2. Greater improvements in intrapsychic functioning and general adjustment will be observed in clients when therapists' interpretations, alone or in interaction with therapists' and clients' level of affiliation, focus on clients' experiences with the therapist rather than clients' experiences in other relationships or situations.

Exploratory Analysis

Having controlled for patient and therapist affiliation, the independent contribution of interpretive and supportive interventions to psychotherapy outcome will be examined. However, no prediction will be made.

Method

A substantial portion of the data that were used in this investigation was

gleaned from the Vanderbilt Psychotherapy Project II. The Vanderbilt II project was designed to study the effects of training in Time-Limited Dynamic Psychotherapy (Henry, Schacht, et al.,1993; Henry, Strupp, et al., 1993), a treatment method that is intended to help therapists work with difficult clients (Strupp & Binder, 1984). The database from the project consists of a wide range of process and outcome variables that were derived from 80 treatment cases in individual, psychodynamic therapy. The database has generated a large number of empirical studies on therapy process and outcome, several of which were cited above (e.g., Henry et al., 1986, 1990; Harrist et al., 1994; Najavits & Strupp, 1994). In addition, the database has been made available to qualified researchers for further analysis. As will be described in more detail below, the current study used independent observer ratings of the interpersonal process of therapy and several outcome measures from a subset of the treatment cases in the Vanderbilt project. The study added to the Vanderbilt II database by identifying the number of interpretive and supportive interventions made by therapists in the selected cases and by rating the object focus of therapists' interpretations.

Therapists and Clients

The therapeutic dyads that were studied in the current investigation were drawn from the first and third cohorts of the Vanderbilt Psychotherapy Project II. Sixteen licensed therapists (10 male and 6 female) were represented in the total Vanderbilt sample, including 8 clinical psychologists and 8 psychiatrists. At the time of their participation in the Vanderbilt project, all therapists were working in

private practice and had at least two years post-degree experience. The average years of experience was 5.75 years (SD= 3.00; range = 2 to 15 years). All therapists had received training in psychodynamic therapy and the majority (n= 10) considered themselves psychodynamic in orientation. The remaining therapists identified their theoretical orientation as eclectic (n= 1), systemic (n= 1), or experiential (n= 1). One therapist did not specify her theoretical orientation. All therapists had been recommended to the Vanderbilt II project by previous supervisors. In addition, all therapists were Caucasian. Their average age was 36 (SD= 5.37; range = 30 to 48).

Each therapist in the Vanderbilt project treated 5 individuals on an outpatient basis over a maximum of 25 weekly sessions. As indicated above, the project was designed to examine the effects of training in Time-Limited Dynamic Psychotherapy (TLDP; Strupp & Binder, 1984). As such, therapists treated two clients prior to their training in TLDP (cohort 1), one client during their training (cohort 2), and two clients after training was completed (cohort 3). Although it would have been preferable to include only clients from the first cohort in the current investigation so as to minimize contamination from specific training effects, an n of 32 was too small to ensure adequate statistical power. For this reason, the researcher decided that selecting clients and therapists from the first and third treatment cohorts (n= 64) would be the next best alternative (the second cohort was excluded because it was a training cohort and therefore likely to differ substantially from the other two cohorts).

All clients in the Vanderbilt II project had responded to newspaper

advertisements for short-term, individual psychotherapy. Respondents were included in the study if their symptomatic complaints, as assessed by the SCL-90-R General Severity Index (Derogatis, 1983, see below for description), were within the normative range for outpatient psychiatric populations, and if their performance in a diagnostic screening interview deemed them suitable for psychotherapeutic intervention. Respondents were excluded from the study if they were abusing substances, if they had severe medical problems, or if their symptomatic complaints were of sufficient severity to warrant pharmacological intervention or inpatient treatment. Respondents were also excluded if their symptoms were only very mild and/or situational in nature. Of the 64 clients that were included in the first and third cohorts of the Vanderbilt sample, 78% were female. Their ages ranged from 24 to 64 years (M= 42.05, SD = 11.08). Ninety-seven percent of clients were Caucasian, and, on average, they had completed 3 years of post-secondary education (range = 6th grade to doctorate). Seventy-two percent of clients had been in therapy before. The mean number of sessions completed by clients while involved in the Vanderbilt project was 20.1 (range = 5-25, SD = 6.1). Ninety-two percent of clients were diagnosed with a DSM-III (American Psychiatric Association, 1980) Axis I disorder, and 66% were diagnosed with a DSM-III Axis II disorder using a computerized version of the NIMH (National Institute of Mental Health) Diagnostic Interview Schedule. All clients were diagnosed with at least one Axis I or Axis II disorder.

Instruments

SASB Interpersonal Process Analysis.

Independent raters' assessments of therapists' and clients' interpersonal behaviours in terms of the SASB model were used as a measure of the therapeutic relationship. These assessments were based on videotapes of the middle 15 minutes of the 3rd session for each therapeutic dyad and were rated according to a standardized procedure outlined by Grawe-Gerber and Benjamin (1989). The third session was selected for analysis in the Vanderbilt II study because ratings of the relationship in this session are believed to be representative of the relationship at other points in therapy, and because third session ratings, as compared to ratings from the first or second session, are more likely to predict outcome (Suh, O'Malley, & Strupp, 1986).

The coding of therapist-client interactions according to the SASB model requires rigorous training and the procedure follows a number of steps. To begin with, transcripts are prepared from each video- or audio-taped session that is to be rated. Following this, each transcript is segmented into individual "thought units" which are defined as any portion of speech that expresses a "`complete thought' or `a psychologically meaningful interaction'" (Grawe-Gerber & Benjamin, 1989, p.6). Coding the individual thought units then involves three decisions. First, the focus (Surface 1, 2, or 3) of each unit is identified. Prior research has shown that therapists tend to focus primarily on the Other (Surface 1) and clients tend to focus primarily on the Self (Surface 2; Henry et al., 1986, 1990). Intrapsychic behaviours are coded on Surface 3 and, in comparison to

Surface 1 and 2 behaviours, occur rarely during a patient-therapist exchange (Henry et al., 1986). The second decision involves rating the degree of affiliation in the unit on a scale of +9 to -9. Within the bounds of the required training, these ratings use verbal and nonverbal cues to assess the process and content of participants' behaviours. A rating of +9 represents maximal affiliation (e.g., sexual bonding, great intimacy, warmth; Grawe-Gerber & Benjamin, 1989, p. 19) and a rating of -9 represents maximal disaffiliation (e.g., torture, murder, attack, Grawe-Gerber & Benjamin, 1989, p. 19). The third decision in the SASB coding procedure involves rating the degree of interdependence in each thought unit, also on a scale of +9 to -9 Here, a rating of +9 represents complete interdependence (Surface 1) or the giving of complete autonomy (on Surface 2), and a rating of -9 represents taking complete control (on Surface 1) or total submission (Surface 2).

Once identified, the affiliation and interdependence ratings for each thought unit form the coordinates that identify the cluster code. For example, a thought unit identified as focusing on the Other (Surface 1) and given an Affiliation rating of 2 (indicating mild friendliness) and an Interdependence rating of 2 (indicating mild independence), would receive a SASB cluster label of "Nurturing and Comforting" (see Figure 2). Alternatively, a thought unit identified as focusing on the Self (Surface 2) and given an Affiliation rating of -4 (indicating moderate unfriendliness) and interdependence rating of -4 (indicating moderate submission) would receive a cluster label of "Sulking and Appeasing." As a final step in the SASB coding process, researchers subject this cluster code to a "final

clinical test." This involves reading a description of the selected cluster and deciding whether the coded material fits this description. If the cluster-code is deemed inaccurate, the entire coding procedure is repeated.

In addition to the simple cluster codes that can be derived using the SASB method, two types of complicated communications can be coded. First among these are "multiple communications" which are interpersonal behaviours that contain more than one discernable message. For example, an individual may "disclose and express" him or herself (SASB cluster 2-2) and "assert and separate" him or herself (SASB cluster 2-1) within the same thought unit. In this situation, the rater would record the appropriate codes for both clusters and identify the thought unit as a multiple communication. The second type of complicated code is applied to "complex communications" which are defined as behaviours that contain more than one interpersonal message that are contradictory. For example, the content of an individual's statement might be coded as "approaching and enjoying" (SASB cluster 2-3) but her or his nonverbal behaviour might appear "walling off and avoiding" (SASB cluster 2-8). In this case, a rater would code both aspects of the message and identify the thought unit as a complex communication. SASB researchers often take special note of complex communications because they are associated with some types of psychopathology (Benjamin, Foster, Roberto, & Estroff, 1986).

SASB process codes can be summarized in a number of ways. Given the emphasis that interpersonal and psychodynamic theory places on the level of affiliation in therapists' and clients' behaviours, the current study focused on the

second step of the rating procedure. The decision to focus on one step of the rating procedure, rather than the different cluster categories, also helped to reduce the number of variables that would be included in analyses. The affiliation ratings derived from this step were used to compute the proportion of thought units made by therapists (or clients) that were affiliative relative to the total number of thought units offered by therapists (or clients). For example, if in one dyad, a therapist offered 52 affiliative thought units and 9 disaffiliative thought units, the proportion of affiliative thought units relative to the total number of units offered was equal to .85. Likewise, if 95 of the client's thought units were affiliative and 5 of his/her thought units were disaffiliative, the proportion of affiliative thought units relative to the total number of units offered was equal to .95. According to this procedure, affiliative thought units included all simple and multiple cluster codes wherein all components were coded as +1 to +9. If a complicated or mixed communication contained even one disaffiliative code, it was counted as a disaffiliative thought unit. The value of the mixed messages in complex communications was lost using this procedure. Future investigations may choose to examine the frequency of complex and multiple communications and determine whether they contribute to the prediction of outcome alone or in interaction with therapists' supportive or interpretive interventions.

In the Vanderbilt II project, SASB process coding was completed by six raters who were either senior undergraduate students or had completed their bachelor's degree in psychology. All raters in the Vanderbilt II study took part in

a two to three month training program that included, among other things, consultations with the author of the SASB model (Dr. Lorna Benjamin) and participation in a week-long SASB training seminar. The interjudge reliability estimate for the SASB process ratings was calculated in terms of Cohen's kappa and was equal to .75. When ratings of therapist or client affiliation made by the two teams did not agree, the average of the two ratings was calculated and used in analyses (empirical evidence pertaining to the validity of the SASB process ratings can be derived primarily from the results of correlational, factor, and circumplex analyses that confirm the overall structure of the SASB model. These analyses are described in detail below).

The Inventory of Therapeutic Strategies.

The independent rater version of the Inventory of Therapeutic Strategies (ITS; Gaston, 1988) was used to measure the type and frequency of therapists' interventions in the third session for each therapeutic dyad. This system of measurement categorizes therapists' interventions according to their intent, content, and object focus. According to the ITS rating protocol, raters use verbal and nonverbal cues to rate therapists' interventions in audio- or video-tapes of therapy sessions. The 50-minute session is the standard unit of measurement and every therapist intervention in that session receives a rating. According to Gaston (1988), the ITS covers "a large range of therapist interventions as employed in behavioral, cognitive, dynamic, and humanistic psychotherapies" (p. 3) and is therefore applicable to a variety of therapy modalities.

The first step in making an ITS rating requires judges to identify an

intervention as either "Exploratory" or "Supportive." In essence, Exploratory interventions are defined as any therapist statement that aims to challenge the client's sense of self. In addition, Exploratory interventions aim to promote clients' recognition of their reactions and invite them to reflect upon the problematic aspects of their reactions. Gaston (1988; Gaston et al., 1994) explains that Exploratory strategies normally provoke some degree of anxiety in clients and typically occur in the form of interpretations or confrontations (e.g., "Talking about it seems to be your way of putting off doing something"). Finally, Gaston (1988) explains that the content of Exploratory interventions can be based on a range of material, including therapists' inferences or information brought directly into the session by clients.

Having identified an intervention as Exploratory, ITS raters are then required to specify the type of problematic reaction that the intervention was aiming to address and the object focus of the reaction. Raters choose from a list of five mutually exclusive reaction categories and five potential object foci. The reaction categories include 1) maladaptive defenses (e.g., "Every time you talk about your success, you quickly start discussing what you don't like about yourself"); 2) unrealistic wishes, needs, or expectations (e.g., "You expect me to prevent you from feeling any pain" or "Really, it seems that you would like to receive help from her and no one else"); 3) difficult emotions (e.g., "You seem to be embarrassed because you forgot our meeting"); 4) problems in cognition, fantasy, or in assigning meaning to events/situations (e.g., "You see yourself as the bad one" or "It is as if the wife of your ex-husband could give him everything

he needs"); and 5) inappropriate attitudes and behaviours (e.g., "You keep buying a lot of clothes, and yet you owe a lot of money" or "You punish yourself by remaining unhappy"). The object categories include 1) the therapist; 2) the client; 3) specific others; 4) a general or specific life event (e.g., the client's aging or his or her husband's heart-attack); or 5) a non-interpersonal situation (e.g., the uncleanliness of the client's house).

Supportive interventions are defined in the ITS as therapeutic strategies that aim to structure a client's sense of self, and to provide a "holding environment" for clients' experiences. According to Gaston (1988), a Supportive strategy can offer "guidance to the patient or recognition of the patient's experience" (p. 10) but it does not directly encourage the patient to reflect on her or his own contribution to the problem or situation being discussed. As such, Gaston (1988; Gaston et al., 1994) maintains that supportive interventions tend to reduce anxiety rather than provoke it. Similarly to Exploratory interventions, Gaston (1988) explains that Supportive strategies can be based on information provided directly by clients at earlier points in the same session or previous sessions, or they can be based on material inferred by therapists from clients' discussions.

Once identified as Supportive, a therapeutic intervention is further differentiated in the ITS, according to its more specific aim. Here, raters choose from eight different kinds of Supportive interventions that aim to: 1) provide alternative ways of handling a situation (e.g., "Could you forgive yourself?"); 2) communicate empathy (e.g., "It must have been hard for you to live with an

alcoholic husband"); 3) recognize external realities (e.g., "It seems to me that he deceived you"); 4) provide information (e.g., "It is normal to be angry at a deceased one"); 5) reassure clients or provide direct help (e.g., "Here is the phone number of a colleague you can see during the holidays if you need to"); 6) encourage self-disclosure or self-reflection (e.g., "What comes to mind?"); 7) acknowledge clients' abilities (e.g., "You seem to be able to get what you need in these situations"); or 8) explain aspects of the treatment (e.g., "I am sort of helping you to see things in a different way"). As with her description of Exploratory strategies, Gaston (1988) explains that Supportive interventions can be offered in a variety of forms, including self-disclosures, questions, or empathic statements.

The ITS is scored by calculating two frequencies: one for the total number of interventions that are classified as Exploratory and one for the total number of interventions that are classified as Supportive. To calculate these scores, the researcher first determines the subtotal of interventions in each of the five Exploratory reaction categories and then adds these together to arrive at a total Exploratory score. Likewise, the researcher calculates the subtotal of interventions in each of the eight Supportive subcategories and adds these together to arrive at a total Supportive score. For Exploratory strategies, a secondary "Object Score" can also be derived by calculating the frequency of interventions in each of the five object categories.

Gaston et al. (1994) calculated the interrater reliability of ITS ratings using the intraclass correlation coefficient (ICC; McGraw & Wong, 1996). Using three

clinical judges, the ICCs for ratings of Exploratory and Supportive strategies were respectively .89 and .95.

The criterion and content validity of an earlier version of the ITS[3] was assessed by Gaston and Ring (1992) by comparing the profile of ITS scores obtained for cognitive and dynamic therapists to the description of each therapy approach that was provided in recommended treatment manuals. Consistent with the technical guidelines of each therapeutic approach, Gaston and Ring (1992) reported that dynamic therapists emphasized Exploratory strategies more than cognitive therapists ($t = 7.93$; $p < .005$) and that cognitive therapists emphasized Supportive strategies more than dynamic therapists ($t = -2.75$, $p < .01$). With regard to the subcategories on the ITS, dynamic therapists placed greater emphasis than cognitive therapists on exploring clients' defenses and emotions ($t = 8.30$, $p < .01$ and $t = 2.53$, $p < .05$). Somewhat surprisingly, dynamic therapists also explored clients' cognitions more than cognitive therapists ($t = 13.23$, $p < .005$). Within the cognitive approach, however,

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[3] The earlier version of the ITS included a third category of interventions labeled "Work Enhancing." This category represented therapists' efforts to encourage clients' participation in the tasks of therapy. The Work-Enhancing category has been amalgamated with the Supportive category in the current version of the ITS because the two categories were found to correlate highly ($r = .77$; Gaston, 1988).

therapists explored clients' cognitions more than any other client reaction (statistics not provided). Gaston and Ring (1992) reported further that dynamic therapists focused more on clients' problematic reactions to the self and other than did cognitive therapists (t = 3.69, p < .005 and t = 10.05, p < .005), and that cognitive therapists focused more than dynamic therapists on client reactions to non-interpersonal situations (t = -2.62, p < .005). An unexpected finding was that clients' problematic reactions to the therapist were not emphasized more in either therapeutic approach. Despite some incongruencies in the preceding findings, Gaston and Ring (1992) concluded that the ITS can adequately distinguish between the different kinds of interventions that therapists use in their interaction with clients.

To assess the discriminant validity of the earlier version of the ITS, Gaston and Ring (1992) correlated therapists' scores on the ITS with ratings of therapists' contribution to the therapeutic alliance. The results indicated that neither the Exploratory nor the Supportive ITS categories correlated significantly with the alliance ratings. Gaston and Ring (1992) concluded that the two measures assess independent aspects of the therapeutic process.

Global Assessment Scale.

Comparisons of clients' performance on the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976; see Appendix B), as rated by therapists and Ph.D. level clinicians before and after therapy, were used as measures of psychotherapy outcome. The GAS is a method of rating clients' overall psychological health during a specified time period, usually the week

preceding the evaluation. In the DSM-III, DSM-III-R, and DSM-IV methods of psychiatric diagnosis (American Psychiatric Association, 1974, 1987, 1994), the GAS is used to assess clients' global functioning (i.e., clients' status on Axis 5 of the multiaxial classification system). In the Vanderbilt II study, one independent clinician was assigned to each client and provided GAS ratings of the client after the initial interview, after therapy termination, and at follow-up (the first two ratings will be used in the current study). Therapists provided GAS ratings of their clients after the first session and after therapy termination. A formal training period for the GAS was not provided in the Vanderbilt II study; however, all of the clinicians and therapists followed the same rating instructions.

GAS ratings are made on a scale of 1 to 100 that has been divided into 10 even intervals. The lowest interval, representing scores from 1 to 10, is said to describe clients who exhibit severe psychiatric difficulties, requiring constant supervision for several days and ongoing assistance in maintaining personal hygiene. The highest interval, representing scores from 91 to 100, is said to describe clients who are completely free of pathological symptoms and are able to engage effectively in a wide range of activities. According to Endicott et al. (1976), most individuals beginning psychological treatment receive scores in the range of 1 to 70, with outpatients normally scoring between 31 and 70 and inpatients scoring between 1 and 40.

The standard procedure for making a GAS rating is for the independent clinician or the therapist to select the interval that best describes the client's lowest level of functioning during the preceding week. The rater then assigns a

scale point from within the 10-point interval based on how closely the client's functioning corresponds to the defining features of either of the adjacent intervals. Ratings are based on clients' lowest level of functioning even if clients also function at higher levels during the same assessment period. In addition, the ratings are intended to reflect clients' functioning only during the specified assessment period and should not be based on any previous diagnoses or on the expected prognosis or presumed nature of clients' current difficulties. Finally, ratings can be based on information obtained from a variety of sources, including direct interviews with the client, with friends or relatives of the client, or case records.

The reliability of the GAS was assessed by Endicott et al. (1976) in five separate studies wherein 2 to 15 clinical judges made independent GAS ratings based on interview data, case records, or clinical case vignettes. Interjudge correlation coefficients ranged from .61 to .91 (M= .76, SD= .24). The lowest correlations were obtained in a longitudinal study of 18 children who were identified as being at risk for developing schizophrenia. Four judges made GAS ratings of each child based on transcripts of interviews with the child's parents. The highest correlations were obtained when 3 judges made independent GAS ratings after completing direct interviews with 38 patients receiving treatment at a follow-up clinic. The standard errors of measurement in the five studies were between 5 and 6, indicating an acceptable error rate for the GAS.

The concurrent validity of the GAS was assessed by Endicott et al. (1976) in several ways. First, Endicott et al. (1976) correlated therapists' and

researchers' GAS ratings of 107 patients with therapists' and researchers' ratings of the same patients on three other measures of psychopathology: the Mental Status Examination Record (MSER; Endicott, Spitzer, & Fleiss, 1975), the Family Evaluation Form (FEF; Spitzer, Gibbon, & Endicott, 1971), and the Psychiatric Status Schedule (PSS; Spitzer, Endicott, Fleiss, 1970). Ratings were obtained on all measures at the time of patients' admission to hospital and six months after admission. Correlations between the GAS and total scores on the MSER and FEF were moderate to high, ranging from -.19 to -.62 (M= -.42, SD = .40)[4]. Correlations between the GAS and individual scale scores on the MSER and PSS were low to moderate, ranging from -.00 to -.47 (M= -.11, SD .99) at intake, and ranging from -.02 to -.55 (M= -.26, SD = .88) at six months.

Endicott et al. (1976) also correlated patients' regressed change scores on the GAS and their regressed change scores on the MSER and PSS. Regressed change was calculated by determining the amount of change that had occurred in patients on each measure from the first to second assessment period while statistically controlling for patients' initial status on the same measures. These correlations ranged from -.42 (regressed change on therapist-

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[4] In the GAS, higher scores indicate better psychological functioning, whereas in the MSER, FEF, and PSS, higher scores indicate greater levels of psychopathology. Therefore, correlations between the GAS and each of the latter measures were expected to be negative.

rated GAS correlated with the FEF) to -.58 (regressed change on researcher-rated GAS correlated with MSER).

Finally, using the same sample of patients, Endicott et al. (1976) determined how well the GAS, in comparison to the MSER and PSS, discriminated change in patients' psychological functioning from the beginning to end of treatment. They also sought to determine the utility of the GAS in predicting rehospitalization. Using a statistic called Î, Endicott et al. (1976) reported that total scores on the GAS were more sensitive to pre-post therapy change than were total or individual scores on the PSS and MSER. Endicott et al. (1976) also reported that researchers' ratings on the GAS that were below 40 for patients who had been discharged from hospital three months after their initial admission were predictive of rehospitalization three and six months after that. Therapists' ratings on the GAS, however, did not predict rehospitalization for patients at any time following the beginning of treatment.

Symptom Check List 90 - Revised.

Psychotherapy outcome was also assessed by comparing clients' responses on Derogatis' (1983) Symptom Check List-90 Revised (SCL-90-R; see Appendix A) at intake and after therapy termination. The SCL-90-R consists of 90 self-report items measuring nine dimensions of psychological distress (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism). Items in the scale constitute a list of psychological symptoms (e.g., "Nervousness or shakiness inside") and respondents are required to rate each symptom on a 5-

point scale (0-4) ranging from "not-at-all" (0) to "extremely" (4) with reference to their experience over the previous seven days.

In the present study, the General Severity Index (GSI) of the SCL-90-R will be used as the primary measure of clients' symptomatic functioning. The GSI, which represents both the number of symptoms and the intensity of distress experienced by respondents, is considered the "best single indicator of the current level or depth of ... disorder" (Derogatis, 1983, p. 11) available from the SCL-90-R. The GSI is obtained by summing subjects' scores on each item on tne SCL-90-R and dividing the grand total by 90. Norms to be used for the interpretation of the SCL-90-R for a number of respondent populations, including male and female psychiatric outpatients, have been provided by Derogatis (1983).

In the Vanderbilt sample, clients' pre- and post-therapy ratings on the SCL-90-R were converted to standardized t-scores to allow for comparison with the scores obtained by the outpatient samples on which the SCL-90-R was normed. Also, in the current investigation, clients' pre- and post-therapy ratings on the SCL-90-R were reverse-scored so that higher ratings indicated fewer symptoms. Reverse-scoring rendered the direction of scoring on the SCL-90-R consistent with that of the GAS, where higher ratings indicated better adjustment.

Derogatis, Rickels, and Rock (1976) reported acceptable alpha coefficients for each symptom dimension on the SCL-90-R that ranged from .77 on Psychoticism to .90 on Depression for a sample of 219 "symptomatic volunteers." Acceptable test-retest reliabilities for the SCL-90-R dimensions

were also reported over a 1-week period for a sample of 94 psychiatric outpatients, ranging from .78 on Hostility to .90 on Phobic Anxiety (Derogatis, Rickels, & Rock, 1976). Finally, the factorial invariance of the nine symptom dimensions was reported as high (.85 for Hostility) to moderate (.51 for Paranoid Ideation) for a sample of 577 female and 425 male respondents (Derogatis & Cleary, 1977b). These figures suggested that males and females used primarily the same items to define the same dimensions on the scale.

The concurrent validity of an earlier version of the SCL-90 was assessed by examining the correlations of the nine symptom dimensions with the clinical, content, and cluster scales of the Minnesota Multiphasic Personality Inventory (MMPI; Derogatis, Rickels, & Rock, 1976). Correlations ranged from .41 to .75. In addition, eight of the nine dimensions showed the strongest convergence with the scales on the MMPI that were clinically comparable.

Evidence of the SCL-90-R's predictive validity was presented by Derogatis (1983) in a review of over 100 studies that demonstrated the sensitivity of the SCL-90 or SCL-90-R to detect change in individuals' psychological status as it was affected by a range of factors. Among these, several studies showed significant changes in SCL-90-R scores for subjects undergoing psychological treatment for a variety of conditions.

Finally, the construct validity of the SCL-90 was assessed by comparing the scale's theoretical structure to the results of factor and intercorrelational analyses performed on the responses of 1002 psychiatric outpatients (Derogatis & Cleary, 1977b). The empirical structure derived from these analyses and the

theoretical structure of the scale were well-matched on all dimensions, except for some overlap between the Anxiety and Phobic Anxiety subscales and some splitting between the schizophrenic and schizoid items on the Psychoticism subscale.

INTREX Introject Questionnaire.

Comparisons of clients' pre- and post-therapy scores on the INTREX Introject Questionnaire - Long Form (LF; see Appendix C; Benjamin, 1995) were used to assess the amount and type of change that occurred in clients' introjects from the beginning to end of therapy. This questionnaire is one of three self-report measures that can be used to assess interpersonal and intrapsychic interactions according to the SASB model. The Introject Questionnaire-LF consists of 36 statements, each of which corresponds with one of the 36 introject behaviours represented in the third surface of the SASB model (see Intrapsychic Surface in Figure 1 above; e.g., "I like myself very much, and feel very good when I have a chance to be with myself" or "I harshly punish, torture myself; I `take it out' on myself"). A respondent indicates on a scale of 0 to 100 the extent to which each statement is descriptive of him or herself "at best" and "at worst," thereby yielding two introject ratings -- one for the "Introject-at-best" and one for the "Introject-at-worst." In the current study, only "at worst" ratings will be used in analyses so as to minimize the risk that ratings will be contaminated by socially desirable responses. Prior research has also shown that at-worst ratings are characterized by greater variability and that they are predictive of outcome (Harrist et al., 1990; Henry et al., 1990).

The Introject Questionnaire is scored by one of several computer programs that determine the position of each response in relation to the horizontal and vertical axes of the SASB model. Introject scores can then be reported in the form of cluster scores that represent respondents' status on each of the SASB clusters in the third surface of the SASB model, or in the form of three coefficients, labelled Attack (ATK), Control (CON), and Conflict (CFL). The ATK coefficient is a measure of central tendency for client responses on the Affiliation dimension of the SASB model, and the CON coefficient is a measure of central tendency for client responses on the Interdependence dimension. The CFL coefficient indicates the extent to which responses on the Affiliation or Interdependence dimensions are contradictory (i.e., responses reflect high degrees of Affiliation *and* high degrees Disaffiliation or high degrees of Interdependence *and* high degrees of Autonomy). The ATK, CON, and CFL coefficients are expressed in values ranging from +1000 to -1000. Positive ATK coefficients indicate introjects that are oriented toward self-attack (or self-hate), and negative ATK coefficients indicate introjects that are oriented toward self-affiliation (or self-love). Likewise, positive CON coefficients indicate introjects that are oriented toward self-control, and negative CON coefficients indicate introjects that are oriented toward self-emancipation. Finally, positive CFL coefficients indicate contradictory responses on the Interdependence axis and negative CFL coefficients indicate contradictory responses on the Affiliation axis.

In the current investigation, only the ATK coefficients from the INTREX questionnaires were included as an outcome measure in the main analyses.

According to Benjamin (1995), "decreases in self-attack, [as measured by the ATK coefficient], can serve as very sensitive measures of improvements in self concept during therapy" (p. 34). In addition, introject theory clearly argues that self-affiliation is a defining feature of mental health, and that self-attack is an indicator of maladjustment (Henry & Strupp, 1994; Greenberg & Mitchell, 1983). Introject theory does not make similar claims regarding an individual's level of self-control or self-emancipation. Instead, the theory seems to maintain that self-control and self-emancipation can both be psychologically healthy or psychologically damaging depending on the affiliative or disaffiliative context in which they occur. The utility of using the ATK coefficient to differentiate psychologically healthy from psychologically maladjusted individuals was demonstrated in a study that compared the ATK, CON, and CFL coefficients of inpatients diagnosed with anorexia nervosa to the coefficients of a group of normal controls (Swift, Bushnell, Hanson, & Logemann, 1986). The results indicated that the clinical sample had significantly higher ATK coefficients than the control sample but did not differ from the control sample on either the CON or CFL coefficients. This study also reported significant negative correlations between the ATK coefficient on the INTREX Questionnaires and a measure of positive self-image. More recently, Wonderlich, Klein, and Council (1996) used the INTREX Introject Questionnaire to compare the Introject states of women suffering from bulimia nervosa to the introjects of a group of female controls. Similar to Swift et al., this study reported that the bulimic patients had significantly higher ATK coefficients than the control sample, but that the CON

coefficients for the two groups were not significantly different.

As with clients' ratings on the the SCL-90-R, clients' ATK coefficients in this study were reverse-scored so that positive scores indicated introjects that were oriented toward self-affiliation and negative scores were oriented toward self-attack. Again, this reversal was performed to render the INTREX scores consistent with the direction of scoring used in the other outcome measures where higher scores indicated better adjustment or greater psychological health.

Empirical evidence pertaining to the validity of the SASB model's overall structure has been discussed at length by Benjamin (1974, 1995, n. d.) and by Alpher (1988) in a comprehensive review. This evidence has emerged out of several studies wherein evolving versions of the SASB questionnaires were administered to samples of normal and clinical subjects (Benjamin, 1974, 1995, n.d.). Within-subject autocorrelational analyses indicated that individual subjects tended to endorse items pertaining to adjacent points on the SASB model similarly, and that individual responses to adjacent items correlated positively whereas individual responses to opposite items correlated negatively. Between-subject circumplex analyses corroborated these results, showing that subjects, as a group, endorsed adjacent items similarly, and that group responses to adjacent items correlated positively and group responses to opposite items correlated negatively. In addition, between-subject factor analyses with transformations supported the two-dimensional structure in the model, with each surface yielding one factor that corresponded with the Affiliation dimension and one that corresponded with the Interdependence dimension. Initially, factor

analyses for responses pertaining to the Introject surface did not provide strong support for its two-dimensional structure (Benjamin, 1974). This led to the revision of items and to additional factor analyses that eventually grouped subject responses into the hypothesized affiliation-interdependence dimensions (Benjamin, n. d.). Finally, to demonstrate the content validity of the INTREX Questionnaires, Benjamin (n. d.) had 122 undergraduate judges, who were not familiar with the SASB model, rate each item on each questionnaire with regard to the three basic dimensions: Focus, Affiliation, and Interdependence. She then computed the canonical correlations between judges' ratings of each item and the INTREX Questionnaire responses of 133 normal individuals. For the Introject Questionnaire, correlations between judges' ratings of the items and respondents' ratings of their introjects "at-best" were equal to .97 and correlations between judges' item ratings and respondents' ratings of their introjects "at-worst" was equal to .98.

With regard to the reliability and validity of the INTREX Introject Questionnaire-LF, Benjamin (n. d.) cites average internal consistency coefficients for "Introject-at-best" cluster scores equal to .95 and "Introject-at-worst" cluster scores equal to .64 for the sample of 133 normal individuals. Elsewhere, Benjamin (1995) cites average test-retest reliabilities for the cluster scores on the Introject Questionnaire-LF equal to .92 for a group of 11 psychiatric inpatients who were tested at the time of their initial hospitalization and, again, when they were hospitalized a second time. Finally, for a sample of 12 undergraduate students who completed the short-form of the INTREX

Questionnaires, the test-retest reliability of the ATK coefficient for "Introject-at-best" ratings was .80 and for "Introject-at-worst" ratings was .65 (the interval between testing was one month). Overall, Benjamin (1995) notes that "at-worst" ratings of the interpersonal or intrapsychic process using the INTREX Questionnaires are, for the most part, less stable than "at-best" ratings. She concludes from this that relationships at their worst are less well integrated than relationships at their best. In addition, she argues that, for normal individuals, this may indicate a certain degree of psychological flexibility which, she argues, is a sign of psychological health (Benjamin, 1984).

Procedure

The researcher obtained approval of the study from her dissertation committee and from Dr. Hans Strupp, principal investigator in the Vanderbilt Psychotherapy Project II. Following this, SASB process codes, clients' pre- and post-therapy scores on the SCL-90-R and the INTREX Introject Questionnaire, and therapists' and independent clinicians' pre- and post-therapy ratings of clients on the GAS were collected from the Vanderbilt database. Audiotapes and transcripts of the third session for each therapeutic dyad were also obtained.

Three doctoral-level graduate students (2 female, 1 male) in clinical psychology were selected as independent judges to provide ratings on the ITS. Each judge had completed at least two practica in general psychotherapy and assessment as a part of his or her clinical training. In line with Gaston's (1988) recommendations, preference was given to judges who were knowledgeable in a variety of therapeutic approaches, including dynamic psychotherapy. Judges

were asked to refrain from attending the researcher's proposal presentation and to refrain from reading posted information about the study so that they remained blind to the study's hypotheses. Judges also signed research contracts outlining their rating responsibilities (see Appendix D) prior to training. To protect the confidentiality of the therapy participants, raters were instructed to discontinue their work with the research materials if they recognized any client or therapist in the audiotaped sessions and to notify the researcher immediately. In light of the fact that raters were selected from a clinical psychology program at a Canadian university and the data were collected from an American university, this situation was not expected to occur and, indeed, did not occur. If it had occurred, judges would have been assigned a different set of sessions or they would have been relieved of their rating duties altogether.

The training of judges began by having them become familiar with the ITS manual and with the definitions of the constructs that were to be rated. Following this, the judges, together with the researcher, reviewed several audiotaped sessions, gleaned from the training program for the Client Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969), and rated each therapist intervention in the audio-taped sessions according to the ITS protocol. Transcripts of these sessions were provided to assist the rating process. Finally, judges practiced independently rating therapy sessions until their ratings reached an acceptable level of interrater reliability [Intraclass correlation coefficient (ICC) = .75; Lambert & Hill, 1994]. Disagreements among ratings in the practice sessions were discussed thoroughly. When it became difficult to arrive at a consensus, the

researcher consulted with Joel Montanez, an ITS rater trained under the supervision of Louise Gaston, to clarify points of confusion and to answer questions pertaining to the rating procedure. The total number of training hours was equal to 25.

After the completion of training, judges rated the therapy sessions from the Vanderbilt II study that were selected for analysis. Each judge rated 10 randomly selected sessions in common with the other two judges so as to calculate the interrater reliability of their ratings, and each rated 18 sessions independently. Judges rated entire sessions which were assigned to raters in a random order with the provision that therapy sessions with the same therapist would not be rated consecutively by any rater at any time. This was a cautionary measure taken to enhance the likelihood that ratings would reflect the actual data rather than raters' biased perceptions of any particular therapist. In addition, measures were taken to ensure that the 10 sessions to be rated in common were evenly dispersed throughout the rating period. As during training, ratings were based on audiotapes and on transcripts of the therapy sessions and they were recorded on a Rating Sheet (see Appendix E). Three 3-hour recalibration sessions were held after judges had rated 9, 19, and 28 sessions so as to minimize rater drift, answer questions, and discuss any points of disagreement. As in the training sessions, disagreements among ratings were resolved through discussion at the recalibration meetings so as to arrive at a single rating for each intervention. Again, Joel Montanez was consulted when consensus was difficult to reach or when other questions pertaining to the rating

procedure emerged. Reliability estimates for the first set of nine ITS ratings was unacceptably low (ICC = .61). Upon closer examination of the ratings, it was found that one rater was not agreeing with the other two and that reliability estimates for the latter two judges were in the acceptable range (ICC = .75). The first judge therefore received five additional training hours until her ratings agreed more consistently with those of the other judges. This judge was also requested to rate her set of independent ratings again using the criteria she learned in the additional training hours. Reliability estimates for all three raters for the second and third sets of ratings were well above the accepted level of agreement (ICC = .84 and .90 respectively).

Results

SASB process data were not available for 4 therapeutic dyads included in the first and third cohorts of the Vanderbilt II sample. In addition, pre-therapy ratings on the SCL-90-R were missing for one client and post-therapy ratings on the SCL-90-R were missing for two clients. Post-therapy GAS ratings made by independent clinicians were also missing for two clients. Finally, preliminary screening for outliers on each of the main research variables indicated that one client obtained extreme scores on two variables: his/her level of affiliation and his/her status on the combined termination variable (see below). This client was dropped from analyses to ensure that all dyads participating in the study were drawn from the same population (Tabachnick & Fiddell, 1989). Thus, the final sample consisted of 59 therapeutic dyads when analyses were performed with the INTREX Introject Questionnaire as the outcome variable, and 56 dyads when

analyses were performed with clients' ratings on the SCL-90-R and/or the GAS as the outcome variable.

A sample of 59 and 56 therapeutic dyads met the criterion recommended by Tabachnick and Fidell (1989) to include at least five subjects per variable in multivariate analyses to attain adequate power. Preliminary power analyses indicated that, for a sample of 59 and 56 therapist-client dyads, the probability of detecting a medium to large effect (f^2= .22) at a significance level of .05 was equal to .57 and .54 respectively. An effect size of .22 was entered into the power equation because this was the mean effect size calculated for the results reported by Gaston and her colleagues (1994, 1998) in previous studies using similar variables and similar analyses (range: f^2= .05 to f^2= .43). Power values of .57 and .54 are clearly less than optimal. However, these values should be considered within the context of Gaston et al.'s research which, in most cases, was based on relatively small samples (Mean n= 36) and still reported significant results. Given that the current study would be based on a substantially larger number of therapist-client dyads, it seemed reasonable to assume that the power of the test would actually be greater than the power analyses indicated and that significant effects would be observed.

Description of Sample

Correlation coefficients between the main research variables are presented in Table 3. The main research variables include: therapists' and clients' SASB affiliation ratings; the frequency of therapists' Supportive and Exploratory interventions; the number of Exploratory interventions with the

Table 3

Correlations among the Main Research Variables

	SASB-T	SASB-C	SUP	EXP	EXP-Th	EXP-Ot	Pre-GAS-T	Pre-GAS-Id	Pre-SCL	Pre-INTRX	Post-GAS-T	Post-GAS-Id	Post-SCL
SASB-C	.40**												
SUP	-.17	.03											
EXP	-.11	-.07	.25*										
EXP-Th	.13	-.08	.22	.82***									
EXP-Ot	-.37**	-.04	.11	.63***	.09								
Pre-GAS-T	.22	-.16	-.23	-.35**	-.17	-.38**							
Pre-GAS-Id	-.10	-.25	-.13	-.04	-.03	-.03	.24						
Pre-SCL	.24	-.14	-.26	- .14	-.07	-.14	.40**	.27*					
Pre-INTRX	.02	-.17	.04	- .01	.12	-.20	.30*	.37**	.28*				
Post-GAS-T	.21	.06	-.25	-.23	-.11	-.19	.71***	.30*	-.36**	-.10			
Post-GAS-Id	-.03	.13	-.20	-.01	-.00	.04	.25	.47***	-.19	-.16	.57***		
Post-SCL	-.04	.02	-.29*	- .12	- .18	.07	.31*	.37**	.62***	.26	.47***	.49***	
Post-INTRX	.08	.14	- .04	.09	.08	.04	.32*	.30*	.14	.51***	.28*	.41**	.37**

Note. SASB= affiliation ratings on the Structural Analysis of Social Behavior Scales; SUP= Supportive Interventions; EXP= Exploratory Interventions; EXP-Th= Exploratory Interventions with the therapist as object; EXP-Ot= Exploratory Interventions with other than therapist as object; GAS= Global Assessment Scale; SCL=General Severity Index on the Symptom Checklist 90-Revised; INTRX= INTREX Introject Questionnaire; Pre= scale completed before therapy onset; Post= scale completed after therapy termination; T= scale completed by or pertaining to Therapist; C= Scale completed by or pertaining to client; Id= Scale completed by independent clinician.

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

therapist as object; the number of Exploratory interventions with another object focus; clients' pre- and post-therapy scores on the SCL-90-R; clients pre-and post-therapy scores on the GAS as rated by independent clinicians and therapists; and clients' pre- and post-therapy scores on the INTREX Introject Questionnaire (represented by ATK coefficients).

Table 3 indicates that therapists' and clients' SASB affiliation ratings were positively correlated ($r = .40$, $p \leq .01$). Therefore, therapists interacted in a more affiliative manner with clients who were more affiliative in their interactions with therapists, and vice versa. In addition, Table 3 indicates that therapists' use of Exploratory interventions was significantly correlated with their use of Supportive interventions ($r = .25$; $p \leq .05$), and with their tendency to offer Exploratory interventions that were focused on the therapist ($r = .82$, $p \leq .001$) or another object ($r = .63$, $p \leq .001$). Together, these correlations indicate that therapists who offered a high number of interventions in one category also tended to offer a high number of interventions in each of the other categories. Neither clients' nor therapists' SASB affiliation ratings were correlated with therapists' overall use of Exploratory or Supportive interventions. However, therapists' SASB affiliation ratings were negatively correlated with their tendency to offer Exploratory interventions that were focused on someone or something other than the therapist ($r = -.37$, $p \leq .01$). This indicates that therapists who interacted more positively with their clients were less likely to challenge their clients on issues that pertained to clients' experiences outside of therapy.

The frequency of therapists' Exploratory interventions was also negatively

correlated with therapists' ratings of clients on the GAS prior to beginning therapy (r= -.35, $p \leq$.001). Similarly, the frequency of therapists' Exploratory interventions that focused on clients' experiences outside of therapy was negatively correlated with therapists' pre-treatment ratings of clients on the GAS (r= -38, $p \leq$ .01). This indicates that the better adjusted patients appeared to therapists at the onset of treatment, the fewer Exploratory interventions therapists tended to offer during treatment. This was especially true of Exploratory interventions that focused on issues outside of therapy. Table 3 also indicates that the frequency of therapists' Supportive interventions was negatively correlated with clients' status on the SCL-90-R at treatment termination (r= -.29, $p \leq$ .05). The frequency of therapists' support, however, was not correlated with clients' status on the SCL-90-R prior to treatment. Thus, clients whose therapists offered more frequent support during therapy reported a greater number symptoms when their treatment was completed, but there was no association between the level of therapists' support and client symptomatology before treatment began. It should be noted that the absolute difference in correlations between the frequency of therapists' Supportive interventions and pre- and post-therapy assessments of clients on the SCL-90-R was quite small (r= .26 vs. r= .29).

Table 3 also reports that clients' post-test scores on each of the outcome measures were highly correlated with their initial status on the same measures (correlations ranged from r=.47, $p \leq$.001, for independent clinicians' pre- and post-therapy ratings on the GAS, to r=.71, $p \leq$ .001, for therapists' pre- and post-

therapy ratings on the GAS). These correlations signified that any measurement of change in clients from beginning to end of therapy that involved subtracting clients' pre-therapy scores from their post-test scores would result in overall change scores that were highly correlated with and dependent on clients' initial level of functioning (Cronbach & Furby, 1970; Growick, 1976; Weintraub, Green, & Herzog, 1973). To avoid the difficulties associated with the use of "raw change" or "raw gain" scores as measures of outcome, clients' pre- and post-test scores on the INTREX measure and the SCL-90-R, and therapists' and clinicians' pre- and post-therapy ratings of clients on the GAS were converted to residual-change scores following a procedure outlined by Growick (1976). This involved predicting clients' post-treatment scores on each of the outcome measures by their pre-treatment scores in a regression analysis and assigning as the residual-change scores the deviation of observed post-treatment scores from the regression line of predicted scores based on initial status. The process of residualizing post-test scores removed that portion of change that could be predicted from pre-test scores alone and therefore rendered them independent of clients' initial level of functioning (Cronbach & Furby, 1970). The correlations between clients' residual-change scores on each of the outcome measures are presented in Table 4. They range from $r = .18$, ns, for the correlation between clients' residual-change on the INTREX measure and therapists' ratings of residual-change on the GAS, to $r = .57$, $p \leq .001$ for the correlation between therapists' and independent clinicians' ratings of residual- change on the GAS.

Finally, to return to Table 3, this indicates that, with one exception, prior to

Table 4

Correlations among Residual-Change Scores for the INTREX Introject Questionnaire, SCL-90-R, and GAS

	INTREX	SCL-90-R	GAS-T
SCL-90-R	.39*		
GAS-T	.18	.40**	
GAS-Id	.33*	.43**	.57**

Note. INTREX= INTREX Introject Questionnaire; SCL-90-R= General Severity Index on the Symptom Checklist, GAS= Global Assessment Scale; T = Scale completed by therapist; Id = Scale completed by independent clinician.

*$p \leq .05$ **$p \leq .01$

beginning therapy and after therapy was completed, clients', therapists', and independent clinicians' ratings of clients' status on each of the outcome measures were significantly correlated. The exception was that at pre-therapy, therapists' and independent clinicians' ratings on the GAS were only mariginally correlated ($r = .24$, $p \leq .07$). On the pre-therapy measures, significant correlations ranged from $r = .27$, $p \leq .05$, for the correlation between the SCL-90-R and independent clinicians' ratings on the GAS, to $r = .40$, $p \leq .01$, for the correlation between the SCL-90-R and therapists' ratings on the GAS. On the post-therapy measures, significant correlations ranged from $r = .28$, $p \leq .05$, for the correlation between the INTREX measure and therapists' ratings on the GAS, to $r = .57$, $p \leq .001$, for the correlation between therapists' and independent clinicians' ratings on the GAS. Additional analyses indicated that the residual-change scores on therapists' and independent clinicians' ratings on the GAS and clients' ratings on the SCL-90-R were also highly correlated (ranging from $r = .57$, $p \leq .01$, for the correlation between residual-change scores on therapists' and independent clinicians' ratings on the GAS, to $r = .40$, $p \leq .01$ for the correlation between the residual-change scores on therapists' ratings on the GAS and clients' scores on the SCL-90-R) and that each of these variables loaded onto one factor in a prinicipal factor analysis (squared multiple correlations ranged from .74 to .83). Together, these significant correlations and factor loadings suggested that there was a fair degree of overlap between what each of the outcome variables, particularly the GAS ratings and the SCL-90-R, was measuring. For this reason, and in order to reduce the number of analyses that

would be conducted to test the main hypotheses, the residual-change scores on the GAS and SCL-90-R measures were converted to Z scores and summed into one outcome measure. The INTREX measure was retained as a separate measure of outcome so that it would be possible to determine whether the therapeutic relationship and/or therapists' interventions contribute specifically to changes in clients' introjects over the course of therapy. The correlation between the residual -change scores on the combined outcome measure and the INTREX Introject Questionnaire was equal to .39, $p \leq .001$.

The means, standard deviations, and range of values for the main research variables are presented in Table 5. Official norms for the SASB affiliation ratings and the ITS are not available in the literature. However, an examination of the mean SASB affiliation scores in Table 5 indicates that, in the current study, therapists and clients were proportionally much more affiliative in their interactions with one another than they were disaffiliative. This is consistent with previous research that used observer ratings on the SASB as a measure of interpersonal process in psychotherapy (e.g., Coady, 1991a, 1991b). Table 5 also indicates that therapists offered Supportive interventions much more frequently than Exploratory interventions. Again, this is consistent with previous studies that used the ITS to classify therapists' interventions and reported on their relative frequency of occurrence (e.g., Gaston, 1998). On average, the therapists in the current sample offered fewer Exploratory interventions than the total group of therapists in Gaston et al.'s (1998) recent study (8.46 vs. 13.0), and they offered more Supportive interventions (188.53 vs. 137.2). For both

Table 5

Means and Standard Deviations for the Main Research Variables

Measure	n	Mean	Standard Deviation	Range
SASB-T	59	.95	.06	.79 - 1.00
SASB-C	59	.95	.03	.87 - 1.00
Support	59	188.53	91.84	47 - 429
Explore	59	8.46	8.79	0 - 34
Explore-Th	59	4.92	7.01	0 - 23
Explore-Ot	59	3.71	5.32	0 - 20
Pre-GAS-T	59	59.73	10.05	33 - 85
Post-GAS-T	59	71.58	11.91	40 - 95
Pre-GAS-Id	59	58.37	6.57	41 - 69
Post-GAS-Id	57	67.09	9.57	48 - 85
Pre-SCL-90-R	58	54.29	8.58	19 - 66
Post-SCL-90-R	57	58.67	9.67	19 - 77
Pre-INTREX	59	-379.12	617.31	970 - -987
Post-INTREX	59	-216.08	673.39	977 - -966

Note. SASB= Affiliation ratings on the Structural Analysis of Social Behaviour Scale; Support= Frequency of Supportive Interventions; Explore= Frequency of Exploratory Interventions; Explore-Th= Exploratory Interventions with the therapist as object; Explore-Ot= Exploratory Interventions with other than therapist as object; GAS= Global Assessment Scale; SCL-90-R= General Severity Index on the Symptom Checklist-90-Revised; INTREX= INTREX Introject Questionnaire; Pre= scale completed before therapy onset; Post= scale completed after therapy termination; -T= scale completed by or pertaining to Therapist; -C= scale completed by or pertaining to Client; -Id= scale completed by Independent Clinician.

Supportive and Exploratory interventions, however, the frequency scores in the current study were within one standard deviation of the mean number of interventions in each category that were offered by Gaston et al.'s (1998) therapists.

For each of the outcome measures listed in Table 5, clients' mean pre-therapy score was within the expected range for outpatient samples. For example, on the GAS, clients' average pre-therapy scores as rated by independent clinicians and therapists (M= 58.37, SD= 6.57 and M= 59.73, SD= 10.05 respectively) fell within the range of scores that Endicott (1976) described as typical for an outpatient sample (between 31 to 70). On the GSI of the SCL-90-R, clients' mean t-score of 54.29 (SD=8.58) was also well within one standard deviation of the standardized mean of 50 (SD = 10) for the outpatient population on which the SCL-90-R was normed. Finally, clients' mean pre-therapy ATK coefficients on the INTREX Introject Questionnaire was equal to -379.12 (SD= 617.31). The standard deviation for clients' ATK ratings was quite large and indicated a considerable degree of variability in clients' ATK coefficients. This is consistent with other research which has measured the ATK coefficients of different clinical samples and reported their means and standard deviations. For example, Alpher (1996) reported that in his sample of women with dissociative disorder, the mean ATK coefficient for introject-at-worst ratings was -482 (SD= 600)[5]. Similarly, Wonderlich, et al. (1996) reported mean ATK coefficients for at-

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[5] It will be recalled that the signs of the ATK coefficients in the current sample

worst ratings equal to -550 (SD= 450)[5] for their sample of women suffering from bulimia. In the current sample, the average, negative rating of clients' ATK coefficients suggested that prior to beginning therapy most clients' introjects were oriented toward self-attack. Clients' mean pre-therapy ATK coefficient in this sample was also considerably more self-attacking than the mean Introject-at-worst ATK coefficient for the normative sample of 133 college students described by Benjamin (1995, M= -23.00, SD= 693.00)[6]. As in the current sample, there was considerable variability in the ATK coefficients of Benjamin's college sample, and, as a result, there is some overlap in the scores of the current and normative samples. Benjamin (1995) attributed the variability of scores in the normative sample, in part, to the fact that participating subjects were not screened for their level of psychological adjustment and that the sample may have included individuals who were experiencing psychological difficulties at the time of assessment. This being the case, some overlap of scores between the normative sample and the current data can be expected.

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were reversed from the original scoring procedures so that introjects oriented toward self-attack were represented by negative, rather than positive integers. To permit comparisons with the current data, the sign of the mean ATK coefficients reported by Alpher (1996) and Wonderlich et al. (1996) for their clinical samples were also reversed from a positive to a negative integer.

[6] To permit comparisons with the current data, the sign of the mean ATK coefficients reported by Benjamin (1995) for the normative sample was reversed from a positive to a negative integer.

Table 5 also indicates that clients in the current study showed improvements from their pre- to post-therapy status on each of the outcome measures. The amount of change that occurred varied from one measure to another. Clients showed the most improvement on the GAS, which was rated by their therapists and by independent clinicians before and after therapy. Regardless of whether therapists or independent clinicians provided the ratings, clients' scores on the GAS improved more than one standard deviation above the mean of their pre-therapy status on that measure. In qualitative terms, prior to beginning treatment, therapists' and independent clinicians' mean ratings on the GAS described clients as displaying "moderate symptoms or generally functioning with some difficulty." By treatment termination, therapists rated clients, on average, as displaying only "minimal symptoms ... but no more than slight impairment in functioning," and independent clinicians rated clients as exhibiting "mild symptoms... but generally functioning pretty well." Thus, it seems that the quantitative improvements in clients' GAS scores were, in the eyes of therapists and independent clinicians, accompanied by qualitative improvements in clients' functioning that enhanced their everyday lives. This type of quantitative and qualitative improvement is what Kazdin (1992) regards as clinically significant change.

Clients showed the least amount of change on the INTREX measure where post-therapy scores were slightly higher than one quarter of a standard deviation than pre-therapy scores. On the SCL-90-R clients' scores improved by slightly more than one half a standard deviation from beginning to end of

therapy. Thus, overall, it appears that clients showed the greatest improvement on measures of outcome that were provided by their therapists or independent clinicians and they showed the least amount of positive change when they rated their improvement themselves.

The overall percentage of clients who improved from beginning to end of therapy also varied depending on the outcome measure being considered. A comparison of pre- and post-therapy scores on the GAS showed that, at therapy termination, 95% (n= 56) and 86% (n= 51) of clients had improved (i.e., higher) scores when they were rated by therapists and independent clinicians respectively. On the SCL-90-R, comparisons of pre- and post-therapy scores showed that 75% (n= 42) of clients had higher scores at the end of treatment and therefore fewer symptoms. Finally, on the INTREX Introject Questionnaire, the ATK coefficients of 63% (n= 37) of clients were higher at the end of therapy than they had been at the beginning, indicating less self-attacking behaviour. Thus again, ratings made by independent clinicians and therapists showed a higher percentage of improvement than ratings made by clients themselves[7].

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[7] A *chi*-square test of association revealed a significant association between the percentage of clients who showed improvements and the outcome measure that was used (χ^2= 12.91, $p \leq .01$). Follow-up *chi*-square goodness of fit tests showed that the percentage of clients who showed improvements on therapists' ratings on the GAS was significantly higher than the percentage of clients who showed improvements on clients' ratings on the SCL-90-R (χ^2 = 9.05, $p \leq .01$), and clients'

Identification of Covariates

Preliminary analyses were conducted to identify characteristics of the client-therapist dyad which were not central to the research questions under investigation but were related to one or more of the variables that would serve as criterion variables in the main analyses (e.g., clients' residual change scores on the INTREX Introject Questionnaire and clients' residual change scores on the GAS and SCL-90-R combined). Significant characteristics were defined as covariates; however, their effects were not statistically controlled in subsequent analyses because this could have altered the data in an unknown manner and may have complicated the interpretation of results (Pedhazur, 1982). The

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ratings on the INTREX Introject Questionnaire (χ^2 = 18.33, $p \leq .001$). The percentage of clients who showed improvements on independent clinicians' ratings on the GAS was also significantly higher than the percentage of clients' who showed improvements on the INTREX Introject Questionnaire (χ^2= 8.76, $p \leq .01$). On the other hand, the percentage of clients who showed improvements on therapists' ratings on the GAS was not significantly different from the percentage who were rated as improved on independent clinicians' ratings on the GAS (χ^2= 2.51, ns). Likewise the percentage of improvement was not significant differently for independent clinicians' ratings on the GAS versus clients' ratings on the SCL-90-R (χ^2= 2.43, ns), and for clients' ratings on the SCL-90-R versus clients' ratings on the INTREX Introject Questionnaire (χ^2= 2.08, ns).

implications of significant covariates for the overall findings will be discussed below.

Correlational analyses were conducted when potential covariates were continuous in nature. These included therapist and client age, therapists' years of post-degree experience, and therapists' and clients' rate of responding. The results of these analyses are presented in Table 6 and indicate that clients' residual change scores on the INTREX Introject Questionnaire were negatively correlated with therapists' age (r= -.27, $p \leq .05$). Therefore, clients who showed the most improvement from beginning to end of therapy in their introjects were iore likely to have been working with younger therapists. No other correlations were significant. To facilitate discussion of this covariate finding, additional correlational analyses were conducted to determine whether therapists' age was associated with other therapist characteristics or behaviour. The following variables were included in the correlations: therapists' years of post-degree experience, therapist rate of responding, therapists' use of Exploratory and Supportive interventions, therapists' use of Exploratory interventions that focused on the therapist or another object focus, and therapists' and clients' level of affiliation. The results showed that therapists' age correlated significantly with three variables: therapist experience (r= .42, $p \leq .01$), therapists' rate of responding (r= .42, $p \leq .01$), and therapists' use of Supportive interventions (r= .37, $p \leq .01$).

Analyses of variance were conducted when potential covariates were categorical in nature. These included therapist and client gender, client marital

Table 6

Correlations between Prospective Criterion Variables and Potential Covariates

Criterion Variable	Therapist Age	Client Age	Therapist Years of Experience	Therapist Rate of Participation	Client Rate of Participation
INTREX	-.27*	.05	-.09	- .05	- .03
Combined Outcome	-.10	-.25	.07	-.16	-.14

Note. INTREX= Residual-change scores on INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on the SCL-90-R and GAS ratings combined; Rate of Participation= total number of responses offered in third session.
*$p \leq .05$

status, clients' years of post-secondary education, whether therapist-client dyads constituted male, female, or opposite-sex dyads, whether therapists were psychologists or psychiatrists, and whether dyads were chosen from the first or third cohort of the Vanderbilt project[8]. Analyses of variance were also conducted

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[8] Henry, Strupp, et al. (1993) compared therapists' behaviours in the Vanderbilt II project prior to and after completing the TLDP training. Their results showed that, after training, therapists were more active in their sessions with clients, they were more likely to focus on clients' experiences and behaviours in the therapeutic relationship, and they were more likely to engage in negative interpersonal transactions with clients. In a separate study, Henry, Schacht, et al. (1993) explored the factors that may have mediated these changes in therapists' behaviours and discussed their implications for manualized training. With regard to the current study, these differences in therapist behaviours were relevant to the extent that they may have contributed to different outcomes for clients in the pre- and post-training cohorts (i.e., Cohorts I and III) of the Vanderbilt II project. For this reason, the training cohort to which clients' belonged in the Vanderbilt II project was included in covariate analyses. For descriptive purposes, Tables 14 to 16 (see Appendix F) also present the results of analyses of variance which compared the two Vanderbilt cohorts on the SASB ratings of therapists' and clients' level of affiliation, the frequency of therapists' Supportive and Exploratory interventions, and the frequency of therapists' Exploratory interventions that focused on the therapist or on another object

to determine whether there were differences between therapists on either of the prospective criterion variables.

It may seem that the inclusion of more than one dependent variable in these analyses rendered multivariate analyses of variance (MANOVA) more appropriate. However, according to the guidelines set out by Tabachnick and Fidell (1988), the sample size was not large enough to use the MANOVA procedure. In addition, the large number of correlations and univariate comparisons that resulted from this procedure yielded an unacceptably high experiment-wise error rate that was of concern. On the other hand, when the experiment-wise error-rate was set at .05 or .01, no covariates were identified. For this reason, covariates were ultimately defined as variables that related to prospective criterion variables at a comparison-wise error rate of .05. Although the disadvantage of this procedure was that some non-covariates could be identified as covariates merely by chance, the fact that covariates would not be statistically controlled in later analyses and therefore would not change the nature of the results seemed to reduce the seriousness of this risk.

The results of the analyses of variance are presented in Appendix F and

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focus. Congruent with the results reported by Henry, Strupp, et al. (1993), the analyses show that, after training in TLDP, therapists offered more Exploratory interventions [$F(1,59)= 13.17$, $p \leq .001$] and more Exploratory interventions that focused on the therapist [$F(1,59)=19.47$, $p \leq .001$] than they did prior to training. No other analyses were significant.

indicate that none of the potential covariates (i.e., therapist and client gender, client marital status, clients' years of post-secondary education, whether therapist-client dyads constituted male, female, or opposite-sex dyads, whether therapists were psychologists or psychiatrists, and whether dyads were chosen from the first or third cohort of the Vanderbilt project) was related to either of the prospective criterion variables.

Analyses of Hypotheses[9]

The main statistical analyses in this study consisted of hierarchical, multiple regressions (Cohen & Cohen, 1983). This method of analysis made it possible to determine the amount of variance in a criterion variable (i.e., clients' residual-change scores on the INTREX Introject Questionnaire and on the combined outcome variable) that could be attributed to a given predictor or predictor set (i.e., therapists' Supportive and Exploratory interventions) while statistically controlling for the variance attributed to predictors or predictor sets entered at earlier points in the regression equation (e.g., therapists' and clients' SASB affiliation ratings). Protected *t*-tests (described below) were used to maintain the experiment-wise, Type I error-rate at an acceptable level (Cohen & Cohen, 1983).

In each of the hierarchical analyses, the main predictor variables (i.e.,

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[9] All results in all analyses pertaining to the main effect of clients' and/or therapists' SASB affiliation ratings in the prediction of outcome are credited to the Vanderbilt Psychotherapy Research Group, unpublished analyses, 1998.

clients' and therapists' SASB affiliation ratings, the frequency of therapists' Supportive and Exploratory interventions, the frequency of therapists' use of Exploratory interventions with the therapist as object or another object focus) were centered around their respective means to eliminate problems associated with multicollinearity between variables in the regression analyses. Data centering involves subtracting each participant's score on a given variable from the overall group mean on that variable (Neter, Wasserman, & Kutner, 1989). Initial analyses indicated that in the absence of centering the predictor variables, interaction terms between them could not be entered at later stages in the regression equations because they correlated too highly with one another. The practice of data centering is recommended by Neter et al. (1989) as a means of eliminating high correlations among variables at different levels in a regression analysis.

Hypotheses 1.

Two hierarchical regressions were performed to examine whether, controlling for therapists' and clients' level of affiliation, therapists' interpretive and supportive interventions would interact with therapist and client affiliation to predict psychotherapeutic change, and to examine whether therapists' Exploratory and Supportive interventions contribute independently to change. The criterion variable in the first regression was clients' residual-change scores on the INTREX Introject Questionnaire. The criterion variable in the second regression was clients' residual-change scores on the SCL-90-R and GAS ratings combined.

The first predictors entered into each regression as a set were therapists' and clients' SASB affiliation ratings. The second predictors entered into each regression were the frequency scores for therapists' Supportive and Exploratory interventions, also entered as a set. Therapists' and clients' SASB affiliation ratings were entered into each equation before therapists' ITS scores for two reasons. Cohen and Cohen (1983) recommend that predictor variables be entered into a hierarchical analysis in the order of causal priority and Interpersonal theory assumes that the interpersonal process of therapy mediates the effectiveness of therapists' interventions (Henry & Strupp, 1994). As noted above, the hierarchical entry of first the clients' and therapists' SASB affiliation ratings and then therapists' use of Supportive and Exploratory interventions made it possible to determine the amount of variance in the outcome measure that could be attributed to therapists' interventions while controlling for the variance attributed to the degree of affiliation in clients' and therapists' interpersonal behaviours.

The third predictor in each regression was the set of two-way interactions between the frequency of Exploratory and Supportive interventions and therapists' and clients' SASB affiliation ratings. In multiple regression analyses, significant interactions between two or more variables indicate that these variables contribute jointly to the prediction of the criterion. If the interaction terms for the specified variables are entered into the regression after each variable has also been entered separately, then any significant interactions indicate that the variables in question contributed jointly to the prediction of the

criterion over and above what each of them contributed independently. In the current study, in each regression equation, the "u x v" notation was used to represent the interaction terms (Cohen & Cohen, 1983). For example, the interaction between the frequency of Exploratory interventions and therapists' SASB affiliation scores were represented as "EXP x SASB-T." Four two-way interaction terms were entered at the third step of each hierarchical analysis, including: EXP x SASB- T; EXP x SASB - C; SUP x SASB - T; and SUP x SASB- C. The interactions between therapists' and clients' SASB affiliation ratings (i.e., SASB- T x SASB- C) and between the frequency of therapists' Exploratory and Supportive interventions (EXP x SUP) were not entered into the analyses because they were not directly relevant to the study's hypotheses. Excluding these interaction terms from this step in the regression analyses preserved the available degrees of freedom for use in testing the main hypotheses.

The last predictor entered into each regression equation was the set of three-way interactions between therapists' and clients' SASB affiliation scores and therapists' Exploratory and Supportive interventions. Using the u x v notation, these interactions were represented as EXP x SASB-C x SASB-T and SUP x SASB-C x SASB-T. Again, three-way interactions that were not directly relevant to the study's hypotheses were not entered into the regression analyses.

As noted above, protected t tests were used in each of the regression analyses to maintain the experiment-wise error-rate at an acceptable level. According to this procedure, researchers test the significance of a set of

variables first, and, if the overall F test is significant, they examine the independent contribution of variables within the set (Cohen & Cohen, 1983). If the overall F statistic for a variable set is not significant, then the researcher does not test the significance of any of the individual variables contained in the set. In that way, the researcher protects the Type I error rate from increasing above the alpha rate that was set for the overall F test (in this study, α was equal to.05).

The results of the hierarchical analyses are presented in Table 17. With regard to the analyses wherein the INTREX Introject measure served as the criterion, Table 17 indicates, first of all, that the set of therapists' and clients' affiliation ratings did not contribute significantly to the regression equation, $F(2, 56) = 2.00$, ns. Thus, in the current study, the level of affiliation in clients' and therapists' interactions was not associated with changes that occurred in the way clients treated themselves (i.e., their introjects) from the beginning to end of therapy.

Table 17 also indicates that, having controlled for the level of affiliation in clients' and therapists' interactions, the set of therapists' Supportive and Exploratory interventions also did not contribute significantly to the prediction of clients' residual-change scores on the INTREX measure, $F(2,54) = .64$, ns. No prediction was formulated in this study regarding the extent to which therapists' interventions would contribute independently to change in clients' introjects. However, an exploratory examination of the findings from this step in the regression suggests that, independent of how positively clients and therapists interacted with one another, therapists' Supportive and Exploratory interventions

Table 17

Hierarchical Regression Analyses with the Affiliation and Intervention Ratings as Predictors and the INTREX Introject Questionnaire and Combined Outcome Measure as the Criterion Variables

Criterion Variable	Predictor	F	df	p	β	Adj. R^2	Incr. R^2
INTREX	SASB-C & SASB-T	2.00[a]	2,56	ns	-	.03	-
	SUP & EXP	.64[a]	2,54	ns	-	.03	-.00
	2-way interactions	.34[a]	4,50	ns	-	-.02	-.05
	3-way interactions	.48[a]	2,48	ns	-	-.05	-.03
Combined Outcome	SASB-C & SASB-T	3.49[a]	2,53	≤ .04	-	.08	-
	SASB-C	2.61	1,53	≤ .01	.37	-	-
	SASB-T	-1.44	1,53	ns	-.20	-	-
	SUP & EXP	.75[a]	2,51	ns	-	.12	.04
	2-way interactions	.41[a]	4,47	ns	-	.11	-.01
	3-way interactions	.69[a]	2,45	ns	-	.11	.00

Note. Adj. R^2= Adjusted R^2 ; Incr. R^2= increment of adjusted R^2 as a result of adding variable or variable set to regression equation; INTREX= residual-change scores on the INTREX Introject Questionnaire; Combined Outcome= residual-change scores on the combined outcome measure consisting of client ratings on the Symptom Checklist-90-Revised, and therapists' and independent clinicians' ratings on the Global Assessment Scale; SASB= independent observer ratings on the Structural Analysis of Social Behaviour Scale; SUP= Supportive Interventions; EXP= Exploratory Interventions; -T= scale completed by or pertaining to therapist; -C= scale completed by or pertaining to client; 2-way interactions= four 2-way interactions (SASB-T x EXP, SASB-C x EXP, SASB-T x SUP, SASB-C x SUP) entered as a set; 3-way interactions= two 3-way interactions (EXP x SASB-T x SASB-C, SUP x SASB-T x SASB-C)

Table 17 (continued)

entered as a set.
[a]F values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the analysis.

were not associated with changes that occurred in clients' introjects over the course of therapy.

Finally, Table 17 reports that, taking into account the contribution of clients' and therapists' affiliation ratings and therapists' interventions, none of the interaction terms between therapists' Supportive and Exploratory interventions, and clients' and therapists' SASB affiliation ratings contributed significantly to the prediction of change in clients' INTREX scores [for the set of 2-way interaction terms F (4,50)=.34, ns; for the set of 3-way interaction terms F(2,48)=.48, ns]. Thus, in this study the type of interventions used by therapists did not interact with the interpersonal process of therapy to predict change in clients' introject behaviours.

With regard to the analyses wherein the combined SCL-90-R and GAS ratings served as the criterion variable, Table 17 indicates that the set of therapists' and clients' affiliation ratings contributed significantly to the regression equation, F (2, 53)= 3.49, $p \leq .04$. Within this set, clients' affiliation ratings were the significant, positive predictors of the combined outcome rating, F(1, 53)= 2.61, $p \leq .01$, $\beta = .37$, while therapists' affiliation ratings did not contribute significantly to the equation. Overall, the set of therapists' and clients' affiliation ratings accounted for 8% of the variance in the combined outcome measure. In this study, therefore, the level of affiliation in clients' interactions with their therapists, but not therapists' affiliation with their clients, was positively associated with changes that occurred in clients' psychological adjustment and symptomatology over the course of therapy.

Table 17 also indicates that, having controlled for the level of affiliation in clients' and therapists' interactions, therapists' Supportive and Exploratory interventions did not contribute significantly to the prediction of clients' residual-change scores on the combined outcome measure, F (2, 51)= .75, ns. Again, an exploratory examination of the findings from this step in the regression analysis suggests that, independent of how positively clients and therapists interacted with one another, therapists' use of neither Supportive nor Exploratory interventions was associated with changes that took place in clients' psychological adjustment or symptom status from beginning to end of treatment.

Finally, Table 17 reports that, taking into account the independent contribution of clients' and therapists' affiliation ratings and therapists' interventions, none of the interaction terms between therapists' Supportive and Exploratory interventions, and clients' and therapists' SASB affiliation ratings contributed significantly to the prediction of residual-change in clients' combined outcome ratings (for the set of 2-way interaction terms F (4,47)= .41, ns; for the set of 3-way interaction terms F(2,45)=.69, ns). Thus, in this study, the type of interventions used by therapists did not interact with the interpersonal process of therapy to predict change in clients' symptoms and psychological adjustment.

Taken together, the results presented in Table 17 do not support the first hypothesis in the study. Therapists' use of neither Exploratory nor Supportive interventions interacted with neither therapists' nor clients' level of affiliation to predict therapy outcome. This was true whether therapy outcome was assessed in terms of changes in clients' introject states or, more generally, in terms of

changes in client symptomatology and psychological adjustment. Contrary to Hypothesis 1, then, the lack of significant interactions observed in this study suggests that, regardless of whether therapists or clients showed high or low levels of affiliation, therapists' use of neither Exploratory nor Supportive interventions was associated with the outcome of therapy.

Table 17 also indicates that, in the current study, therapists' interventions, whether Supportive or Exploratory, did not make an independent contribution to the prediction of change in clients over the course of therapy. This was true whether change was assessed in terms of changes in clients' introjects or changes in clients' symptomatology and psychological adjustment.

Hypothesis 2.

Two hierarchical regressions were performed to test the assertion that greater improvements would be observed in clients' intrapsychic functioning and general adjustment when therapists' interpretations, alone or in interaction with therapists' and clients' level of affiliation, focus on clients' experiences with the therapist rather than on clients' experiences in other relationships or situations. As in the analyses that tested hypothesis 1, the criterion variable in the first regression was clients' residual-change scores on the INTREX Introject Questionnaire. The criterion variable in the second regression was clients' residual-change scores on the SCL-90-R and GAS ratings combined.

Given that regression analyses do not test the significance of group mean differences, it may seem that factorial ANOVA or MANOVA would have been more appropriate to determine whether interpretations focused on the therapist

or on another object are associated with better outcomes. However, in order to use ANOVA or MANOVA procedures to make direct comparisons between the outcomes associated with either type of interpretation, it would have been necessary to group dyads according to whether therapists used one or the other type of interpretations. In this study, therapists in each dyad used both types of interpretations and therefore could not be assigned to one category or the other. At most, therapists in each dyad could be grouped on two separate variables according to whether, relative to the other therapists, they used a high or low number of interpretations focused on the therapist and whether they used a high or low number of interpretations focused on another object. This grouping procedure would have resulted in the loss of information and still would not have permitted the direct comparison of outcomes associated with the two different types of interpretation. For this reason, the decision was made to avoid the grouping of variables and to use regression analyses to determine, first of all, whether either type of interpretation was associated with outcome.

The first predictors entered into each regression equation were therapists' and clients' SASB affiliation ratings, entered as a set. The second predictors were the frequency of therapists' Exploratory interventions that focused on the therapeutic relationship (EXP-th) and the frequency of therapists' Exploratory interventions with another object focus (EXP-ot). These variables were also entered as a set. Following this, the third predictor entered into each regression was the set of 2-way interactions between therapists' Exploratory interventions with the therapist as object (EXP-th) and Exploratory interventions with another

object focus (EXP-ot), and clients' and therapists' SASB affiliation ratings. As before, the" u x v " notation was used to represent the interaction terms entered into the equation. For example, the interaction between the frequency of Exploratory interventions that focused on the therapist and therapists' SASB affiliation scores was represented by EXP-th x SASB-T. Four interaction terms were entered into each regression analysis, including: EXP-th x SASB-T; EXP-ot x SASB-T; EXP-th x SASB-C; EXP-ot x SASB-C. As in previous analyses, in order to preserve the available degrees of freedom, 2- and 3-way interaction terms (see below) that were not relevant to the study's hypotheses were not entered into the regression equations.

Finally, the fourth predictor entered into each regression was the set of 3-way interactions between therapists' Exploratory interventions that focused on the therapist as object or Exploratory interventions with another object focus, and therapists' and clients' SASB affiliation ratings. Two interaction terms were entered at this step of the analysis, including: EXP- th x SASB-T x SASB-C and EXP-ot x SASB-T x SASB-C.

The results of the hierarchical analyses are presented in Table 18. They indicate that when clients' scores on the INTREX Introject Questionnaire served as the criterion and when the contribution of therapists' and clients' SASB affiliation ratings was taken into account (the contribution of the set of therapists' and clients' SASB affiliation ratings to the prediction of change on the INTREX measure was discussed above and will not be repeated here), therapists' Exploratory interventions, whether they focused on the therapist or another

Table 18

Hierarchical Regression Analyses with the Objects of Therapists' Exploratory Interventions predicting Residual-change on the INTREX Introject Questionnaire and the Combined Outcome Measure

Criterion Variable	Predictor	F	df	p	β	Adj. R^2	Incr. R^2
INTREX	SASB-C & SASB-T	2.00[a]	2,56	ns	-	.03	-
	EXP-Th & EXP-Ot	.69[a]	2,54	ns	-	.04	.01
	2-way interactions	1.20[a]	4,50	ns	-	.13	.09
	3-way interactions	.04[a]	2,48	ns	-	.10	-.03
Combined Outcome	SASB-C & SASB-T	3.49[a]	2,53	≤.04	-	.08	-
	SASB-C	2.61	1,53	≤.01	.37	-	-
	SASB-T	-1.44	1,53	ns	-.20	-	-
	EXP-Th & EXP-Ot	2.00[a]	2,51	ns	-	.06	-.02
	2-way interactions	.73[a]	4,47	ns	-	.07	.01
	3-way interactions	.37[a]	2,45	ns	-	.05	-.02

Note. Adj. R^2= Adjusted R^2 ; Incr. R^2= increment of adjusted R^2 as a result of adding variable or variable set to regression equation; INTREX= residual change scores on the INTREX Introject Questionnaire; Combined Outcome= residual-change scores on the combined outcome measure consisting of client ratings on the Symptom Checklist-90-Revised, and therapists' and independent clinicians' ratings on the Global Assessment Scale; SASB= independent observer ratings on the Structural Analysis of Social Behaviour Scale; EXP-Th= Exploratory Interventions with therapist as object; EXP-Ot= Exploratory Interventions with other than therapist as object; -T= scale completed by or pertaining to therapist; -C= scale completed by or pertaining to client; 2-way interactions= four 2-way

Table 18 (continued)

interactions (SASB-T x EXP-Th, SASB-C x EXP-Th, SASB-T x EXP-Ot, SASB-C x EXP-Ot) entered as a set; 3-way interactions= two 3-way interactions (EXP-Th x SASB-T x SASB-C, EXP-Ot x SASB-T x SASB-C) entered as a set.
[a]F values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the analysis.

object, did not contribute significantly to the regression equation, F (2, 54)= .69, ns. Thus, in the current study, the object of therapists' interpretations was not associated with the change that occurred in clients' introject states over the course of therapy.

Table 18 also indicates that, taking into account the independent contribution of therapists' Exploratory interventions, none of the interaction terms between therapists' Exploratory interventions with the therapist as object or with another object focus and therapists' and clients' SASB affiliation ratings contributed significantly to the regression equation [for 2-way interactions, F (4,50)= 1.20, ns; for 3-way interactions, F(2,48)=.04, ns]. This suggests that, in the current study, the object of therapists' interpretations did not interact with therapists' and clients' level of affiliation to predict change in clients' introjects.

With regard to the analyses wherein the combined SCL-90-R and GAS ratings served as the criterion, Table 18 indicates that, after controlling for the significant contribution of therapists' and clients' affiliation ratings (this contribution was discussed above and will not be repeated here), neither Exploratory interventions that focused on the therapist nor Exploratory interventions with another object focus contributed significantly to the regression equation, F (2, 51)= 2.00, ns. Thus, in the current study, therapists' interpretations, whether they addressed clients' experiences in therapy or in other situations, were not associated with the change that occurred in clients' symptoms or psychological adjustment over the course of therapy.

Table 18 also indicates that, taking into account the independent contribution of therapists' Exploratory interventions regardless of object focus, none of the interaction terms between therapists' Exploratory interventions with the therapist as object or another object focus and therapists' and clients' SASB affiliation ratings contributed significantly to the regression equation [for 2-way interactions, F (4,47)= .73, ns; for 3-way interactions, F(2,45)=.37, ns]. This suggests that, in the current study, the object of therapists' interpretations did not interact with therapists' and clients' level of affiliation to predict change in client symptomatology or overall adjustment.

Taken together, the findings presented in Table 18 do not support the second hypothesis in the study. They indicate that regardless of whether outcome was assessed in terms of change in clients' introjects or, more generally, changes in clients' symptoms and psychological adjustment, therapists' interpretations that focused on the therapeutic relationship and interpretations with another object focus were not associated with therapy outcome. In addition, neither type of interpretation interacted with therapists' and clients' level of affiliation to predict outcome. Therefore, there was no evidence to support the assertion that either type of interpretation was associated with better outcomes than the other.

Exploratory Analyses

Hierarchical Regressions on Individual Outcome Variables.

The findings cited above indicate that therapists' interventions did not interact with therapists' and clients' affiliation ratings to predict outcome. Given

that one of the measures of outcome used in the above analyses was created by combining indices of client symptomatology and client adjustment, it seemed worthwhile to examine whether different results would have been obtained if the contribution of therapists' and clients' affiliation ratings and therapists' interventions had been examined separately for each of the outcome indices. Three exploratory regression analyses were therefore conducted to examine this possibility with residual-change scores on the SCL-90-R, and residual-change scores on therapists' and independent clinicians' GAS ratings each serving as a criterion for one regression. As in the previous analyses, the predictor variables were entered into each regression equation hierarchically in the following order: 1) therapist and client SASB affiliation ratings; 2) the frequency of therapists' Supportive and Exploratory interventions; 3) the 2-way interactions between therapists' and clients' affiliation ratings and therapists' interventions (excluding interactions not relevant to the study's hypotheses); 4) the 3-way interactions between the affiliation and intervention ratings (excluding interactions not relevant to the study's hypotheses).

The results of these exploratory regressions are presented in Table 19. With regard to the SCL-90-R, Table 19 indicates that the set of therapists' and clients' affiliation scores contributed marginally to the prediction of residual-change on this measure, $F(2, 53)= 2.91$, $p\leq .06$, with clients' affiliation ratings serving as a marginal, positive predictor, $F(1,53)= 1.95$, $p\leq .06$, $\beta= .28$, and therapists' afilliation ratings serving as a significant, negative predictor, $F(1,53)= -2.09$, $p\leq .04$, $\beta= -.30$, within the set. With regard to the GAS ratings, Table 19

Table 19

Exploratory Regressions with Residual-Change Scores on the Symptom-Checklist-90-Revised and the GAS Ratings as Separate Criterion Variables

Criterion Variable	Predictor	F	df	p	β	Adj. R^2	Incr. R^2
SCL-90-R	SASB-C & SASB-T	2.91[a]	2,53	≤.06	-	.07	-
	SASB-C	1.95	1,53	≤.06	.28	-	-
	SASB-T	-2.09	1,53	≤.04	-.30	-	-
	SUP & EXP	.96[a]	2,51	ns	-	.13	.06
	2-way interactions	.27[a]	4,47	ns	-	.09	-.04
	3-way interactions	.38[a]	2,45	ns	-	.07	-.02
GAS-Id	SASB-C & SASB-T	2.73[a]	2,54	≤.08	-	.06	-
	SASB-C	2.32	1,54	≤ .02	.33	-	-
	SASB-T	-.70	1,54	ns	-.10	-	-
	SUP & EXP	.56[a]	2,52	ns	-	.06	.00
	2-way interactions	.59[a]	4,48	ns	-	.04	-.02
	3-way interactions	1.38[a]	2,46	ns	-	.04	.00
GAS-Th	SASB-C & SASB-T	1.66[a]	2,56	ns	-	.02	-
	SUP & EXP	.28[a]	2,54	ns	-	.01	-.01
	2-way interactions	.64[a]	4,50	ns	-	-.03	-.04
	3-way interactions	1.21[a]	2,48	ns	-	-.03	.00

Table 19 (continued)

Note. Adj. R^2= Adjusted R^2 ; Incr. R^2= increment of adjusted R^2 as a result of adding variable or variable set to regression equation; SCL-90-R= residual-change scores on the Symptom Checklist-90-Revised; GAS-Id= Residual-change scores on independent clinicians' ratings on the GAS; GAS-Th= residual-change scores on therapists' ratings on the Global Assessment Scale; SASB= independent observer ratings on the Structural Analysis of Social Behaviour Scale; SUP= Supportive Interventions; EXP= Exploratory Interventions; -T= scale completed by or pertaining to therapist; -C= scale completed by or pertaining to client; 2-way interactions= four 2-way interactions (SASB-T x EXP, SASB-C x EXP, SASB-T x SUP, SASB-C x SUP) entered as a set; 3-way interactions= two 3-way interactions (EXP x SASB-T x SASB-C, SUP x SASB-T x SASB-C) entered as a set.

[a]F values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the analysis.

indicates that the set of therapists' and clients' affiliation scores contributed marginally to the prediction of residual-change in independent clinicians' ratings on the GAS, $F(2, 54)= 2.73$, $p\leq .08$, with clients' affiliation ratings serving as a significant, positive predictor within this set, $F(1,54)= 2.32$, $p\leq .02$, $\beta=.33$. Together, the set of therapists' and clients' affiliation ratings accounted for 7% of the variance in the SCL-90-R residual change scores and 6% of the variance in the residual-change scores of independent clinicians' GAS ratings. Table 19 indicates that the set of client and therapist SASB ratings did not contribute to the prediction of residual-change in therapists' ratings of clients on the GAS, $F(2,56)= 1.66$, ns.

Taken together, the findings in Table 19 provide tentative support for the hypothesis that clients' level of affiliation is positively associated with positive change in clients' symptoms and general adjustment over the course of therapy. The findings also suggest tentatively that therapists' level of affiliation may be associated with negative changes in clients' symptom status.

Table 19 also reports that, controlling for therapists' and clients' affiliation ratings, the set of frequency scores for therapists' Exploratory and Supportive interventions did not contribute to the prediction of change on any of the outcome measures [$F(2,51)= .96$, ns, with the SCL-90-R as the criterion; $F(2,52)=.56$, ns, with independent clinicians' ratings on the GAS as the criterion; $F(2,54)= .28$, ns, with therapists' ratings on the GAS as the criterion]. Thus, in this study, therapists' interventions were not associated independently with changes in clients' symptoms or with changes in clients' general adjustment.

Finally, Table 19 indicates that, controlling for therapists' and clients' affiliation ratings and therapists' Exploratory and Supportive interventions, the interaction terms between the affiliation ratings and therapists' interventions did not add significantly to any of the regression equations [For 2-way interactions, $F(4, 47)=.27$, ns, with the SCL-90-R as the criterion; $F(4, 48)= .59$, ns, with independent clinicians' ratings on the GAS as the criterion; and $F(4,50)=.64$, ns, with therapists' ratings on the GAS as the criteiron. For 3-way interactions, $F(2, 45)=.38$, ns, with the SCL-90-R as the criterion; $F(2,46)=1.38$, ns, with independent clinicians' ratings on the GAS as the criterion; and $F(2,48)= 1.21$, ns, with therapists' ratings on the GAS as the criterion.] These results suggest that, in this study, regardless of whether outcome was assessed in terms of changes in clients' symptom status or psychological adjustment, therapists' interventions did not interact with the interpersonal process of therapy to predict outcome.

Hierarchical Regressions with Most- and Least-Improved Quartiles on Outcome.

As reported above, significant findings were not obtained for the interaction between therapists' interventions and therapists' and clients' level of affiliation in predicting outcome when analyses included the entire sample of therapists and clients. It seemed possible that the significant interactions between these variables that are predicted by interpersonal and psychodynamic theory, and that have been reported in the literature, would be revealed if a subset of dyads were considered from within the entire sample based on the

amount and type of change that occurred. For this reason, additional analyses were conducted to explore whether therapists' and clients' degree of affiliation and therapists' interventions would predict therapeutic outcome if only the most improved quartile and the least improved quartile of clients on the INTREX Questionnaire, and the most- and least-improved quartile of clients on the combined outcome variable were included in analyses[10]. As in the original analyses, two hierarchical regressions were performed with 30 clients' residual-change scores on the INTREX Introject Questionnaire serving as one criterion and 28 clients' residual-change scores on the SCL-90-R and GAS ratings combined serving as the other criterion.

The predictor variables were entered into each regression in the following order: 1) clients' and therapists' SASB affiliation ratings; 2) the frequency of therapists' Exploratory and Supportive interventions; 3) the two-way interaction terms between therapists' and clients' affiliation ratings and therapists' interventions (e.g., EXP x SASB-T, SUP x SASB-T, EXP x SASB-C, SUP x SASB-C); 4) the three-way interaction terms between therapists' and clients'

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[10] The most- and least-improved quartile of clients was determined separately for the INTREX and combined outcome measures, and the clients included in the most- and least-improved groups on each measure were not exactly the same. Nevertheless, nine clients were included in the most-improved group on both the INTREX measure and the combined outcome rating, and six clients were included in the least-improved group on both measures.

afilliation ratings and therapists' interventions (e.g., EXP x SASB-T x SASB-C, SUP x SASB-T x SASB-C).

The results of these regression analyses are presented in Table 20. First, they indicate that the set of therapists' and clients' level of affiliation predicted change on neither the INTREX measure nor the combined SCL-90-R and GAS ratings [for the INTREX measure, $F(2, 27)= 2.46$, ns; for the combined outcome ratings, $F(2, 25)= 2.50$, ns]. This means that clients' and therapists' level of affiliation was not associated with therapeutic outcome for the most- and the least-improved quartiles in the sample. This was true whether outcome was measured in terms of changes in clients' introjects or their general adjustment and symptom status.

Table 20 also reports that, having controlled for therapists' and clients' degree of affiliation, therapists' Exploratory and Supportive interventions did not contribute to the prediction of residual-change on either outcome measure [for the INTREX measure, $F(2, 25)= .76$, ns; for the combined SCL-90-R and GAS outcome measure, $F(2, 23)= 1.08$, ns). Thus, for this subset of therapists and clients, therapists' interventions were not associated with the changes that took place in clients' introjects or in clients' psychological adjustment and symptomatology.

Finally, Table 20 indicates that, taking into account the independent contribution of therapists' and clients' degree of affiliation and therapists' interventions, none of the interaction terms between the affiliation ratings and therapists' interventions were predictive of outcome [For the 2-way interactions,

Table 20

Exploratory Regressions with the Most- and Least-Improved Quartiles on the INTREX Introject Questionnaire and Combined Termination Measure

Criterion Variable	Predictor	F	df	p	Adj. R^2	Incr. R^2
INTREX- Q	SASB-C & SASB-T	2.46[a]	2,27	ns	.09	-
	SUP & EXP	.76[a]	2,25	ns	.13	.04
	2-way interactions	.28[a]	4,21	ns	.02	-.11
	3-way interactions	2.12[a]	2,19	ns	.24	.22
Combined Outcome-Q	SASB-C & SASB-T	2.50[a]	2,25	ns	.10	-
	SUP & EXP	1.08[a]	2,23	ns	.28	.18
	2-way interactions	.09[a]	4,19	ns	.19	-.09
	3-way interactions	.55[a]	2,17	ns	.18	-.01

Note. Adj. R^2= Adjusted R^2 ; Incr. R^2= increment of adjusted R^2 as a result of adding variable or variable set to regression equation; INTREX-Q= residual-change scores on the INTREX Introject Questionnaire, including only the 15 most- and 15 least-improved dyads; Combined Outcome-Q= residual-change scores on the combined outcome measure consisting of client ratings on the Symptom Checklist-90- Revised, and therapists' and independent clinicians' ratings on the Global Assessment Scale. Residual-change scores included only the 14 most- and 14-least improved dyads; SASB= observer ratings on the Structural Analysis of Social Behaviour Scale; SUP= Supportive Interventions; EXP= Exploratory Interventions; -T= scale completed by or pertaining to therapist; -C= scale completed by or pertaining to client; 2-way interactions= four 2-way interactions (SASB-T x EXP, SASB-C x EXP, SASB-T x SUP, SASB-C x SUP) entered as a set; 3-way interactions= two 3-way interactions (EXP x SASB-T x SASB-C, SUP x SASB-T x SASB-C) entered as a set.

[a]F values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the analysis.

$F(4,21) = .28$, ns, with the INTREX measure as the criterion, and $F(4,19) = .09$, ns, with the combined outcome measure as the criterion. For the 3-way interactions, $F(2,19) = 2.12$, ns, with the INTREX measure as the criterion, and $F(2,17) = .55$, ns, with the combined outcome measure as the criterion]. Therefore, in this study, for the segment of therapist-client dyads that showed the least and the most amount of improvement over the course of therapy, therapists' interventions did not interact with clients' level of affiliation to predict outcome, as measured by changes in clients' manner of interacting with themselves and changes in clients' symptoms and overall adjustment.

Hierarchical Analyses with Affiliation and Intervention Ratings Reversed.

Clients' and therapists' SASB affiliation ratings were entered as predictors into the main regression analyses prior to the frequency scores for therapists' Exploratory and Supportive interventions. As was explained above, this order of entry seemed consistent with the assumptions of several interpersonal and psychodynamic theorists who maintain that the effectiveness of therapists' interventions depends on the status of the therapeutic relationship (e.g., Blatt & Behrends, 1987; Henry & Strupp, 1994). To explore the possibility that the reverse may be true and that therapists' interventions may actually have a mediating influence on the effectiveness of the therapeutic relationship, the first two steps of the main, hierarchical analyses were repeated with the order of entry for the intervention and affiliation ratings having been reversed. Two hierarchical analyses were performed in this manner, with clients' residual-change scores serving as criterion variables in one analysis and their combined

ratings on the SCL-90-R and GAS serving as the criterion in the other. The predictors were entered into each regression as follows: 1) the frequency of therapists' Supportive and Exploratory interventions; 2) clients' and therapists' SASB affiliation ratings. The 2- and 3-way interaction terms were not entered into these analyses because, after controlling for the influence of the intervention and affiliation ratings, the results for the contribution of the interaction terms would have been the same as the results that were already described for them in the main analyses.

The results of these analyses are presented in Table 21. They indicate that therapists' interventions, when entered into the regression equations prior to the affiliation ratings of clients and therapists, did not make a significant contribution to the prediction of either outcome variable (for the INTREX measure, $\underline{F}(2, 56)= .69$, ns; for the combined outcome measure, $\underline{F}(2,56)= 1.25$, ns). Thus, therapists' interventions were not associated with changes in clients' introjects or in their symptom status and psychological adjustment.

Table 21 also indicates that, controlling for the influence of therapists' interventions, therapists' and clients' affiliation ratings did not contribute further to the prediction of either outcome measure [for the INTREX measure, $\underline{F}(2,54)=1.51$, ns; for the combined outcome measure, $\underline{F}(2,51)= 1.52$, ns). This indicates that, having accounted for the types of interventions that were used by therapists, therapists' and clients' level of affiliation were not associated with changes in clients' introjects or in clients' psychological adjustment and symptom status.

Table 21

Exploratory Regressions with Affiliation and Intervention Ratings Reversed and INTREX Introject Questionnaire and Combined Outcome Measure as Criterion Variables

Criterion Variable	Predictor	F	df	p	Adj. R^2	Incr. R^2
INTREX	SUP & EXP	.69[a]	2,56	ns	-.01	-
	SASB-T & SASB-C	1.51[a]	2,54	ns	.03	.04
Combined Outcome	SUP & EXP	1.25[a]	2,56	ns	.01	-
	SASB-T & SASB-C	1.52[a]	2,51	ns	.12	.11

Note. Adj. R^2= Adjusted R^2 ; Incr. R^2= increment of adjusted R^2 as a result of adding variable or variable set to regression equation; INTREX= residual-change scores on the INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on clients' ratings on the Symptom-Checklist-90-Revised, and therapists' and independent clinicians' ratings on the Global Assessment Scale combined; SUP= Supportive Interventions; EXP= Exploratory Interventions; SASB= independent observer ratings on the Structural Analysis of Social Behaviour Scale; -T= scale completed by or pertaining to therapist; -C= scale completed by or pertaining to client.

[a]F values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the analysis.

Hierarchical Analyses using Dyads with Youngest Therapists.

As reported above, preliminary, covariate analyses indicated that clients who were working with younger therapists reported greater improvements in their introjects. These findings suggested that younger therapists may have worked with their clients in a manner that was different from the older therapists, and that this difference in treatment enabled clients to revise the status of their introjects. Exploratory analyses were conducted to determine whether, within the subset of dyads that were led by the younger therapists in the Vanderbilt II sample (< 37 years), therapists' and clients' degree of affiliation and therapists' interventions would interact in the manner hypothesized by psychodynamic and interpersonal theory to predict therapeutic outcome. As in the original analyses, two hierarchical regressions were performed with clients' residual-change scores on the INTREX Introject Questionnaire serving as one criterion and their residual-change scores on the SCL-90-R and GAS ratings combined serving as the other criterion.

The predictor variables were entered into each regression in the following order: 1) clients' and therapists' SASB affiliation ratings; 2) the frequency of therapists' Exploratory and Supportive interventions; 3) the two-way interaction terms between therapists' and clients' affiliation ratings and therapists' interventions (e.g., EXP x SASB-T, SUP x SASB-T, EXP x SASB-C, SUP x SASB-C); 4) the three-way interaction terms between therapists' and clients' afilliation ratings and therapists' interventions (e.g., EXP x SASB-T x SASB-C, SUP x SASB-T x SASB-C).

The results of these regression analyses are presented in Table 22. First, they indicate that the set of therapists' and clients' level of affiliation marginally predicted change on the INTREX measure, $F(2, 32)= 2.75$, $p\leq .08$, and accounted for 9% of the variance in the INTREX ratings. The affiliation ratings for clients were the significant, positive predictors within this set, $F(1,32)= 4.92$, $p\leq .03$, $\beta= .38$. This indicated that clients' level of affiliation was associated with positive change in their introjects over the course of therapy. Therapists' and clients' affiliation ratings did not predict change on the combined SCL-90-R and GAS ratings, $F(2, 25)= 2.50$, ns. This means that clients' and therapists' level of affiliation was not associated with the changes that occurred in clients' general adjustment and symptom status.

Table 22 also reports that, having controlled for therapists' and clients' degree of affiliation, therapists' Exploratory and Supportive interventions did not contribute to the prediction of residual-change on either outcome measure [for the INTREX measure, $F(2,30)= .38$, ns; for the combined SCL-90-R and GAS outcome measure, $F(2,27)= .49$, ns). Thus, for the group of therapists who were under 37 years of age, therapists' interventions were not associated with the changes that took place in clients' introjects or in clients' psychological adjustment and symptomatology.

Finally, Table 22 indicates that, taking into account the independent contribution of therapists' and clients' degree of affiliation and therapists' interventions, none of the interaction terms between the affiliation ratings and therapists' interventions was predictive of outcome [For the 2-way interactions,

Table 22

Exploratory Regressions using Therapeutic Dyads with Therapists under 37 Years

Criterion Variable	Predictor	F	df	p	β	Adj. R^2	Incr. R^2
INTREX	SASB-C & SASB-T	2.75[a]	2,32	≤.08	-	.09	-
	SASB-C	4.92	1,32	≤.03	.38	-	-
	SASB-T	.01	1,32	ns	.01	-	-
	SUP & EXP	.38[a]	2,30	ns	-	.07	-.02
	2-way interactions	1.58[a]	4,26	ns	-	.04	-.03
	3-way interactions	.97[a]	2,24	ns	-	.05	-.01
Combined Outcome	SASB-C & SASB-T	2.21[a]	2,29	ns	-	.19	-
	SUP & EXP	.49[a]	2,27	ns	-	.23	.04
	2-way interactions	.58[a]	4,23	ns	-	.27	.04
	3-way interactions	.50[a]	2,21	ns	-	.28	.01

Note. Adj. R^2= Adjusted R^2 ; Incr. R^2= increment of adjusted R^2 as a result of adding variable or variable set to regression equation; INTREX= residual-change scores on the INTREX Introject Questionnaire; Combined Outcome= residual-change scores on the combined outcome measure consisting of client ratings on the Symptom Checklist-90- Revised, and therapists' and independent clinicians' ratings on the Global Assessment Scale; SASB= independent observer ratings on the Structural Analysis of Social Behaviour Scale; SUP= Supportive Interventions; EXP= Exploratory Interventions; -T= scale completed by or pertaining to therapist; -C= scale completed by or pertaining to client; 2-way interactions= four 2-way interactions (SASB-T x EXP, SASB-C x EXP, SASB-T x SUP, SASB-C x SUP) entered as a set; 3-way interactions= two 3-way interactions (EXP x SASB-T x SASB-C, SUP x SASB-T x SASB-C) entered as a

Table 22 (continued)

set.
[a]F values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the analysis.

F(4,26)= 1.58, ns, with the INTREX measure as the criterion, and F(4,23)= .58, ns, with the combined outcome measure as the criterion. For the 3-way interactions, F(2,24)= .97, ns, with the INTREX measure as the criterion, and F(2,21)= .50, ns, with the combined outcome measure as the criterion]. Therefore, in this study, for the subset of therapist-client dyads that were led by younger therapists, therapists' interventions did not interact with clients' level of affiliation to predict outcome, as measured by changes in clients' manner of interacting with themselves and by changes in clients' symptoms and overall adjustment.

Simultaneous Regressions with the Main Research Variables

The final set of exploratory analyses consisted of two simultaneous regressions which were conducted to examine whether any of the predictors included in the main hierarchical analyses work concurrently to predict psychotherapy outcome. The criterion variables in the simultaneous regressions were the same as the criterion variables included in the hierarchical regressions (e.g., clients' residual-change scores on the INTREX Introject Questionnaire and clients' residual-change scores on the GAS and SCL-90-R ratings combined). The predictor variables included: therapists' and clients' SASB affiliation ratings, the number of therapists' Exploratory and Supportive interventions, and the two- and three-way interactions between therapists' and clients' affiliation ratings and therapists' interventions (e.g., EXP x SASB-T, SUP x SASB-T, EXP x SASB-C, SUP x SASB-C, EXP x SASB-T x SASB-C, SUP x SASB-T x SASB-C).

The results of the simultaneous regressions are presented in Table 23.

Table 23

Simultaneous Regressions with the Affiliation and Intervention Ratings as Predictors and the INTREX Introject Questionnaire and Combined Outcome Measure as the Criterion Variables

Criterion Variable	Predictor	t-score	p	β
INTREX	SASB-C	1.18	ns	.25
	SASB-T	-.22	ns	-.04
	SUP	-.39	ns	-.06
	EXP	.82	ns	.13
	SASB-T x EXP	.80	ns	.12
	SASB-C x EXP	-.35	ns	-.06
	SASB-T x SUP	.03	ns	-.14
	SASB-C x SUP	-.72	ns	.01
	EXP x SASB-T x SASB-C	.31	ns	.06
	SUP x SASB-T x SASB-C	-.83	ns	-.17
Combined Outcome	SASB-C	2.34	≤.02	.46
	SASB-T	-1.96	≤.06	-.33
	SUP	-1.60	ns	-.25
	EXP	-.11	ns	-.02
	SASB-T x EXP	.60	ns	.09
	SASB-C x EXP	-1.28	ns	-.21
	SASB-T x SUP	-.31	ns	-.06
	SASB-C x SUP	-.56	ns	-.13
	EXP x SASB-T x SASB-C	1.48	ns	.26
	SUP x SASB-T x SASB-C	-.87	ns	-.17

Table 23 (continued)

Note. $F(10,48) = .72$, ns, Adjusted $R^2 = -.05$, with INTREX Introject Questionnaire as the criterion; $F(10,45) = 1.68$, ns, Adjusted $R^2 = .11$, with the combined Termination measure as the criterion; INTREX= residual-change scores on the INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on client ratings on the Symptom-Checklist-90-Revised, and therapists' and independent clinicians' ratings on the Global Assessment Scale combined; SASB= independent observer ratings on the Structural Analysis of Social Behaviour Scale; SUP= Supportive Interventions; EXP= Exploratory Interventions; -T= scale completed by or pertaining to therapist; -C= scale completed by or pertaining to client.

They indicate that none of the variables entered into the simultaneous equation predicted residual-change on the INTREX measure, $F(10,48)= .72$, ns. When the combined termination variable served as the criterion, the overall F-test also was not significant, $F(10,45)= 1.68$, ns. However, clients' and therapists' affiliation ratings, when considered individually, were, respectively, significant, positive predictors, $t(1,45)= 2.34$, $p\leq .02$, $\beta= .46$, and marginal, negative predictors, $t(1,45)= -1.96$, $p\leq .06$, $\beta= -.33$ of residual-change on the combined outcome variable. According to Cohen and Cohen (1983), t-tests for individual variables in a regression equation can reach significance even when the overall F-statistic is not significant when most variables in the equation account for only a small amount of the variance in the criterion variable. They explain that the estimate of variance for the regression is, in fact, equal to the average contribution to the equation of each individual predictor variable. When a large number of predictors contribute only a small amount to the overall variance, this lowers the average contribution and renders the overall F nonsignificant. Cohen and Cohen (1983) recommend that, in these situations, researchers should not accept the individual predictors as significant. Rather, researchers should follow the logic of the protected t-test by accepting individual predictors as significant only when the overall F- statistic is also significant. In that way, it is argued, researchers control the probability of obtaining spurious results. In light of these recommendations, it was concluded that, in the current investigation, none of the variables entered into the simultaneous regression was a significant predictor of change in clients' status on the SCL-90-R and GAS ratings combined. Taken

together, the results in Table 23 indicate that therapists' and clients' level of affiliation, therapists' interventions, and the interactions between these variables did not work concurrently to predict change, either in clients' introjects or their overall adjustment and symptom status.

Discussion

The current study is not the first to examine the interaction of the therapeutic relationship and therapists' interventions as they contribute to the outcome of therapy. The study is, however, the first to use a clinically representative sample of clients and therapists to examine the contribution of the therapeutic relationship and specific types of interventions to a specific type of outcome, namely changes in clients' introjects or their manner of interacting with themselves. The therapy relationship was operationalized in terms of interpersonal process and it was assessed from the perspective of independent observers using the SASB model to rate both therapists' and clients' behaviours in the second 15 minutes of the third session. Therapists' interventions in the entire third session were also rated by trained observers using the Inventory of Therapeutic Strategies. Finally, changes in clients' introjects were measured in terms of clients' responses on the INTREX Introject Questionnaire before and after therapy. Changes in clients' at-worst, rather than at-best, introjects were the focus of the investigation. More general aspects of outcome were assessed in terms of changes from the beginning to the end of therapy in clients' responses on the Symptom Checklist-90 Revised, and therapists' and independent clinicians' ratings of clients on the Global Assessment Scale.

Contrary to the study's predictions and contrary to interpersonal and psychodynamic theory, the study did not find that in the context of otherwise affiliative client-therapist interactions, therapists' use of more challenging or interpretive interventions was associated with changes in clients' introjected behaviours. Likewise, the study did not find that therapists' use of more supportive interventions in the context of less affiliative relationships, brought about change in the way clients interacted with themselves. The study's results, therefore, are not consistent with previous research which found that therapists' interpretive and supportive interventions interacted with the status of the therapeutic relationship to predict change in clients' symptoms and more general aspects of functioning (e.g., Gaston & Ring, 1992; Gaston et al., 1994, 1998).

A second purpose of the study was to examine the relative contribution of therapists' interpretations that focused on clients' experiences in therapy and interpretations that focused on clients' experiences in other relationships to the prediction of outcome. Again, the overall context of the therapy relationship was considered, and outcome was assessed in terms of changes in clients' introjects as well as changes in their general adjustment and symptom status. The study's hypotheses were not supported in that, regardless of the relationship context in which therapists' interpretations were offered, interpretations that focused on clients' reactions to the therapist did not contribute more to the prediction of outcome than interpretations that were more general in scope.

In what follows, the major findings in the study will be considered more extensively as they pertain to the study's hypotheses and interpersonal and

psychodynamic theory as a whole. Following this, the implications of the study's findings will be discussed in terms of current therapeutic practice and related theory and research. Finally, methodological limitations of the study will be considered and directions for future research will be proposed.

The Therapeutic Relationship and Therapy Outcome[11]

The therapeutic relationship was included in this study as a main variable of interest because of the consistent finding in the literature that positive therapeutic relationships are associated with positive outcomes. It was also included in this study because of the widely-held assumption among psychodynamic and interpersonal theorists that a positive therapeutic relationship must be in place before other therapist techniques and interventions can have an ameliorative effect. In this study, the therapeutic relationship was assessed by independent raters using the SASB system to identify the level of affiliation in therapists' and clients' behaviours. According to the SASB model, affiliative therapist behaviours are, among other things, affirming, understanding, and nurturing. Affiliative client behaviours are self-disclosing, self-protecting, and indicate enjoyment of the interaction. The SASB system, as was discussed in earlier portions of this manuscript, has several advantages over other methods of describing the relationship, including that it provides a fine-grained analysis of

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[11] All results in this study pertaining to the main effects of therapists' and clients' SASB affiliation ratings in the prediction of outcome are credited to the Vanderbilt Psychotherapy Research Group, unpublished analyses, 1998.

clients' and therapists' moment-to-moment interactions. Ratings of the interpersonal process of therapy made by independent observers using the SASB system have also correlated consistently with measures of outcome in previous studies (e.g., Coady, 1991a, 1991b; Henry et al., 1986, 1990; Svartberg & Stiles, 1992; Tasca & McMullen, 1992).

Psychotherapy theory and research have discussed the importance of a positive therapeutic relationship offered by the therapist to the client as a vital condition for therapeutic change (Bowlby, 1988; Freud, 1912/1966; Rogers, 1957). In this study, however, the therapists' affiliative behaviours were not predictive of outcome, whether outcome was assessed in terms of changes in clients' introjects, or more general changes in clients' symptoms and psychological functioning. Clients' affiliative behaviours, on the other hand, were small but significant predictors of outcome when outcome was assessed in terms of general change but not when it was assessed in terms of specific improvements in clients' introjects.

Several theorists from a number of theoretical perspectives have hypothesized that the client's perceptions and behaviours in the therapeutic relationship are in many ways more important than the therapist's in predicting therapy outcomes. Rogers (1951,1957), for example, argues that it is important for therapists to be accepting and understanding toward clients; however, if clients do not perceive their therapists as such, then therapists' positive behaviours, as rated by outside observers or other individuals, are not likely to be predictive of change. In a related vein, Bowlby (1988) and Henry and Strupp

(1994) argue that clients' capacity to perceive positive behaviour in others and to form positive interpersonal attachments is fundamental to the success of psychotherapy. Henry and Strupp (1994) imply further that, in therapy, a direct, behavioural indicator of clients' perceptions and their capacity to attach is the quality of clients' interpersonal interactions. Together, these propositions imply that in a process-outcome study, ratings of therapists' behaviours should correlate less strongly with therapy outcome than ratings of clients' behaviours because they are less directly associated with the perceptions that cause clients to change. In addition, they imply that in some cases, namely those in which clients' perceptions of therapists' interactions are significantly different from those of outside observers, the association between observer ratings of therapists' behaviours and therapy outcome may not be significant at all.

It will be recalled that the Vanderbilt II project, from which the client sample for the current study was selected, was originally designed to help therapists work with difficult clients. In addition, 66% of the clients in the first and third cohorts of the sample were diagnosed with a personality disorder at the beginning of therapy. Several theorists, particularly those from the interpersonal perspective, propose that a defining feature of individuals with personality disorders is the extremely distorted perceptions they have of their interpersonal interactions (Benjamin, 1996; Brokaw & McLemore, 1991; Pincus, 1994). These distortions are said to develop in the context of early, dysfunctional caretaking experiences and to contribute to rigid and maladaptive interpersonal behaviours. A small number of studies have examined the perceptions of individuals with

personality disorders and compared them to those of normal controls or individuals with other diagnoses. Although some of these studies do not support the interpersonal hypotheses (e.g., Stern, Herron, Primavera, & Kakuma, 1997), others do provide evidence that individuals with personality disorders have difficulty recognizing facial expressions of emotions (Mikhailova, Vladimirova, Iznak, & Tsusulkovskava, 1997) and that they rate their family environments more negatively than do their parents (Gunderson & Lyoo, 1997). Considered in the context of the current research and in the context of the high percentage of clients with Axis II diagnoses contained in the current sample, it is conceivable that many of the clients in the sample had distorted perceptions of their interpersonal relationships and that their experience of their therapists in particular did not coincide with the way that therapists were rated by the objective observers. In that way, it is also conceivable that the independent observer ratings of therapists' behaviours did not correlate consistently with therapy outcome because they did not, in fact, represent the experiences that clients had with therapists or the factors that caused clients to change.

Though in some ways plausible, this explanation does not take into account the relatively strong, positive correlation that was observed between the SASB ratings of therapists' and clients' behaviours. If one accepts that clients' capacity to attach and, particularly, the nature of their perceptions and attachment to therapists was exemplified in the quality of clients' in-session behaviours, then the positive correlation between the observer ratings of therapists' and clients' behaviours indicates that there was some degree of

congruence between the manner in which therapists were perceived by independent observers and the manner in which they were perceived by clients. Indeed, interpersonal theory maintains that positive correlations between ratings of interpersonal behaviour often arise because of what is called the principle of complementarity. This principle is said to operate in all human interactions and is defined as a "reciprocal process by which we pull certain reactions from others and, in turn, respond with a limited set of behaviours" (Leary, 1957, p. 156). Overall, the principle of complementarity is based on the assumption that the behaviour of one individual in an interaction influences the experiences and behaviour of the other. For this reason, it can be argued that in order for ratings of an interaction to reflect a complementary pattern or for correlations to be observed between two sets of complementary behaviours, there must be a certain degree of congruence between the ratings of these behaviours and the actual experiences of the individuals involved. Furthermore, it can be argued that, in the current study, if one accepts that independent observer ratings of clients' and therapists' behaviours were correlated because the principle of complementarity was at work in their interactions, one must also accept that the affiliation ratings were to some extent valid measurements of clients' and therapists' experiences of one another. Previous research has, in fact, demonstrated that therapeutic interactions tend to be complementary, with the affiliative and disaffiliative behaviour of one individual predicting similar behaviour in the other (Henry et al., 1986; Svartberg & Stiles, 1992; Tasca & McMullen, 1992). To the extent that the current results corroborate these

findings, it can be argued that the lack of association that was observed between therapists' behaviours and outcome was due to other factors than simply a lack of congruence between the ratings of therapists' behaviours and the interpersonal experiences that clients had with therapists in therapy.

Another difficulty with the largely nonsignificant association that was observed in this study between the SASB ratings of therapists' behaviours and ratings of outcome stems from the fact that Henry et al. (1990), using a subset of the Vanderbilt II sample, did observe a significant association between these variables. Henry et al.'s (1990) sample was drawn from the first cohort of the Vanderbilt II project (total n for first cohort = 32 clients) and consisted of the seven least- and seven most- improved clients. Therapists' SASB-rated behaviours were summarized in terms of the different foci and clusters that are represented in the SASB model. In a manner similar to the current study, therapists' behaviours were also summarized in terms of the overall percentage of communications that received at least one disaffiliative code. Henry et al.'s (1990) findings indicated that therapists treating the least-improved clients differed from those treating the most-improved clients in two cluster categories: they were more belittling and blaming (Cluster 6), and more ignoring and neglecting (Cluster 8). They also offered a higher percentage of disaffiliative communications overall. This latter finding conflicts more or less directly with the results of the current study which found that the overall proportion of affiliative therapist communications was not related to the outcome of therapy.

As indicated above, one major difference in methodology between Henry

et al.'s (1990) investigation and the current study was that the former study was based on a relatively small subset of clients that were included in the latter. It could be argued that this difference alone accounts for the difference in findings between the two studies and that similar results would have been obtained if the samples had been more comparable. In this regard, however, it is important to note that exploratory analyses were conducted in the current study on a restricted sample consisting of the 15 most- and 15 least-improved clients, both on the Introject Questionnaire and on the combined termination rating, and that these analyses still did not yield significant results. Respectively, 50% (n= 15) and 46% (n= 13) of the clients included in these exploratory analyses were from the same cohort (i.e., Cohort I) of the Vanderbilt II project as the clients in Henry et al.'s (1990) investigation.

Perhaps a more important difference in the methodologies of the two studies was the manner in which observer ratings of therapists' behaviours were summarized. Again, Henry et al.(1990), in addition to simply tallying the percentage of disaffiliative communications, categorized therapists' behaviours into the appropriate SASB foci and clusters. This method of summation conveys a considerably greater amount of information than the method that was used in the current investigation, including information about the relative interdependence of the behaviours being rated, which is the third dimension in the SASB model. It is possible that the greater detail with which the cluster data in Henry et al.'s (1990) study described therapists' and clients' interactions increased the probability that these data would yield significant results. This

possibility is suggested not only by the discrepancy in findings between Henry et al.'s (1990) study and the current investigation, but also by the pattern of results reported by Coady (1991a) in his study of client and therapist interpersonal process and psychotherapy outcome. In a manner similar to Henry et al. (1990), Coady (1991a) summarized therapists' behaviours in terms of the overall percentage of disaffiliative communications and in terms of the SASB foci and clusters that they represented. Also similar to Henry et al., Coady (1991a) based his analyses on a small sample of clients with good (n= 5) and poor outcomes (n= 4). Unlike Henry et al., Coady (1990) observed significant associations between therapists' SASB-rated behaviours and outcome only when the behaviours were summarized in terms of the different SASB categories but not when they were summarized as the percentage of disaffiliative communications. Thus, it seems that whatever association there was between the specific categories of therapists' behaviours and outcome, this was lost when the behaviours were grouped together in more general terms. To the extent that Coady's (1991a) findings generalize to the current situation, it is possible that different results would have been obtained in the present study if the SASB ratings of therapists' behaviours had been categorized into discrete SASB clusters.

It is important to note that in the current study, ratings of clients' behaviours were also summarized in terms of the proportion of affiliative and disaffiliative behaviours but, unlike the ratings of therapists' behaviours, they predicted outcome when outcome was assessed in terms of changes in

symptoms and general adjustment. This is noteworthy because, in comparison to the ratings of client behaviours, those of therapist behaviours, when they were converted to proportion scores, were more variable in nature and therefore more likely, from a statistical standpoint, to vary with other aspects of the therapeutic endeavour. To account for the discrepancy in findings, it may be plausible to assume, as was suggested earlier, that clients are the more important participants in the dyad, and, short of discounting therapists' contribution entirely, it is possible that clients' behaviours are the more reliable indicators of how the therapeutic relationship is going and the effect that it is having on clients' efforts to change. Indeed, the association between clients' SASB-rated behaviours and outcome may be stronger than that between therapists' behaviours and outcome, and therefore the association may be more robust to variations in the way ratings of client behaviours are summarized.

Together with the findings of the current study, evidence in support of the proposition that clients' behaviours play a greater role in predicting the outcome of therapy can be taken from a recent study that examined the association between the therapeutic alliance and outcome in interpersonal and cognitive-behavioural psychotherapy, pharmacotherapy, and a clincial management placebo (Krupnick et al., 1996). In this study, therapists' and clients' contribution to the alliance was assessed by independent observers using the Vanderbilt Therapeutic Alliance Scale. Outcome was assessed in terms of pre- to post-therapy changes in clients' responses on two self-report measures of depression. Similar to the current findings, this study reported that observer

ratings of clients', but not therapists', contribution to the alliance were associated with outcome in all four treatment modalities. Support for the stronger contribution of clients' behaviours to outcome can also be taken from the fact that in the studies conducted by Henry et al. (1990) and Coady (1991a), the number of SASB clusters describing client behaviours that were associated with outcome far exceeded the number of clusters that described therapists' contribution to the relationship.

On the other hand, a previous study conducted by Henry et al. (1986), which was based on a different sample, also summarized therapist and client behaviours in terms of the different SASB clusters and foci, but found that an equal number of SASB clusters for therapists and clients were related to therapy outcome. It is also noteworthy that in Coady's study, unlike in the current investigation, the categorization of clients' behaviours in terms of the percentage of communications that received a disaffiliative code, did not relate significantly to measures of client change. Thus, in the end, it may be necessary to conduct additional research on the relative contributions of therapists' and clients' interpersonal behaviours to the outcome of therapy before the association between therapists' behaviours and outcome and, particularly, the lack of significant findings in the current study can be fully understood.

Ratings of therapists' behaviours did contribute to the prediction of outcome in exploratory analyses. For example, SASB-ratings of therapists' affiliative behaviours were negative predictors of changes in clients' symptoms when the client-rated residual-change scores on the SCL-90-R were separated

from therapists' and independent clinicians' ratings of clients on the GAS to represent therapy outcome. In addition, ratings of therapists' behaviours contributed negatively to the prediction of outcome in a simultaneous regression where the SCL-90-R was combined with the GAS to serve as the outcome measure. The two analyses yielded similar results because in both instances therapists' SASB-rated behaviours were, surprisingly enough, negative predictors of change and because therapists' SASB-rated behaviours, when considered together with the positive contribution of clients' behaviours, accounted for similar amounts of the outcome variance (7% and 11% respectively).

In both analyses, the negative contribution of therapists' SASB-rated behaviours to the prediction of outcome was marginal in significance. In the first analysis, the findings were obtained in partial violation of the procedures outlined for conducting regression analyses with protected t-tests. These procedures specify that, in order to maintain the Type I error rate for an analysis at an acceptable level (in this case, alpha was set at .05), the contribution of individual predictors in a regression should only be considered when the set of predictors of which the individual variable is a part makes a significant contribution to the regression equation. In the current study, the set of therapists' and clients' SASB-rated behaviours predicted client symptom change on the SCL-90-R only marginally at a p-value of .06. By proceeding to examine the individual contribution of therapists' and clients' behaviours despite the marginal contribution of the predictor set, the Type I error rate for the entire analysis was

also increased above the traditional .05 level. In the second, simultaneous regression, the overall F-test was not significant and the contribution of therapists' behaviours to the prediction of outcome was also marginally significant at the .06 level.

A p-value of .06 is only slightly above the Type I error rate that is deemed acceptable in the scientific community. For this reason, it seems worthwhile to consider the possibility that the exploratory findings revealed genuine associations between therapists' interpersonal behaviours and clients' improvement in therapy. A number of explanations can be offered for the unexpected, negative association that was observed between these variables, including that clients who enjoyed more positive relationships with their therapists became more attached to their therapists and therefore felt more anxious about terminating their treatment as their sessions continued. Alternatively, it has already been suggested that a large number of clients in this study, particularly those who had been diagnosed with personality disorders, may have misconstrued the positive behaviours of their therapists. Although it seems that this would have been more likely to occur later in therapy after the "honey-moon" phase was over, it is possible that, even in the third session, the clients with personality disorders in the current sample were vulnerable to interpreting the positive behaviours offered by their therapists in terms of the negative experiences they endured with others in the past. These interpretations may have contributed to the negative association between therapists' affiliative behaviours and changes in clients' symptoms.

As was already discussed above, this latter explanation is difficult to reconcile with the positive correlation that was observed between therapists' and clients' SASB-rated behaviours. The former explanation is also difficult to reconcile with the fairly consistent finding in the literature that positive therapist behaviours and characteristics, when they predict outcome, generally do so in a positive direction (Orlinsky, Grawe, & Parks, 1994). Indeed, when one considers the SASB literature in particular, it becomes apparent that negative associations between positive therapist behaviours and outcome have never been reported (see Summary presentation in Table 1). Considered overall then, it may be important to approach these unexpected, exploratory findings with caution and to remain open to alternative explanations for what may have been spurious results.

Therapists' Interventions, the Therapeutic Relationship, and Therapy Outcome

No predictions were made in this study regarding the independent contribution of therapists' interpretations and supportive interventions to psychotherapy outcome. In some ways, the nonsignificant association that was observed between these variables is consistent with the findings of previous research which has shown that individual categories of interventions rarely contribute to the prediction of therapeutic change (Elliott et al., 1987; Hill et al.,1988). This study may therefore be another demonstration that the independent association between specific therapist interventions and psychotherapy outcome is, at best, very weak or, at worst, nonexistent, and therefore difficult or impossible to observe.

The lack of significant interactions that were observed between therapists' interventions and the interpersonal process of therapy is more difficult to explain, especially since the current study was designed as an extension of Gaston et al.'s (Gaston & Ring, 1992; Gaston et al., 1994, 1998) research which reported fairly promising results. Using Gaston's (1988) Inventory of Therapeutic Strategies (ITS), Gaston et al. measured the content and intent of therapists' interventions and reported with some degree of consistency that therapists' interpretations (or exploratory interventions) were predictive of positive outcome when the therapy relationship was rated as positive on the California Psychotherapy Alliance Scale, and that therapists' supportive interventions predicted positive outcomes when ratings of the relationship were more negative. To the extent that the current findings do not coincide with those of the previous investigations, they need to be examined closely. In the following sections, therefore, specific aspects of the current study's methodology will be examined that may, in and of themselves, account for the nonsignificant findings. Following this, the methodologies of the current study will be compared with those of previous investigations to identify additional factors that may have contributed to the discrepant results.

The Current Methodology: Rating Methods for the ITS and SASB Measures.

To begin with the current methodology, one factor that may have contributed to the nonsignficant interaction that was observed between the therapeutic relationship and therapists' interventions is the different rating

procedures that were used to assess the relationship and intervention variables in this study. The unit of analysis in the SASB rating method which was used to assess the therapeutic relationship was the "thought unit" which is defined as any portion of speech that expresses a "`complete thought' or a `psychologically meaningful' answer" (Grawe-Gerber & Benjamin, 1989, p.6). For the most part, thought units are phrases and, rarely, entire sentences. In the Vanderbilt II project, from which the SASB data for this study were derived, independent observers used videotapes and transcripts to rate each therapist and client thought unit in the second 15-minute segment of the third session. The observer ratings were summarized for both therapists and clients in terms of the proportion of thought units that were rated as affiliative over the total number of units rated. These summary scores were then entered into analyses.

Therapists' interventions were operationalized in this study in terms of observer ratings on the ITS. The units of analysis for the ITS ratings were therapists' sentences. Independent observers rated each therapist sentence in the entire third session using audiotapes and transcripts. These ratings were then summarized in terms of the frequency of therapists' statements that were supportive and the frequency of statements that were exploratory, and these frequency scores were later entered into analyses.

It is difficult to speculate on the extent to which the slightly different units of analysis and the different methods of summarizing the SASB and ITS ratings affected the results. It is possible that these differences introduced confounds into the rating procedures and that these confounds reduced the likelihood that

the two variables would interact . According to Lambert and Hill (1994), very little research has been conducted to determine the effects that different units of analysis have on empirical findings. Their recommendation is for researchers to "choose units that match their constructs, balancing issues of reliability of judging the unit and clinical meaningfulness" (p. 97). On the surface, it seems that both of these criteria were met in the current investigation.

Perhaps a more important difference in the rating procedures pertains to the fact that the SASB ratings were based on observations of the second 15-minute segment of the third session whereas the ITS ratings were based on observations of the entire session. This implies that the SASB and ITS ratings were based on different amounts of information and it raises the possibility that the SASB and ITS ratings did not interact in this study because they were not equally representative of the relationship and intervention variables that they were intended to measure. Prior research has examined whether ratings of therapists' and clients' behaviours that are based on segments of single sessions can be generalized to represent participants' behaviours in entire sessions (Friedlander et al., 1988; Weiss, Marmar, & Horowitz, 1988). The rating scales that were included in these studies (i.e., The Hill Counselor Verbal Response Category System, Revised; The Family Therapy Coding System; The Classification System for Counseling Response - Client; The Therapist Action Checklist; and The Patient Action Checklist) examined primarily therapists' and clients' verbal response modes and therapists' interventions. The results showed that for each of the rating scales, ratings from segments could be

generalized to entire sessions, but only if the data were aggregated across sessions. This research suggests that, in this study, similar ratings may have been obtained on the SASB measure regardless of whether segments or entire sessions had been rated, and that, with all other rating procedures being equal, it was reasonable to assume that the SASB and ITS ratings would interact . Further research is required to confirm that the findings of the preceding studies actually apply to the SASB rating method, however, given that the SASB system is fairly complex and, in comparison to other rating scales, yields very sophisticated assessments of therapists' and clients' interpersonal behaviours.

Another point to consider with respect to the rating procedures is the difference in stimulus materials that were used by observers to make the SASB and ITS ratings. As was indicated above, raters in the Vanderbilt II project used transcripts and video-tapes to make the SASB ratings whereas raters who were hired for the current study used transcripts and audiotapes to make the ITS ratings. Again, this implies that, in this study, the ratings of the therapeutic relationship and of therapists' interventions were based on different amounts of information. Financial concerns and ethical constraints precluded the use of video-tapes to make the ITS ratings. Nevertheless, the difference in rating methods may have differentially affected the representativeness of the ITS and SASB ratings and this may have affected the likelihood that the ratings would interact. Research on the effects that different stimulus materials have on ratings of the therapeutic process has yielded varying results (see Lambert & Beutler, 1994). One recent study provided fairly convincing evidence that ratings

of process variables that are made using the Interpersonal Communications Rating Scale (ICRS) are comparable regardless of whether they are based on video- or audio-taped segments of sessions (Tracey & Guinee, 1990). This study is important because the ICRS measures very similar dimensions of behaviour (e.g., affiliation, power, extremity) to those that are assessed by independent observers using the SASB system. On the other hand, a study conducted by Weiss et al. (1988) reported that observer ratings on the Therapist and Patient Action Checklists were more reliable when observers used video- rather than audio-tapes of sessions. Although the Checklist rating method is in many ways different from the procedures followed by the SASB and ITS raters in the current study, Weiss et al.'s findings do raise the possibility that the differences in stimulus materials that were used to obtain ratings in this study had an impact on the results.

Considered overall, then, the rating procedures used in this study for the SASB measure differed in several respects from those that were used to obtain ratings on the ITS. Although it may seem that each of these differences, when considered individually, was not likely to have a substantial influence on the final ratings, it is possible that the effect of these differences was cumulative and that their impact on the study's overall findings was quite strong. Clearly, future research will need to investigate this possibility further. In the meantime, however, it is important to regard the differences in rating methods as a limitation of the study and to consider the potential impact that these differences had on the results.

A final aspect of the present methodology that may have contributed to the nonsignificant findings was already alluded to above and pertains to the fact that information about the relative interdependence of therapists' and clients' interpersonal behaviours was excluded from the current analyses. SASB ratings of therapists' and clients' behaviours along the interdependence dimension is included in the Vanderbilt II database. However, the researcher chose not to use the interdependence ratings or the SASB cluster ratings because there was a need to reduce the number of variables included in analyses and because interpersonal and psychodynamic theory places the greatest emphasis on the affiliative dimension of therapists' and clients' interactions. The sophisticated nature of the SASB rating method and its extensive validation in the literature also appeared to justify the decision to focus on only one dimension of the SASB ratings. In retrospect, however, it is possible that by including information about the interdependence of therapists' and clients' behaviours in analyses a more elaborate description of therapists' and clients' interactions would have been provided. This more elaborate description may have increased the likelihood that the ratings of therapists' and clients' behaviours would interact with ratings of other aspects of the therapeutic endeavour, including ratings of therapists' interventions.

A Comparison of the Current and Previous Methodologies.

The methodology of the current study differed in several respects from the methodologies used by Gaston and her colleagues in previous research, most notably in the clients that were included in the samples, the point during therapy

at which the relationship and intervention ratings were obtained, and the manner in which the therapeutic relationship was assessed. In the following paragraphs, the nature of these differences will be elaborated upon and the impact they may have had on the current findings will be discussed.

The client samples in the current and previous studies differed primarily with regard to the psychiatric diagnoses that clients received at the beginning of therapy. Clients in the current sample reported a range of problems, although clients with only mild and/or situational difficulties were excluded from the Vanderbilt II study, from which the current sample was derived. At the onset of therapy, 66% of the clients included in the present sample were diagnosed with a DSM-III personality disorder. In Gaston et al's 1994 study, clients also reported a broad range of problems; however, only 30% of these clients received a DSM-III Axis II diagnosis. The percentage of clients diagnosed with personality disorders in Gaston et al.'s 1998 study was comparable to that in the current investigation (66%); however, these clients were diagnostically more homogeneous because all of them also received a current diagnosis of major depression (the percentage of clients with Axis II diagnoses was not reported by Gaston and Ring, 1992).

With regard to the overall pattern of results, the findings reported by Gaston et al. in their 1994 study were the most consistent with the predictions of interpersonal and psychodynamic theory. This study was the only one in Gaston et al.'s publications to report that positive outcomes were associated both with more frequent interpretations in the context of positive therapeutic relationships

and with more frequent supportive interventions in the context of relationships that were more negative. Gaston et al.'s other studies reported significant interactions between therapists' interpretations and the alliance, or between therapists' supportive interventions and the alliance, but not both. Gaston et al.'s 1994 study therefore differed from the current investigation and from Gaston et al.'s 1992 and 1998 studies both in terms of the greater consistency of its findings and in terms of the lower level of disturbance that was represented in the client sample. Together, the differences between Gaston et al.'s 1994 study, the current investigation, and previous research conducted by Gaston and her colleagues may indicate that therapists' interpretive and supportive interventions and the therapeutic relationship are more likely to have the effect predicted by interpersonal and psychodynamic theory when clients are less psychologically disturbed.

Further research will be required to clarify whether and how clients' psychiatric diagnoses affect the manner in which therapists' interventions and the therapeutic relationship interact. In line with the propositions of interpersonal theory, however, it seems plausible that in the current study and in Gaston et al.'s 1992 and 1998 studies, clients with personality disorders behaved in therapy in a more erratic manner than the clients with less severe difficulties in Gaston et al.'s (1994) investigation, and that they responded less consistently to therapists' interventions or not at all. It also seems plausible that, in the current investigation, therapists had more difficulty working with clients diagnosed with character-based disorders and that they offered their interventions to these

clients in a less congruent manner. Some evidence to support the latter proposition can be derived from a recent study conducted by Rosenkrantz and Morrison (1992). In this study, therapists were presented with clinical vignettes of therapy sessions in which patients with borderline personality disorder projected either a "Rewarding object relations unit" (i.e., they projected a positive self-image that idealized the other and relied on him/her to fulfil needs) or a "Withdrawing unit" (i.e., they projected a negative self-image that viewed the other as hostile and punitive). Following this, therapists rated how they imagined themselves reacting in the reported sessions. The results showed that therapists who read the "Rewarding" vignettes rated themselves more positively and saw themselves as more active and powerful than did those who read the "Withdrawing" vignettes. To the extent that Rosenkrantz and Morrison's findings generalize to the current investigation, they may indicate that the greater percentage of clients with personality disorders in the current study presented unique difficulties to therapists, and that these difficulties affected the manner in which therapists intervened and the outcomes they attained.

The studies conducted by Gaston et al. also differed from the current investigation with regard to the length of treatment that was offered and the points during treatment for which ratings of the alliance and therapists' interventions were obtained. Unlike in the current investigation in which treatment was limited to 25 sessions for all clients, therapists in Gaston et al.'s 1994 study offered long-term treatment (Mean number of sessions = 76) to 15 of the 32 patients included in their sample. Also unlike the current investigation in

which ratings of the therapeutic relationship and therapists' interventions were obtained only for the third session, independent judges in all of Gaston et al.'s studies provided relationship and intervention ratings after early, middle, and late sessions. With regard to results, Gaston et al. (1994) found that significant interactions between the alliance and intervention ratings occurred only for the clients in long-term therapy. Similarly, in Gaston et al.'s 1998 study, which examined the interaction between therapists' interventions and the therapeutic alliance at three different points in treatment, significant interactions were only observed after the 10th session. Considered overall, then, the pattern of findings reported by Gaston and her colleagues may indicate that the timing with which therapists offer their interventions plays a role in their overall effect, and that the effects of therapists' interventions may not interact with the status of the therapeutic relationship until therapy is well-underway. With regard to the current study, it is possible that therapists' use of the relationship and supportive and interpretive interventions did not contribute to the prediction of outcome because these variables were assessed at such an early stage in treatment. It is also possible that therapists in the current study did not use interpretive interventions, in particular, at a rate that would have contributed to outcome until later in therapy when the relationship was well-established or the client's pertinent issues had become clear. To some extent the preceding hypotheses are indirectly supported by studies which have found that therapists are most confrontational during the middle portions of treatment, and that a low-high-low pattern of confrontation across the early, middle, and later stages of therapy is

associated with positive outcomes (Dietzel & Abeles, 1975; Sexton, Hember, & Kvarme, 1996; Tasca & McMullen, 1992). Clearly, additional research will need to be conducted to confirm whether the point in therapy at which therapists' interventions and the therapeutic relationship were assessed had an impact in the present study on whether significant interactions between these variables were observed.

Finally, the manner in which the therapeutic relationship was assessed in the current study differed in several respects from Gaston et al.'s investigations. For example, the measures that were used to assess the therapeutic relationship in the two sets of studies focused on different relationship dimensions. The current study used the SASB observer method to rate both therapists' and clients' affiliative contribution to the therapeutic relationship. Gaston and her colleagues, on the other hand, used the rater version of the California Psychotherapy Alliance Scale (CALPAS-R; Marmar & Gaston, 1988) to assess only the patient's contribution to the therapeutic relationship. Two subscales of the CALPAS-R were included in Gaston et al.'s analyses: the Patient Working Capacity (PWC) subscale and the Patient Commitment (PC) subscale. The PWC subscale measured characteristics of the patient that enabled him or her to participate in therapy, such as his or her capacity to self-disclose, to observe him or herself and modulate emotional experiences, and her or his ability to work actively with the therapist's comments (Gaston & Marmar, 1994). The PC subscale measured affective aspects of patients' participation in therapy, including their confidence in the therapy process, their willingness to make

sacrifices in therapy, and their trust in therapy and the therapist. Some items on the PWC and, particularly, the PC subscales on the CALPAS-R tap client characteristics and behaviours (e.g., trust and confidence in the therapy process, and the ability to self-disclose) that may contribute to or be related to the level of affiliation that clients demonstrate in sessions. Overall, however, the CALPAS-R, in contrast to the SASB, focuses on intrapersonal aspects of clients' participation in therapy, rather than on interpersonal facets of their interactions with therapists. In addition, the CALPAS-R, more so than the SASB, focuses on client characteristics and behaviours, particularly client involvement, that are specifically relevant to the work of therapy, rather than on relationship dimensions that are also relevant to many other types of interactions. The greater specificity with which the CALPAS-R applies to the therapeutic situation may have rendered it more likely to interact with ratings of other aspects of the therapeutic endeavour, including measures of therapists' interventions.

The measures that were used in the current and previous investigations also followed very different rating procedures. In the current study, independent observers provided affiliation ratings for each therapist and client behaviour that occurred in the second 15-minute segment of the third therapy session. The multiple ratings were then summarized into a single score that represented the overall proportion of affiliative ratings. In Gaston et al.'s research, independent observers provided general ratings of clients for the entire session on each of six PWC and PC subscale items. The average of these ratings for each subscale was then entered into analyses. To some extent, the methods used by the

SASB rating system may have provided more accurate ratings because they were based on smaller units of behaviour and required raters to make fewer inferences at each step of the rating process. However, in contrast to the CALPAS-R ratings, the SASB ratings were only obtained for a segment of the third session. Although these ratings may generalize to the entire session, it is possible that important information about the therapeutic relationship from other portions of the third session was excluded from the SASB ratings and that this reduced the likelihood that the SASB measure, in comparison to the CALPAS-R measure, would interact with ratings of therapists' interventions.

Finally, the stimulus materials that were used to make the SASB and CALPAS-R ratings were the same in both sets of studies (i.e., videotapes). However, only in Gaston et al.'s research did they correspond to the materials that were used to assess therapists' interventions. Again, it is possible that the similarity in rating procedures that were used to assess the relationship and intervention variables in Gaston et al.'s research increased the likelihood, relative to the current study, that significant interactions between these variables would be observed.

Taken as a whole, the methodologies of the current and previous studies, despite their differences, are similar in many ways, especially with regard to the overall constructs that were measured and the types of analyses that were employed. The differences between the two sets of studies may nevertheless have been substantial, especially when the additive effects they may have had on the empirical findings are considered. Future studies, therefore, would do

well to design alternative methods in which the effects of these differences are more adequately controlled so that the true nature of the interaction between therapists' interventions and the status of the therapeutic relationship can be better understood.

Exploratory Findings.

Exploratory analyses were conducted in the present study to determine whether reversing the order of the intervention and relationship variables in the first two steps of the hierarchical analyses would yield different results from those that have already been discussed. These analyses were conducted in part because Gaston and her colleagues (1994, 1998) entered the ITS ratings of therapists' interventions and ratings of the therapeutic alliance into their hierarchical analyses in this order. Their reading of psychoanalytic theory seemed to be that therapists' interventions, in some cases, mediate the effectiveness of the therapeutic alliance in contributing to positive outcomes. Citing Zetzel (1956) and Greenson (1965) in particular, they argued that weak alliances with clients can be improved through the use of supportive interventions and that this can lead to more positive therapeutic results. Other authors have taken a similar stance and have hypothesized that a range of therapist activities, including their interpretive and supportive interventions, impact on the status of the alliance (Allen et al., 1996; Bond, Banon, & Grenier, 1998; Sexton et al., 1996). The current study took an alternative position and, in keeping with the emphasis implied in Henry and Strupp's writings (1994) and the writings of Blatt and Behrends (1987), it was argued that the therapeutic alliance

is what mediates the effectiveness of therapists' interventions. In the end, it is likely that both positions have merit and that both are consistent with psychoanalytic/psychodynamic thought (Henry et al., 1994). For this reason, it appeared worthwhile to explore the alternative point of view.

The results of the exploratory analyses were inconclusive. They indicated that when the order of entry was reversed, neither therapists' interventions nor the ratings of therapists' and clients' level of affiliation predicted change in clients' introjects or more general improvements in clients' symptoms and adjustment. The previously significant contribution to outcome that was observed for clients' SASB-rated behaviours was no longer in effect when this variable was entered into analyses after the ratings of therapists' interventions. At the same time, therapists' interventions did not contribute significantly to the prediction of outcome and therefore could not be regarded as a mediating factor.

Especially with regard to the findings that pertain to the SASB-ratings, the results of the exploratory analyses do not coincide with the large number of studies in the literature which, using a range of statistical procedures, have concluded that the therapeutic relationship is a strong predictor of outcome (Henry et al., 1994; Horvath & Symonds, 1991; Orlinsky et al., 1994). Even Gaston et al. (1994, 1998) found that ratings of the alliance predicted therapeutic improvements in regression analyses when the alliance ratings were entered into the regression equations after the ratings of therapists' interventions. To account for the unexpected findings, it may be necessary to consider again the manner in which the SASB ratings were summarized. As was indicated above, the act of

summarizing the SASB data for therapists and clients in terms of the proportion of their behaviour that was affiliative versus the total number of behaviours that were rated resulted in the loss of information about the relative interdependence of therapists' and clients' interactions. This information would have been available if the SASB data from the Vanderbilt II project had been summarized in terms of the SASB clusters. It is possible that the simpler descriptions of the interpersonal process that were offered by the affiliation proportion scores resulted in weaker associations between clients' (and possibly therapists') SASB-rated behaviours and outcome than would have been observed if the ratings had been summarized in terms of the multi-dimensional SASB clusters. It is also possible that any reductions in statistical power that resulted from delegating the SASB proportion scores to later stages in the hierarchical analyses nullified the effects that were previously obtained, at least for the SASB ratings of cients' behaviours.

Finally, exploratory, correlational analyses revealed that therapists' use of supportive interventions was negatively associated with clients' post-treatment scores on the SCL-90-R. This implied that the more supportive therapists were in the third session, the higher the number of reported symptoms by the client when therapy was completed. At first glance, this could suggest that supportive types of therapy are potentially harmful to clients. However, this conclusion would be premature because clients' post-test scores on measures of symptomatology reveal nothing, in and of themselves, about how much clients' symptoms changed over the course of therapy. As was discussed above, a

better indicator of change is the residual-change score which takes into account the difference between clients' pre- and post-test ratings on a measure of outcome while controlling for clients' initial status on that variable. In the current study, therapists' use of supportive interventions was not associated with the residual-change that occurred in clients' scores on the SCL-90-R from beginning to end of treatment.

An alternative explanation for the negative correlation between the frequency of therapists' support and clients' symptom status at the end of therapy is that therapists tended to offer more support to clients whom they perceived as experiencing greater amounts of distress. The reasons for therapists' higher level of support may have been varied. For example, therapists' may have believed that providing added support would help to relieve their clients' symptoms. In addition, therapists, themselves, may have experienced a reduction in anxiety when they felt that they were being supportive. Finally, highly distressed clients may actually have pulled for more supportive interventions from therapists and they may have resisted interventions that were more challenging in nature. It is of interest that therapists' level of support correlated only with clients' post-treatment scores on the symptom measure and not with clients' symptom status before therapy began. This may indicate that it took time for therapists to assess the extent of their clients' difficulties and for them to decide on how to intervene.

Psychotherapy Process and Introject Change

The fact that significant findings were not obtained in this study for the

changes that took place in clients' introjects warrants special attention because the introject concept was central to the entire investigation. Several methodological issues have already been discussed that may account for the nonsignificant findings that pertain to the prediction of outcome in this study as a whole. Some additional issues that pertain to the nonsignificant prediction of changes in clients' introjects in particular also need to be considered.

It is important to recall that changes in the affiliative dimension of clients' at-worst introjects were hypothesized to occur when therapists' interventions, particularly their interpretations, introduce an element of loss into clients' experience of the therapeutic relationship. This loss, when it occurs in the context of otherwise affiliative interactions and adequate amounts of support, was said to provide the motivating force by which clients begin to do for themselves what previously they were depending on their therapists to do for them; they begin to treat themselves in a caring and affiliative way. A component of psychodynamic/psychoanalytic theory that was not discussed in the introduction to this study and was not incorporated into the study's design maintains that therapists' interpretations, in so far as they challenge clients' perceptions, represent just one potential area of loss for clients. Theorists have argued that other losses may also play a role in helping clients' introjects to change, including, for example, the loss clients feel when their therapists go on vacation, or the loss in closeness they experience when they do not feel understood (Blatt & Behrends, 1987; Safran, 1993). An assumption that may therefore be implied in psychodynamic/psychoanalytic theory is that each of the

losses that clients experience in therapy, when considered individually, may have a relatively small effect on clients' intrapsychic behaviours, but when considered together their effect may be quite large. In the current study, if assessments of other client losses had been included in analyses along with the measure of therapists' interpretations, it is possible that their cumulative effect would have been more substantial and that significant results involving clients' introjected behaviours would have been observed.

Another point of consideration is that clients' at-worst ratings on the INTREX Introject Questionnaire may have been a less reliable indicator of change than other measures of outcome, and therefore less likely to be associated with any of the process variables. Internal consistency coefficients for at-worst ratings on the Introject Questionnaire are reported to be adequate in the validation literature. However, Benjamin (1984, 1995) has acknowledged that the test-retest reliabilities of at-worst ratings, especially among clinical populations, are considerably lower than the reliability ratings for at-best ratings, and that at-worst ratings are liable to vary with the client's mood at the time of testing. At-worst introject ratings were used in this study because they are less likely than at-best ratings to reflect socially desirable answers and because prior research has shown at-worst ratings to correlate with other indices of psychological change and to be predictive of outcome (Harrist et al., 1990; Henry et al., 1990). In addition, Benjamin (1984,1995) argues that the variability in clients' at-worst ratings from one testing session to another may actually reflect the lack of stability clients have experienced in their interpersonal relationships.

To that end, she maintains, rather than invalidating the ratings as accurate measures of client functioning, the variability may, in fact, confirm their validity by representing a diagnostically important aspect of client pathology.

The variability of clients' introject ratings may indeed have diagnostic and theoretical appeal. However, the possibility remains that, in the current investigation, changes in clients' Introject ratings from beginning to end of therapy reflected more than just the true changes that occurred in clients' introjects, and, for this reason, they did not vary with aspects of the therapeutic process that were hypothesized to initiate introject change. Some clients, for example, whose introjects improved over therapy may not have had this improvement reflected in their INTREX scores if their participation in a research project caused them to feel especially optimistic about what they could achieve in therapy and if this caused them to be unrealistically positive about the status of their introjects before therapy began. Improvements in intrapsychic functioning may also have been masked for clients who were feeling depressed on the day they provided their termination ratings and if this caused them to be unrealistically pessimistic about the progress they had made. Alternatively, some clients whose introjects did not improve, if they were experiencing a particularly positive mood on the day they provided the termination ratings, may have given themselves more positive ratings than otherwise would have been the case.

It is interesting to note that in the current investigation, the correlations between the residual-change scores on clients' INTREX ratings and the change-

scores on each of the other outcome measures (Mean r=.30), though in most cases significant, were considerably lower than the correlations among the residual-change scores of the other outcome measures with one another (Mean r=.47). This may indicate that the Introject Questionnaire was assessing a distinct concept from what was assessed by the other rating scales, or that clients' ratings on the Introject measure, more than clients', therapists', and independent clinicians' ratings on the other measures, were affected by fluctuations in client mood or other aspects of client experience and behaviour. Along these lines, it is also interesting that 15 of the 59 clients in the current investigation actually entered therapy with relatively friendly introjects (Mean ATK coefficients= 538.87), and that at therapy termination, the introjects of 24 of the 59 clients had become more negative than they were when treatment first began. By comparison, the number of clients who deteriorated from pre- to post-therapy on the SCL-90-R (n= 13) and GAS ratings made by therapists (n= 3) and independent clinicians (n= 7) was considerably smaller. Again, this may suggest that the Introject Questionnaire was measuring an aspect of outcome that was quite different from what the other measures were assessing. It may also suggest that the questionnaire was more difficult for clients to complete. Considering that the introject is a fairly sophisticated psychological concept, it is possible that some clients had difficulty assessing this aspect of their functioning until they had been in therapy for a time and had gained insight into their problems and behaviour. As they gained insight, these clients may have become more conscious of their intrapsychic functioning and better able to

describe it. Although the majority of these clients may, in reality, have made improvements in the way they were treating themselves, this may not have been reflected in their introject ratings. Indirect support for the notion that clients may have difficulty giving accurate ratings of their introject status can be taken from a study reported by Moseley (1983) in which ratings of the working alliance predicted client change on a variety of outcome measures but were not associated with changes in client self-concept. Similar to the current study, Moseley noted that 4 of the 25 clients in his study showed decreases in self-esteem over the course of treatment. He speculated that these negative changes were therapist-induced because the four clients were treated by just two of the 25 counselors participating in the study. He did not consider an alternative explanation which maintains that some clients may have had difficulty assessing their feelings and actions toward themselves until they gained insight into these aspects of their functioning as a result of their participation in therapy.

Considering the difficulties that clients may have had in rating their intrapsychic behaviours, it may have been beneficial in this study to use multiple criteria to identify the type and amount of change that occurred in clients' introjects over the course of therapy. Such methods were used by Henry et al. (1990) in the study cited earlier that identified significant differences in the interpersonal behaviours of therapists and clients in dyads with good and poor outcomes in the first cohort of the Vanderbilt sample. Similar to the current study, Henry et al. used clients' at-worst ratings on the INTREX Introject Questionnaire as the primary outcome measure. Unlike the current study, Henry

et al. used clients' ATK coefficients and information about the SASB Quadrants in which clients' at-worst introjects were classified to identify the most- and least-improved clients in their sample. Also unlike the current investigation, in which some clients began therapy with relatively positive introjects, the at-worst introjects at the beginning of therapy for all of the clients in Henry et al.'s sample were negative. The seven clients who were selected for the most-improved category had shown improvements of at least 500 points in their ATK coefficients in the direction of greater self-affiliation. In addition, the most-improved clients whose at-worst introjects were categorized in Quadrant II (labeled "Reject Self," which is considered the most pathological state), had shown movement into Quadrant III (labeled "Oppress Self") by therapy's end. The seven clients selected for the least-improved category had shown either no change in their ATK coefficients or change in the direction of greater self-hostility. The at-worst introject ratings of this group had also moved from Quadrant III to Quadrant II.

Henry et al.'s (1990) methodology differed in other ways from the current investigation and it is difficult to isolate any one methodological factor that contributed to the difference in findings between the two studies. Henry et al.'s selection criteria, for example, resulted in a very small sample that consisted of two extreme outcome groups. In contrast, the current study included a larger number of clients with a continuum of outcomes, and this may have diluted the effects that otherwise may have been observed. The use of such a small sample was not advisable in this study because it would have precluded several of the analyses that were central to the research questions under investigation.

Nevertheless, Henry et al.'s methods may highlight the importance of using more stringent criteria to identify negative and positive intrapsychic change, and they may demonstrate that changes in clients' introjects need to be fairly substantial before their interpersonal correlates in the therapeutic process can be observed.

The Focus of Therapists' Interpretations and Introject Change

Therapists' interpretive interventions were categorized into those that focused on clients' reactions to the therapist or the therapeutic relationship, and those that focused more generally on clients' reactions to other people and situations. In line with psychoanalytic/psychodynamic theory, it was hypothesized that the greater emotional immediacy of interpretations that focused on the therapeutic relationship would render them more effective in challenging clients' perceptions and bringing about introject change. This hypothesis was not confirmed, however, neither when the impact of therapists' interpretations was considered independently, nor when it was considered in the context of the therapeutic relationship.

The finding that therapists' interpretations of clients' reactions in therapy did not contribute independently to the prediction of outcome and introject change coincides in many ways with previous research which has failed to show a consistent link between therapists' transference interpretations and a variety of outcome measures (see Henry, Strupp, Schacht, & Gaston, 1994 and Piper, Joyce, McCallum, & Azim, 1993 for reviews). The overwhelming majority of studies have shown either that the frequency of therapists' transference interpretations did not predict outcome at all or that it predicted changes in the

opposite direction than was hypothesized. Exceptions to these findings have been reported only rarely (e.g., Malan, 1976; Marziali, 1979), and these studies have been strongly criticized on methodological grounds. It is interesting that even Gaston and Ring (1992), using a precursor to the ITS measure that was used in the current study, found a significant, independent association between the object of therapists' interpretations and outcome, but this association was for interpretations that focused on clients' reactions to individuals outside of therapy, not to therapists themselves. For the cognitive therapists in Gaston and Ring's study, the association was positive; however, for the brief dynamic therapists, the association was negative in direction, indicating that therapists who offered more frequent interpretations of clients' reactions to people outside of therapy obtained less positive results.

In contrast to the relatively large number of studies that have examined the independent contribution of therapists' interpretations to outcome, very few, if any, have considered the impact of therapists' transference and non-transference interpretations as they interact with the relationship context in which they are offered. Several studies have examined the coincidental contribution of transference interpretations and the therapeutic alliance (e.g., Piper et al., 1993; Piper, Azim, Joyce, & McCallum, 1991) and several have examined the impact that transference interpretations have on the relationship itself (e.g., Piper et al., 1991). However, no studies have considered whether relationship factors actually mediate the impact of therapists' transference and non-transference interpretations on clients' efforts to change. According to Henry et al. (1994), the

interpersonal process of therapy or the relationship between therapists and clients may, in fact, play a crucial role in distinguishing effective from less effective interpretations. They refer to research which has shown that clients are more likely to respond defensively to interpretations than to other types of interventions (e.g., Elliott, James, Reimschuessel, Cislo, & Sach, 1985; Salerno, Farber, McCullough, Winston, & Trujillo, 1992) and suggest that interpretations, especially when they occur at high levels, may be more likely than other interventions to be perceived by clients as accusatory or critical; that is, in terms of negative interpersonal process. On the other hand, Henry et al. (1994) also cite research which has shown that transference interpretations that are followed by affective responding by patients do relate to positive outcomes (e.g., McCullough et al., 1991). They argue that there may be circumstances under which high levels of transference interpretations are beneficial in helping clients to explore their interpersonal patterns, such as when therapists and clients have established a solid relationship with one another and the exploration of this relationship no longer overwhelms clients' capacities to cope. An assumption that may be implied in this argument is that in the context of a positive interpersonal process, therapists' interpretive focus on clients' reactions in therapy may indeed have a more powerful influence on client improvement than interpretations that are more general in focus and less immediately relevant. Other authors have suggested similarly that the effectiveness of interpretations of all kinds relative to other types of intervention may depend on the status of the therapeutic relationship, and they have similarly emphasized the need to

consider both of these variables in studying the contributions of therapists' interventions to outcome (Spiegel & Hill, 1989).

Despite the clear mandate in the therapy literature to incorporate relationship factors into the study of therapists' interpretive interventions, this investigation did not demonstrate that the therapeutic relationship mediates the effectiveness of different types of therapists' interpretations, and it did not demonstrate that, in the context of positive therapeutic relationships, interpretations that focus on clients' experiences in therapy are particularly effective in bringing about change. Several explanations may account for the nonsignificant findings, including the proposition that therapists' interpretations, whatever their form, simply do not play a major role in facilitating positive therapeutic results. Other explanations may point to the same methodological issues that were discussed earlier as contributing to the lack of significant interactions that were observed for the therapeutic relationship and therapists' supportive and interpretive interventions in predicting positive outcomes and introject change. In particular, it is again possible that the difference in stimulus materials and therapy segments that were used to assess therapists' interventions and the therapeutic relationship introduced confounds into the study that reduced the likelihood of obtaining significant results. The method of summarizing the SASB ratings of therapists' and clients' behaviours in terms of the proportion of affiliative behaviours may not have included enough information to allow significant interactions between these ratings and ratings of therapists' interpretations to emerge. Finally, it is possible that therapists' interpretations,

regardless of their object focus, were assessed too early in therapy to observe their ameliorative effect.

Other factors that may account for the nonsignificant findings in this study are suggested in the empirical literature that has examined the association between interpretive interventions and therapy outcome. With regard to transference interpretations in particular, this literature indicates that the association between therapists' transference interpretations and outcome is complex and, in the words of Henry et al. (1994), it "is a function of numerous interacting factors" (p. 476). The relationship context in which therapists' interpretations are offered is one of the more important factors identified in the literature; however, there are other factors that were not incorporated into this study that may also play a role.

For example, research indicates that while the overall frequency of therapists' transference interpretations does not contribute to positive change, the accuracy or correctness with which therapists' interpretations identify patient conflicts may be associated with positive therapeutic results (Crits-Cristoph et al., 1988; Piper et al., 1993). Other research has suggested that certain characteristics of patients can moderate the effectiveness of therapists' interpretations, such as patients' enduring capacity to establish loving and equitable relationships (labeled Quality of Object Relations). This research has shown that patients who are high in Quality of Object Relations may actually be less tolerant of frequent transference interpretations made by therapists, possibly because of their greater interpersonal sensitivity (Piper et al., 1991; Piper,

McCallum, Azim, & Joyce, 1993). Finally, several researchers have suggested that clients' overall level of disturbance, the timing with which therapists introduce their interpretations, and the readiness of the patient to receive them may have important influences on how effective interpretations are in bringing about change (Henry et al., 1994, Spiegel & Hill, 1989).

The assessment and identification of the factors listed above was beyond the resources and scope of the current investigation. Future researchers may nevertheless choose to focus on these factors more directly and this may help to illuminate the nature of the current findings and association between therapists' transference and non-transference interpretations and psychotherapy outcome.

Therapist Age and Client Introject Change

Covariate analyses identified only one variable that was extraneous to the research purposes but was significantly related to one of the outcome measures: therapists' age was negatively correlated with clients' residual-change scores on the INTREX Introject Questionnaire. This meant that clients who reported the most improvement in their introjects from beginning to end of therapy were more likely to have been working with younger therapists. It is difficult to account for this correlation in the absence of more extensive data describing the therapists who took part in this study. However, supplemental correlations did indicate that younger therapists were generally more active than older therapists, and that within this activity, they offered a higher frequency of supportive interventions. Neither therapists' rate of participation, nor their level of support correlated with outcome. The fact that these variables were correlated with therapist age

nevertheless raises the possibility that younger and older therapists also behaved differently in other respects and that these differences are what caused clients to respond differently in therapy. Younger therapists were less experienced than older therapists and it is likely that they graduated more recently from their doctoral programs. Therefore it is possible that some aspect of their training or even differences in attitude that resulted simply out of being younger members of their respective professions enabled younger therapists to work with clients in a way that helped them to revise their introject structures.

Exploratory analyses were conducted to determine whether, within the subset of dyads that were led by the youngest therapists in the Vanderbilt II project, therapists' use of supportive and exploratory interventions interacted with clients' and therapists' affiliation ratings to predict introject change. These analyses indicated that clients' level of affiliation marginally[12] predicted change in their introjects, and that neither therapists' level of affiliation nor any of the interaction terms yielded significant results. Thus again, even when controlling for the covariate of therapist age, there was little evidence to support the

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[12] In the exploratory analyses, the set of therapists' and clients' SASB-rated behaviours contributed marginally to the prediction of introject change at a *p*-value equal to .08. In accordance with the procedures outlined above for conducting regression analyses with protected *t*-tests, this implied that the *p*-value for the contribution of any variable contained in this set could not be considered less than .08.

psychodynamic/interpersonal proposition that an appropriate balance between supportive and challenging interventions is what helps clients' introjects to improve.

The exploratory findings must be interpreted with caution given the reduced sample size and coincidental reductions in statistical power. In addition, the marginal contribution of clients' affiliation ratings to the prediction of outcome leaves open the possibility that this finding was observed merely by chance. Limitations notwithstanding, the exploratory findings support the proposition that clients are more likely to engage in interpersonal behaviours that are associated with improvements in their introjects when they are working with younger therapists. The factors that facilitate these behaviours have not been made clear. It is interesting that research on the influence of therapist and client age on the therapeutic endeavour in general has increasingly found that therapist-client age similarity, rather than their respective ages considered in isolation, is positively associated with therapy outcome (Beutler, Machado & Neufeldt, 1994). In the current study, however, clients were on average older than therapists (mean age: 42 vs. 36 years) and therefore the younger therapists were actually further apart from clients in age. This raises the possibility that different factors are at work in bringing about improvements in clients' introjects than are responsible for initiating more general aspects of change. For example, it is possible that, on the one hand, clients prefer therapists who are similar to them in age because they are more likely to share a similar outlook on life. This may help clients to feel understood and to feel more satisfied with themselves. At the

same time, clients may find differences in outlook embodied by the younger therapists somewhat appealing and this may challenge clients to engage in a relationship with their therapists and to incorporate their experiences in the relationship into their introject structures. Indeed, it is possible that, in the current study, the age difference between therapists and clients, rather than therapists' interpretive interventions, is what provided the challenging force that interpersonal and psychodynamic theorists argue is necessary for intrapsychic change to occur. Clearly additional research will be required to investigate this hypothesis and to consider other factors that may have contributed to this portion of the study's results.

Therapist Affiliation, Client Adjustment, and Exploratory Interventions

Therapists' and clients' SASB affiliation ratings did not correlate with therapists' use of supportive and exploratory interventions. This lack of association between the two measures is consistent with the nonsignificant correlations that were reported by Gaston and Ring (1992) between ITS ratings of therapists' technical interventions and the CALPAS-R ratings of the therapeutic alliance. The lack of significant correlations in this study therefore helps to demonstrate again that the ITS assesses something other than relationship factors in the therapeutic process and it helps to confirm the discriminant validity of the SASB and ITS measures. A surprising finding was that therapists' level of affiliation did correlate negatively, and quite strongly, with their use of exploratory interventions that focused on clients' reactions to people or situations other than the therapist or the therapeutic relationship. This finding

indicated that therapists who interacted more positively with their clients were less likely to interpret client behaviours relevant to situations outside of therapy. In addition, therapists' overall use of exploratory interventions and their use of exploratory interventions that focused on clients' extra-therapy experiences were negatively correlated with therapists' ratings of clients' pre-therapy adjustment on the GAS. Although several explanations can be offered for these findings, many of them are complicated by inconsistencies in the pattern of correlations. For example, therapists' exploratory interventions that focused on clients' reactions in therapy did not correlate with therapists' level of affiliation or with therapists' ratings of clients' pre-therapy adjustment.

It is possible that therapists interacted more positively with clients whom they rated as better adjusted at the beginning of therapy. Clients may have responded to their therapists' positive interactions by interacting more positively themselves. Therapists who perceived their clients as engaging in affiliative behaviour may have seen less of a need to challenge their clients on aspects of their perceptions and behaviour and therefore may have offered fewer interpretations. This explanation is supported by the fact that therapists' extra-therapy interpretations were correlated with their level of affiliation and with their ratings of client adjustment prior to beginning therapy. It is also supported by the significant correlation that was observed between therapists' and clients' SASB-rated behaviours. However, the explanation does not account for the lack of correlation between therapists' level of affiliation and their interpretation of clients' in-therapy reactions, and raises questions as to why therapists would

reduce only the number of interpretations that pertained to clients' behaviours outside of therapy but not their exploration of clients' behaviours in sessions. This explanation is also not supported by the fact that neither therapists' nor clients' level of affiliation correlated with therapists' ratings of client adjustment at the beginning of treatment.

Another explanation posits that the causal association between therapists' level of affiliation and their Exploratory interventions may have been reversed and that therapists who focused less on clients' reactions to extra-therapy situations uncovered lesser amounts of troubling information about the client and therefore felt freer to interact with clients in a positive way. This explanation is again plagued by the lack of correlation between therapists' level of affiliation and therapists' transference interpretations. Therefore it only seems plausible if one accepts that hearing about clients' presumably worrisome behaviours outside of therapy would be more troubling to therapists than actually witnessing and exploring these behaviours as they occur within the therapy session itself.

Finally, it is possible that therapists, working from a psychodynamic perspective, felt they could be flexible in their use of interpretations that focused on clients' experiences outside of therapy and allowed this to fluctuate depending on the client's issues and how well they felt the interaction was going. On the other hand, the therapists may have been strongly committed to their use of interpretations that focus on the therapeutic relationship because this is central to psychodynamic technique. As such, therapists' exploratory focus on clients' extra-therapy reactions may have varied depending on other aspects of

the interaction, while therapists' focus on clients' reactions in therapy may have remained constant throughout the therapeutic endeavour.

The latter explanation is perhaps the most plausible of the three and most consistent with the overall pattern of correlations, but it is by no means conclusive. Indeed, the sheer complexity of the correlations in this study makes it difficult to draw definite conclusions about their implications. For this reason, further research will be required to clarify the nature of the associations that were observed between therapists' use of exploratory interventions, their level of affiliation, and their ratings of client adjustment.

Therapy Outcome and Rater Perspective

One of the primary outcome measures used in this study was created by combining three individual measures of client functioning: the SCL-90-R, as rated by clients, and the GAS, as rated by independent clinicians and by therapists. Exploratory analyses were conducted to determine whether the findings in this study would have been different if each of these outcome measures had been considered separately. Three sets of regression analyses were conducted with the same predictor variables that were included in the main analyses and with each of the above-named outcome measures serving as the criterion variable in one analysis. The results added little to the overall findings of the study. Similar to the main analyses, clients' level of affiliation predicted outcome when outcome was assessed in terms of residual-change in clients' scores on the SCL-90-R and in terms of independent clinicians' ratings of clients' adjustment on the GAS. In both analyses, the contribution of clients' affiliation

ratings to outcome was only marginal in significance[13]. The only new finding, which was already discussed above, showed that therapists' level of affiliation was a marginal, negative predictor of changes in clients' scores on the SCL-90-R.

The exploratory analyses did not add greatly to the process variables that predicted outcome in this study. The analyses did, however, reveal an interesting pattern pertaining to the perspective from which outcome was assessed. As was indicated above, aspects of the therapeutic process predicted outcome when outcome was assessed from the perspective of clients using the SCL-90-R, and when it was assessed by independent observers using the GAS. None of the process variables was related to outcome when outcome was assessed by therapists using the GAS. This finding may have important implications for therapists' role in clinical situations, especially when one considers that therapists normally have a considerable degree of authority in deciding the type of therapy that clients should receive and when clients are ready to terminate their treatment. Indeed, the fact that none of the process

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[13] In both analyses, the set of therapists' and clients' SASB-rated behaviour was marginal in its contribution to outcome. According to the procedures of the protected t-test, the contribution to outcome of any variable contained in this set should also be considered marginal, even if, as in the case of clients' SASB-scores predicting changes in independent clinicians ratings on the GAS, the p-value associated with it is .05 or less.

variables measured in this study predicted change in therapists' ratings of client adjustment suggests either that the changes therapists observed in clients resulted out of factors that were not assessed in this study, or that the process variables were assessed inaccurately, or that therapists' assessments of the changes that clients made in therapy were themselves subject to bias. With regard to the first possibility, some researchers have suggested that therapists do indeed have a privileged position in the therapeutic endeavour and they may be privy to information pertaining to therapy process and outcome that is not available to the outside observer or even to clients themselves (Newman, 1983). In the current study, it is possible that the ratings of therapists' interventions and/or the ratings of therapists' and clients' level of affiliation, because they were provided by independent observers, did not capture aspects of the therapeutic process that only therapists could observe and therefore did not relate to the changes in client functioning that therapists reported as having occurred.

With regard to the second possibility, research on rater bias has shown that ratings of the therapeutic process made by independent observers are often influenced as much by the personal characteristics of the raters as they are by the characteristics of the process that is being rated. For example, studies have shown that independent observers' assessments of themselves as dominant or affiliative, their gender, their liking for and perceived similarity with the individuals they are rating, and their theoretical orientation all have an influence on the ratings they provide (Mahalik, Hill, O'Grady, & Thompson, 1993; Raue, Putterman, Goldfried, & Wolitzky, 1995). Thus, it is possible that, in the current

study, biases associated with the ratings of the therapeutic process that were provided by independent observers reduced the likelihood that they would relate to outcomes assessed from a different perspective, including the perspective of the therapist.

Finally, with regard to the latter explanation, many researchers have argued that therapists, themselves, are not immune to bias in their perceptions and that their assessments of outcome may be the least reliable of all (Lambert, Shapiro, & Bergin, 1986). Here, it is argued that therapists, because of their personal involvement in the therapeutic process and, presumably, because they have a vested interest in viewing the therapy as having been successful, may provide ratings of outcome that are more positive than would otherwise be observed. It is interesting that, in the current study, therapists' ratings of clients on the GAS showed the highest percentage of clients as having made improvements over the course of therapy. This is in comparison to the percentage of clients who showed improvements on independent clinicians' ratings on the GAS and clients' ratings of themselves on the SCL-90-R. It is possible that therapists' ratings of client improvement on the GAS were somewhat inflated and therefore were not associated with ratings of other aspects of the therapeutic process that were made from different perspectives. The accuracy of therapists' outcome ratings may, in fact, have been a pertinent issue in the current study because therapists knew they were participating in a research project and had probably guessed from the video- and audio-taping of their sessions that their work would be evaluated closely.

In the end, it is possible that all of the above factors played a role in the pattern of findings that were obtained in the exploratory analyses, and that, regardless of the perspective from which outcome was assessed, individual biases played a role in the ratings that were made. Clients too, may have provided ratings of outcome on the SCL-90-R that were influenced by their participant-observer status in sessions. This tendency may have been reduced somewhat by the straight-forward manner in which items on the SCL-90-R are worded and this may account for the fact that process ratings made by independent observers did predict change in clients' pre- and post-therapy ratings of their symptom status. Nevertheless, the overall pattern of results that were obtained in this study for the different outcome measures may serve to underscore what Lambert et al. (1986) identified as the multidimensional nature of the change that occurs in therapy and the importance of measuring this change from a variety of different angles. In addition, the fact that the findings obtained in the main analyses reached statistical significance but the exploratory findings did not may highlight the advantages of combining correlated outcome measures obtained from different perspectives into one variable that, ultimately, contains a range of important information.

Summary of Conclusions and Implications for Theory and Practice

The conclusions that can be derived from the current study are varied, and all of them require empirical validation. Taken as a whole, the results seem to emphasize relationship factors in the therapeutic endeavour, particularly the level of affiliation in clients' in-session behaviours, over other factors, such as

therapists' use of supportive and interpretive interventions, as they contribute to the outcome of therapy. In addition, the findings are primarily relevant when outcome is assessed in general terms rather than in terms of specific changes in clients' introject structures.

As indicated above, within the therapeutic relationship, the results of this study emphasize the client's contribution to the therapeutic interaction, rather than the therapist's. This aspect of the study's findings is consistent with the theoretical assumption that, regardless of how affiliative or helpful therapists may be in their interactions with clients, clients must perceive this affiliation and in some way receive it before it can have an influence on clients' efforts to change. The findings also indicate that therapists' and clients' affiliation ratings were correlated fairly strongly. This is consistent with the principle of complementarity that is said to operate in all interpersonal interactions, and may suggest that clients were aware of and to some extent affected by their therapists' behaviour, even if therapists' affiliation ratings did not directly contribute to the prediction of outcome. In the end, several methodological issues have also been suggested to account for the lack of significant findings pertaining to therapists' contribution to the therapeutic relationship. For example, it is possible that the practice of summarizing the SASB ratings of therapists' moment-to-moment behaviours in terms of the overall proportion of affiliative behaviours, rather than the discrete SASB cluster categories, undermined what may have been a tenuous association between therapists' behaviours and outcome. In addition, the manner of assessing outcome merely in terms of changes along the affiliation

dimension of clients' introjects may not have been stringent enough to allow it to vary with changes that occurred in therapists' behaviours.

With regard to therapists' use of supportive and interpretive interventions, the study's findings did not support the psychodynamic/interpersonal hypothesis that therapists' interventions would interact with the status of the therapeutic relationship to predict change. Also contrary to traditional psychoanalytic theory, the findings did not indicate that therapists' use of interpretations that focused particularly on clients' experience of the therapeutic relationship were more effective than general interpretations in initiating positive outcomes. Certain aspects of the current methodology and differences in methodology between the current study and previous research suggest factors that may account for the nonsignificant findings. For example, different but overlapping therapy segments and different stimulus materials (i.e., video-tape versus audio-tape) were used to assess the therapeutic relationship and therapists' interventions in the present study. This may have reduced the likelihood that the two variables would interact. In addition, clients in the current study were more psychologically disturbed than those in previous studies that obtained more positive results. Therefore, it is possible that therapists' interventions would have had the effect predicted by interpersonal and psychodynamic theory if clients had embodied a different set of characteristics. Previous studies also assessed therapists' interventions and the therapeutic relationship at several points in therapy, not just in the third session. It is possible that therapists' interventions are primarily important in later stages of therapy, and that this would have become evident if

additional assessments of the interventions had been made. Finally, the current and previous studies used measures of the therapeutic relationship that assessed different dimensions of clients' and therapists' interactions and this may have added to the discrepant findings that were observed between the two sets of studies.

The fact that none of the variables entered into the main analyses predicted changes in clients' introjects suggests that the processes that contribute to this type of improvement are more complicated than those suggested in the introduction to this study and in interpersonal/psychodynamic theory. In keeping with the psychodynamic assumption that some type of loss is required for introject change to occur, it has been suggested that therapists' interpretive interventions may represent just one source of loss that clients experience in therapy, and that other losses also play a role in challenging clients to change. Furthermore, it has been suggested that several losses may work together to have a cumulative effect on the changes clients make in how they interact with themselves. Exploratory analyses in the current study showed that clients who were working with younger therapists were more affiliative in their interactions and that this was associated with improvements in clients' introjects. It is difficult to specify exactly what, if anything, enabled younger therapists to work with clients in a way that facilitated more friendly client interactions and intrapsychic change. However, one possibility is that clients found the differences in outlook embodied by their younger therapists more appealing, and at the same time, challenging, and that this combination provided

the necessary conditions for their introjects to change. Whatever the factors that account for this finding, it may be necessary to expand psychodynamic/interpersonal theory to include specific therapist characteristics as contributing to clients' intrapsychic change.

A final issue that was discussed was the possibility that, especially at the beginning of therapy, clients may have had difficulty understanding the introject concept and this may have interfered with the reliability and validity of their introject-at-worst ratings. Again, it was suggested that more stringent criteria for identifying improvements in clients' introjects that are derived from multiple sources may have ensured more accurate ratings and yielded a different pattern of results.

Despite many unanswered questions, the findings of the current investigation have several implications for the practice of psychotherapy. For example, the emphasis on the client can serve as a reminder to therapists that the client is key to the success of the overall endeavour and can help to motivate therapists to monitor closely their clients' reactions to therapists' interventions and the interpersonal climate of the relationship as a whole. This may be especially important in situations where clients' reactions are different from those of therapists' and/or deviate from what would be expected from an objective point of view. In line with the recommendations of interpersonal theory, the findings may also encourage therapists to discuss openly with clients their feelings about the therapeutic relationship and clients' perceptions of their progress. Although therapists' interpersonal behaviours did not contribute

directly to the outcome of therapy, the relatively strong correlation between therapists' and clients' affiliation ratings may help to remind therapists that clients are aware of their therapists' behaviours and that their impact on clients' experiences and responses in therapy may be quite strong.

The possibility was discussed that therapists' interventions may have had a greater impact on the outcome of therapy if they had been assessed at a later point in treatment. This being the case, the study's findings may help to remind therapists that their focus in early sessions should be to build the therapeutic relationship and that interpretive interventions in particular become important later on. This may be especially important when therapists are working with more severely disturbed clients such as those who have been diagnosed with character disorders and have difficulty relating to others. In addition, the current study, when considered in the context of previous research, may help to remind therapists that, contrary to traditional psychoanalytic theory, frequent interpretations of clients' reactions to the therapeutic relationship, especially when they are offered without regard for accuracy or client's readiness to receive them, do not have a beneficial effect and may even cause harm.

Finally, although the study's hypotheses regarding the impact of therapists' supportive and interpretive interventions on clients' introject structures were not confirmed, therapists may still benefit from considering the theoretical assumptions upon which the study was based. For example, therapists may do well to consider the variety of losses that their clients potentially experience in therapy and to consider that even when the relationship is going well, these

losses may play a role in the progress clients make during sessions. Indeed, therapists may benefit from considering that even differences in personal characteristics (e.g., age) may contribute to feelings of loss in clients and that, if they are handled correctly, these losses can help motivate clients to initiate introject change.

Methodological Limitations of the Study

A primary strength of the current study is that it was based on a sample of experienced therapists working with a clinically representative sample of clients. In comparison to investigations that have examined aspects of the therapeutic process and outcome using an analogue design or student therapists working out of university clinics, the study is in a better position to generalize its findings to real-life therapy situations. At the same time, it is important to point out that the external validity of the study is limited by the fact that the majority of clients and all of the therapists included in the Vanderbilt II sample were Caucasian and by the fact that the client sample was predominantly female and quite well-educated. The fact that clients who were relatively symptom-free or who were severely disturbed were not included in the Vanderbilt II project and the fact that therapy was limited to 25 sessions also precludes generalizing the findings to longer-term interventions and to treatments for clients who are more or less disturbed. Finally, it will be recalled that the clients in the Vanderbilt II project were volunteers who were recruited through a local newspaper to take part in a research project. It is conceivable that these clients differed from clients who are mandated to treatment or who would refuse to have their sessions recorded for

research purposes or to complete multiple questionnaires.

Another aspect of the study's methodology that should be considered is the self-report method by which several of the outcome measures were obtained. For example, the potential difficulties associated with asking clients to report on a fairly sophisticated psychological concept such as the introject have already been discussed. In addition, it has been suggested that systematic biases that are unrelated to clients' actual status on the outcome measures may have influenced the ratings that were provided, particularly by therapists and clients because of their participant-observer status in the therapeutic endeavour. The possibility also exists that independent clinicians' ratings were subject to biases of their own and that their evaluations of clients' adjustment at the beginning and end of therapy did not take into account information that was only available to the therapy participants themselves. In general, it seems that an ideal, though expensive, way of assessing outcome, not to mention aspects of the therapeutic process, would have been to obtain measures of the same variables from a variety of perspectives and using a variety of instruments. To some extent this was accomplished on a smaller scale in the current study by combining therapists' and independent clinicians' ratings of client adjustment and clients' ratings of their symptomatology into one outcome variable. Future research may do well to consider other ways that various rating perspectives can be taken into account.

Finally, the study used a quasi-experimental design. Although clients' outcome ratings were obtained before and after therapy sessions were

completed, the fact that none of the process variables was manipulated directly and that a placebo control group of clients was not available for comparison precludes any conclusions about causal relationships between the interpersonal process of therapy, therapists' manner of intervening, and the outcome of the therapeutic endeavour.

Directions for Future Research

Numerous recommendations for future research follow from the current study. To begin, it seems important for the study to be repeated using a different method of summarizing the SASB data. Researchers with the Vanderbilt Psychotherapy Research Project may, in fact, choose to re-examine the interaction between the therapeutic relationship and therapists' interventions by including SASB cluster-data, rather than proportion scores of affiliative versus disaffiliative interactions, in analyses. Although issues of statistical power would become relevant as the number of variables increased, this type of analysis would take advantage of the greater amount of information that is available in the cluster data, including information about therapists' and clients' relative interdependence. It would also provide more detailed descriptions of the types of therapist and client behaviours that facilitate the effectiveness of therapists' interventions. Prior to conducting such an investigation, the Vanderbilt researchers may also wish to examine the extent to which SASB ratings based on 15-minute segments of therapy sessions generalize to entire sessions, and the extent to which ITS ratings based on video-tapes correspond with the same ratings made with audio-tapes.

The potential problems that may have been associated with using self-report questionnaires to assess the pre- and post-therapy status of clients' introjects also call for researchers to develop alternative or additional methods of evaluating this aspect of client functioning. Prior to completing questionnaires in a study clients may in fact benefit from some type of training on how to access their intrapsychic behaviours and how to describe them in accurate terms. Researchers may also consider using in vivo methods to assess clients' status on the introject variable; for example, by asking clients to perform a challenging task and then to report on the self-talk they engaged in as they completed it. Although it is difficult to identify strictly behavioural methods of assessing an intrapsychic event, researchers may consider exploring behavioural correlates or even other thought processes that signify introject change.

Given the possibility that therapists' interpretations are not the only source of loss that clients experience in therapy, future research may also endeavor to identify other losses that affect client functioning and are associated with introject change. This research may begin with a qualitative survey of therapeutic events that are disappointing for clients and then proceed to identify more specifically the disappointments and losses that are associated with introject change. Indeed, a qualitative study on clients' perceptions of the factors and processes that facilitate changes in their introjects may add considerably to current understandings of the concept.

The issue of timing has also been suggested as a potential factor influencing the effectiveness of therapists' interventions. It may therefore be

useful for researchers to conduct a similar study to this one that nevertheless includes ratings of therapists' interventions and ratings of the relationship from later portions of therapy. In fact, a time-series design characterized by repeated assessments of the therapeutic relationship, therapists' interventions, and clients' status on the introject, may provide valuable insight into the circumstances under which therapists' interventions are most effective in bringing about introject change and other processes that lead up to this change. In accordance with the recommendations put forward by Greenberg (1986) and Marmar (1990), a time-series design which includes measures of more immediate in-session and between-session change events, such as changes in clients' depth of experiencing and vocal quaility, or within-session resolution of conflicts and mastery of problems, may be particularly useful in clarifying the factors and processes that ulitmately lead to more global improvements in clients' intrapsychic functioning.

Finally, research in the area of client introject change would benefit from replications of this study based on a more diverse sample of clients and therapists. In particular, it may be useful to examine the interaction of therapists' interventions and the therapeutic relationship in the context of treatments that extend over a longer term and involve clients from more diverse socio-economic and ethnic backgrounds, and who represent a better mix between women and men. In addition, it may be worthwhile to examine the factors that facilitate introject change among clients with different psychiatric diagnoses. It is conceivable, for example, that clients diagnosed with a paranoid personality

disorder would require different techniques even just to establish a therapeutic relationship than clients without this personality disorder who are experiencing a major depression. The former group of clients may also be much more sensitive to losses in the relationship once it is established than those in the latter group, and therapists may need to adjust their interventions accordingly. Along these lines, several studies have recently demonstrated that clients' responses to supportive and interpretive forms of therapy depend to some extent on their personal characteristics, including their motivation for therapy (Horowitz, Marmar, Weiss, DeWitt & Rosenbaum, 1984), the quality of their object relations (Horowitz et al., 1984; Piper, Joyce, McCallum & Azim, 1998), and their overall level of dysfunction (Jones, Cumming, & Horowitz, 1988; Wallerstein, 1989). Future research examining the role of supportive and interpretive interventions in facilitating changes in clients' intrapsychic functioning may do well to incorporate some of these variables as potential mediating factors.

In conclusion, the current study leaves open a number of possibilities for future research and raises many questions about the processes that facilitate intrapsychic change in clients. The nonsignificant findings in the study are disappointing but nevertheless point to several methodological issues that need to be considered when conducting research in this area. The significant findings in the study are in many ways reminiscent of previous research which has demonstrated the importance of the therapeutic relationship as it contributes to therapy outcome, and may help to further emphasize therapists' appreciation for the bond that they establish with clients. Together, the findings of the study

suggest that the processes that contribute to intrapsychic change in clients are indeed very complex and that the interactive influence of the therapeutic relationship and different therapist interventions on clients' introject structures, if it exists, is not easily understood. In this way, the findings present a considerable challenge to researchers to further clarify this influence and to explore other processes and variables, however subtle, that help clients to change this basic and important aspect of their relationships with themselves.

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Appendix A

Symptom Check List 90 - Revised

SCL—90—R®

SIDE 1

INSTRUCTIONS:

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

SEX

MALE ○

FEMALE ○

NAME: _____

LOCATION: _____

EDUCATION: _____

MARITAL STATUS: MAR___SEP___DIV___WID___SING___

DATE (MO DAY YEAR)

ID. NUMBER

AGE

VISIT NUMBER: _____

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

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

Please continue on the following page ▶

SCL—90—R®

SIDE 2

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

Appendix B
Global Assessment Scale

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30) should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g., 35, 58, 63). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

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

90 Transient symptoms may occur, but good functioning in all
| areas, interested and involved in a wide range of
| activities, socially effective, generally satisfied with
| life, "everyday" worries that only occasionally get out of
81 hand.

80 Minimal symptoms may be present but no more than slight impairment in
| functioning, varying degrees of "everyday" worries and problems that
71 sometimes get out of hand.

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

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

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

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

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

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

10 Needs constant supervision for several days to prevent
| hurting self or others, or makes no attempt to maintain
1 minimal personal hygiene.

Appendix C
INTREX Introject Questionnaire

LONG

INTREX form *A*.

Please use the answer sheet marked *A* and indicate how well each question describes **YOURSELF AT YOUR WORST.**
Use the scale which appears at the top of the answer sheet.

---

1. I neglect myself, don't try to develop good skills, ways of being.
2. Because I want to help myself, I try to figure out what is really going on within me.
3. Instead of getting around to doing what I really need to do for myself, I let myself go and just daydream.
4. I just let important personal matters, choices, thoughts, issues slip by without paying much attention.
5. Knowing both my faults and strong points, I comfortably let myself be "as is".
6. I let myself feel glad about and pleased with myself just as I am.

---

7. I accuse and blame myself until I feel guilty, bad and ashamed.
8. I practice and work on developing worthwhile skills, ways of being.
9. I tenderly, lovingly, cherish and adore myself.
10. I naturally and easily provide for, nurture and take care of myself.
11. I angrily and harshly reject myself as worthless, and leave what happens to me to fate.
12. I ignore and don't bother to know my real self.

---

13. I like myself very much, and feel very good when I have a chance to be with myself.
14. I very carefully watch, hold back and restrain myself.
15. I have the habit of keeping very tight control over myself.
16. I let myself murder, kill, destroy and reduce myself to nothing.
17. I tear away at and empty myself by greatly overburdening myself.
18. I gently and warmly stroke and appreciate myself for just being me.

---

19. I keep an eye on myself to be sure I am doing what should and ought to be done.
20. I try very hard to make myself be like an ideal.
21. I comfortably let myself hear and go by my own deepest inner feelings.
22. Even when it means harming myself greatly, I let my own sickness and injury go unattended.
23. I put all kinds of energy into making sure I follow the right standards and am proper.
24. I harshly punish, torture myself; I "take it out" on myself.

---

25. I make myself do and be things which are known not to be right for me. I fool myself.
26. I just let myself go along with today as it is and don't plan for tomorrow.
27. I comfortably look after my own interests and protect myself.
28. I let myself drift with the moment; I have no internal direction, goals or standards.
29. I put a lot of energy into figuring out what I'm going to need for myself and how to get it.
30. I freely, easily and confidently let myself do whatever comes naturally.

---

31. I understand and like myself just as I am. I feel solid, "together".
32. Without concern, I just let myself be free to turn into whatever I will.
33. I am reckless; I carelessly let myself end up in self-destructive situations.
34. I keep myself open to connecting with people, places or things which would be very good for me.
35. I put myself down, tell myself that I have done everything wrong and that others can do better.
36. I think up ways to hurt and destroy myself. I am my own worst enemy.

Subject _____ Date _____

Use this answer sheet to rate: _____

Please use pencil and completely fill in the circle which describes your views.

Use this scale:

NEVER NOT AT ALL — ALWAYS PERFECTLY

0 10 20 30 40 50 60 70 80 90 100

A rating of less than 50 indicates "false"; a rating of 50 or more indicates "true".

For questions 1 to 16 rate HIM or HER.

1. 0 10 20 30 40 50 60 70 80 90 100
2. 0 10 20 30 40 50 60 70 80 90 100
3. 0 10 20 30 40 50 60 70 80 90 100
4. 0 10 20 30 40 50 60 70 80 90 100
5. 0 10 20 30 40 50 60 70 80 90 100
6. 0 10 20 30 40 50 60 70 80 90 100
7. 0 10 20 30 40 50 60 70 80 90 100
8. 0 10 20 30 40 50 60 70 80 90 100
9. 0 10 20 30 40 50 60 70 80 90 100
10. 0 10 20 30 40 50 60 70 80 90 100
11. 0 10 20 30 40 50 60 70 80 90 100
12. 0 10 20 30 40 50 60 70 80 90 100
13. 0 10 20 30 40 50 60 70 80 90 100
14. 0 10 20 30 40 50 60 70 80 90 100
15. 0 10 20 30 40 50 60 70 80 90 100
16. 0 10 20 30 40 50 60 70 80 90 100

For questions 17 to 32 rate YOURSELF with him or her.

17. 0 10 20 30 40 50 60 70 80 90 100
18. 0 10 20 30 40 50 60 70 80 90 100
19. 0 10 20 30 40 50 60 70 80 90 100
20. 0 10 20 30 40 50 60 70 80 90 100
21. 0 10 20 30 40 50 60 70 80 90 100
22. 0 10 20 30 40 50 60 70 80 90 100
23. 0 10 20 30 40 50 60 70 80 90 100
24. 0 10 20 30 40 50 60 70 80 90 100
25. 0 10 20 30 40 50 60 70 80 90 100
26. 0 10 20 30 40 50 60 70 80 90 100
27. 0 10 20 30 40 50 60 70 80 90 100
28. 0 10 20 30 40 50 60 70 80 90 100
29. 0 10 20 30 40 50 60 70 80 90 100
30. 0 10 20 30 40 50 60 70 80 90 100
31. 0 10 20 30 40 50 60 70 80 90 100
32. 0 10 20 30 40 50 60 70 80 90 100

Appendix D
Contract for ITS Raters

Investigator: Wiebke Peschken
Supervised by: Dr. David Martin
Professor of Psychology
Director of the Psychological Service Centre
University of Manitoba

Your work in the study entitled, "Interpersonal process, therapists' supportive and interpretive interventions, and intrapsychic change in psychodynamic therapy" will involve rating 28 audio-taped therapy sessions according to the Inventory of Therapeutic Strategies (ITS). You will be expected to attend several training sessions prior to beginning the actual rating and you will be expected to adhere closely to the procedures described during this training period. You will be paid $1000 for your work.

The ITS training sessions will be held at the Psychological Service Centre, University of Manitoba. You will not be permitted to remove the tapes or transcripts used during training from the Psychological Service Centre.

Once training is completed, you will be required to complete the main ratings for the study at the Department of Psychology in the research room specified by Wiebke Peschken. You will not be permitted to take the audiotapes or transcripts of the sessions outside of that room at any time during or after your involvement in the study. You will also not be permitted to allow anyone into the room who is not directly involved in the study.

In the event that you should recognize or have been or become personally acquainted with one or more of the clients in the training tapes, or with one or more of the therapists and clients in the tapes to be rated for the main analyses, you will be required to stop the tape and notify the researchers immediately. At this time, you will either be re-assigned a different set of tapes or you will be relieved of your rating duties.

To protect the confidentiality of the therapists and clients in the training tapes and the tapes used in the main analyses of the study, you will not be permitted to divulge any identifying information (e.g., names, occupations, physical characteristics) to anyone other than the researchers cited above. You will also be required to refrain from discussing the contents of the tapes with anyone other than the researchers or research assistants involved in the study.

*****

ITS Rating Contract (continued)

I have read and understood the above. I will abide by the guidelines outlined in this document during the time that I am carrying out my rating duties in the study entitled "Interpersonal process, therapists' supportive and interpretive interventions, and intrapsychic change in psychodynamic psychotherapy" and after these duties are completed. I have received a copy of this contract.

_____
(print name)

_____

(signature) (date)

_____

(researcher) (date)

Appendix E

Inventory of Therapeutic Strategies Rating Sheet

Transcript ID#: Rater Initials:

UNIT #	INTENT	REACTION	OBJECT	SUPPORT

APPENDIX F

Table 7

Means and Analyses of Variance for Criterion Variables as a Function of Therapist or Client Gender

	Therapist Gender				Client Gender			
Criterion Variable	Male	Female	F	p	Male	Female	F	p
INTREX	-111.00	150.96	3.03	ns	-16.90	4.78	.01	ns
Combined Outcome	.18	-.17	.30	ns	-.21	.11	.18	ns

Note. df=1, 59 for analyses on INTREX; df= 1, 56 for analyses on Combined Outcome; INTREX= Residual-change scores on INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on SCL-90-R and GAS ratings combined.

Table 8

Means and Analyses of Variance for Criterion Variables as a Function of Client Marital Status

	Client Marital Status						
Criterion Variable	Single	Married	Separated	Divorced	Widowed	F	p
INTREX	-41.80	40.56	-109.31	78.02	-456.63	.74	ns
Combined Outcome	.19	.26	1.28	-.55	.25	.44	ns

Note. df= 4,59 for analyses on INTREX; df= 4,56 for analyses on Combined Outcome variable; INTREX= Residual-change scores on INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on SCL-90-R and GAS ratings combined.

Table 9

Means and Analyses of Variance for Criterion Variables as a Function of Dyad Composition

Criterion Variable	Dyad Composition				
	Female	Male	Opposite Sex	F	p
INTREX	148.66	-403.82	-19.57	1.54	ns
Combined Outcome	.44	1.86	-.30	1.80	ns

Note. df=2,59 for analyses on INTREX; df= 2,56 for analyses on Combined Outcome; INTREX= Residual-change scores on INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on SCL-90-R and GAS ratings combined.

Table 10

Means and Analyses of Variance for Criterion Variables as a Function of Therapist Professional Affiliation

Criterion Variable	Therapist Affiliation			
	Psychiatrist	Psychologist	F	p
INTREX	50.81	-45.90	.40	ns
Combined Outcome	.21	-.10	.22	ns

Note. df=1,59 for analyses on INTREX; df= 1,56 for analyses on Combined Outcome variable; INTREX= Residual-change scores on INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on SCL-90-R and GAS ratings combined.

Table 11

Means and Analyses of Variance for Criterion Variables as a Function of Vanderbilt Cohort

Criterion Variable	Vanderbilt Cohort			
	Pre-Training in TLDP	Post-Training in TLDP	F	p
INTREX	27.10	-30.01	.14	ns
Combined Outcome	.52	-.51	2.66	ns

Note. df=1, 59 for analyses on INTREX; df=1,56 for analyses on Combined Outcome variable; INTREX= Residual-change scores on INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on SCL-90-R and GAS ratings combined.

Table 12

Means and Analyses of Variance for Criterion Variables as a Function of Client Education

Criterion Variable	Client Education								
	6th Grade	High School	2 yr College	4 yr College Degree	Some Grad School	Master's Degree	Doctorate	F	p
INTREX	175.73	87.77	-54.32	-115.17	22.34	-263.34	173.43	.34	ns
Term	-1.77	-.72	-.41	-.06	.84	-.08	1.95	1.34	ns

Note. df= 6,59 for analyses on INTREX; df=6,56 for analyses on Combined Outcome variable; INTREX= Residual-change scores on INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on SCL-90-R and GAS ratings combined.

Table 13

Means and Analyses of Variance for Criterion Variables as a Function of Differences between Individual Therapists

Therapist	INTREX	Combined Outcome
1	-510.18	-1.10
2	-189.42	.48
3	89.45	3.06
4	-311.26	-1.23
5	9.02	.72
6	83.17	.74
7	-57.87	-1.71
8	155.97	.28
9	-295.71	.34
10	1010.94	2.10
11	-69.73	1.23
12	-136.77	-.20
13	647.25	-1.36
14	-46.83	.30
15	305.24	-.69
16	-158.57	-1.74
F	1.35	1.16
p	ns	ns

Note. df=15, 43 for analyses on INTREX; df=15, 40 for analyses on Combined Outcome; INTREX= Residual-change scores on INTREX Introject Questionnaire; Combined Outcome= Residual-change scores on SCL-90-R and GAS ratings combined.

Table 14

Means and Analyses of Variance for SASB ratings of Therapists' and Clients' Level of Affiliation as a Function of Vanderbilt Cohort

	Vanderbilt Cohort			
	Pre-Training in TLDP	Post-Training in TLDP	F	p
SASB-C	.96 (.03)	.95 (.03)	.10	ns
SASB-T	.95 (.05)	.96 (.09)	.69	ns

Note. df=1, 59; ()= Standard Deviation; SASB= Affiliation Ratings on the Structural Analysis of Social Behavior Scale; -C= scale pertaining to client; -T= scale pertaining to therapist.

Table 15

Means and Analyses of Variance for Frequency of Supportive and Exploratory Interventions as a Function of Vanderbilt Cohort

	Vanderbilt Cohort			
	Pre-Training in TLDP	Post-Training in TLDP	F	p
Frequency of Supportive Interventions	171.71 (93.25)	207.14 (88.16)	.14	ns
Frequency of Exploratory Interventions	4.87 (5.86)	12.42 (9.82)	13.17	≤ .001

Note. df=1, 59; ()= Standard Deviation.

Table 16

Means and Analyses of Variance for the Object of Therapists' Exploratory Interventions as a Function of Vanderbilt Cohort

	Vanderbilt Cohort			
	Pre-Training in TLDP	Post-Training in TLDP	F	p
Frequency of Exploratory Interventions with Therapist as Object	1.58 (2.50)	8.61 (8.47)	19.47	≤ .001
Frequency of Exploratory Interventions with Other Object	3.29 (5.68)	4.18 (4.95)	.41	ns

Note. df=1, 59; ()= Standard Deviation.