

# RESEARCH IN PSYCHOTHERAPY

PSYCHOPATHOLOGY, PROCESS  
AND OUTCOME

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Society for Psychotherapy Research

# RESEARCH IN PSYCHOTHERAPY PSYCHOPATHOLOGY, PROCESS AND OUTCOME

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Society for Psychotherapy Research

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**RESEARCH IN PSYCHOTHERAPY  
PSYCHOPATHOLOGY, PROCESS AND OUTCOME**

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## **Editorial**

The Italian section of the Society for Psychotherapy Research (SPR) was founded in 1995 to promote the culture of research in psychotherapy in Italy, widely neglected until then, both in the academic field and in various psychotherapy schools. The primary aim was to spread the knowledge emerging from international research about the effectiveness of psychotherapies, the process and the outcome and, more generally, the psychopathology field. A second aim was to create a scientific climate and community in order to promote the growth of an Italian generation of qualified researchers, capable of producing ideas and knowledge, using reliable tools, and taking part in the international debate on how and why psychotherapies work.

The title of an early SPR meeting suggests that “Research is good for clinical practice’s health” but also that “Clinical practice is good for research’s health”. Impelled by this conviction, SPR-Italy has always striven to establish a culture capable of responding with the proverbial patience of those involved in empirical research to all those who, from the perspective of hermeneutic hypersubjectivism or of pragmatic hyperobjectivism, consider psychotherapy of little interest to science and in any case an “unmeasurable” quantity.

Over the last fifteen years, SPR-Italy has become a reality, both in academic contexts and in private psychotherapy schools; many young people are investing their energy in research and various groups have long taken part in the international debate on psychotherapy research. The Italian section of the Society for Psychotherapy Research was established in 1995, thanks to the efforts of Professor Salvatore Freni and his group of researchers; it soon gained the support of many colleagues who felt the need to promote scientific research in

psychotherapy (for a history of the Italian section of SPR, go to Menu, *Italy Area Group*, History).

Apart from the national meetings, the main means of diffusion of ideas in Italy has been the journal *Ricerca in Psicoterapia* [*Research in Psychotherapy*]. Since 1998, our journal has given Italian researchers the opportunity to publish the results of their work, knowing that they will be read by an interested public, regardless of the school to which they belong. In 2006, thanks to the joint efforts of an Italian group of SPR researchers, the first Italian manual for research in psychotherapy was published (Dazzi, Lingiardi, & Colli, 2006), which enjoyed international SPR sponsorship and boasted an introduction by the past president of SPR, John Clarkin.

We are pleased to acknowledge that the reason for these fast and fruitful changes is also owed to a *Zeitgeist* change, so that the idea of theories and models based on the clinical and intellectual authority of their representatives has given way, at least partly, to the idea (and to the practice) of a psychotherapy that, through research, has come to account for the characteristics and the effectiveness of its interventions. Psychotherapists wondering how and why a certain therapy is working, and for what kind of patient it might be indicated (or contraindicated), are no longer a minority of lunatics.

One first result of this change was the appearance in university courses of programs inspired by research and, after a little more effort, research has been planned in public services and in psychotherapy schools (see, for example, Fava & Masserini, 2002, 2006).

Psychotherapy researchers in Italy follow the international debate and draw their knowledge from scientific publications mostly written in English. Therefore, as SPR-Italy, we felt the need to testify to the international community of our way of thinking, doing and disseminating research. Changing our journal *Ricerca in Psicoterapia* to

the present *Research in Psychotherapy: Psychopathology, Process and Outcome* was the natural corollary.

The state of the art is rich both in solid knowledge and in open questions on which the curiosity and energy of researchers can be focused. The creation of a journal about research in psychotherapy that is moving in sync with the international scenario must necessarily define its themes and its aims.

We are starting to unearth interesting data about the factors that influence the course of psychotherapy: the characteristics of the patient, the characteristics of the psychotherapist, and obviously those of their relationship (Norcross, 2002; Norcross & Wampold, 2011; Castonguay & Beutler, 2006). We know, for example, that therapies with patients who have difficult socioeconomic circumstances, a hostile/antagonistic interpersonal style, or little ability to identify and describe their own relations or to focus on their own or others' mental states tend to have a worse outcome.

Another important field of research sees psychotherapy as an essential area to delve into for clinical intervention. If, on the one hand, today's clinician know that, to be efficient, s/he must be able to implement general and transversal factors in assigning a therapy, on the other hand s/he also knows that s/he must have the specific tools to cure a specific disorder, going beyond the patient uniformity myth. The therapy of a patient affected by an obsessive-compulsive personality disorder requires specific characteristics, which are quite different from those required by a patient affected by a borderline personality disorder. Research on personality disorders, particularly research aimed at identifying clinical-diagnostic subtypes (see also see PDM Task Force, 2006), as in the case of team works by Westen and Shedler (Thompson-Brenner & Westen, 2005) and by Blatt, Shahar and Zurhoff (2002), is fundamental.

Particular attention will be given to the choice of tools for the evaluation of patients and for the gathering of data. We particularly support, whenever possible, well-tested, reliable and popular tools, rather than “local” tools or tools which have been used in a very small number of studies. Another subject of our research will be the therapeutic alliance, to be considered less and less as a non-specific factor/umbrella term explaining the fate of each therapy (Horvath, 2006), and to be restored more and more to its constructive dimension (Hill & Knox, 2009), as for example in the rupture/resolution cycle (Safran & Muran, 2000).

The development of treatments, especially the manualized ones, poses important questions: for example, whether the mechanisms of change assumed for a certain disorder actually correspond to the efficient ingredients of the cure. An investigation of what happens at the core of a session is probably the best way of resolving this question. Another example is the recent trials of effectiveness for the treatment of borderline personality disorder (Bateman & Fonagy, 2009; McMain, Links, Gnam, Guimond, Cardish, Korman, & Streiner, 2009), which show how a well-structured control group is able to generate more or less the same degree of change as in target treatments (*Mentalization Based Treatment and Dialectical Behavior Therapy*) (also see Gabbard, 2009). Do “all roads lead to Rome?” given the same intensity and pattern of treatment, or do different therapies share common elements of efficacy? It is clear that this issue forces us to engage with the EST vs. ESR debate, and invites us to reflect on the limitations of the excessive manualization of treatments (Chambless & Ollendick, 2001; for a wider debate, see Dazzi, 2006). As Luborsky (2001) argued, “the EST movement needs to be taken seriously, certainly from a scientific standpoint, but also from a political one” (p. 599). At this point it is necessary to make a reference to the article by Westen, Morrison and Thompson-Brenner (2004) and the important distinction between

*efficacy* (evaluated under “laboratory” conditions) and *effectiveness* (“ecologic” efficacy in the clinical context); in other words, between a “hypothetic” and “real” patient. And here is the centrality of diagnosis, and the necessity for the community of psychotherapists to develop a critical reflection on the DSM-5 proposals and their limitations (Shedler, Beck, Fonagy, Gabbard, Gunderson, Kernberg, Michels, & Westen, 2010).

Another promising trend is the study of the interplay between the different variables. For example, how do the personality structure of the patient, the use of specific techniques, the personal style of the therapist and the quality of their relationship interact, leading treatments to a positive or negative outcome? Questions like this are the challenge for the current and the next generation of researchers, researchers who must be encouraged to study the relation among therapeutic factors, specific characteristics of the patient and of the therapist, mediators and moderators of change. Is it possible to explain a higher or lower effectiveness of a therapeutic action (Jones, 2000; Gabbard & Westen, 2003)? How come in certain situations change never occurs, despite a “theoretically” efficient therapy being applied?

It goes without saying that one of the most fertile grounds for understanding how the therapeutic process takes place is the intensive analysis of session transcriptions. In this context, a special place in the training of Italian researchers is occupied by one of the founding fathers of the international society, Lester Luborsky, who, with his *Core Conflictual Relationship Theme* (CCRT) (Luborsky & Crits-Christoph, 1998), paved the way for the analysis of transcriptions, in search of the dominant interpersonal patterns of the patient and of the way they act in the therapeutic relationship [see also *Psychotherapy Process Q-set* by Enrico Jones (2000)]. It is worth noting that the instrument, originally a psychodynamic matrix, has aroused the interest of therapists of every school, thanks to the clarity with which



the construct of transference schemes was operationalized. Since the first applications of CCRT, this intensive analysis of the process, which can often be applied to single-case research, was very successful in our country, including, among others, research on defense mechanisms with the Defense Mechanism Rating Scale (DMRS; Lingiardi, Lonati, Fossati, Vanzulli, & Maffei, 1999), studies on metacognition (Dimaggio & Lysaker, 2010; Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007; Semerari, Carcione, Dimaggio, Falcone, Nicolò, & Procacci, 2003), analysis of narrative processes (Santos, Goncalves, Matos, & Salvatore, 2009), research on referential activity (De Coro, Ortu, Caviglia, Andreassi, Pazzagli, Mariani, Visconti, Bonfanti, Bucci, & Maskit, 2004), application of the Adult Attachment Interview (De Bei, Tanzilli, Miccoli, & Lingiardi, 2009), and operationalization of rupture/resolution processes (Colli & Lingiardi, 2009). Following this tradition, *Research in Psychotherapy* will gladly receive contributions of research based on session transcripts.

It is possible that the intensive analysis of clinical dialogue will prove the right picklock to open a treasure chest so far hidden by generic and static constructs. We are in a way obliged to reason about how the aforementioned therapeutic alliance is measured. Assessed by self-report instruments (with all the concomitant problems of reliability: what if the evaluator has scant auto-reflexive abilities? will s/he be able to correctly report what s/he hears/thinks compared with the therapist?) and in definite points of the therapy, it essentially remains a static concept, present or absent at a certain level. But what the clinician is interested in is understanding how therapist and patient construct their alliance and develop their relationship (from the first moment they look at each other or shake hands and start talking), how it wavers and consolidates, and what kind of efforts they both have to

make to keep it alive or construct it together (Safran & Muran, 2000; Ackerman & Hilsenroth, 2001, 2003).

It will be interesting to reflect on training paths, a theme which has not been sufficiently developed yet, and the evaluation of the effectiveness of training methods, particularly those related to the knowledge of empirical research data. Speaking of training, *Research in Psychotherapy* nominates itself to stimulate and accept the work of young Italian and international researchers.

Finally, we have to cope with the issue of funding for research. One of the many solutions to this problem is European funding, especially when it involves virtuous co-ordination among research groups (academic and otherwise) and the participation of colleagues, professionals and administrators of public and subsidized health services (doctors, psychologists, educators, social and healthcare workers). Let us remember that our tools of analysis can be used in very different fields, and that if the clinical and scientific contribution offered by research in psychotherapy is undervalued or ignored (apart from a small circle of "experts"), it is psychotherapy itself that is in danger of being marginalized or expelled from the contexts of care.

It should be clear by now which are the key words that characterize the articles you will be reading in this journal, which will sometimes appear as a special issue. It will have themes like, for example, process research, multi-instrumental research, single-case research, narrative cases, clinical and methodological theory of research design, dialog between models, but also personality disorders psychotherapies, neurosciences for psychotherapy research, qualitative vs. quantitative research, conceptual research, meta-analytic studies, etc.

Research has succeeded in responding to the criticisms that psychotherapy as a clinical practice has received: now it must learn to

speak to clinicians, showing how research findings could provide valuable help in their daily work with patients.

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## **The Contributions of the Psychotherapy Process Q-set to Psychotherapy Research**

J. Stuart Ablon<sup>1</sup>, Raymond A. Levy<sup>1</sup> & Lotte Smith-Hansen<sup>2</sup>

This year marks the 25<sup>th</sup> anniversary of the year that the late Enrico Jones first published his manual for the Psychotherapy Process Q-set (PQS). The manual has since been published in Jones' landmark book, *Therapeutic Action* (2000), and was recently revised and updated by the Massachusetts General Hospital Psychotherapy Research Program. In this article, we mark the 25<sup>th</sup> anniversary of the PQS by reviewing both the early findings from the measure and more current research driven by those first findings.

Jones recognized that conducting horse races between different forms of psychotherapy would likely just lead to more findings of fairly equivalent outcomes. While those horse races have served the important function of providing an evidence base for a variety of different forms of psychotherapy, Jones understood that they would do little to advance our understanding of how patients improve in psychotherapy. Furthermore, he feared that Lester Luborsky's "dodo bird verdict" might lead researchers to conclude prematurely and perhaps erroneously that common factors were the only active ingredients in the treatment process.

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While many experienced clinicians like Jones felt strongly that specific techniques in context were important predictors of treatment outcome, he wanted to test this hypothesis empirically. Thus, he spent the better part of a decade developing and refining a robust, sensitive, pantheoretical measure for studying psychotherapy process.

The contributions of the PQS to psychotherapy research have been of immense value. As we review below, the measure has been used to examine therapy process in studies ranging from single case designs to large randomized controlled trials, including the NIMH Treatment for Depression Collaborative Research Program (TDCRP). It has helped researchers identify key processes operating in treatment within different theoretical orientations, including psychoanalysis and psychodynamic psychotherapy, cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), and control-mastery therapy (CMT). It has even helped researchers describe the unique, ideographic and idiosyncratic processes occurring within individual dyads of therapists and patients (also known as “repetitive interaction structures,” “role-responsiveness” or “enactment”) which many believe lie at the very heart of therapeutic action.

### **The Psychotherapy Process Q-Set**

The PQS itself is an instrument designed to describe psychotherapy process at the level of an individual psychotherapy session. It consists of 100 items describing therapist behaviors (n = 41), patient behaviors (n = 40), and therapist-patient interactions (n = 19).

Examples of therapist (T) items include: T conveys a sense of nonjudgmental acceptance, T clarifies, restates or rephrases P’s communication, and T encourages P to try new ways of behaving with others. Examples of patient (P) items include: P brings up significant issues and material, P is tense and anxious, and P feels helped. Examples of interaction items include: P’s treatment goals are

discussed, the therapy relationship is a focus of discussion, and P's feelings or perceptions are linked to situations or behavior of the past. Each item is worded in neutral, descriptive language, and tied to specific behavioral and linguistic cues in order to minimize the amount of inference required by the rater. As we review below, the pantheoretical orientation of the PQS enables comparisons of therapy process between different treatment orientations.

The PQS is an ipsative measure in that independent observers rating the therapy session (from either transcripts, audiotapes, or videotapes) are instructed to sort the 100 items into categories representing items ranging from least characteristic to most characteristic of the session. In other words, the raters are required only to compare the 100 items to each other for this particular hour, not to make judgments about how the session compares to other sessions or to other standards. The instructions specify the number of items required in each of the 9 categories, and the measure thus counterbalances bias and halo effects by assuming a forced normal distribution. Different from other process measures in the field which typically examine segments of the therapeutic hour, the PQS uses an entire hour as the unit of analysis, thereby facilitating a more representative view of the session [The reader is referred to Jones, Cumming, & Horowitz (1988) or Jones (2000) for a detailed description of the development of the PQS].

Several characteristics of the PQS speak to its strengths as a measure. It has demonstrated reliability and validity across a variety of different treatment samples including archived treatments of psychodynamic, cognitive-behavioral, client-centered, gestalt, rational-emotive and interpersonal therapies (Ablon & Jones, 1999, 2002; Jones et al., 1988; Jones, Hall, & Parke, 1991; Jones & Pulos, 1993). The inter-rater reliability across all 100 PQS items has consistently yielded alpha coefficients between .83 and .89 per rater pair. Reliability analyses for individual items have also yielded acceptable to excellent



values (between .50 and .95) across samples. The measure's construct and discriminant validity has also been demonstrated across studies (Jones et al., 1988; Jones et al., 1991; Jones, Krupnick, & Kerig, 1987; Jones & Pulos, 1993).

As mentioned above, Jones first developed the PQS manual 25 years ago (Jones, 1985), but later published it in his book *Therapeutic Action* (Jones, 2000). By now, the measure exists in both paper and electronic versions, and has been revised, updated, and translated into numerous foreign languages, including German (Albani, Ablon, Levy, Mertens, & Kachele, 2008), Japanese (Ablon & Goodrich, 2004), Portuguese (Serralta, Nunes, & Ezirik, 2007), Spanish (Avila-Espada, Rampulla, Vidal, & Herrero, 2008; Toro, Guitierrez, Avila-Espada, & Vidal, 2008), Italian, and Norwegian.

### **Early Research: Process Predictors of What Works for Whom**

One of the first studies conducted with the PQS verified Jones' belief that common or non-specific factors were not solely responsible for therapeutic change, but rather that specific processes would predict outcome depending on their context. Specifically, he hypothesized that distinct processes might operate differently depending on variables such as patient characteristics, therapist characteristics, presenting problem, symptom severity, and phase of treatment.

Jones, Cumming and Horowitz (1988) investigated the treatments of 40 patients with post-traumatic stress disorder (PTSD) receiving 12 sessions of psychodynamic psychotherapy in order to examine the effects of specific therapist actions and techniques. At the beginning of the treatment, patients were separated into two groups depending on the severity of their symptoms. Results showed that different PQS items were associated with therapeutic success in each group. Specifically, the authors found that specific PQS items, in interaction with patient

pretreatment disturbance levels, predicted treatment outcome. In fact, successful therapies with less disturbed patients were described by observers using the PQS as expressively oriented, as therapists emphasized patient feelings to help him/her experience them more deeply, made connections between the therapeutic relationship and other relationships, and drew attention to patient's nonverbal behaviors. In contrast, successful therapies with more severely disturbed patients were shown to be more supportive in nature, as therapists gave more explicit advice and guidance, acted to strengthen defenses, reassured patients, and behaved in a teacher-like (didactic) manner. The diverse therapeutic strategies described with the PQS in the two groups seemed similar to what Sifneos (1972) described as "anxiety suppressive" *vs* "anxiety provoking" or the "supportive" *vs* "expressive" techniques delineated by the Menninger Study (Wallerstein, 1986).

### **Tracking Treatment Process Over Time**

In another early landmark study, Jones, Parke and Pulos (1992) studied the development of process over time by applying the PQS to another sample of 30 patients with a range of neurotic disorders who received 16 sessions of short-term psychodynamic treatment in a naturalistic setting. The PQS items rated most characteristic of the treatments confirmed the importance of techniques traditionally considered integral to brief psychodynamic treatments, including transference and defense interpretations, the importance of the therapy relationship, and reformulation of patients' in-session behavior. The findings also suggested that these treatments were characterized by a gradual shift from an external, reality-oriented construction of personal difficulties to an emphasis on inner experience and on the relationship with the therapist.

In identifying which PQS items were associated with outcome, the authors found that the items associated with positive outcomes included: P achieves a new understanding or insight, P is introspective, P readily explains inner thoughts and feelings, P's aspirations or ambitions are topics of discussion, and P feels helped. Negative correlates of outcome included P resists examining thoughts, reactions, and motives, and P is controlling.

### **Comparing Process in Different Types of Treatment**

Jones and Pulos (1993) then used the PQS to compare the process in the aforementioned sample of 30 patients receiving 16 sessions of psychodynamic treatment to a sample of 32 patients receiving 16 session CBT. They found that the two treatments were similar in terms of important patient characteristics, since out of the 38 PQS items not distinguishing the two treatments, as many as 26 were descriptive of patient attitudes and emotional states, e.g., anxiety, guilt, inadequacy, depression, degree of trust in T, and sense of feeling understood by T.

In line with the authors' hypothesis, important differences distinguished the two treatments in terms of therapist stance and technique however. The techniques employed by psychodynamic clinicians were consistent with that orientation's theoretical frame, and included evocation of affect, bringing troublesome feelings into awareness, integrating current difficulties with previous life experiences, and using the therapist-patient relationship as a change agent. Different techniques characterized the cognitive-behavioral therapies, including controlling negative affect through the use of intellect, vigorous encouragement, and support and reassurance.

### *Factor Analysis of PQS Items: Associations with Outcome*

In addition to producing the above findings, the study by Jones and Pulos (1993) represented an important methodological advance through the use of factor analysis to identify underlying factors across the two treatments.

Using a principal components analysis, the authors found four conceptually interpretable factors, including 1) Psychodynamic Technique (e.g., T is neutral, T interprets warded-off or unconscious wishes, feelings, or ideas), 2) Cognitive-Behavioral Technique (e.g., T actively exerts control over the interaction, there is discussion of specific activities or tasks for P to attempt outside of session), 3) Patient Resistance (e.g., P rejects *vs* accepts T's comments and observations, P resists examining thoughts, reactions or motivations related to problems), and 4) Negative Patient Affect (P feels sad or depressed, P feels inadequate or inferior).

To the investigators' surprise, Psychodynamic Technique was significantly correlated with four out of five measures of patient improvement in CBT (and showed a near-significant trend with outcome in the psychodynamic treatment). In contrast, Cognitive-Behavioral Technique was found to have little or no relationship with outcomes in CBT, but showed a negative association with one of four outcomes in the dynamic treatment.

### *The Smuggling Hypothesis: Adherence to Prototypical Treatment Processes*

The finding from Jones and Pulos (1993) that psychodynamic strategies were positively correlated with therapeutic outcome across both CBT and psychodynamic treatment led to a systematic line of inquiry concerning the incidence and effect of borrowing treatment processes from one approach for use in another.

This new line of research began when Ablon and Jones (1998) used expert ratings of PQS items to develop prototypes of ideal treatment process. Specifically, Ablon and Jones first gathered panels of experts in psychodynamic and cognitive-behavioral therapy, respectively, and asked them to use the PQS to describe the process of an ideal session that adhered to their theoretical principles. Cluster analysis was then used to determine whether the panels of experts had distinct views of therapy process. Regression scores were calculated to determine the degree to which each individual item of the PQS contributed to the experts' view of ideal therapy process. Each factor array of 100 scores represented a prototype ideal treatment process according to the experts.

As the next step, using the same dataset as Jones and Pulos (1993), Ablon and Jones (1998) correlated observer ratings of actual sessions with the prototypes to determine the degree to which the actual treatments corresponded to the ideal, prototypical process prescribed by the psychodynamic and CBT experts. Finally, to determine which processes constituted the active ingredients of the treatments, they assessed the degree to which adherence to the prototypes correlated with outcome.

Surprising results emerged again. Therapists in the psychodynamic treatments fostered processes consistent with both ideal psychodynamic and cognitive-behavioral treatment, while in contrast therapists in the CBT group fostered mostly CBT processes, and not psychodynamic processes, thus adhering more closely to prescribed techniques. These results suggest that the psychodynamic clinicians employed a more heterogeneous set of treatment strategies than their CBT colleagues.

However, results furthermore showed that adherence to the CBT prototype was associated with positive outcome for only one of the six symptom measures across the psychodynamic and CBT samples, while

degree of adherence to the psychodynamic prototype was consistently associated with positive outcome across the two groups. This was true despite very little adherence to the psychodynamic prototype in the CBT sample. Thus, the surprising finding that psychodynamic process emerged as a positive predictor of outcome in the CBT sample was a replication of previous findings in the same sample using different methods. This study also suggested, however, that the active ingredients in a treatment do not necessarily need to be the most characteristic ones. Even minimal adherence to certain therapy processes can be robust predictors of treatment outcome.

Following these findings, Ablon and Jones (1999, 2002) conducted a replication study using data from the psychotherapy arms of the NIMH Treatment of Depression Collaborative Research Program (TDCRP), at the time a state-of-the-art controlled clinical trial for depression (Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester, & Parloff, 1989). Results revealed significant areas of difference in process between IPT and CBT, as well as important points of similarity in the processes of both approaches. Differences in process were consistent with the theoretical distinctions between the two orientations, and centered on the therapist's stance, activity, and technique. When prototype methodology was applied, however, it became evident that both treatments adhered equally strongly to the CBT prototype. Of note, while the CBT therapists fostered a robust CBT process to the exclusion of other processes, the IPT therapists were found to be fostering both CBT and psychodynamic process. However, adherence to the CBT prototype correlated positively with treatment outcome across both groups. In summary, these results challenged the assumption that the two treatment approaches tested in the TDCRP relied on mutually distinct interventions and techniques and that positive outcomes validated their proposed mechanisms of change. The moral of this line of research seemed to be brand names of therapy

could be quite misleading when it comes to actual treatment processes fostered and active ingredients promoting positive change.

#### *Other PQS Findings from the TDCRP*

Building on these findings, Coombs, Coleman and Jones (2002) used the TDCRP dataset to explore the role of emotion in CBT and IPT, focusing on the therapists' stance toward patients' experience and expression of emotion. Their factor analysis revealed three key factors: Factor 1, termed *Collaborative Emotional Exploration*, was significantly related to positive outcome in both CBT and IPT. The PQS items on this factor included P is introspective, readily explores inner thoughts and feelings, T is sensitive to the patient's feelings, and P has cathartic experience. Factor 2, termed *Educative/Directive Process*, included Discussion centers on cognitive themes, T behaves in a teacher-like, didactic manner, and There is discussion of specific activities or tasks for the patient to attempt outside of the session; this factor was not related to positive outcomes. These results are especially interesting given the earlier findings by Jones and Pulos (1993) that psychodynamic treatments tend to focus more on patient emotion than CBT, and that emotional exploration was correlated with improvement on four of five outcome measures in the CBT sample.

Using the CBT and IPT archives from the TDCRP, Karlsson and Kermott (2006) investigated which PQS process factors were associated with reflective functioning (RF; Fonagy, Target, Steele, & Steele, 1998). The authors found that the PQS items most strongly associated with RF were T accurately perceives the therapy process, T draws attention to feelings regarded as unacceptable by the patient (e.g., anger, envy, or excitement), T is sensitive to the patient's feelings, attuned, empathic, P brings up significant issues and material, P is committed to the work of

therapy, and P achieves new understanding insight. These PQS items were in turn significantly associated with positive outcomes.

In contrast, the PQS items associated with lower levels of RF were T actively exerts control over the interaction (e.g., structuring and/or introducing new topics), P does not initiate topics, is passive, P does not feel understood by the therapist, P feels weary or suspicious, and P rejects therapist's comments and observations. These items were in turn significantly related to poorer outcomes.

Taken together, the PQS findings from the TDCRP shed important light on psychotherapy process and outcome in CBT and IPT treatments. However, they also revealed the significant limitations of controlled trials of manualized treatments when it comes to studying psychotherapy process. This realization led to the next wave of research using the PQS to study psychotherapy naturalistically. While RCTs maximize internal validity, Jones and colleagues proposed the study of naturalistic treatments as an important complement to controlled studies in an effort to study psychotherapy process from a more ecologically valid perspective.

### **Adherence to Prototypical Treatment Processes in Naturalistic Treatments**

To complement the research from the TDCRP and other RCTs, Ablon, Levy and Katzenstein (2006) studied 17 naturalistic treatments of panic disorder by seven self-identified psychodynamic clinicians delivering treatment as usual. Using the PQS, they found that the therapists employed a large spectrum of interventions, and the treatments included process variables typically associated with CBT. In fact, adherence to the CBT prototype was stronger than adherence to the psychodynamic and IPT prototypes, despite the self-identified psychodynamic orientation of the clinicians. However, adherence to IPT



and psychodynamic process was most associated with positive outcomes. In other words, the most predominant processes were not the active ingredients of the treatment, a replication of findings from prior studies.

The authors then went a step further by using individual Q-item analyses to isolate the specific ingredients of the treatment process that predicted positive change, coining the phrase “empirically supported change processes.” Specifically, they found that emphasizing feelings in order to deepen them was the single most important predictor of outcome ( $r = .70$ ). In fact, processes aimed at facilitating expression of the patient’s negative affect, such as self-accusations, shame, and guilt, negative feelings toward the therapist, and emotions deemed unacceptable by the patient were significantly associated with positive outcomes. This replicated the findings by Coombs et al. (2002), discussed above, showing that collaborative emotional exploration was key in both CBT and IPT as delivered in the TDCRP.

Ablon & Jones (2005) also used the PQS to compare therapy process from three different treatment settings: two psychoanalyses ( $n = 130$  sessions), three long-term analytic therapies (two sessions weekly;  $n = 229$  sessions), and two short-term dynamic therapies ( $n = 122$  sessions). The authors calculated each sample’s correspondence to the psychodynamic prototype, and found that the two psychoanalyses demonstrated a significantly greater correlation with the prototype, while the psychoanalytic psychotherapy treatments showed a weaker correlation and the short-term dynamic therapies an even weaker correlation. The differences between each sample were statistically significant, providing the first empirical evidence that psychoanalysis proper fosters more of an analytic process than psychodynamic psychotherapy. This study also highlighted several specific items that differentiated the psychoanalyses from the long-term psychotherapies in surprising ways, providing a potential focus for future research.

### **Rapid vs Slow Response to Treatment**

Another unique study using the PQS was conducted by Comminos and Greyer (2008) who compared the process of early sessions of “rapid responders” and “gradual responders.” The process findings revealed that the rapid responders were better able to work with intensive feelings (e.g., guilt) in early stages of therapy. In contrast, the gradual responders had high ratings of defensiveness and externalization early in treatment, despite no differences in early working alliance, which confirms prior findings regarding the importance of focusing on affect in treatment while utilizing different treatment processes depending on patient characteristics.

### **Single Case Studies**

While the aggregated data in studies of therapy process at the group level have contributed enormously to our understanding of process and outcome, Jones and colleagues realized that their findings are too global to pinpoint the specific active ingredients in individual treatments. In parallel with the studies reviewed above, a separate group of studies using single-case designs have used the PQS to examine similar research questions about what processes operate in treatment, how process changes over time, whether therapists adhere to prescribed technique based on theoretical orientations, and how process relates to outcome. Gottman (1973) referred to single case studies as “N-of-one-at-a-time research,” emphasizing that findings from  $N = 1$  studies are valuable in part because they can be repeated across cases, leading to an accumulation of rich knowledge about therapy process and outcome. As the reader will see below, the PQS represents an ideal instrument for such research.

### *The Case of Mrs. C*

The first intensive single-case study using the PQS was conducted by Jones and Windholz (1990), who examined the 6-year psychoanalysis of Mrs. C. Mrs. C was a social worker in her late 20s who sought treatment for her lack of sexual enjoyment, inability to relax, drivenness at home and at work, and self-critical tendencies. The analysis consisted of approx. 1,100 hours over six years, and the authors selected a 10-session block of audio-recordings from each year (i.e., hours 91-100 in year 1, hours 258-267 in year 2, hours 429-438 in year 3, and so on).

In order to provide a view of the salient processes in the treatment overall, the authors first identified the PQS items that demonstrated consistently high ratings and little variability across time. Consistent with traditional psychoanalytic technique, results showed that the analyst's stance was consistently neutral, accepting, and non-defensive, and that he refrained from offering direct support, reassurance, and advice. The patient was consistently rated as anxious, tense, active in initiating dialogue, but not controlling nor demanding.

In order to examine changes in therapeutic process over time, the authors compared the process from Year 1 to Year 2, from Year 3 to Year 4, and from Year 5 to Year 6. For example, from Year 1 to 2, Mrs. C began feeling less shy and embarrassed, more trusting and secure, and less concerned about how the analyst might judge her, while the analyst's communications became more direct, clear, and evocative.

Interestingly, the authors found evidence for the emergence of a transference neurosis in the fourth year of the analysis. Q-descriptors signified a remarkable heightening of Mrs. C's resistances and symptoms, as well as an increase of disturbing affect during the analytic hours, especially defiance, guilt, and intense hostility toward the analyst. Even at this difficult point in the analysis, however, she

clearly made active efforts to work constructively with the analyst's interpretations. Of note, the data from the last period of the analysis suggested a resolution of the transference resistances, signaled in part by the patient's greater openness about her desires, feelings, and fantasies, including sexual desires and a need for intimacy.

Over the six-year period, the authors found that Mrs. C's discourse became gradually less intellectualized and dominated by rationalization, and increasingly reflected greater access to her emotional life and a developing capacity for free association. The analyst became gradually more active in challenging the patient's understanding of an experience or an event, identifying recurrent patterns in her life experience and behavior, interpreting defenses, and emphasizing feelings the patient considered wrong, dangerous, or unacceptable.

Spence, Dahl and Jones (1993) took the investigation of Mrs. C's analysis one step further by using more sophisticated methodology — time series analysis. They found that associative freedom increased over time to a significant degree, and was significantly associated with the number of interventions used by the analyst in each hour, but only in the later phases of treatment. Three interventions in particular were identified which increased associative freedom in the current session and in the next three sessions; specifically, when the analyst made an interpretation directed toward the patient's defensive style, identified a recurrent theme in the material, or discussed the patient's dreams or fantasies, Mrs. C verbalizations in response demonstrated a higher degree of freedom in her associations.

A factor analysis conducted by Ablon and Jones (2005) revealed three clusters of items reflecting recurring patterns of interaction in the analysis. The process captured by the factor Patient Self-Exploration/Analyst Acceptance included Mrs. C being introspective, readily examining her thoughts and reactions, and actively bringing up material; and the analyst typically accommodated her to improve the

relationship during difficult interactions. However, this interaction structure became less prevalent over time. In contrast, the factor termed Analyst Activity gradually became more prevalent as the analysis progressed, as evidenced by the analyst exerting gradually more control over the interaction and more frequently interpreting warded-off or unconscious wishes, feelings, and ideas.

The third recurring interaction structure identified by the factor analysis was termed *Playing Stupid* because the analyst frequently interpreted Mrs. C's behavior during these types of interactions as her "playing stupid." The items loading most strongly on this factor included Sexual feelings and experiences are discussed, T suggests the meaning of others' behavior, and Love or romantic relationships are the topic of discussion. A close examination of these interactions revealed that Mrs. C often found herself feeling confused when talking about sexual matters; in response, the analyst typically talked more and provided longer explanations and interpretations of why she found it necessary to keep herself in a confused, muddled state of mind, related in part to a memory of a time she had to "play dumb" to hide something important she knew. Interestingly, Mrs. C repeated this dynamic by having trouble understanding the analyst's interpretations in the session.

In sum, various authors used the PQS to describe in detail the dyad-specific processes involved in the successful six-year analysis of Mrs. C, including her resistance, transference, access to deepening unconscious wishes, and eventual easing of restrictions on her self-expression.

### *The Case of Mr. A: An Integrative Psychoanalysis*

Porcerelli, Dauphin, Ablon and Leitman (2007) examined treatment process in the five-year psychoanalysis of Mr. A. Mr. A was a married computer technician, age 50, who sought treatment for chronic anxiety

and a phobia related to driving on expressways. Underlying his anxiety was hostility towards his wife, inhibitions regarding advancement at work, sensitivity to criticism, and conflicts over sexuality. He was diagnosed with avoidant personality disorder based on clinician ratings with the Shedler-Westen Assessment Procedure (Shedler & Westen, 1998). Mr. A was seen 3-4 times weekly on the couch for five years, but only 20 audio-recorded sessions were available for the study (four intake sessions, three therapy sessions at each year's end, and one session at follow-up).

PQS ratings of the 15 therapy sessions showed that the treatment was consistently characterized by strong psychodynamic process, as the ratings correlated significantly with the psychodynamic prototype developed by Ablon and Jones (1998, 2002). This was exemplified by therapist behaviors such as drawing attention to feelings deemed unacceptable by the patient, interpreting ward off feelings and ideas, emphasizing feelings in order to help the patient experience them more deeply, and conveying non-judgmental acceptance. Discussion frequently focused on Mr. A's dreams and fantasies and on the therapeutic relationship, both highly reflective of psychodynamic process. Characteristic patient behaviors included bringing up significant issues and material, being committed to the work of therapy, understanding the nature of therapy, experiencing ambivalent and conflicted feelings about the therapist, and being concerned about what the therapist thought of him.

Interestingly, the process in the three sessions from Year 3 (but not in other years) also showed significant correlations with the interpersonal and cognitive-behavioral prototypes, suggesting a more integrative process at that point in treatment. Of note, at this time Mr. A and his analyst were often discussing his rage at his wife as her health deteriorated and threatened to deplete him emotionally and financially; this focus on his current relationships likely drove the

correlation with the IPT prototype. Furthermore, they often discussed Mr. A's efforts to "behave differently" in relation to his wife between sessions; this focus on "homework" and advice giving likely drove the correlation with the CBT prototype. In sum, Mr. A's treatment was a successful psychoanalysis with significant integrative elements.

#### *The Case of Ms M: Mutual Influence in a Therapist-Patient Dyad*

The first single-case study using time series analysis of PQS data was conducted by Jones, Ghannam, Nigg and Dyer (1993) who examined the treatment of Ms. M who was in intensive, twice-weekly psychodynamic psychotherapy with Dr. X. over a period of 2½ years (208 sessions). M was a divorced woman in her mid-30s who sought treatment for longstanding depression. Her current depressive episode occurred in the context of difficulties with her son, age 16, who wanted to live with his father, her ex-husband. A key historical event was the accidental drowning of her older brother (who was a rival for her parents' attention) when she was a child; as a result, she felt blamed by her mother and abandoned by her father. Dr. X's formulation was grounded in Control-Mastery Theory (CMT) which is a cognitive-psychodynamic theory emphasizing the role of pathogenic beliefs and unconscious guilt in psychopathology.

The PQS was used to rate the videotapes from every fourth session (n = 53), and showed that Ms. M was characteristically compliant, trusting, and undemanding. She felt understood by the therapist, and accepted the therapist's comments and observations. Dr. X was consistently responsive, affectively involved, confident, and self-assured. While supportive and didactic, she also employed traditional psychodynamic technique such as interpreting and linking current feelings and experiences to the past and identifying recurrent patterns in M's life.

The authors identified four key dimensions of the therapy process through the use of an exploratory principal components factor analysis which showed four clusters of PQS items. The first factor, *Therapist Acceptance/Neutrality*, reflected Dr. X's non-judgmental acceptance, empathy, facilitation, and neutrality. Factor 2, *Therapist Interactive*, captured Dr. X's more authoritative behaviors, i.e., the times when she took on a more controlling, challenging, and didactic role. The factor included items related to the patient as well; presumably in response to Dr. X's authoritative stance, M had difficulty understanding Dr. X and felt misunderstood. The third factor, *Psychodynamic Technique*, reflected the therapist's use of traditional techniques such as interpreting warded off feelings or ideas, emphasizing unacceptable feelings, interpreting defenses, and allowing difficulties to emerge without appeasing or accommodating the patient. Factor 4, *Patient Dysphoric Affect*, captured M's depression and anxiety, and her efforts to control these feelings during sessions.

Taking these findings a step further, the authors used time series analysis to explore whether the four factors were related in either unidirectional and bidirectional ways. The reader is referred to Jones et al. (1993) for a detailed description of the statistical techniques employed. In brief, time series analysis was used to test whether (a) the therapist influenced the patient, (b) the patient influenced the therapist, (c) neither influenced the other, or (d) the therapist and patient influenced each other bidirectionally. The method has been used to study mother-infant, husband-wife, as well as patient-therapist interactions.

The authors found that the processes between Dr. X and M were in fact mutual and reciprocal, challenging the conventional idea that primarily the therapist's techniques bring about change in the patient. Specifically, the authors concluded that Dr. X was more neutral, non-judgmental, and facilitative in the beginning, and that M's depressive



affect during sessions gradually 'pulled' Dr. X toward a more involved and authoritative stance; this change in process in turn predicted M's reduction in depression. These findings support the notion of 'role responsiveness' (Sandler, 1976) and the idea that certain repetitive interaction structures typically develop between therapist and patient.

In addition, it was found that change in patient dysphoric affect both predicted and was predicted by both supportive and expressive techniques. Specifically, sometimes Dr. X was more reassuring in response to M's depression and anxiety, and sometimes M became less depressed in response to Dr. X's reassurance. In addition, Dr. X's transference interpretations led to increased depression and anxiety, while M's depression level predicted how often Dr. X interpreted the transference. Presumably the patient experienced Dr X's interpretations as narcissistic injuries rather than empathic, helpful explanations of her unconscious motivation.

The use of factor analysis and time series by Jones et al. (1993) represented two important methodological advancements. Building on these, Pole and Jones (1998) used the archived sessions of M's treatment to further investigate why, contrary to conventional psychoanalytic wisdom, decreased therapist acceptance and neutrality led to symptom improvement in the patient and how exactly therapy contributed to her other improvements, such as increased awareness of unconscious guilt. They furthermore examined whether M's degree of free association (measured by word co-occurrence) and discussion of key topics (related to her mother, father, brother, and guilt) were related to treatment outcomes.

Using time series analysis, the authors found that M's associative freedom (i.e., the degree to which she spoke freely and explored intrapsychic topics in depth) increased over the course of treatment, was facilitated by Dr. X's use of psychodynamic techniques, and in turn predicted symptomatic improvement. Furthermore, M became more

conscious of her guilt over time and her increased capacity to free-associate predicted her later ability to express and experience guilty feelings. Dr. X's use of psychodynamic technique also directly influenced M's conscious experience of guilt. The analysis of key topics showed that Dr. X demonstrated a non-neutral, challenging stance during discussion of certain topics (mother, father, and guilt), but not others (brother), actively taking the stance that M had a right to have had better mothering and to be a better mother to her own children without having to fear hurting her mother. In other words, Dr. X was not less accepting of M as a person but rather less accepting of her guilt-inducing beliefs regarding her parents. Finally, time series analysis showed that M's symptoms were ameliorated by discussion of specific key topics (mother or father) but not others (brother).

Further building on these findings in their study of Ms M's treatment, Pole, Ablon and O'Connor (2008) found that overall, the treatment significantly resembled CBT and CMT prototypes (and in fact resembled ideal CBT process more than ideal CMT process), but did not resemble the psychodynamic prototype. However, looking in more detail at the PQS items describing the therapist's and patient's behaviors as well as their interactions, it was found that Dr. X's behaviors were more adherent to ideal CMT therapist behaviors than ideal CBT and psychodynamic behaviors. Interestingly, M's behaviors were more adherent to ideal CBT patient behaviors than ideal CMT and PDT behaviors. In other words, the treatment's overall resemblance to CBT was driven mostly by the patient's CBT-like behaviors. The interactions between M and Dr. X were closely adherent to both ideal CMT and ideal CBT interactions.

The authors furthermore found that Dr. X's adherence to the CBT and CMT prototypes predicted symptom improvement, while adherence to the psychodynamic prototype did not. Symptom improvement did not in turn influence adherence to any of the three prototypes. Looking in

more detail at what therapist, patient, and dyadic behaviors predicted symptom reduction, the authors found that improvement was predicted by therapist adherence to ideal CMT behaviors (e.g., focusing on guilt), patient adherence to ideal CMT behavior (e.g., testing the limits of the therapy relationship) and psychodynamic behaviors (e.g., achieving new insight), and patient-therapist interactions consistent with ideal CBT (e.g., discussion of homework) and psychodynamic (e.g., discussion of dreams and fantasies). Of note, the patient's strong adherence to CBT behaviors was not associated with improvement.

This series of single-case studies represented an important advance beyond conventional ways of measuring adherence that tend only to examine therapist techniques, by suggesting that treatment processes are co-created by therapist and patient.

#### *The Case of Maria: Ideal Technique on a Case by Case Basis*

While Pole et al. (2008) employed a generic CMT prototype specifying general ideal CMT process, Pole, Ablon, O'Connor and Weiss (2002) used the PQS to develop case-specific CMT treatment guidelines in the case of Maria. Maria was a married woman, age 30, originally from Mexico, who had forsaken her studies in veterinary medicine to care for her children and support her husband in his professional pursuits. She sought treatment for depression related to the feeling that her life had gotten off track since she withdrew from school due to an unexpected pregnancy. The CMT formulation focused on the guilt she felt for wanting to pursue her own interests (as opposed to devoting all her time to her family), and for potentially surpassing her mother, grandmother, and other women from her culture. Each of the 16 sessions was videotaped and rated with the PQS.

At the outset, the therapist and his supervisor developed a case-specific measure of ideal CMT technique based on their formulation of the patient's particular difficulties. This was done in collaboration with

the progenitor of CMT. The guidelines specified that in an ideal session, the therapist would focus on the patient's guilt; provide supportive, encouraging, and reassuring statements; interpret unconscious wishes, feelings, and ideas; and facilitate the patient's speech (which was especially important since she doubted her English proficiency).

The authors found that Maria's self-rated in-session affect associated with feeling ineffective and depressed fluctuated from session to session, but showed improvement over time, as did the therapeutic alliance (rated by patient, therapist, and independent observers). Session outcomes in terms of therapist helpfulness, patient response, and overall session quality (also rated by patient, therapist, and independent observers) showed a range from session to session, but improved moderately over time. Therapist-rated adherence was close to ideal CMT throughout and improved over the 16 sessions.

Furthermore, adherence to ideal CMT technique was associated with reduced ineffective and depressed affect in session and with positive patient- and observer-rated session outcomes. Adherence was more strongly correlated with positive session outcomes than was the therapeutic alliance, and even predicted outcome above and beyond the combined effects of the passage of time, the in-session affect, and the therapeutic alliance.

These findings speak clearly to the importance of developing measures of case-specific ideal technique based on theory-driven formulation of individual patients' difficulties, rather than adhering rigidly to generic techniques specified by treatment manuals (which can be associated with negative process and outcomes, as shown by Castonguay, Goldfried, Wise, Raue, & Hayes, 1996; Henry, Strupp, Butler, Schacht, & Binder, 1993).

Amalia X was an adult German woman who sought psychoanalysis for depression with underlying self-esteem difficulties related to excessive body hair growth (hirsutism). She felt that, starting in puberty, her life had suffered severe strain related to this problem, resulting in significant anxiety, depression, irritability, compulsiveness, and social insecurity. She attended 517 sessions with good results.

Amalia is considered the German specimen case, and her analysis has been studied extensively. Albani, Blaser, Jacobs, Jones, Thomä, & Kächele (2002) used the PQS to examine five therapy hours from early in treatment and five hours from the end of the treatment. The PQS items that were characteristic across these ten sessions included the analyst being empathic, neutral, accepting, and tactful, while the patient was consistently active in beginning the hour and bringing up significant issues and material, spoke of wanting to be separate, and accepted the analyst's comments and observations. The sessions were consistently characterized as having a specific focus, e.g., the patient's body image, relationships, or cognitive themes.

In comparing the early treatment process to the process at the end of treatment, the authors identified several PQS items that distinguished the two treatment phases. In the beginning, the analyst more often asked for more information, clarified, facilitated the patient's speech, and identified recurrent themes in the patient's experience; the patient had a clearer and more organized expression, felt shy and inadequate more often, and expressed shame and guilt more frequently (compared to the end of treatment). At the end of treatment, the analyst reformulated the patient's behavior less, had a reduced focus on the patient's feelings of guilt, and was less active in exerting control of sessions; the patient was more controlling, provocative, resistant to examining thoughts and feelings, and more able to express anger (compared to the beginning of treatment).

Neither the beginning nor the ending closely resembled the psychoanalytic prototype, suggesting that the psychoanalytic work was just beginning or coming to a close. These findings indicate that psychoanalytic treatments are more varied than adherents of theoretical purity suggest and that treatments do not necessarily conform to theoretical prototypes, a replication of earlier findings.

At the same time, session 152 of Amalia's treatment has in fact been identified as a prime example of modern psychoanalytic technique. In this session, Amalia brings up an important dream, and the analyst helps her explore its unconscious meanings by drawing no sharp distinctions between fantasy and reality. The most characteristic PQS items for this session included P's dreams and fantasies are discussed; T's remarks are aimed at facilitating speech; T interprets warded-off or unconscious wishes, feelings, or ideas; and the analytic relationship is a focus of discussion. The least characteristic items included T acts to strengthen defenses; P does not feel understood; P does not initiate topics, is passive; and real *vs* fantasized meanings of experience are actively differentiated.

As described by Levy, Ablon, Ackerman and Seybert (2008), session 152 was particularly difficult to rate with the PQS, in part because of the complex dialogue, personal associations, and intimate exchange between analyst and patient. The raters indeed had the experience of being invited into "a very private world of dyadic meaning."

The PQS items most difficult to rate for session 152 included item 42 (P rejects rather than accepts T's comments and observations) in part because Amalia at times first resisted the analyst's interpretations, but then shifted focus to deepen the conversation. Another difficult item was item 58 (P resists examining thoughts, reactions, or motivations) mainly because she readily explored parts of the transference, but resisted expressing her sexual thoughts and feelings. In fact, item 11 (sexual feelings or experiences are discussed) was difficult to rate in

part because Amalia made several references to sexual content without direct mention, and in fact appeared to actively resist deeper discussion of it.

A final example was item 12 (silences occur during the hour). This item was difficult to rate because the session contained several long silences, including one reflecting significant resistance prior to Amalia's changing the subject. However, the raters felt that the silences did not change the flow of the session in major ways, as the session had a vitality and productive energy to it overall. The silences seemed to reflect shifts in focus, rather than ruptures in the relationship or suppressed aggression, so the raters rated them as less salient. In sum, while some items were difficult to rate, the PQS allowed the researchers to capture even the private meanings and unique processes of session 152 of Amalia's analysis.

### *The Case of Beth*

Beth was a woman in her mid-20s who sought treatment soon after choosing to leave graduate school in the physical sciences due to intense competition and performance pressures. She felt lost and stuck in her professional pursuits, and had applied for no jobs since leaving graduate school. She broke off her romantic relationship with her girlfriend of many years soon after leaving graduate school, but continued to live with her. Beth was in twice-weekly psychotherapy for approximately 15 months with Dr. A, a psychologist of a psychodynamic orientation who was asked to conduct the treatment as she would if seeing Beth in private practice.

Katzenstein (2007) examined process and outcome in Beth's treatment using the PQS ratings from every other hour ( $n = 61$ ), derived from the transcripts of the videotaped sessions. The treatment process was found to adhere most closely to the psychodynamic prototype ( $r = .43$ ) and the cognitive-behavioral prototype ( $r = .38$ ) with no statistically

significant difference in adherence between the two. The process correlated significantly less with the interpersonal prototype ( $r = .20$ ). However, adherence to psychodynamic process was the only significant predictor of symptom level and symptom change.

A principal components factor analysis revealed two factors underlying the PQS items. Factor 1 was labeled *Patient's Affective and Cognitive Distancing* and described a stance frequently taken by Beth during sessions. Specifically, she had a strong tendency to distance herself from her own experience, as exemplified by PQS items such as P is controlling, P is anxious and tense, P discusses experiences as if distant from feelings, and P resists examining thoughts, reactions, or motivations. The item with the strongest negative factor loading was P is introspective and readily explores inner thoughts and feelings.

Factor 2 was labeled *Therapist Cutting Through to Affect*, and described Dr. A's efforts to help Beth focus on and talk about her inner experience. This stance was exemplified by PQS items such as T emphasizes the patient's feelings to help him/her experience them more deeply, T's remarks are aimed at facilitating speech, and T asks for more information or elaboration.

Time series analysis showed that Beth's level of symptom distress 1) resulted in more frequent distancing and disengaging from her thoughts and feelings, and 2) led Dr. A to focus more on affect to help her access her thoughts and feelings more deeply. These efforts in turn predicted a reduction in Beth's level of symptom distress in a reciprocal manner.

Interestingly, in the exit interview with an independent clinician, Beth spoke eloquently about these processes when asked what made the treatment effective: "My therapist had me talk in very concrete terms and get in touch with a lot of my feelings... I was able to talk about those things instead of spending all my energy staying away from it... She made me aware that I talked about my feelings in abstract



ways... I think this was a big part of what was helpful to me about our therapy and what helped me feel better.”

Taken together, the single-case studies reviewed above provide a rich description of process and outcome in each dyad as an important complement to the aggregated data in studies at the group level. Most importantly, single-case studies have allowed for an ideographic examination of the particular processes at play in individual treatments, greatly facilitated by prototype methodology, factor analysis, and time series analysis.

To review, these ideographic processes included 1) Mrs. C's development and resolution of a transference neurosis, and her tendency to “play stupid” in certain sessions, 2) the use of interpersonal and cognitive-behavioral techniques during Year 3 of Mr. A's analysis (but not during other years), 3) the process by which M's depressive affect gradually pulled Dr. X away from his original neutral position towards a more involved and authoritative posture, which in turn predicted improvement in M's depression, and the importance of Dr. X's gradual change to become more challenging of M's guilt-inducing beliefs regarding her parents, 4) the usefulness of developing and adhering to case-specific ideal technique, driven by a CMT formulation, by Maria's therapist, 5) the ‘private world of dyadic meaning’ between Amalia and her analyst, and 6) Beth's tendency to distance herself from her feelings, Dr. A's efforts to help her access them, and the resulting improvement in symptoms. Of note, in several of these studies, researchers identified how these ideographic, idiosyncratic processes between patient and therapist (often called “enactments,” “role-responsiveness” or “repetitive interaction structures;” Jones, 2000) relate to positive treatment outcome.

### **The PQS in Relation to Other Measures of Process**

While the PQS has primarily been used to examine process and outcome in psychotherapy studies, the instrument has also been found to be helpful in elucidating key constructs such as the therapeutic alliance and countertransference.

Price and Jones (1998) examined the PQS in relation to alliance using the archived sample of 30 brief psychodynamic treatments from Jones, Parke and Pulos (1992). They found that 19 PQS items correlated significantly with alliance as measured by the CALPAS (Marmar, Gaston, Gallagher, & Thompson, 1989), including P feels helped, P conveys positive expectations about therapy, P achieves a new understanding or insight, P is committed to the work of therapy, P is introspective and readily explores inner thoughts and feelings, and P understands the nature of therapy and what is expected.

The PQS items were examined with a factor analysis which detected three underlying factors, including one named *Patient-Therapist Interaction* which strongly predicted CALPAS scores. The items with the strongest factor loadings included those reflecting that the patient felt trusting, secure, and understood by the therapist, understood the therapist's comments, accepted the therapist's observations, and had clearly positive feelings toward the therapist.

Tobin (2006) identified patterns of positive and negative countertransference as reported by therapists using the Feeling Checklist immediately following a therapy session. These patterns of countertransference were found to appear in relation to specific therapeutic interactions, identified with the PQS, and suggested that therapists' countertransference feelings were determined primarily by how effective they believed they were in the session.

Heaton, Hill and Edwards (1995) took a novel approach, and examined the construct validity of the PQS with the Therapeutic Procedures Inventory (TPI; McNeilly & Howard, 1989) and the Hill

Counselor Verbal Response Category System (HCVRCS; Hill, 1978, 1985, 1992). Therapist techniques such as interpreting, paraphrasing, and giving directives were highly correlated between the PQS and TPI, which both assess process rated at the level of the entire therapy hour. Surprisingly, none of the clusters from the PQS were correlated with corresponding clusters on the HCVRCS, i.e., approval, directives, question, paraphrase, interpretation, confrontation, and self-disclosure. The authors speculated that the reason for these findings may be that the HVRCS measures process at the level of the individual sentence or speaking turn aggregated up to the session level (while the PQS captures process at the level of the entire therapy hour).

These findings highlight the importance of examining the PQS in relation to other measures of process (including those that take a more fine-grained look at treatment process at a micro-level), and suggest that much remains to be explored by combining measures.

### **Innovations with the PQS**

Branching out from the lines of research reviewed above, more recent studies have applied the PQS to exciting new areas of investigation. Recognizing the need to expand process research into the area of child and adolescent psychotherapy, Schneider (2003) developed the Child Psychotherapy Q-Set (CPQ) by adapting the PQS for treatment with children, including play therapy, and is in the process of publishing an Adolescent Psychotherapy Q-set building on previous work by Bambery, Porcerelli and Ablon (2007, 2009).

Brent (2007) applied the original PQS to a sample of depressed adolescents receiving cognitive-behavioral treatment for inflammatory bowel disease. Replicating earlier findings, it was found that the treatment adhered most strongly to the CBT prototype; however, symptom improvement was strongly associated with processes from CBT, IPT, and dynamic therapy. Kelley et al. (2009) even used the PQS

to study placebo effects in acupuncture treatment of irritable bowel syndrome. And Valter (1997) applied the PQS to a group treatment for latency-age girls with histories of sexual abuse, and used the PQS items to classify the self-object functions present in the group process.

As a final example of innovation, Pinto-Ferreira (2006) examined therapy process in the email communications between therapists and patients in 30 dyads. The email correspondence in each case complemented a low-frequency face to face therapy. Results showed that therapists' behaviors/communications were characterized by a clear, secure, and committed attitude. This commitment was seen in the patients' communications as well, and it was concluded that email correspondence can effectively be used to support traditional face to face treatment.

### **Conclusions from 25 Years of Studying Process and Outcome of Psychotherapy using the PQS**

In conclusion, across many studies of psychotherapy process and outcome, researchers have successfully used the PQS to identify what processes influence treatment, how these processes change over time, and how they are associated with outcome. Here are some of the clinical and methodological lessons learned:

- Treatments of any kind are rarely theoretically pure and often include processes typically associated with other theoretical orientations. These borrowed processes need not be the most characteristic processes to play an important role in treatment outcome. Emotional exploration predicts positive outcomes across many different types of treatment. How clinicians help patients understand and regulate their emotions is critical to helping patients get better.
- Research using the PQS has also provided methodological clues for the future of psychotherapy research. You can't judge a book by its

cover. Even in controlled trials, treatments are not pure. Thus, naturalistic studies have important value as a complement to RCTs. Studying therapist adherence is too simplistic since patients are co-authors of treatment process. Single-case studies provide an essential view of treatment not captured by aggregated data. The mysteries of psychotherapeutic change might best be understood by the intensive study of one treatment at a time since each dyad seems to create its own unique process associated with change.

The strengths of the PQS lie in its ability to capture therapy process in neutral, descriptive language that allows researchers from various theoretical orientations to communicate about the active ingredients in positive and negative outcomes of treatment. Extensive research with the PQS has begun to answer fundamental questions regarding psychotherapy about which many in our field have strong theory-driven hypotheses and opinions. It is our hope that the neutral language of the PQS will continue to inspire open-minded investigations across theoretical divides to answer increasingly complex questions about how all forms of psychotherapy work.

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## **A supportive approach in psychodynamic-oriented psychotherapy. An empirically supported single case study**

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### **Abstract**

This paper evaluates process and outcome in a 2 years supportive psychotherapy psychodynamic-oriented of a young adult self-referred for concerns about University choice. The diagnosis was Panic Attack Disorder (DSM-IV) with features of obsessive-compulsive and narcissistic personality disorder (PDM). Twenty-eight verbatim transcripts of the sessions were coded with the Psychodynamic Intervention Rating Scales, the Collaborative Interactions Scale and Defense Mechanism Rating Scale. A log linear analysis model showed the trends of process variables during the treatment. A hierarchical regression analysis evaluated the importance of tailoring the clinician interventions in respect to the average level of defenses. Outcome results showed how patient's diagnosis changed and symptoms decreased.

### **Key words**

Psychodynamic-oriented supportive psychotherapy, therapist intervention, therapeutic alliance, defense mechanisms, process-outcome.

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## **Theoretical background**

Psychodynamic individual psychotherapies are described as a continuum that extends from supportive to expressive psychotherapies (Gabbard, 2005). Psychoanalysis, which is found at the “expressive” pole of the spectrum, includes approaches that accomplish personality change by analyzing the relationship between the therapeutic couple and insights derived from the exploration of unrecognized feelings, thoughts and conflicts (Luborsky, 1984). As Gabbard (2009) recently pointed out, the aim of supportive psychotherapy is not to change the patient’s personality but to help the patient cope with symptoms, conscious conflicts or transient problems. Several authors have suggested different definitions of supportive intervention, but all agree that this kind of treatment helps to improve patient self-esteem, maximizes patient adaptive skills, and restores ego functions, maintaining or reestablishing a consistent level of functioning, given the patient’s personality and life circumstances (Dewald, 1971; Ursano & Silberman, 1996). Although in real clinical practice, psychodynamic therapists use a mix of supportive and expressive approaches, there are substantial differences regarding the indications for use of supportive therapy. They range from the classical view that supportive therapy should be prescribed for “low functioning” patients, to the view that this intervention should be used with “high functioning patients” to scaffold ego functions (Hellerstein, Pinsker, Rosenthal, & Klee, 1994; Douglas 2008). As Douglas suggested (2008), supportive therapies help the patient see things more clearly by sustaining reality, and testing and challenging unrealistic ideas. The clinician must help the patient to regulate a wider range of affects, and to talk about his/her inner life in a more consistent way. Therapeutic actions need to be characterized by affective mirroring and interpersonal warmth (Markowitz, 2008). The supportive intervention should help the patient socialize better with

others by strengthening control over socially unacceptable behavior and encouraging more consistent ways of relating to others (Misch, 2000). The patient who cannot experience trusted and consistent relationships, or is avoided by others, can find an accepting person in the clinician. The clinician's openness and interest in the patient is communicated through validation and confirmation of what the patient has said, liked and so on (Appelbaum, 2005). To reach these objectives, a detailed assessment is crucial (Misch, 2000). Moreover, during the intervention, the clinician needs to examine the patient's real or transference relationships and past-present pattern of emotional responses and behaviors (Gabbard, 2009).

In conclusion, interventions need to be tailored according to these specific aims. As Douglas (2008, p. 447) suggested, one of the central rules of supportive interventions is "Do not say everything you know, only what will be helpful." The clinician has to do "just enough" to reduce anxiety, increase self-esteem and hope, support inconsistent psychological functions, and improve overall functioning. For example, in supportive psychotherapies, transference does occur, but the clinician does not interpret it. The clinician manages the transference only, encouraging the development of the patient's positive feelings towards the therapist himself (Misch, 2000). These positive feelings are useful for the patient to maintain a good working alliance and to have consistent identification with the clinician (Rockland, 1989; Safran & Muran, 2000; Douglas, 2008). Working alliance is a crucial aspect in both expressive and supportive interventions. In supportive psychotherapies, working alliance is recognized as a highly important element of the treatment. However, it becomes the subject of discussion only when problems within the relationship threaten to disrupt the treatment itself (Appelbaum, 2005; Colli & Lingardi, 2009). The aim of supportive therapy is to avoid alliance rupture and enhance collaborative processes in order to create and maintain a holding

environment (Skean, 2005). The psychodynamic framework maintains that an important way to understand a person is in the context of the unfolding relationship with the therapist. Through this relationship, the patient brings his or her interpersonal world into the treatment room and allows the therapist to experience aspects of the client's structuring of reality (Skean, 2005). In order to foster the therapeutic effect, one of the priorities of supportive intervention is to create a "holding environment," an atmosphere based on emotional safety and trust (Crits-Christoph & Connolly, 1999). The clinician needs to work actively from the very beginning, helping the patient to contain anxiety, shame, and anger (Winston, Rosenthal, & Pinsker, 2004). The approach to patient defense mechanisms plays a central role in differentiating expressive from supportive psychotherapies. In expressive interventions, defenses are identified and examined in depth in order to reach the underlying conflict. In supportive treatments, defenses are questioned only when they become maladaptive for the patient (Gabbard, 2009).

Many clinical papers have been devoted to distinguishing expressive from supportive therapies, and expressive versus supportive interventions. However, very few studies have studied empirically the specificity of the therapist's intervention, alliance and defensive trends in supportive psychotherapies as compared with expressive intervention or psychotherapies, as will be seen in the literature reported below. The aim of this paper is to discuss these issues in a single case supportive approach in a psychodynamic-oriented psychotherapy.

Several studies have investigated the therapist's in-session activities that could influence therapeutic alliance (for a review see Ackerman & Hilsenroth, 2001, 2003). Some studies have examined the therapist's misapplication of techniques that impede the development of the alliance. However, mixed results have been found. Eaton, Abeles, and Gutfreund (1993) identified a significant positive relationship between a

weak alliance and the therapist's failure to structure the session and failure to address resistance. Marmar, Gaston, Gallagher, and Thompson (1989) investigated the therapeutic alliance in brief dynamic grief therapy and reported a significant positive relationship between the therapist's increased focus on avoidance of important issues, the patient's hostile resistance, and patient's negative experience of the alliance. These diverging results may be due to the amount of time and emphasis placed on addressing resistance as well as the way in which the resistance was addressed.

The influence of alliance depends on how the therapist's actions are attuned to certain patient factors such as personality style, ego strength, core conflictual relationship and, finally, defense level functioning (Despland, de Roten, Despars, Stiglar, & Perry, 2001; Lingiardi, Shedler, & Gazzillo, 2006). It is therefore necessary to study the efficacy of specific therapist interventions in fostering the alliance. This must be done by considering not only the specific action of the therapist, but also the relationship and accuracy of the therapist's techniques according to several patient factors and in relation to a specific moment of the therapy and session. One of techniques the therapist uses is to deal with patient defenses and to interpret defensive maneuvers. Several studies investigating the relationship between defensive functioning and therapeutic alliance have produced mixed results. Some have found a direct positive relationship (Gaston, Marmar, Thompson, & Gallagher, 1988) while others have failed to find such a relationship (Hersough, Høglend, Monsen, & Havik, 2001). Foreman and Marmar (1985) found that when therapists actively focused on patient defenses and resistances, the alliance improved within four sessions. These results have been supported by other studies (Bond, Banon, & Grenier, 1998; Perry & Bond, 2000). In these studies, defense interpretations enhanced therapeutic work without increasing defensiveness in both high and low alliance patients.

Milbrath, Bond, Cooper, Znoj, Horowitz, and Perry (1999) suggested that interpreting a patient's defense mechanism was followed by greater emotional elaboration and insightful connections. Other studies have found that patient defensive functioning per se is less significant for alliance formation than how the therapist chooses to intervene according to the patient's defense functioning. These studies investigated the relationship between patient therapeutic alliance and defenses, and therapist interventions at a global session level. Although this could be a useful strategy for studying therapeutic alliance in general, it may be less useful for studying the process of alliance construction and, in particular, alliance rupture and resolution processes (Colli & Lingardi, 2009; Watson & McMullen, 2005).

The question of how a clinician should deal with patient defense during a psychotherapy session is crucial for psychodynamic therapies in general, and for supportive psychodynamic psychotherapies (Siefert, Hilsenroth, Weinberger, Blagys, & Ackerman, 2006). A way to assess expressive versus supportive psychotherapy is to consider the ratio between the expressive interpretative level of the therapist interventions and the patient defense level of functioning (Despland, et al., 2001; Junod, De Roten, Martinez, Drapeau, & Despland, 2005), rather than using only the therapist's expressive interventions (Gabbard, 1994).

Despland et al. (2001) examined what they termed "therapist adjustment," which refers to how a therapist adjusts his interventions to a patient's level of defensive functioning. These authors first used the Defense Mechanism Rating Scale (DMRS; Perry, 1990; see also Lingardi, Lonati, Fossati, Vanzulli, & Maffei, 1999) to calculate patients' overall defensive functioning score (ODF: from 1 = very immature defenses to 7 = highly mature defenses). They then rated therapist interventions using the Psychodynamic Interventions Rating Scale (PIRS; Cooper & Bond, 1992) and rank ordered therapist interventions according to an Expressive Supportive Intervention Level

continuum (ESIL: from 1 = very supportive to 7 = very expressive) (Figure 1). The adjustment ratio of therapist intervention was then calculated by dividing ESIL by ODF (see Figure 1). In this way, an adjustment score of 1 indicated that the therapist adjusted his/her interventions perfectly to the patient's defensive level. A lower level ( $AR < 1$ ) indicated that the therapist intervention was adjusted toward the supportive pole, instead, a higher level ( $AR > 1$ ) indicates that therapist intervention was adjusted toward the expressive pole. The general conclusion that can be drawn from the studies cited is that addressing a patient's defense can produce a positive effect.

**Figure 1.** Scales used to measure adjustment of interventions to defense mechanisms.

Intervention Scale (ESIL)			Defense Scale (ODF)	
Transference interpretation	7		7	Mature
Defense interpretation	6		6	Obsessional
Defense interpretation	5		5	Hysterical, other neurotic
Question, clarification, WES	4		4	Minor image - distorting
Reflection	3		3	Disavowal
Support strategy, CA	2		2	Major image - distorting
Association	1		1	Action

*Note.* ESIL: Expressive-Supportive Intervention Level; ODF: Overall Defensive Functioning scores; WES: Work-Enhancing Strategy; CA: Contractual Arrangement.

Empirical research in psychotherapy is only concerned with evidence-based forms of psychotherapy with “scientifically proven efficacy.” Supportive therapy has not been sufficiently manualized or tested in controlled clinical trials for it to be considered evidence-based (Douglas, 2008). However, research studies have reported clinical observations that supportive therapies are effective for a broad range of conditions. Winston and Winston (2002) pointed out the need for further clinical trials to establish the legitimacy of supportive psychotherapy as an



evidence-based form of psychotherapy with scientifically proven efficacy. Empirical psychotherapy research includes outcome and process studies (Orlinsky, Ronnestad, & Willutzki, 2004; Dazzi, Lingiardi, & Colli, 2006).

Despite the great number of process and process-outcome studies, there have been very few studies investigating the psychotherapy process in supportive therapies (Orlinsky, et al., 2004). Unfortunately, little empirical effort has been made to understand further the nature of this process. In addition, in these studies, the role of therapist intervention, alliance and defense interpretation was not investigated in supportive psychotherapies. The main topic of this paper is to demonstrate empirically how a supportive psychodynamic-oriented therapy helped a young woman referred for anxiety disorder. The following hypotheses were supported:

1. Outcome. A reduction in psychopathological symptoms and an improvement in personality functioning was expected, as assessed at the beginning and at the end of the therapy.
2. Therapist intervention. A higher level of supportive vs. interpretative intervention was expected from the therapy. However, it was expected that interpretative intervention would be introduced in the central part of the therapy.
3. Alliance development. A positive trend in therapeutic alliance level through the therapy was expected. Specific trends of rupture and collaborative processes were expected according to supportive versus interpretative therapist interventions.
4. Defense structure and change during therapy. A stable structure of variety and frequency of defenses were expected in the assessment phase in the central and final parts of the therapy. However, we expected that the relational process between therapist and patient, comprising expressive as well supportive interventions, would lead to the appearance of different kinds of defenses that could be detached



from the various phases of the treatment. We also expected that the therapy would allow a more flexible defense structure.

5. Alliance ruptures, therapist interventions and patient defenses. The relationship between therapist interventions, therapeutic alliance ruptures, and patient defense mechanisms were investigated. Specifically, we wanted to test the relationship between two different indexes of the Adjustment Ratio of therapist interventions: Session Adjustment Ratio (SAR, that is the ratio between the expressive level of the therapist's intervention and the average patient's defensive functioning) and the Interaction Adjustment Ratio (IAR, obtained by comparing the expression level of intervention to the patient's defensive level of functioning immediately before the intervention). We expected IAR to be a better predictor of patient alliance ruptures than the SAR.

## **Method**

### *Clinical Case*

Matilde is a 20-year-old student who referred herself to a Clinical Service in order to resolve some concerns about her choice of University course. She attends the second year of Medical School, but is not sure that this is the right career for her. She wears casual clothes, does not use any kind of make up, and does not follow fashion. She left the small town where her family live to study, and now shares an apartment with other students near the Medical School. She feels confused and insecure, and this insecurity caused her quite severe crises of crying, pervasive anxiety, and some physical symptoms, such as psychomotor agitation and tachycardia. She had taken light tranquilizers in the previous three months. She is fluent, clear and precise in the cognitive evaluation of her disease.

At the beginning of the first session, she seemed quite distrustful, but aware that she needed someone to teach her new means and perspectives for understanding and handling her uneasiness. She recognized that she needed help in facing the state of uneasiness that she feels.

Matilde is smart, reflective and trim, and has a clear and accurate way of speaking and thinking. She did not talk about any other satisfying relationships and does not have many friends. In her native small town, she lived with her parents and a younger sister. She still stays with them when she returns for vacations. She is very proud of her family, and has a good relationship with her mother. They often talk a lot and she recounts her problems. Sometimes Matilde feels guilty for worrying her mother and involving her in Matilde's anxiety and uneasiness. Matilde describes her father as rigid and very involved in practical duties. She has a 10-year-old sister, Sarah. They are very close, and Matilde describes Sarah as very different from her. The younger sister is very funny, ironic and with a lot of energy. They spend a lot of time playing together, and Matilde becomes unconcerned about her worries when Sarah is close to her. She says she is very lucky to have such a family.

Although Matilde's descriptions of her family were detailed, most of the time they were neutral and dull. She often told about things they did together, without any reference to shared emotions or feelings.

Matilde described herself as very close to her schoolmates and said she had several friends during high school years. Her schoolmates considered her as their main confiding friend, although they seemed to share school topics only. Now that she is at University, she is frequently in touch with them. They do not know anything about the difficult period she was going through. Since starting University, her life is very taken up with studying and she does not seem to have the time or desire to be engaged in social relationships.

She has never had a boyfriend. She feels very uncomfortable talking about sexual topics, saying that sex is not important at the moment.

### *Assessment and Treatment*

Matilde underwent three assessment sessions and one feedback session. In the feedback session, a once-a-week supportive psychodynamic-oriented psychotherapy was proposed and accepted by Matilde. The supportive therapy lasted 22 months. Therapy was concluded by consent. The treatment included approximately 56 sessions. The present study is focused on 28 audiotaped and transcribed sessions, 50% of the entire treatment. The sessions considered are spread over the entire intervention period. Matilde's sessions were divided into five periods. The first period (t1–four sessions) was called the assessment/beginning period. These sessions were also used to complete the SWAP. The fifth period (t5–four sessions) was defined as the final period because the therapist and patient agreed about the conclusion of the treatment and talked about it. The central part of the treatment was divided into three phases (t2–seven sessions, t3–seven sessions, t4–six sessions) based on interruptions for holidays.

SWAP-200 and GAF pre- and post-treatment were scored on assessment and treatment conclusion, respectively.

## **Measures**

### *Assessment measures*

*Shedler–Westen Assessment Procedure* (SWAP-200; Westen & Shedler, 1999a, 1999b). The SWAP-200 is a set of 200 personality-descriptive statements, each printed on a separate index card (Shedler & Westen, 1998; Westen & Shedler, 1999a, 1999b). A clinician who knows a patient well is asked to describe him/her by arranging the

statements into eight categories, from those that are not descriptive (assigned a value of "0") to those that are highly descriptive (assigned a value of "7"). Thus, the procedure yields a numeric score from 0 to 7 for each of the 200 personality-descriptive variables. Items are written in straightforward language, and items that require inferences about internal mental processes are written without recourse to jargon. The instrument is based on the Q-sort method that requires clinicians to arrange items into a fixed distribution (Block, 1978). The item set was developed and revised over a 7-year period and incorporates constructs drawn from a wide range of sources. These include the Axis II diagnostic criteria of the DSM-III (3<sup>rd</sup> ed.; American Psychiatric Association, 1980), the DSM-IV, selected Axis I criteria that reflect personality traits (e.g., depression and anxiety), research in personality psychology, clinical literature on PDs from the past 50 years, and the feedback of hundreds of psychologists and psychiatrists who used earlier versions of the instrument to describe their patients (Shedler & Westen, 1998; Westen & Shedler, 1999a).

The Symptom Checklist 90 Revised (SCL-90-R; Derogatis, 1983) is a self-report symptom inventory. The 90 items of the questionnaire are scored on a five-point Likert scale of distress from 0 (none) to 4 (extreme), indicating the rate of occurrence of the symptom during the time reference (Derogatis, Lipman, & Covi, 1973). The SCL-90 is intended to measure symptom intensity on ten different dimensions: Somatization (SOM), Obsessive-compulsive (O-C), Interpersonal sensitivity (I-S), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobic anxiety (PHOB), Paranoid ideation (PAR), Psychoticism (PSY), and sleep difficulties (SLEEP). A Global Severity Index (GSI) of distress is calculated. According to the Italian Manual, an intensity raw score higher than one is considered in the clinical range, and qualifies as penetrating the clinical range. The internal consistency coefficient alphas for the nine symptom dimensions ranged from .77 for

Psychoticism, to .90 for Depression. Test-retest reliability coefficients ranged between .80 and .90 after one week of therapy. The few validity studies of the SCL-90-R demonstrate levels of concurrent, convergent, discriminant, and construct validity comparable to other self-report inventories (Derogatis, 1983).

The Global Assessment of Functioning (GAF; DSM IV) is a numerical scale based on the fifth axis in the DSM system for reporting the clinician's judgment of the individual's overall level of functioning. The aim of the scale is to assess psychiatric status, ranging from 1 (lowest level of functioning) to 100 (highest level), measuring the psychological, social, and occupational functioning of adult patients. The GAF scale is divided into 10 ranges of functioning. Making a GAF rating involves choosing a single value that best reflects the individual's overall level of functioning. The description of each 10-point range in the GAF scale has two components: the first part covers symptom severity, and the second covers functioning. The GAF rating is within a particular decile if either symptom severity or level of functioning falls within the range.

### *Process Measures*

*Defense Mechanisms Rating Scale – DMRS.* The DMRS (Perry, 1990; Perry, Kardos, & Pagano, 1993; Lingiardi, et al., 1999; Perry, 2001;) manual describes how to identify 28 individual defense mechanisms in videotaped or audiotaped sessions or transcripts. The introduction includes general directions for the qualitative and quantitative identification of defenses, along with suggestions about handling problems presented by different data sources. The body of the manual consists of directions for identifying 28 individual defenses. The manual includes a definition of each defense, a description of how the defense functions, a section on how to discriminate each defense from similar defenses (e.g., suppression vs. repression vs. denial), and a three-point

scale. Each scale is clearly identified with specific examples of (0) no use of the defense, (1) probable use and (2) definite use of the defense. The examples provide prototypical instances of the defense, which expands and complements the formal definitions. In the DMRS system there are seven defense levels arranged hierarchically, with each defense assigned to a particular level. The defense levels are characterized in brief as follows, in descending order of health:

7. High Adaptive Level (also called “Mature”): affiliation, altruism, anticipation, humor, self-assertion, self-observation, sublimation, suppression;
6. Obsessional: isolation, intellectualization, undoing;
5. Other Neurotic: repression, dissociation, reaction formation, displacement;
4. Minor Image-distorting (also called “Narcissistic”): omnipotence, idealization, devaluation;
3. Disavowal: negation, projection, rationalization, autistic fantasy;
2. Major-Image-distorting (also called “Borderline”): splitting of others’ image, splitting of self-image, projective identification;
1. Action: acting-out, passive aggression, hypochondriasis.

The rater identifies each use of the defense as it occurs, bracketing the part of the text in which it operates. After completion of the ratings, the number of times each defense was identified in the text is divided by the total instances of all defenses, yielding a percentage score for each defense. The total percentage of defenses at each level then forms the basis for a “defense profile” (see Figure 1, later in this paper) which represents the nature of the patient’s functioning, and may be compared with earlier or later functioning in the course of treatment.

All the defense scores are summarized by an Overall Defensive

Functioning (ODF) score (Perry & Høglend, 1998). If all defenses are at the “1” level, the ODF score would be 1, and if all were at the “7” level the ODF would be 7. In clinical samples based on whole interviews, scores usually range between 2.5 and 6.5.

*Collaborative Interactions Scale-CIS*. The CIS (Colli & Lingardi, 2009) is a rating system for the assessment of alliance ruptures and repairs in psychotherapy. External raters conduct their evaluations on transcripts. The CIS comprises two main scales: one for the evaluation of patient rupture and collaborative processes, CIS-P, and one for the evaluation of therapist positive and negative contributions to the therapeutic relationship, CIS-T. The CIS-P includes three main subscales, the Direct Rupture Markers Scale (DRMs), the Indirect Rupture Markers Scale (IRMs), and the Collaborative Processes Scale (CPs). DRMs are characterized by an aggressive and accusatory statement of resentment or dissatisfaction with the therapist or some aspect of the therapy process (Safran, Muran, Stevens, & Rothman, 2008). IRMs are characterized by indirect forms of emotional disengagement from the therapist, from some aspect of the therapy process, or from his/her internal experience (Safran, et al., 2008). Patient CPs include the patient bringing salient and significant themes, sharing intimate and salient information with the therapist, self-observation of his/her reactions, or working actively with the therapist’s comments. The CIS-T Positive Intervention scale evaluates collaborative and repairing therapist interventions. The CIS-T Negative Intervention scale evaluates negative contributions by the therapist. Although the CIS is rooted in the psychodynamic relational and cognitive-interpersonal approaches, the items are written in a transtheoretical language, which makes it useful for researchers from a variety of backgrounds.

*The Psychodynamic Intervention Rating Scales* (PIRS; Cooper & Bond, 1992) detects nine types of therapeutic intervention based on psychodynamic psychotherapy. The scale includes two main categories: the interpretative and non-interpretative. Interpretive interventions consist of transference (TI) and defense interpretations (DI). Non-interpretive interventions include acknowledgments (A), clarifications (Cl), questions (Q), therapist associations (Ass), reflections (R), work-enhancing strategies (WES), support strategies (SS), and contractual arrangements (CA). PIRS has been developed to code all therapist utterances (TU). The raw count is expressed as a frequency of all interventions. The PIRS was scored by two experienced raters trained in the use of this scale. Inter-rater reliability was good, with Kappas for all categories greater than .79. According to the literature, the PIRS shows consistent reliability and construct validity (Milbrath, et al., 1999). Some evidence for construct validity is sustained by relationships between class of therapist intervention and the patient's initial level of distress, and between subsequent therapist elaboration and patient outcome (Despland et al., 2001).

Therapist interventions were organized following Despland et al. (2001), according to a rank-ordering scale from the most supportive (1) association, to the most exploratory, (7) transference interpretation. Acknowledgments (e.g., "Uh-hunh") by the therapist are omitted as they are considered neutral interventions.

### **Procedure**

The first aim of this paper was to assess possible trends and changes in therapist intervention, therapeutic alliance and defenses over time. A two way log-linear model was chosen to assess associations between the different categories included in these variables during the therapy. The log-linear analysis is a non-dependent procedure for associating categorical or grouped data, looking at all levels of possible main and



interaction effects, with the primary purpose of finding the most parsimonious model that can account for cell frequencies in a table. More specifically, a saturated model was preferred. A saturated log-linear model for two variables is one that incorporates all possible effects: a 1-way effect for each variable, all 2-way interaction effects for models with two variables. Overall, there will be  $(2k - 1)$  terms plus a constant in the equation of a saturated model predicting the log of an expected table frequency, where  $k$  is the number of variables. A saturated model imposes no constraints on the data and always reproduces the observed cell frequencies. As such, the saturated model forms the “baseline” for log-linear analyses. Since the number of sessions was not the same for all periods, a specific procedure was carried out to homogenize cell frequencies. For all variables, tables will be presented that report the effect parameter estimates for the variables and their interactions (Knoke and Burke, 1980) and the probability of the standardized parameters. Only significant  $p < .001$  effects will be interpreted.

The therapist interventions, assessed with the PIRS, were divided in two main categories, supportive versus interpretative. To assess the relationship between therapist intervention, therapeutic alliance and defenses at a microanalytic level, we referred to a procedure described by Despland et al. (2001) to estimate the adjustment ratio of therapist interventions with respect to the level of patient defensive functioning (Figure 1). We have calculated two different indexes of Adjustment Ratio of therapist interventions: Session Adjustment Ratio (SAR) and Interaction Adjustment Ratio (IAR). As already described, SAR is the ratio between the expressive level of the therapist’s intervention and the average patient’s defensive functioning. IAR is an index created for this research and obtained by comparing the expression level of intervention and the patient’s defensive level of functioning immediately before the IAR intervention. It was designed to understand better the relationship

between therapist intervention and patient functioning in a specific moment of the session.

## **Results**

### *Outcome*

#### *Case formulation assessment at the beginning phase*

According to SWAP-200, Matilde is conscientious and responsible. She has moral and ethical standards and strives to live up to them. She is able to use her talents, abilities, and energy effectively and productively. However, she lacks a stable image of who she is or would like to become (e.g., attitudes, values, goals, or feelings about herself may be unstable and changing). She has trouble making decisions and tends to be indecisive or vacillate when faced with choices.

Matilde is excessively devoted to work and productivity, to the detriment of leisure and relationships and tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered. She tends to be overly concerned with rules, procedures, order, organization, schedules, etc. and is self-critical. She sets unrealistically high standards for herself and is intolerant of her own human defects. She expects to be “perfect” (e.g., in appearance, achievements, performance, etc.), and, therefore, tends to feel guilty, unhappy, depressed and despondent. She feels inadequate, inferior, thinks of herself as a failure and tends to avoid social situations because of a fear of embarrassment or humiliation.

Matilde appears to find little or no pleasure, satisfaction, or enjoyment in life’s activities. She tends to be insufficiently concerned with meeting her own needs and tends to oscillate between undercontrol and overcontrol of needs and impulses. She appears to

have a limited or restricted range of emotions and, in particular, has difficulty acknowledging or expressing anger. More generally, Matilde tends to be inhibited or constricted and has difficulty allowing herself to acknowledge or express wishes and impulses. Her mood tends to cycle over intervals of weeks or months between excited and depressed states and she tends to be anxious. Moreover, she has anxiety attacks lasting from a few minutes to a few hours, accompanied by strong physiological responses (e.g., racing heart, shortness of breath, feelings of choking, nausea, dizziness, etc.). She tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.).

Matilde seems to know less about the ways of the world than might be expected, given her intelligence and background; she appears naive or innocent. She thinks in concrete terms and interprets things in overly literal ways; she has limited ability to appreciate metaphor, analogy, or nuance. Matilde thinks in abstract and intellectualized terms, even in matters of personal importance and tends to see herself as logical and rational, uninfluenced by emotion. She prefers to operate as if emotions were irrelevant or inconsequential.

Matilde's SCL-90-R symptom profile reveals a pattern and magnitude within the clinical range, and qualifies her as a positive clinical case. Overall intensity of distress is somewhat elevated and she has endorsed a marked number of symptoms. Scores in certain areas approach, or have already penetrated, the clinical range. Matilde's depression, anxiety, and obsessive-compulsive levels are above average, and clinical in nature. Matilde's level of somatization is significantly elevated suggesting a clinical picture involving enhanced distress associated with somatic complaints. Difficulties with feelings of personal inadequacy and considerations about devalued self-worth (interpersonal sensitivity) approach the clinical level. Matilde's psychoticism score is approaching the clinical range. However, it is more likely that this reflects a slight

experience with social alienation, rather than a thought disorder. Matilde's record reveals levels of phobic anxiety, anger-hostility, paranoid ideation, and sleeping difficulties that are not particularly marked.

Moreover, according to the GAF, Matilde shows moderate symptoms (flat affect, occasional panic attacks) and moderate difficulty in social functioning (e.g., few friends).

#### *Assessment at the conclusion phase*

According to the SWAP-200, Matilde is conscientious and responsible and has moral and ethical standards that she strives to live up to; she is able to use her talents, abilities, and energy effectively and productively. She is also able to assert herself effectively and appropriately when necessary; she enjoys challenges and takes more pleasure than before in accomplishing things. She can now find meaning and satisfaction in the pursuit of long-term goals and ambitions. Matilde finds meaning in belonging and contributing to a larger community and finds contentment and more happiness in life's activities. She forms closer friendships characterized by mutual support and shared experiences and is more attracted to the idea of a love relationship characterized by genuine intimacy and caring.

Notwithstanding all this resources, Matilde still does not have a stable image of who she is or would like to become, and tends to see herself as logical and rational, uninfluenced by emotion. Sometimes she prefers to operate as if emotions were irrelevant or inconsequential. Matilde very often thinks in abstract and intellectualized terms, even in matters of personal import, and describes experiences in general terms, sometimes being unable to offer specific details. She also tends to think in concrete terms and interpret things in overly literal ways, and sometimes her ability to appreciate metaphor, analogy, or nuance is limited.

Matilde is still excessively devoted to work and productivity, to the detriment of leisure and relationships. She can be competitive with others and sometimes overly concerned with rules, procedures, order, organization, schedules and so on, and she tends to adhere rigidly to daily routines (becoming anxious or uncomfortable when they are altered). Matilde is self-critical and sets unrealistically high standards for herself and is intolerant of own human defects. She expects herself to be “perfect” and has fantasies of unlimited success and power.

Matilde has difficulty allowing herself to experience strong pleasurable emotions (e.g., excitement, joy, pride) and tends to be inhibited or constricted, having difficulty allowing herself to acknowledge or express wishes and impulses. She appears to have a limited range of emotions and is often anxious. She appears to fear being alone and may go to great lengths to avoid this situation.

Matilde sometimes appears unable to describe important figures in a way that conveys a sense of who they are as people. Descriptions of others still come across as two-dimensional and lacking in richness. Sometimes, it seems she has little psychological insight into her own motives and behaviors. She is unable to consider alternate interpretations of her experiences and seems to know less about the ways of the world than might be expected, given her intelligence and background.

Matilde's SCL-90-R symptom profile reveals a pattern and magnitude considered to be within the normal range. Overall intensity of distress is not particularly remarkable. Only some symptomatic distress levels obsessive-compulsive and anxiety-still penetrated the clinical range. There is some evidence to suggest that Matilde is still experiencing difficulty with feelings of personal inadequacy and considerations about devalued self-worth. Distress, however, is only approaching clinical levels. Matilde's record reveals that levels of somatization, depression,

anger-hostility, phobic anxiety, paranoid ideation, psychoticism, and sleeping difficulties are not particularly marked.

According to the GAF, Matilde presents some mild symptoms (depressed mood and anxiety) and mild difficulties in social functioning but, generally, functions well, and has some meaningful interpersonal relationships.

As well as a qualitative comparison, the results of the SCL-90 R and SWAP-200 were also compared at a statistical level using the Wilcoxon rank-sum test. At the assessment-beginning phase and at the conclusion phase, the SCL-90 R reported a significantly different rank distribution ( $z = -2.37, p < .05$ ) showing lower levels of symptomatology at the end of the treatment. PD SWAP-200 scores at the assessment-beginning phase and at the conclusion phase showed a significantly different rank distribution ( $z = -2.29, p < .05$ ) confirming a lower level of clinical scores in personality dimension at the end of the treatment. Table 1 summarizes case formulation at the beginning and at the conclusion phase.

### *Process*

#### *Therapist interventions*

Table 2 reports the results of the log-linear model. Row (periods), Column (supportive versus interpretative), and Interaction had a significant effect ( $p < .001$ ). As expected, supportive interventions were significantly more frequent than interpretative interventions. Over time, therapist interventions were significantly more frequent in times t2 and t3 and diminished significantly in times t4 and t5. This trend could highlight how, in the first part of the therapeutic process (t2 and t3), the therapist mainly had to support the patient.

Specifically, t2 was devoted to supportive intervention such as questions, clarification, association, and reflection in order to make Matilde feel supported, understood and more engaged in her

therapeutic process. Instead, t3 and t4 showed an increase in expressive intervention. The relationship between patient and therapist was already established so the therapist interventions could be addressed more at an interpretative level, such as addressing dynamic

**Table 1.** Case Formulation at the beginning and at the conclusion phases.

Diagnosis	Assessment	Outcome
DSM	Axis I: Panic Attack Disorder	Axis I: No diagnosis
	Axis II: No diagnosis	Axis II: No diagnosis
PDM	P axis: features of obsessive-compulsive personality disorder and of a narcissistic personality disorder	P axis: features of obsessive-compulsive personality disorder and of a narcissistic personality disorder
	M axis: Mild Constrictions and inflexibility	M axis: Mild Constrictions and inflexibility
	S axis: none	S axis: none
SCL - 90	GSI=1.14	GSI=.69
	SOM=1.17	SOM=1.10
	O-C=1.40	O-C=1.10
	I-S=1.00	I-S=1.00
	DEP=1.85	DEP=.77
	ANX=1.70	ANX=1.10
	HOS=.50	HOS=.33
	PHOB=.29	PHOB=.29
	PAR=.33	PAR=.20
	PSY=1.00	PSY=.50
SLEEP=.00	SLEEP=.00	
GAF	51 - 60	65
SWAP - 200	PD Factor: Obsessive-compulsive (68) and schizoid (60)	PD Factor: Obsessive-compulsive (62.82)
	Q Factor: Avoidant style (60.69)	Q Factor: Obsessive style (70.50)
	High Functioning (55.40)	High Functioning

*Note.* For descriptive purposes, we report only meaningful values of the different instruments.

conflict, to refer to, or explain the reasons for processes that mitigate or diminish affect, or processes that reflect shifts in the content of topics or representations of persons. In the final phase (t5), the therapist interventions were very low to allow Matilde to access the end of the process. Regarding interaction, the supportive interventions are significantly more present in time t2 and give more significant space to expressive intervention in times t3 and t4.

**Table 2.** PIRS log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of standardized parameters.

Periods	PIRS Therapist intervention		
	Expressive Intervention	Supportive Intervention	Overall Intervention
t1	-.11**	.11**	-.02
t2	-.37***	.37***	.28***
t3	.20***	-.21***	.25***
t4	.23***	-.23***	-.16***
t5	.04	-.04	-.35***
	-1.79***	1.79***	

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

$\chi^2_{rc(4)} = 186.19$   $p < .001$

$Y^2_{r(4)} = 5299.50$   $p < .001$  (Periods)

$Y^2_{c(1)} = 38893.36$   $p < .001$  (Expressive intervention vs. Supportive intervention)

$Y^2_{rc(1)} = 188.09$   $p < .001$  (Interaction periods x Expressive intervention vs. supportive intervention).

### *Alliance development*

Matilde did not use Direct Rupture Markers (DRM) in the therapy session and the therapist did not use Negative Intervention (NI). The three remaining categories, PI, IRM, CP were analyzed using the log-linear model to assess the trend of therapeutic processes (Table 3). Row (periods), Column (therapist or patient alliance processes), and Interaction had a significant effect ( $p < .001$ ). Therapist positive intervention and patient collaboration processes were significantly more frequent than patient indirect rupture markers. The therapist Positive Interventions (PI) made it possible to focus attention on the “here and now” of the relationship. Matilde responded to this positive therapeutic attitude with a high level of Collaborative Processes (CP) instead of



Indirect Rupture Markers (IRM). She was able to convey significant themes, and sometimes to share intimate and salient information with the therapist. Over time, therapeutic processes were significantly more frequent in times t1 and t2 and became significantly lower in t4. In t4, the patient and therapist seemed to have broken a sort of equilibrium. In this period, compared with the other phases, the patient and therapist needed to reinforce therapeutic alliance less. There was a growing number of patient Indirect Rupture Markers (IRM). Clinically, the patient indirectly expressed a form of emotional disengagement from the therapist. The patient skipped from topic to topic in a manner that prevented the therapist from exploring the issues in depth. She responded in an overly intellectualized way and became less able to be collaborative. For this reason, the therapist improved her efforts to reestablish a collaborative level of alliance with his positive intervention. Interaction patterns generally revealed that more processes (collaborative or rupture processes) were significantly more present in the patient than in the therapist. However, striking results appeared in t4 when the patient became significantly less collaborative, made significantly more ruptures, while the therapist needed to make significantly more positive interventions. No rupture markers, however, were present in the last period.

**Table 3.** CIS log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of the standardized parameters.

Period	CIS			
	Therapist Positive Intervention	Indirect Rupture Markers	Collaborative Processes	Overall processes
t1	-.32***	-.16***	.48***	.42***
t2	-.10***	-.66***	.76***	.68***
t3	-.19***	-.34***	.53***	.32***
t4	1.27***	1.15***	-2.42***	-1.67***
t5	-.66***	.01	.65***	.24***
	1.28***	-1.73***	.45***	

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

$\chi^2_{rc(8)} = 4778.81$   $p < .001$

$Y^2_{r(4)} = 14052.34$   $p < .001$  (Periods)

$Y^2_{c(2)} = 40058.07$   $p < .001$  (PI, IRM, CP)

$Y^{2r}_{rc(8)} = 6165.52$   $p < .001$  (Interaction period x PI, IRM, CP).

*Defense structure and change along therapy*

Matilde's Borderline defenses were so low that a log-linear model could not be interpreted. A log-linear model was applied to the other six categories of defense (Table 4). Row (periods), Column (defense categories), and Interaction had a significant effect ( $p < .001$ ). Overall Matilde showed a significantly high presence of mature, obsessive and disavowal defenses and a significantly low level of narcissistic defenses.

Matilde showed good adjustment skills and ability when dealing with stressors, in preserving her ideas and thoughts as consistent and not distorted (mature defenses). Among the mature defense patterns, self-observation was the most representative. Matilde seemed to be able to think about her thoughts, feelings and actions. However, she did not seem to rely significantly on others (low Affiliation). Moreover, her defensive pattern made her unable to experience simultaneously the cognitive and affective components of life's events. Matilde's affective aspects were kept from consciousness (obsessional defenses). Among the obsessional defense patterns, intellectualization was significantly the most representative compared with undoing. Matilde seemed to neutralize the arousal of emotional content mostly through intellectualization. Finally, Matilde tended to resolve emotional conflict by avoiding perceiving or consciously acknowledging the more unpleasant aspects of external reality (disavowal). On the other hand, Matilde's defensive pattern was scarcely characterized by Minor Image Distortion (also called "Narcissistic.") Overall defenses were significantly lower in the assessment/beginning phase than in the second and third therapy periods. In t1 she showed a significantly higher presence of Mature, Obsessional and Disavowal defenses and a very scarce presence of Minor Image distortion. The assessment/beginning phase appeared to be devoted mostly to case history collection and assessing patient motivation. Regarding interaction, the range of defenses in the

first period confirmed the overall pattern of defenses. However in the following periods narcissistic and acting out defenses were significantly present. Acting out defenses diminished abruptly in the fourth period. The final period was characterized by a very low (more maladaptive) level of defenses compared with the previous periods.

In t2 Matilde's use of High Adaptive Level, Obsessional and Neurotic defenses decreased significantly as Minor image distortion increased. Attempts at mental inhibition or avoiding stressful events from consciousness seemed to be scarcely present. Matilde became more and more open to the clinician's interventions. At the same time, because issues concerning herself and her self-esteem began to be addressed, Matilde tried to compensate through a more consistent use of Minor image distortion mechanisms.

In t3, Minor Distortion Image mechanisms were still present and Action mechanisms increased significantly. On the other hand, Disavowal mechanisms decreased significantly compared with the assessment\beginning phase. The clinical material confirmed that, in this very central period, Matilde experienced a critical moment of regression in which primitive aspects seemed to prevail. She used Action mechanisms very consistently, also showing great attachment to the clinical setting. In this period, Matilde left the therapy for several sessions.

In t4, Action mechanisms decreased very significantly, and the overall pattern of defenses was not as consistent when compared with the previous period. Matilde no longer experienced the need to use a consistent pattern of defenses in the therapeutic relationship. This period seemed to be devoted to the elaboration of her experiences, and a real change in Matilde's dysfunctional pattern of functioning seemed to occur.

In t5, most defensive mechanisms seemed to decrease significantly (Mature, Obsessional, and Disavowal). In this period too, Matilde no

longer experienced the need to use a consistent pattern of defenses. The therapeutic couple was working on separation. Although literature about expressive interventions shows that, at the end of treatment, defensive mechanisms are usually activated; this did not happen in Matilde's intervention. Because of the supportive nature of Matilde's treatment, the clinician did not address defenses during separation, but tried to consolidate her adjustment. According to the referral, Matilde's main conflictual aspects were related to interpersonal and social functioning. From a qualitative point of view, we paid attention to the trend of Mature defensive mechanisms related to this domain: Altruism and Affiliation. Altruism was less frequent in the treatment; therefore, Matilde did not show a vicarious and gratifying fulfillment of other needs. Affiliation showed meaningful changes during the treatment. It seemed to increase over periods, showing a more consistent ability to turn to others for help and support in facing everyday difficulties.

**Table 4.** DMRS log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of the standardized parameters.

Period	DMRS Defenses						Overall
	Mature	Obsessive	Neurotic	Narcissistic	Disavowal	Action	
t1	.80***	.91***	.30	-3.30***	.93***	.36*	-.75***
t2	-.60***	-.38***	-.76***	1.50***	-.05	.29***	.36***
t3	.01	-.18**	-.38***	.68**	-.90***	.77***	.41***
t4	.16*	.00	.44***	.64**	.14*	-1.38***	-.09
t5	-.38***	-.34***	.40***	.49*	-.12*	-.05	.06
	.61***	.77***	.34***	-1.76***	.86***	-.82***	

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

$\chi^2_{rc(20)} = 938.85$   $p < .001$

$Y^2_{t(4)} = 59.46$   $p < .001$  (Periods)

$Y^2_{c(5)} = 2150.10$   $p < .001$  (Defense categories)

$Y^2_{rc(20)} = 992.85$   $p < .001$  (Interaction period x defense categories).

More detailed analyses were carried out for the three main defense categories: mature, obsessive and disavowal. Among the mature defenses, a log-linear model was applied to the most frequent categories: affiliation, self-assertion, self-observation (Table 5). Row (periods), Column (mature defense categories), and Interaction had a significant effect ( $p < .001$ ). Overall, Matilde showed a significantly higher presence of self-observation defenses and a significantly lower level of affiliation defenses. Overall, mature defenses were significantly

more present in t3 and significantly less present in the assessment/beginning phase. However, interaction effects showed a significant increase of affiliation defenses from t1 to t4.

**Table 5.** DMRS mature category log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of the standardized parameters.

Period	DMRS Mature defenses			Overall mature
	Affiliation	Self-Assertion	Self-Observation	
t1	-2.75***	1.15**	1.60***	-.99**
t2	.81***	-.97***	.15	-.10
t3	.66***	-.05	-.61***	1.03***
t4	1.44***	-.25*	-.90***	.01
t5	.14	.11	-.25*	.05
	-.82***	-.11	.93***	

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

$\chi^2_{rc(8)} = 197.62$   $p < .001$

$Y^2_{r(4)} = 179.34$   $p < .001$  (Periods)

$Y^2_{c(2)} = 290.39$   $p < .001$  (Mature defenses)

$Y^2_{rc(8)} = 244.83$   $p < .001$  (Interaction periods x mature defense).

A log-linear model was applied to the most frequent categories of obsessional defenses: intellectualization and undoing (Table 6). Row (periods), Column (obsessional defense categories), and Interaction had a significant effect ( $p < .001$ ).

Overall, Matilde showed a significantly higher presence of intellectualization defenses and a significantly lower level of undoing defenses. Overall, obsessional defenses were significantly lower in the assessment/beginning period, and greater in the central phase (t2, t3, t4). Regarding interaction, Matilde appeared to use alternatively intellectualization and undoing.

**Table 6.** DMRS obsessive category log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of the standardized parameters.

Period	DMRS Obsessive defenses		
	Intellectualization	Undoing	Total
t1	.55***	-.55***	-.72***
t2	-.39***	.39***	.28***
t3	.21***	-.21***	.33***
t4	-.43***	.43***	.21***
t5	.06	-.06	-.10
	.43***	-.43***	

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

$\chi^2_{rc(8)} = 197.62$   $p < .001$

$Y^2_{r(4)} = 114.84$   $p < .001$  (Periods)

$Y^2_{c(1)} = 187.66$   $p < .001$  (Obsessive defenses)

$Y^2_{rc(4)} = 151.85$   $p < .001$  (Interaction periods x defenses).

### **Alliance ruptures, therapist interventions and patient defenses: therapist interventions adjustment ratio and patient collaboration**

One of the aims of our research was to investigate the relationship between therapist intervention, patient defense and collaboration. We performed a hierarchical regression analysis and considered as independent variables — IV — the Interaction Adjustment Ratio, the Session Adjustment Ratio and the Expressive Intervention Level preceding each patient communication characterized by the presence of at least one rupture marker. We considered as Independent Variable the mean patient intensity of collaboration in the two subsequent interactions after therapist intervention.

The results are reported in Tables 7 and 8.

The Interaction Adjustment Ratio was significantly negatively correlated with patient alliance ruptures. The other two variables — Session Adjustment Ratio and Expressive Intervention Level — did not correlate significantly with the dependent variable.

**Table 7.** Characteristics of therapist intervention which could predict an alliance rupture.

Model	Correct R-Squared	Standard Error of Estimate	Adjustment Range				
			Variation of R-Squared	Variation of F	df1	df2	Sig. variation of F
IAR	.653	.66228	.664	63.22	1	32	.001
IAR-SAR	.644	.67110	.002	.164	1	31	.688
IAR-SAR-ESIL	.646	.66977	.012	1.123	1	30	.298

*Note.* IAR (Interaction Adjustment Ratio): the ratio between the Expressive-Supportive Intervention Level (ESIL) of the intervention and the patient's level of defensive functioning in patient communication antecedent to the intervention evaluated. SAR (Session Adjustment Ratio): the ratio between the Expressive-Supportive Intervention Level (ESIL) of the intervention and the patient's level of defensive functioning during the session summarized by the ODF assessed by the DMRS. ESIL (Interaction Expressive Supportive Intervention Level): determined by constructing an expressive Supportive Intervention Level summary score for the PIRS by rank ordering the intervention scores from the most supportive to the most expressive.

**Table 8.** Regression analysis. Characteristics of a therapist's intervention could predict an alliance rupture.

Model	Variables	Beta	T	p.
1	IAR <sub>(a)</sub>	-.815	-7.951	.001
2	IAR	-.834	-7.311	.001
	SAR <sub>(b)</sub>	.046	.405	.688
3	IAR	-.848	-7.399	.001
	SAR	-.156	-.701	.489
	ESIL <sub>(c)</sub>	.235	1.060	.298

*Note.*

a. IAR (Interaction Adjustment Ratio): the ratio between the Expressive-Supportive Intervention Level of the intervention and the patient's level of defensive functioning in patient communication antecedent to the intervention evaluated.

b. SAR (Session Adjustment Ratio): the ratio between the Expressive-Supportive Intervention Level of the intervention and the patient's level of defensive functioning during the session summarized by the ODF assessed by the DMRS.

c. ESIL (Expressive Supportive Intervention Level): determined by constructing an expressive Supportive Intervention Level summary score for the PIRS, by rank ordering the intervention scores from the most supportive to the most expressive.

## Discussion and Conclusion

The aim of this study was to investigate empirically a psychotherapy process and outcome in a supportive approach in a psychodynamic oriented psychotherapy. Very few studies have investigated psychotherapy process and outcome in supportive therapies (e.g., Orlinsky et al., 2004). In specific terms, the literature supports assessing specific process variables such as clinician intervention, working alliance and defensive mechanism, and their interplay, in supportive psychotherapies. As Douglas (2008) suggested, although research has reported that supportive therapies are effective for a broad range of conditions, this clinical approach has not been sufficiently manualized and consequently, very few studies have been devoted to assessing process and outcome in supportive interventions. One of the specific aims of this study, therefore, was to contribute to

understanding the nature of the supportive psychotherapy process, using validated measures of the process itself through the combined use of a clinical-qualitative and statistical-quantitative methodology. In keeping with the clinical-qualitative pole of this spectrum, this paper is also focused on a specific case formulation of the patient. As Hilliard (1993) pointed out, single-case studies highlight the importance of assessing patient idiographic and intrasubjective features (Lingiardi, Gazzillo, & Waldron, 2010). In the clinical context, this aspect is represented by the diagnosis. Moreover, the nature of the single-case perspective requires a rich diagnostic process that includes both a nosographic approach (such as DSM-IV) and a more multifaceted point of view which can assess the interplay of specific clinical variables. As McWilliams (1999) suggested, the DSM approach reflects an empirical descriptive orientation that deliberately eschews psychodynamic assumptions. Moreover, the PDM task force (2006) intended to expand the DSM efforts by cataloging the symptoms and behaviors of mental health patients, demonstrating the importance of focusing on the full range and depth of emotional and social functioning. These variables represent the specific patient's psychological functioning that "makes diagnosis meaningful" (Barron, 1998; Shelder & Westen, 2007). This paper therefore aimed to produce a complete case formulation in order to arrive at a sophisticated rationale that links assessment to treatment. First of all, as Misch (2001) suggested, a case formulation was produced. Three clinical interviews and the administration of SCL-90 allowed the clinician to understand the level of functioning: the SWAP-200 and the GAF were applied by the therapist in order to reflect on diagnostic aspects and plan the most suitable psychological treatment. The diagnosis was conducted by combining both the DSM-IV nosographic approach and the PDM psychodynamic perspective. According to the DSM-IV, Matilde suffered from Panic Attack Disorder and, according to PDM, anxiety disorder with obsessive-compulsive



narcissistic personality disorder features. The SWAP-200 revealed a high level of functioning, with aspects of obsessive-compulsive, schizoid and avoidant style. The choice to unite DSM-IV, PDM and SWAP-200 was based on the suggestions of Westen, Gabbard and Blagov (2006) that anxiety disorder may be better explained in the context of a specific personality disorder. In this particular case, supportive therapy was prescribed to a “high functioning patient” in order to scaffold ego functions in transient and specific crisis situations (Hellerstein et al., 1994; Douglas, 2008).

Regarding the psychotherapy process, therapist interventions, working alliance and defensive mechanisms trends made it possible to understand how supportive psychotherapy works.

First, the therapist used supportive interventions as well as expressive interventions. Supportive strategies were more frequent in the first part of the treatment, while in the core section of the psychotherapy the interventions became more expressive. This aspect was in line with the literature that describes how supportive therapies do not use only supportive intervention, but a specific and patient-tailored combination of supportive and interpretative strategies (Douglas, 2008; Gabbard, 2009).

The therapeutic alliance trend followed a U-shaped pattern with lower alliance levels in the core phase of the therapy (Stiles & Goldsmith, 2010). In this phase, there was also a high presence of expressive intervention. This result may be explained in several ways.

The lower level of alliance in the middle phase may be explained as the consequence of a deeper elaboration by Matilde of her problems with consequent emotional activation. In other terms, we could say that in the middle phase, there was an increased intensity in the patient’s ambivalence in relation to the process of separation-individuation (Malan, 1976).

As suggested by Luborsky, this therapeutic alliance pattern with weaker alliance in the middle phase and the co-occurrence of expressive interventions could also be explained by a surge in transference, which may then be diminished by therapist interpretations (Luborsky, 1984). In any case, at this level of analysis we are unable to say whether therapist expressive interventions are a response to a weaker alliance of the patient, or vice versa.

Matilde's alliance rupture style was characterized by the presence of withdrawal maneuvers: emotional disengagement from the therapist, skipping from topic to topic, responding in an overly intellectualized fashion, and very short answers (Safran & Muran, 2000). Considering Matilde's personality style, in the light of SWAP 200 results, to be very close to an introjective organization (Blatt & Shichman, 1983) it could be said that her rupture style was in line with her personality structure, characterized by a more passive and introvert way of functioning. In other words, the way Matilde organized and structured the relationship with her therapist, especially in very difficult moments of the therapy, was very similar to the relational style emerging from the assessment. This result points to the importance of personality assessment also in the case of Axis I disorders, in order to help therapists tailor their intervention and prepare to manage difficult moments in therapy.

Regarding defensive mechanisms, Matilde's structure included mainly mature, obsessional and disavowal defenses, in line with her high level of functioning and the diagnostic aspects highlighted with the SWAP-200. Some of Matilde's maladaptive defensive mechanisms, such as obsessional and disavowal defenses, decreased significantly during the treatment. This result is in agreement with Gabbard's (2009) considerations that in supportive therapies, maladaptive mechanisms are treated and interpreted, and for this reason, can be reduced. This result is also in accordance with Wallerstein's (1989) findings about the possibility of supportive therapies to produce structural changes.

Structural change was also supported by a comparison between the SWAP-200 evaluations at the beginning and termination phases. At the conclusion phase, the schizoid traits disappeared, meaning that Matilde was less introverted and in contact with her feelings.

The changes in Matilde's capacity to stay connected with her feelings, suggested by the decrease in obsessional defenses and the increase in high functioning levels of the SWAP (which also evaluated the patient's capacity to reflect on his/her emotions), seem peculiar of dynamic therapy, which encourages exploration of patient emotions, as pointed out by Shelder (2010).

Another aim of our study was to evaluate at a micro level the relationship between the adjustment ratio of the therapist's interventions in relation to the patient's defensive functioning and patient alliance ruptures in order to investigate the causal link between our set of variables (defenses, therapist interventions and therapeutic alliance). To evaluate the relationship between therapist interventions and patient defensive functioning, we referred to a procedure proposed by Despland et al. (2001): the Adjustment ratio (AR). Specifically, we investigated the relationship between two different indexes of AR: the Session Adjustment Ratio and the Interaction Adjustment Ratio, which is an index devised ad hoc for this study.

The results show that the Interaction Adjustment Ratio (IAR), which evaluates the adjustment of therapist intervention in relation to patient defense levels in the immediacy of the interaction, is negatively associated to a collaborative relationship with the patient. This result suggests that if the therapist's intervention is too expressive when considering the patient's defensive functioning that precedes therapist intervention, the quality of the alliance would suffer a negative effect. The other two variables, the Session Adjustment Ratio, which, as already mentioned, indicates the adequacy of the intervention compared with patient global defensive functioning and not the current

interaction, and the expressive level independent of the defensive functioning, were not able to predict an immediate change in the quality of the alliance. This result seems to suggest that in developing collaboration with a patient, one should not only relate to the global expressive level of intervention, or to the patient's global defense level, but one should always consider the patient's defensive level in the immediacy of the interaction. Moreover, this result seems to be in agreement with several authors who suggest that the negotiation process takes place at a micro level of interaction (Boston Change Process Group, 2010; Colli & Lingiardi, 2009). In any case, it is important to note that at this level of analysis, the effect of the interventions subsequent patient responses were evaluated. In other words, we do not know if an intervention which is too expressive could have a positive effect later on the quality of the relationship. From another point of view, these results seem to suggest, in agreement with other studies (Hersough et al., 2001), that it is also necessary to redefine the optimal AR proposed originally by Despland (Despland et al., 2001). The optimal AR and ranking of supportive expressive interventions were established at a theoretical level and were not empirically derived. In the future, it will probably be necessary to derive an optimal AR level empirically, by taking into consideration other variables such as patient personality, therapeutic approach, stage of therapy, etc. Our proposal of a new AR index, the Interaction Adjustment Ratio, and the need to verify the optimal AR in relation to different therapies and patients, is in line with Hill and Knox's (2009) considerations about the "need to learn more about the timing of relational events and to develop innovative methods for studying this phenomenon, because it is a complicated process that takes place over time and varies from dyad to dyad" (Hill & Knox, 2009, p. 27).

This study has several limitations. First, this paper focused on a single case study, so the conclusions cannot be generalized to other

patients with the same diagnosis. Second, the sessions analyzed for the process dimension were only 50% of Matilde's entire therapeutic process. These sessions were those for which audio-recorded tapes were available. Third, the choice to divide the process into five periods was related to the actual divisions which occurred during the psychotherapy (i.e., holidays). This method did not take into account specific patient "life events" which could have affected the course of the therapy. The process variables including therapeutic interventions, defensive mechanisms and working alliance, were analyzed through three separate log linear models without applying a unique and more complex model. In such a model, reciprocal influences between process variables should have been assessed. Finally, the dimensions measured may have been influenced by any number of other psychological and contextual processes that were not assessed. Perhaps future studies of different individuals in diverse settings might reveal more of the hallmarks of the clinical utility of combining the use of qualitative and quantitative approaches in the study of process and outcome dimensions. As Kazdin (2008) pointed out, to reduce the gap between research and practice it is fundamental to evaluate therapeutic change mechanisms. In supportive psychotherapy, a complete case formulation is important, in order to have a clinical base line from which to study the change. Moreover, both the qualitative and quantitative approaches contributed to highlighting the nature of moderator variables in terms of clinical change. In such a way, processes which explain why psychodynamically-oriented supportive psychotherapy works, or how it produce changes, can be assessed.

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## **Dynamics of sense-making and development of the narrative in the clinical exchange**

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### **Abstract**

The present work is aimed at exploring the relationship between the dynamics of sense-making carried out by the clinical exchange and the content of the patient's narrative. To this end the relationship between the formal and functional mapping of a psychotherapy carried out by the Discourse Flow Analysis (DFA) and the analysis of the patient's narrative provided by the Innovative Moment Coding System (IMCS) have been compared. The comparison concerns a 15-session good outcome Emotion-Focused Therapy (Lisa's case). Findings highlight the association between the formal and functional characteristics of the clinical dialogue and the content of the narrative. More in particular, an association between the U-shape trajectory of the super-ordered meaning depicted by DFA and the evolution of the innovative content of the narrative enucleated by the IMCS were found.

### **Key words**

Process research; meaning making; DFA; IMCS

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## **Introduction**

Several clinical approaches — psychodynamic (Hoffman, 1998; Storolow, 1994), cognitive (Dimaggio & Semerari, 2004), humanistic (Hermans & Hermans-Jansen, 1995) and narrative (Santos, Gonçalves, Matos, & Salvatore, 2009) — share a meta-theoretical perspective seeing the psychotherapy as an intersubjective dynamics of sense-making aimed at changing patient's symbolic (affective and/or cognitive) modality of interpreting his/her experience (Gennaro, Al-Radaideh, Gelo, Manzo, Nitti, Auletta & Salvatore, 2010), or anyway able to open toward new, innovative way of thinking and feeling – therefore of interpreting the experience and acting own life (Santos & Gonçalves, 2009). Viewing psychotherapy process under this light implies conceiving clinical exchange as a “transformative dialog” (Gergen, 1999, p. 250), where new meanings are elaborated, new categories are developed, and one’s presuppositions (Chambers & Bickhard, 2007) are transformed within and thanks to the interpersonal context. This means that the clinical valence of patient-therapist relationship does not consist of pushing the patient to change the content of his/her representations about self and world (e.g., the way of seeing relations with others, judgments on events and acts, and so on); rather psychotherapy has to be seen in a broader way, as an intersubjective attempt aimed at opening new semiotic configurations, that is new paths of sense-making able to offer patients an innovative way to organize their experience (Salvatore, Gelo, Gennaro, Manzo, & Al-Radaideh, 2010). In other words, the clinical exchange is a dialectic encounter between the patient's and the therapist's way of interpreting the world, producing (for both participants) semiotic novelty working as a lever for patient's change.

As suggested by Lauro-Grotto, Salvatore, Gennaro and Gelo (2009) sense-making could be depicted as a dynamic process, that is a process

depending on time. Different perspectives of philosophical, semiotic and sociologic thought, as well as a number of psychological models (Valsiner & Van der Veer, 2000; Gergen, 1999; Nightgale & Comby, 1999; Cole, 1996; Edward & Potter, 1992) have argued for the classical additional and static idea of communication as the transmission of semantic contents, underlining the pragmatic (Austin, 1962) and pathic (Freda, 2008) valence of meaning as well as its contingency to the discursive circumstances (Salvatore, Tebaldi, & Potì, 2006/2009; Salvatore et al., 2010). Meaning deals with the exchange of signs (i.e. words, utterances, behaviours and so on). On the other hand, signs are part of a whole dynamic context concurring to sustain and shape the flow of the communication. Each sign is mobilized by the participants of the dialogue as an answer to the previous signs, and as an anticipation of the future ones (Linell, 2009). Thus, sense-making is inherently a time-dependent process, where meaning is not laid within the signs; rather it is an emerging property of the exchange, raising from the combination of the signs, that is from the act of saying something in a certain way, to someone, in a specific space and time, in the light of a specific and socially defined relation between speakers (Harre & Gillet, 1994, Wittgenstein, 1953; Greenberg & Pinsoff, 1986). In other words, the meaning of the signs depends on the way they are used (Wittgenstein, 1953) — namely, how they are combined with other signs within the intersubjective circumstances of the discourse.

#### *A dynamic and contextual look at psychotherapy process*

As sense-making, the psychotherapy has to be conceived of as a dynamic phenomenon too, that is a process depending on the time and concerning the global form and organization of the intersubjective field of communication between therapist and patient (Salvatore et al., 2009). Which means that the clinical exchange is carried out not only by means of what is said, and not only by how it is said, but also by means

of *when* what said is said — that is, before and after what (Salvatore et al., 2009; Lauro-Grotto et al., 2009). To exemplify let us consider the following sequences characterizing a hypothetical patient's sentence:

*Patient 1: When I lose through gamble I got very angry and therefore I desired to be helped by the therapist.*

*Patient 2: When I desired to be helped by the therapist I got very angry and therefore I lose through gambling*

As one can see, even if the contents are the same for both sequences, the difference in the sequence of the signs (indeed a matter of time) makes a difference in the meaning: while the first sentence expresses the patient's need of therapist support because of his gamble losing, the second sentence expresses the gambling as a form of “acting out” in front of patient's desire of being supported. It is worth noting that such view is not new in the clinical field. The psychoanalytic hermeneutic tenet of the free association is indeed based on the criterion of temporal contiguity between signs, that is on the assumption that the meanings depend on the way signs combine with each other through time.

#### *A method for grasping the dynamicity of the psychotherapy process*

The acknowledgment of the dynamicity of the clinical process triggers a commitment for innovative methodology (Greenberg, 1994; Salvatore, Gennaro, Grassi, Manzo, Melgiovanni, Mossi, Olive, & Serio, 2007; Valsiner et al., 2009). As matter of fact, despite of some pioneering attempts (Kowalik, Schiepek, Kumpf, Roberts, & Elbert, 1997; Schiepek, Kowalik, Schiitz, Kohler, Richter, Strunk, Miihlnickel, & Elbert, 1997; Stiles, 2006; Tschacher, Schiepek, & Brunner, 1992; Tschacher, Baur, & Grawe, 2000), current methods are still based on the idea of recomposing the process in terms of the linear addition of single time-discrete events (Elliott & Anderson, 1994; Russell, 1994; Stiles, 2006). Recently a new method of analysis – the Discourse Flow Analysis (DFA) — have proposed in order to address this methodological issue (Salvatore et al., 2007; Salvatore et al., 2010; Gennaro et al., 2010;

Nitti, Ciavolino, Salvatore, & Gennaro, 2010). DFA is aimed at mapping the dynamics of sense-making sustaining the psychotherapy. To this end it focuses the formal and functional characteristics of the dialogue between the therapist and the patient (i.e., the degree of connectivity among the meanings), not considering the semantic contents exchanged through that dialogue.

#### *Aim of the study*

As far the studies that have applied the DFA have been dealt with its construct validity — that is on its consistency with the theoretical model (the Two Stage Semiotic Model, see below) on which DFA is grounded. However, these studies have left apart the relationship between the formal and functional characteristics of the clinical dialogue mapped by the DFA and the content of the narrative. Needless to say that understanding this relationship is a central topic for the developing of the method. As matter of fact, even if it is conceivable and even desirable (Salvatore et al., 2010) that the modelling of the psychotherapy could be a matter of not observable theoretical constructs rather than of empirical concepts directly derived from the experience, nevertheless the clinical meaningfulness of the theoretical constructs depends on the fact that they are however connected to the clinical experience. Only at this condition the conceptual model is able to help the interpretation of the clinical experience. The present work intends to address this lack. It investigates the relationship between the formal and functional mapping of a psychotherapy case and the content of the patient's narrative, as provided by a method focused on such level of analysis — the Innovative Moments Coding System (IMCS; Gonçalves, Matos, & Santos, 2008). The main aim is to chart out which kind of movements at level of narrative content corresponds to the dynamics of sensemaking carried out by the clinical dialogue as depicted by the DFA.

## **The Discourse Flow Analysis**

### *The theoretical framework: the Two Stage Semiotic Model*

DFA is based on a general model of the psychotherapy, holding the dynamic and dialogical nature of the clinical exchange: the Two Stage Semiotic Model (TSSM). The TSSM is based on three main assumptions (Salvatore et al., 2010; Gennaro et al., 2010; Nitti et al., 2010): the Two stage articulations; the Non-linearity, and the Quasi periodicity micro-dynamics of the psychotherapy process.

*Two stage articulation.* The TSSM claims that a clinical efficacious therapy course highlights two periods: the first stage reflects a de-constructive phase, (Hayes & Strauss, 1998; Kossmann & Bullrich, 1997; Mahoney & Marquis, 2002) when the clinical exchange is mainly aimed at constraining patient's system of assumptions (concepts of self and others, affective schemata, meta-cognitive modalities, relational and attachment strategies, unconscious plans, etc.) working as super-ordered meanings regulating the interpretation of experience (Teasdale & Barnard, 1993). The weakening of the patient's critical super-ordered meaning (Salvatore & Valsiner, 2006; Samoilov & Goldfried, 2000) paves the way for the second, constructive phase when the therapeutic dialogue allows the elaboration of innovative super-ordered meanings, replacing the previous ones in regulating the patient's way of interpreting the experience. It is worth noting that, as concerns the patient's super-ordered meanings, the two stages are different both from a quantitative and a qualitative point of view. From a quantitative point of view, the model holds that the incidence of the super-ordered meanings decreases in the first stage while increases in the second. From a qualitative point of view, the model assumes that the clinical value (i.e., the function played by the content of the node within the

clinical exchange) of the super-ordered meaning changes as well. In the first period of a psychotherapy one can assume that the super-ordered meanings reflects the dysfunctional way of thinking and feeling that the person has before to ask for a psychotherapy. As matter of fact, given that generally one demands a psychotherapy in order to address problems and critical issues in her/his life, and given that it is assumable that those problems and critical issues are associated, even caused, by this way of thinking and feeling, one is led to conclude that the patient enters psychotherapy with dysfunctional super-order meanings, that is meanings associated with the conditions leading a person to become a patient. On the contrary, according to the TSSM assumption, the super-order meanings of the second stage of good outcome psychotherapy should be associated with the positive results of the clinical work, therefore, broadly speaking, functional.

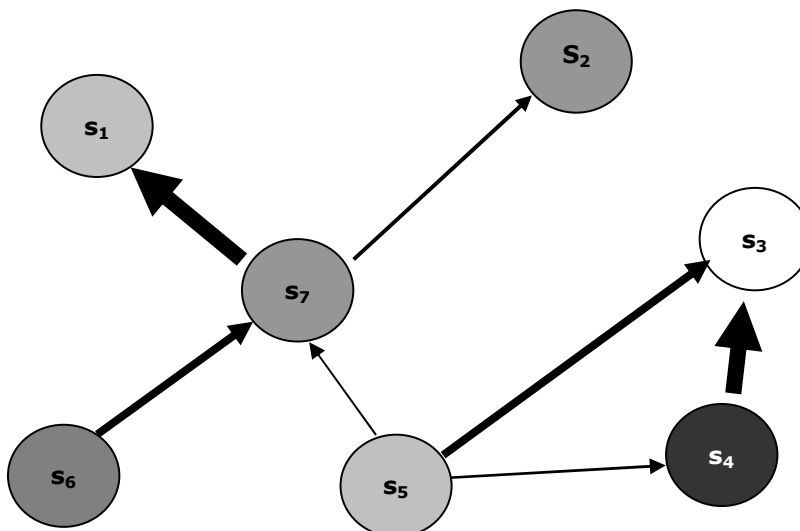
*Non-linearity.* The second assumption of the TSSM maintains that the therapeutic process draws not linear trajectories through time. It follows from the previous assumption. Since clinical relationship performs different functions in the therapy accordingly to the two stages (that is a deconstructive and a constructive function), different functional organization or mode of working of the clinical process have to be associated with this articulation. In other terms, the de-constructive and the constructive stages are expected to be characterized by different patterns of relationships among those features of the therapeutic dialog, which contribute to meaning-making.

*Quasi periodicity of the micro-dynamics.* The third assumption assumes a heartbeat-like quasi-periodic mechanism of working, in which moments of “basic” sense-making, during which the active system of assumptions works, are interrupted by circumscribed moments of recombination of the connections between meanings, which could be seen as an “irruption” of semiotic variability. The new pattern of connections produced by this irrupting moment afterwards becomes



more and more firmly established, implementing a further phase of basic sense-making that will be interrupted by another irruption moment, and so on.

*The rationale of the method.* DFA assumes that sense-making depends on the associations for temporal adjacency between meanings — that is, on the way meanings combine each other throughout the discourse flow (therefore through the time). Accordingly, DFA maps the psychotherapeutic dialogue in terms of associations for adjacency between semantic contents (i.e., the fact that one meaning comes just after another) occurring within the clinical exchange. DFA does it by referring to the notion of “Discourse Network.” A Discourse Network is a web with each node representing one of the units of meaning (henceforth: semantic content) that is active in the dialogue between therapist and patient. Any line between two nodes represents the temporal association between the corresponding semantic contents; the thickness of the line represents the strength of the association (that is, the probability that a certain semantic content will be followed immediately by the other). For instance, referring to Figure 1, the



**Figure 1.** An example of nodes network: each node S(n) represents a semantic content. The thickness of the arrows that reflect directional linkage represent the strength of the temporal association between contents.

Discursive Network is described by the semantic content (S5) followed mostly by the semantic content (S3) and in some cases by (S4) and (S7). In turn, this last semantic content precedes (S1) mostly and in some cases (S2); and so on.

### *Procedure of analysis and indexes*

DFA is applied to the verbatim transcript of the dialogue between therapist and patient throughout three different steps that will be briefly described.

The first step consists of a computer-aided content analysis, which identifies and categorizes the semantic contents active in the whole verbatim transcription of patient-therapist dialogue (DFA refer only to verbal content, paralinguistic or extra verbal data are not taken into consideration). This passage is performed through various sub-steps:

1. the transcript is divided into units of analysis called Elementary Context Units (ECU) through the software T-LAB (Lancia, 2002). An ECU starts with the characters just subsequent to the last character of the previous ECU and ends with the first punctuation mark (".", "!" or "?") after the 250th character; at any rate the length must not be more than 500 characters.
2. In order to reduce the lexical variability due to syntax, a procedure of lemmatization classifies each word according to its headword (for example, word forms like "child," and "children" are transformed into its lemma "CHILD"). This operation leads to a list of the lemmas present in the transcript.
3. A matrix having the ECUs as rows and the lemmas as columns is drawn where in the generic cell  $x_{ij}$  the value "1" represent the presence of the  $j^{\text{th}}$  lemma in the  $i^{\text{th}}$  ECU, "0" otherwise. The obtained matrix represents a digital model of the text, in its distribution of

presence/absence of the lemmas in the ECUs composing the text.

4. A Multiple Correspondence Analysis (MCA; Benzécri, 1973) is applied to the digital matrix representing the text obtained as output of the previous sub-step. Each factor enucleated by the MCA describes the joint behavior of groups of lemmas and can be interpreted as a significant semantic dimension expressed by the conversation.
5. A Cluster Analysis (CA; Bolasco, 1999) is then performed, adopting the factors resulting from the MCA as criterion of classification. According to its composition, each ECU is assigned to the cluster with which it has the highest association. Therefore, each cluster will represent a subset of words tending to occur in the same sentences. Therefore, each cluster can be understood as a unit of meaning — that is a thematic nucleon (or semantic content, or node), made up of a set of words whose aggregation reflects the “isotopy” (i.e., “iso” = same; “topos” = place) of semantic traits (Lancia, 2004; on this topic see also Salvatore, Gennaro, Auletta, Al-Radaideh, Aloia, Masiello, Montreforte, Tonti, Manzo, & Gelo, 2010).
6. Each ECU is indexed according to the cluster it belongs to. Therefore, the output of DFA’s first step (sub-steps 1-6) is the transformation of the transcript into a sequence of thematic contents, each of them representing the semantic content of an ECU.

The second step of the DFA method is aimed at building a model of the text in terms of Discursive Network where nodes are represented by the semantic content (i.e., the Clusters) and the connections among them represent the strength of their association for adjacency. The strength of the association among the cluster is calculated using a procedure of Markov’s analysis of sequence (Bakeman & Gottman, 1997). This procedure calculates each semantic content’s probability of coming straight after every thematic content (including itself, given that a semantic content can follow itself too).

The third step of the DFA method is aimed at analyzing the formal and functional characteristics of the Discourse Network as produced by the previous step, insofar as they are considered indicative of relevant aspects and qualities of the dynamics of sense-making. This passage is carried out by means of some indexes, which gives a synthetic description of the Discursive Network's functioning. The main indexes are the following (for further detail, see also Salvatore et al., 2010; Gennaro et al., 2010; Nitti et al., 2010; Salvatore et al., 2007):

*Super-Ordered Nodes (SN)*. This index quantifies the incidence of the nodes carrying out a function of super-ordered meaning regulating the meaning-making process. Thus it measures the incidence of the super-ordered meanings the TSSM's first assumption (i.e., the Two stage articulation) is concerned with. DFA assumes the high frequency of occurrence of a node (i.e., the number of the times the semantic content occurs in the unit of text under analysis in other terms) and its high associability with the other nodes as the markers of this super-ordered regulative function. Super Order Nodes are calculated as the percentage of nodes of the network having both high frequency, calculated as more than a 1.5 ratio between token (occurrences of a given thematic content) and type (kinds of thematic content), and high associability, calculated as having outgoing and/or incoming connections with more than 33% of the nodes in the network.

According to the TSSM's first assumption, one is expect to find a U-shape trend of this index through the psychotherapy course, with a first part of the psychotherapy characterized by a decreasing trajectory followed by a second part where the SN increases.

*Activity (A)*. It is the index providing a quantitative description of the micro-dynamics of the sense-making the TSSM's third assumption (i.e. the Quasi-periodic micro-dynamics) is concerned with. It depicts the

discourse's capability of broadening (or constraining) the paths of sense-making, by enriching or restricting the possibilities of combination among the semantic content. It is calculated in terms of the nodes ratio between the outgoing and incoming connections. A node with more outgoing connection than incoming generates meaning variability, because its activation entails an enlargement of the spectrum of semantic content respect on the previous node. The opposite occurs in the case of nodes having more incoming connections than outgoing. This kind of nodes represents semantic content that "absorbs" meaning variability.

According to the TSSM's third assumption, one is expect to find a heartbeat-like quasi-periodic of this index through the psychotherapy course.

*Connectivity.* It is a measure the network's density of associations, that is of the relative amount of connections among the semantic content. It is calculated as the ratio between the active connections present in the network (as identified through the Markovian analysis) and the network's maximum theoretical amount of connections.

*Heterogeneity.* It depicts how the connections are distributed among the nodes. It is calculated as the standard deviation of the distribution of the amount of connections starting from and arriving at every semantic node.

#### *The construct validity of DFA*

Several case studies have investigated the DFA's construct validity, in terms of the consistency between the operative representation of the psychotherapy process provided by the method and the TSSM's assumptions. Salvatore and colleagues (in press) have applied DFA to a good outcome 15 sessions Emotion Focused psychotherapy (the same

case adopted in the present work) and have highlighted the presence of the expected U-shape trend of the SN, indicative of the two stage articulation. Moreover the same study, in accordance with the TSSM's second assumption (non-linearity), has highlighted the different way of functioning of the clinical dialogue in the two periods. Gennaro and colleagues (in press) have applied the DFA to a good outcome 124 sessions Metacognitive Interpersonal psychotherapy (Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007) highlighting how results are consistent with the three TSSM assumptions. Finally, Nitti et al., (2010) applied the DFA to 43 psychotherapy sessions randomly sampled from the total of 79 sessions of a good outcome psychodynamic psychotherapy. They have found that the indexes measuring the structural and dynamics characteristics of the Discourse Networks are able to discriminate between two periods of the psychotherapy as independently defined accordingly to the TSSM criterion of the two stages articulation.

Taken as a whole, these studies provide evidence supporting the TSSM's assumptions, as well as the DFA's validity as a method providing a meaningful map of the psychotherapy process in terms of its formal and functional characteristics. Moreover, the variety of therapy and setting involved in the studies legitimates to think that the method could be considered as independent on the type of setting (brief versus long therapy) as well as on the clinical orientation.

## **Method**

### *Data*

The present study concerns the whole textual corpus obtained from the verbatim transcript of a 15-session good outcome psychotherapy taken from the York Psychotherapy Depression Project. The data on which it is based are obtained by two previous studies (Gonçalves et al.,

2009; Salvatore et al., 2010) which have already independently applied the two methods here compared (respectively IMCS and DFA) on the case. In accordance with its dialogical theoretical framework, DFA were applied to the whole transcript of the dialogue between therapist and patient. IMCS were applied only to the part of the text produced by the patient.

The patient (Lisa) was a young, married woman in her late 20s who received an Emotion-Focused Therapy for depression (see Greenberg & Watson, 1998; Goldman, Greenberg, & Angus, 2006). The York Psychotherapy Depression Project envisaged the recruitment of participants by advertisement, an initial session of assessment based on the use of the full multi-axial version of the SCID III-R, and a set of outcome measures applied before treatment, at mid-treatment (session 8), at post-treatment, and at 6- and 18-month follow-ups: the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Rosenberg Self-Esteem Scale (Rosenberg, 1965), the Inventory for Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), and the Symptom Checklist-90-R (Derogatis, Rickels, & Roch, 1976). Lisa made significant gains on all measures, maintaining and even improving, particularly in terms of self-esteem at the follow-up assessments (for details see Angus, Goldman, & Mergenthaler, 2008). Lisa also completed a process measure, the Working Alliance Inventory Short-Form (Horvath & Greenberg, 1989), after session 4, 7 and 15. The case of Lisa has been recently analyzed according to different theories and methodologies (see Angus, Goldman, & Mergenthaler, 2008).

#### *The Innovative Moments Coding System*

The Innovative Moments Coding System (IMCS) has been adopted in order to analyze the content of patient's narrative. This choice has been made according to the following criteria:

- a) IMCS shares a semiotic and dynamic conception of the psychotherapy process with the DFA (Matos et al., 2009; Gonçalves, Ribeiro, Matos, Santos & Mendes, 2010, Santos, Gonçalves, Matos & Salvatore, 2010).
- b) IMCS is specifically focused on the novelty produced within the narrative, that is the semantic content potential marking a clinically relevant development. This characteristic is particular relevant for our scope of analyzing the clinical meaningfulness of the formal and functional characteristics of the dialogue measured by the DFA.

IMCS is a method applied to the verbatim transcript of the patient's narrative within the session. It is aimed at analyzing the way the narrative of the patient conveys and reflects the clinical change. IMCS is based on a narratological conception of the psychotherapy. According to this standpoint, the therapeutic change depends on the promotion of the patient's capability of elaborating alternative accounts of the events (Freedman & Combs, 1996; White, 2007). This elaboration leads to substitute/develop the dysfunctional narratives grounding the patient's problems, allowing the client to construct innovative ways of interpreting the self and the relationship with the world. In its turn, the construction of this innovative ways leads the client to feel, think, and act differently from the past modalities framed by the problematic story. In sum, similarly to the DFA, the IMCS assumes a way of viewing the psychotherapy as a semiotic process at producing novelty in sense-making: new meanings that the patient can deploy in order to re-shape her/his life. Differently from the DFA, however, the IMCS focuses the content level of the sense-making.

The IMCS is aimed at identifying the narrative (namely, the Innovative Moments) producing a change – or however a movement of dialectization – of the problematic dominant narrative the patient is constrained with. The method considers 5 types of Innovative Moments



(i-momentos) (for details see Gonçalves, Matos, & Santos, 2009; Goncalves, 2010):

1. *Action*, that is an i-moment referred to specific actions that are not predicted by the problematic story.
2. *Reflection*, that is an i-moment in which the patient thinks differently than what one could expect from the problematic story, or when he/she understands something new, that contradicts the problematic story.
3. *Protest* i-moment could be an action or a thought reflecting a reaction of resistance against the problematic narrative and its detrimental effects, and which leads the person to protest against the problematic narrative and/or the assumptions that support it. Protest implies both aspects of resistance and re-assessment of the client's position in relation to the problem.
4. *Re-conceptualization* is an i-moment that involves two components: the contrast between the past self and the present self, and the description of the processes that allowed the self's transformation from the past to the present. This i-moment implies the activation of a meta-level, enabling the patient to see the difference between the old plot and the (anticipated) new one, as well as to construct the development of the new story.
5. *Performing change* is an i-moment revealing new experiences, projects, or activities at personal, professional, and relational level - which were impossible before, given the constraints of the dominant narrative - marking the consequences of the occurred change.

The IMCS measures the relevance of the i-moments in terms of *duration*, which is the amount of time (in percentage) that each i-moment occupies in the whole session. Therefore, the application of the IMCS allows calculating the duration of each type of i-moments as well as the total duration of the i-moments respect of the rest of the patient's

discourse. This can be calculated for the whole therapy as well as for more specific unit of analysis (sessions or block of sessions).

It is worth noting that the 5 i-moments can be grouped in two more general categories. Action, Reflection and Protest are i-moments that represent a rupture in respect to the dominant narrative. Re-conceptualization and Performing change can be interpreted more as the marked of an elaborative process producing a consolidation of the new perspectives opened by the weakening of the dominant narrative. Consistently with this interpretation of the clinical significance of the i-moments, Action, Reflection and Protest characterize the first part of the therapy, while the Re-conceptualization and the Performing change are typical of the final part of the clinical course of good outcome psychotherapy (Matos, Santos, Gonçalves, & Martins, 2009). On the basis of these findings, authors interpret Re-conceptualization and Performing change as the final step of the process of elaboration of innovative sense-making in the psychotherapy. The following analysis adopt these two groups of i-moments as variables. In other terms, we consider the aggregate duration of Action, Reflection and Protest as the index of the “reactive” innovation the patient introduces and the aggregate duration of Re-conceptualization and New Experience as the index of the narrative’s innovation reflecting an “elaborative” semiotic activity of the patient.

#### *Procedure and data analysis*

The study analyzes the relationship between the SN index elaborated by the DFA and the aggregate duration of the reactive i-moments (Action, Reflection and Protest) and the elaborative i-moments (Re-conceptualization and Performing change). The aggregate duration of the reactive i-moments is given by the sum of the duration of the Action, Reflection and Protest. The aggregate duration of the elaborative

i-moments consists of the sum of the Re-conceptualization and Performing change.

The analysis of the relationship among these three variables has been carried out adopting the session as unit of analysis. This means that the study is based on a data matrix made of 15 cases (the 15 sessions), with every case characterized by three values, one for each of the three indexes (i.e., SN, duration of the reactive i-moments; duration of the elaborative i-moments). This choice obviously reduces the potency of the statistical analysis. Nevertheless it is the only possible, given that the DFA assumes the session as the minimal unit of analysis.

We adopted the Spearman's Rho for measuring the degree of association between the SN and the two indexes derived by the IMCS: a non-parametric test in consideration of the assumed not independence of the cases has been chosen (Borckardt, Mash, Murphy, Moore, Shaw, & O'Neil, 2007).

In accordance with the TSSM (in particular the assumption of two stage articulation and non-linearity) the analysis of the association between the indexes were performed separately for two blocks of contiguous sessions, supposed corresponding to the two stages conceptualized by TSSM. To this end we applied the criterion provided by the DFA — and already applied to this case by Salvatore and colleagues (in press) — that assumes the session having the minimal peak of the SN as cut off (obviously this criterion is sensate only in presence of the assumed U-shape trend of the SN). SN has been found equally low in sessions 3, 10 and 14; we have chosen session 10 as cut off is the only one among these three sessions to be consistent with the U slope. Therefore, we chose the latter as the cut off point to split the 15-session psychotherapy into two stages. Following these results, the de-constructive stage goes from session 1 to 10, and the constructive stage from session 11 to 15.

## **Hypotheses**

Our study deal with the analysis of the clinical value of the super-order meanings, as conceptualized by the TSSM's first and second assumptions (Two stage articulation and Non-linearity), and operatively measured by the DFA index SN (Super-Ordered Nodes). More in particular, we focus the following points, that we present separately for the two stages of the psychotherapy.

*First stage.* TSSM claims that in the first stage of the good outcome psychotherapy, the decreasing of the SN depicts the progressive reduction of the incidence of the dysfunctional patient's system of assumption. And this process opens the room to the elaboration of innovative meanings. In accordance with this assumption we expect to find a negative association between the SN trend and the duration of the i-moments. More specifically, we hypothesise that the negative association with SN concerns only the reactive i-moments (i.e., Action, Reflection and Protest, see above). This is because, in accordance with their clinical meaning (see above), the emergence of the reactive i-moments do not require specific elaborative competence in the patient, being more a matter of rupture/resistance against the dominant narrative (this is the reason for which these IMs are the first to emerge, then to be characteristics of the first phase of the therapy, see above). Therefore, one is led to conclude that the emergence and increasing of the duration of these group of i-moments is directly associated with the weakening of the power of the patient's system of assumption grounding the dominant narrative. On the contrary, we do not expect an association between the SN's trend and the elaborative i-moments. This is because the emergence of the elaborative i-moments entails a previous development of the patient competence to elaborate own narrative (not for chance it occurs late in the therapy). Therefore, the weakening of the patient's super-ordered meaning is not sufficient for the development of the duration of the elaborative i-moments – what

needs are new super-ordered meanings grounding and nourishing the patient's commitment on innovative in own narrative.

*Second stage.* In accordance with the TSSM, in this stage the SN change in their clinical value, concerning new, functional super-ordered meanings, product of the psychotherapeutic work. As consequence of this, we expect to find a change in the association between SN and the i-moments. More in particular, we expect the following results. Firstly, we expect to find the raising of a positive association between the SN and the elaborative IMs. This is because, as above said, the development of the elaborative i-moments requires not only the weakening of the initial patient's assumptions, but also the elaboration of new, functional super-ordered meanings. Secondly, as consequence of that, we expect to find the same negative association between the SN and the reactive i-moments. Yet the quantitative and qualitative content of this association is different respect on the first stage. In the second stage this negative association would reflect the fact that thanks to and alongside the unfolding of the clinical work the initial reactive modality of performing innovation in narrative tend to reduce their duration, being progressively developing in more sophisticate forms (i.e. the ones depicted by the elaborative i-moments). Grossly speaking, in the second stage the reactive i-moments no more represents a progress of therapy (as in the first stage), rather having to be meant as a critical point (their presence in the late phase of the therapy is typical of negative outcome cases; see Matos et al., 2009). Consequently, the duration of the reactive i-moments has to be expected to be negatively associated with the SN trend, describing the positive development of the clinical work.

The expectations above defined can be summarized in terms of the following 3 operative hypotheses:

*Hypothesis 1)* In the first stage of the psychotherapy a negative correlation between SN and the summed duration of Action, Reflection

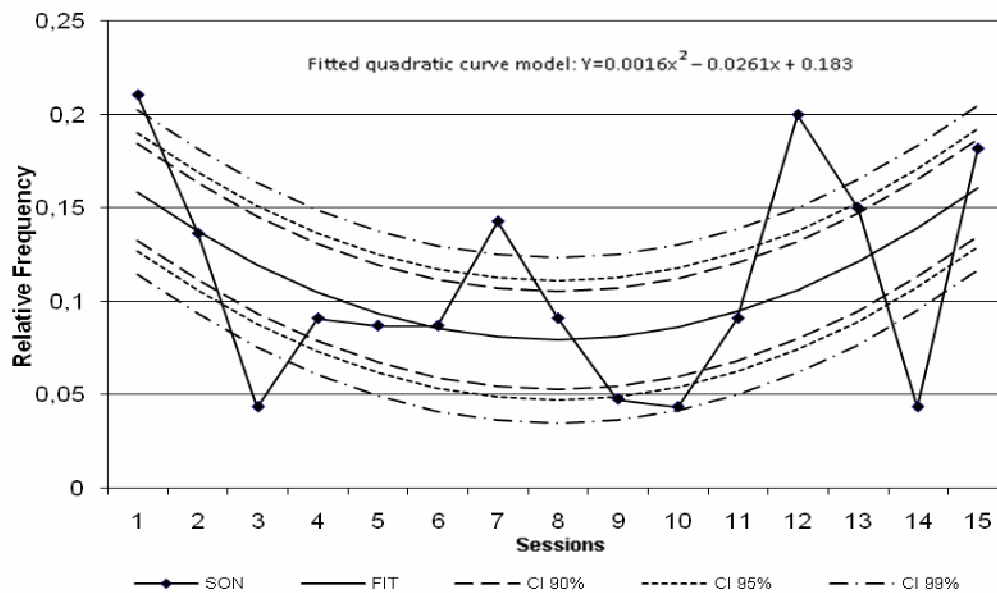
and Protest (namely the reactive i-moments), with SN decreasing and duration increasing.

*Hypothesis 2)* In the second stage of the psychotherapy a positive correlation between SN and the summed duration of Reconceptualization and Performing change (namely the elaborative i-moments).

*Hypothesis 3)* In the second stage of the psychotherapy a negative correlation between SN and the summed duration of Action, Reflection and Protest (namely the reactive i-moments), with SN increasing and duration decreasing.

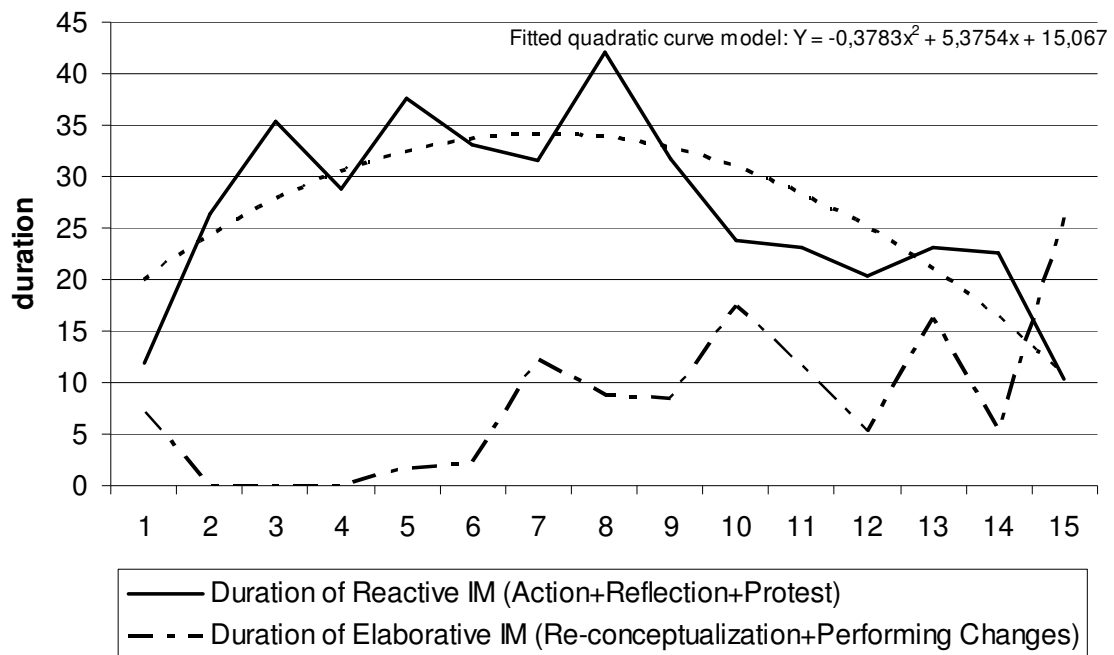
## **Results**

Figure 1 presents the trend of the SN through the sessions. This trend presents a course significantly close to a U-shape, with 11 out 15 sessions (sessions 1, 2, 4, 5, 6, 8, 9, 10, 11, 14, 15) having a position that is consistent with a U format (chi square highly significant:  $p > .01$ ). Sessions 3, 10 and 14 are the minimal peaks and sessions 1, 12 and 15 the maximum peaks. Basing on the analysis of the confidence interval, Salvatore and colleagues (Salvatore et al., in press) have highlighted how the Super-Ordered Node values present a course significantly close to a U-shape at a significance level between  $\alpha = 5\%$  and  $\alpha = 1\%$ .



**Figure 1.** Fitted Quadratic curve (FIT) of Super-Ordered Nodes (SON) over the sessions with correspondent Confidence Intervals (CI), taken from Salvatore and colleagues (2010).

The Figure 2 shows the trend of the duration of the reactive i-moments and elaborative i-moments. As already highlighted by Gonçalves and colleagues (in press), the duration of the reactive i-moments increases in the first part of the therapy, getting the maximum peak in the session 8, after which it decrease. This trend draws a U-inverse trajectory. The second order equation ( $y = -0,378x^2 + 5,908x + 13$ ) explains the 65% of the variance of this trajectory. The duration of the elaborative i-moments seems to have a different trend in the two stages. In the first stage (i.e., session 1-10 sessions) it is quite instable, alternating maximum and minimal peaks, while in the second stage shows a constantly increasing trajectory.



**Figure 2.** Quadratic curve of Rective i-moments duration and curve about Elaborative i-moments duration.

The Table 1 reports the coefficients of correlation (Spearman's Rho) between the SN and the two indexes derived by IMCS, for the two stages of the psychotherapy. The SN correlates significantly with the reactive i-moments both in the first and in the second stage (first stage:  $Rho = -.639$ ;  $p = .032$ ; second stage:  $Rho = -.754$ ;  $p = .043$ ). In the first stage the correlation between SN and the elaborative i-moments is close 0; in the second stage is quite high, though only trendily significant ( $Rho = .522$ ;  $p = .104$ ).



**Table 1.** Spearman's Rho correlation between SN and duration of reactive i-moments and SN and elaborative i-moments into the two stages of the psychotherapy.

	First stage (sessions 1-9)	Second stage (sessions 10-15)
SN vs Reactive i-moments	-.639*	-.754*
SN vs Elaborative i-moments	-.008	.522

\* Correlation is significant at the .05 level (1-tailed).

## Discussion

Preliminarily, it is worth noting that SN as well as the duration of the reactive i-moments and of the elaborative i-moments show trend that are consistent with the theoretical models that informs the methods providing those indexes (respectively the TSSM and the narratological model of the psychotherapy). Previous studies have been devoted to the analysis of these trends (Salvatore, 2010; Gonçalves, 2010), therefore we do not address this topic here. We just refer to them in a general fashion because they support the reliability of the conceptual significance of the indexes our analysis is based on.

Coming on the focus of our study, results are quite consistent with the hypothesis. The significant anticorrelation between SN and the reactive i-moments in both stages was what expected by the hypothesis 1 and hypothesis 3. Moreover, also the trend of the associations between these two indexes are those hypothesised: in the first stage the associations reflect the decreasing of SN and the contextual increasing of the reactive i-moments (as stated by the hypothesis 1); the inverse happens in the second stage (as stated by the hypothesis 3). Also the correlation between SN and the elaborative i-moments is consistent with the hypothesis, even if not fully. Consistently with our expectation, we have find no correlation between SN and duration of elaborative i-moments in the first stage, while we have found a quite high positive correlation between the two indexes, as expected by the hypothesis 2. One could observe that this correlation is only trendily significant.

Nevertheless, we are led to consider it meaningful, given the very low power of the analysis due to the limited number of cases ( $n = 6$ ).

Taking these results as a whole, they lead to conclude that — at least in the Lisa's psychotherapy — the weakening of the initial patient's assumptions have created the room for the emergence of innovative meanings challenging the dominant narrative. After and thanks to this first phase, that has lasted two third of the therapy, Lisa has had the opportunities to elaborate new super-ordered meanings, and with them to develop and consolidate new narratives, reflecting projectual and reflexive competences acquired within and through the clinical work.

### **Conclusion**

This study has been aimed at deepening the relationship between the formal and functional — in last analysis: abstract — description of the dynamics of sense-making sustaining the psychotherapy process provided by DFA and the contents of the narrative that such dynamics produces. The conceptual framework of the DFA (the TSSM) is based on the idea of a systematic connection between these two levels of sense-making and then of the psychotherapy process. Such a connection does not concern the specific content of the clinical exchange — that is it is not assumed that a give level/mode of functioning of the Discourse Network correspond to a certain set of content. Rather, the connection is laid at the level of the clinical value of the content of the narrative: the clinical relevance of the DFA requires that the formal and functional aspects of the sense-making that this method allows to grasp are systematically associated with the clinical value of what the patient thinks and feels, then says in session — namely, the content if her/his narrative.

The study we have reported in this paper has provided evidence supporting this assumption. It as analyzed the association between the main DFA index (SN) — which is an index concerning a functional level

of analysis (namely the regulative function of some hierarchically super-ordered meaning, as defined by exclusively formal criteria), fully unconnected with the level of the content – and two indexes derived by the IMCS – which is a method of analysis focused on the content of the narrative, interpreted in the terms of their clinical value (as therapeutically relevant moment of change). The findings of this analysis support the DFA definition of this index: the association between the SN and the i-moments through the psychotherapy course leads to conclude that SN is a valid way of measuring the incidence of the super-ordered meanings regulating the patient's narrative. Indeed, assuming the validity of this index enables to draw a meaningful picture of Lisa case: the patient produces innovation in her narratives consistently with the fact that her super-ordered system of assumptions is before weakened (deconstructive stage) and then developed in new ways (constructive stage). More in general, the findings provided by the study support the basic idea that the formal and functional level of description of the psychotherapy process has clinical relevance because it is connected with the clinical value of the content of patient's narrative.

This evidence is hearting, but obviously all but definitive. Our study suffers of not marginal limitations. First of all, it is focused just on a case. Therefore, the results it provides require to be further tested on other cases, including negative outcome cases as well as cases reflecting other kinds of therapeutic orientation. Secondly, the splitting of the sessions in order to articulate the psychotherapy in two stages has not been made accordingly to an independent clinical criterion, as in accordance with the model that the study is aimed at validating. A third issue concerns the limited number of cases, compromising the statistical power of the analysis.

These limitations (that we are addressing by further studies by now in course) suggest prudence. Nevertheless, they do not obscure the

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relevance of the methodological and theoretical goal this study has intended to address. Connecting the formal and functional description of the sense-making provided by DFA and the IMCS clinical interpretation of the content of the patient's narrative is a methodological operation that goes beyond the DFA. The elaboration of abstract models of the clinical phenomena is a lever for the development of the field. As other scientific domains show, the commitment on abstract models empowers the capacity of generalization and of connection among phenomena empirically distanced (Gennaro et al., 2010). Abstraction allows the elaboration of a shared language within the clinical domain and between the clinical domain and other areas of the psychology and social science. The opportunities entailed in such perspective are evident at the level of theory, of clinical practice as well as training. Nevertheless, progress in this direction is possible only at the condition that the abstraction does not mean lack of clinical significance. Therefore we need not only formalization of models, but also clinical analysis and empirical studies anchoring the theoretical elaboration to the clinical experience.

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## **Alliance in Common Factor Land: A view through the research lens\***

Adam O. Horvath<sup>1</sup>

### **Abstract**

The alliance has evolved into one of the most researched psychotherapy process variables. In this paper it is argued that migration of the concept of the alliance from its psychodynamic roots onto “Common Factor Land” has brought not only great benefits but substantial challenges as well. Currently the alliance has no consensual definition, nor has its relation to other relationship constructs been clearly charted. As a consequence, alliance assessment tools have been substituted for a concept definition and taken over the grounds that theorizing about a construct would normally occupy. The historical background of the events that lead to the current state are reviewed and some consequences of positioning the alliance on the conceptual space where Common Factors “live” are examined. Some possible avenues of moving the alliance project forward and re-connecting the empirical research to clinical practice are explored.

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Measured by the common-sense metric of the number of research papers published on the topic, the alliance has to be judged as a prodigious success. Entering the key-word “alliance” into the PsychInfo database brings up a list of over 6000 articles which have been published over the last 20 years. Clearly, the notion of the alliance has captured the attention and imagination of researchers like few other topics in the history of psychotherapy research. Looking beyond the number of publications, however, there appears to be a growing unease among some of the leading researchers in the area of therapy relationship about the theoretical ambiguities that seem to persist concerning the alliance [2006 #1102]. And yet, it is likely that this lack of clarity and consensually accepted definition of the modern version of the alliance is also responsible for the concept’s popularity across such a broad spectrum of investigators and in such diverse contexts.

In the first part of this paper I will attempt to summarize what I believe to be the historical roots behind both the popularity and ambiguities surrounding this concept. In the second part of the article I will indicate some possible avenues of progress I see as viable avenues we could use to move forward towards developing the research on the alliance in useful directions both theoretically and pragmatically.

### **A brief look at the “rear view mirror”**

To understand the current challenges facing those of us who do research on the alliance, and to make a case for my claim that there are serious challenges facing us, I will briefly review the history of the development of the notion of an alliance between a therapist and client.

The concept of alliance has deep roots in psychodynamic theory. Freud (1912/1958) noted the paradoxical situation the client finds him/her self in at the beginning of treatment: the analytic process activates the client's defenses and yet she or he must overcome this obstacle, and rise above the negative responses to transference in order

to stay in analysis and actively engage in the therapeutic work. Prior to introducing the topic, Freud concerned himself almost exclusively with the negative transference aspects of the analyst-analysand relationship. In 1912 volume “The dynamics of transference” he serves notice that the model of the relational dynamics between therapist and client must be extended to accommodate the client’s positive engagement and active collaboration in the therapeutic work in spite of the challenges and pain of reprocessing hitherto repressed memories. Meissner summarizes his dilemma succinctly:

“He recognized that factors allowing the patient to persist in the analytic effort in the face of these powerful resistances were somehow connected to the relationship to the analyst, but he had nowhere to put these motives except in transference. As a result, positive transference became for him the aspect that enabled the patient to see the analyst as an authority to be trusted and believed”

(Meissner, 2001b, p. 222).

In elaborating his idea of the patient’s positive collaborative stance, Freud suggested that the client “clothes” the therapist with the qualities of individuals with whom/she has had positive relations. But, of course, the metaphor of the client covering the therapist with such positive memories is a “shorthand” which leaves a lot of questions unanswered: Where does the analysand’s motivation and resources come from? Is this a conscious, ego driven process, or is the “unobjectionable transference” driven by unconscious motives and subject to the same distortions as transference? What contributions can, or should, the therapist make to strengthen the process? Freud never fully attended to these problems, and the issue of the client’s positive, perhaps conscious, attachment to the therapist and the therapy process, remained problematic<sup>1</sup> among many analytical theorists.

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<sup>1</sup> For a good discussion of the topic see: Meissner 2001a and 2001b.

In the 1950s Zetzel (1956) and Greenson (1965) re-explored the notion of the client's "positive alignment," coined the word "alliance," and attempted to resume work on Freud's "unfinished project." They used the concept of the observing/conflict free ego to locate the client's resources which enable the patient to "objectively" reflect on the therapy process and make disinclinations between their transference based projections and the "real" therapist<sup>2</sup>.

However, the reaction to the effort to assert the alliance as the third (along with transference and the real relationship) active component of the therapist-client relationship remained (and remains) controversial. The main objection came from a number of important contributors who believe that all aspects of the relation between therapist and client are transference based, and proposing a relational dynamics outside this framework was confusing at best, and dangerous at worst (e.g., Brenner, 1980). Their core argument was that a notions such as "observing ego" or indeed any suggestion that conscious, non transference based, elements of the relationship play a significant role in analysis would distract the therapist's attention from the focus of the work which is the interpretation of transference. Transference, in some form, in this perspective encompass the whole therapist-client relationship. This is where things stood until both Luborsky (1976) and Bordin (1975, 1976) each put forward proposals that the concept of the alliance could be lifted clean out of its psychodynamic theoretical framework, and introduced the idea that the alliance may be a common and ubiquitous component of all helping relationships.

It is important to consider the historical/intellectual context in which this idea of the alliance as generic therapy ingredient was put forward. It happened at a time when the research community was trying to come to terms with the "Dodo Bird Verdict," a finding primarily

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<sup>2</sup> Other analytical writers such as Ferenczi and Sullivan indicated lively interest in the issue and took a very different approach to therapist-client relationship to avoid this dilemma.

based on Smith & Glass' (1977) meta-analysis, suggesting that different "brands" of psychological treatments, based on different theoretical models, produced nearly identical benefits for the clients. The most prevalent interpretation of the "Verdict" was that there were some underlying common factors operative across different treatments, and these common ingredients were responsible for the lion's share of what makes therapy "work."<sup>3</sup> As a consequence, there was a great deal of interest in locating variables that could account for these "common ingredients."

It was in this context that Bordin and Luborsky moved the concept of the alliance to the "pan-theoretical" stage by "divorcing" the theory of the alliance from its psychodynamic roots and by dissociating the idea of the alliance from specific modes of therapy. These moves gave rise to a concept rather unique in the psychotherapy literature; one which largely relied on "commonsense" lexical understanding for its definition as opposed to most of the variables we use in psychology which are subject to "persuasive definition," a form of defining which takes the concept beyond its "customary" form (as it is usually understood in non-professional conversation) by stipulating specific use and specific delimiters of its extent unique to the way the concept is applied within the cognate area.

It is also useful to note at this juncture that our understanding of the "pan-theoretical alliance" is essentially based on only two theoretical sources: Bordin's seminal contribution was introduced in his SPR presidential address (1975) which was subsequently published in a slightly edited form in (1976). Luborsky discussed his perspective on the topic in a chapter of the book "Successful psychotherapy" in 1976. Although both of these authors (especially the former) are often referred to as having defined the "modern" concept of the alliance, I believe that

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<sup>3</sup> There were earlier proponents of the "common factor" theory (see Rosenzweig, 1936; Frank and Frank, 1991) as well as those who did not agree with this interpretation of the "Dodo Birds' pronouncements (e.g., Chambless, 2002).

these claims are based on two fundamental misunderstandings of these contributions: First, Bordin's and Luborsky's description of the alliance differ in significant aspects. Second, both of these authors' writings are somewhat ambiguous *descriptions* of the alliance as a process (i.e., how does it come about, what are its purported functions) rather than definitions of a concept (Horvath, 2009a, 2009b).

### **The search for common factors**

Spurred on by the "Dodo Bird Verdict," many of us had been working to find ways of integrating different psychotherapy models. One of the practical avenues that the psychotherapy integration movement has been pursuing works on the assumption that these common underlying change principles are already built into the various psychotherapy models, but are hidden from sight due to a kind of "Tower of Babel" (TB) effect; different therapies are talking about similar or identical principles using different language/words.

"Psychological Commons" is the label I use to identify the conceptual space we have created to accommodate these pan-theoretical or generic concepts. By fiat of reforming language, an attempt is made to reverse the TB process. Existing constructs such as transference and alliance are brought to the Commons, divested of their theory specific roots and links, and offered up for use by clinicians and researchers of "all stripes," in a kind of pared down, common sense version of the original concept. What we hoped to achieve is a focus on the core change processes without getting tangled up in the minutiae of theoretical links and hinges that cling to the concept in their "home turf." What is sacrificed at the altar of unification is precision as well as the loss of the complex set of the delimiters and qualifiers that made possible for the concept within its "home theory" to be linked as a piece in a coherent whole. At the Psychological Commons, using this process, transference can be pared down to something like "ghosts of the relationship past,"

and the notion of alliance can stand for a host of different aspects of the relationship and, indeed, sometimes for the relationship as a whole.

I do not mean to underestimate the value of searching for common language; the weeding away of some of the overblown theoretical complexities, and digging for the core transformational processes in therapy. It stands to reason, and I firmly believe it is true, that there has to be a finite number of processes that are activated in successful therapy. It is equally likely that there are no unique, non overlapping sets of change processes that are exclusive to each different kind of therapy. It seems, however, worthwhile to examine the trade-offs involved in bringing constructs developed within a theoretical model into the “Psychological Common” using a liberal or permissive language-based approach, and hoping that the construct will find its proper home among the different theoretical models that continued to exist and to which most of us seem to commit our allegiance to<sup>4</sup>.

Loosening the boundaries of a construct makes it easy to adopt and use it without challenging the fundamental assumptions underlying the differences between theories of psychotherapy. However, there is also a risk that, using this process, the construct simply becomes a synonym for something that already exist (by a different name perhaps) in the “host’s” theory, and creates a Tower of Babel problem in reverse: The discourses, originating within different theoretical circles, now use the same words, but to mean different things.

### **Will the “real” alliance please stand up?**

It appears to me very likely that we are facing such challenges in the current evolution of research on the alliance. The alliance concept,

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<sup>4</sup> I am well aware that, in recent surveys, close to the majority of clinicians seem to profess an “eclectic” stand. It seems to me that these statistics reflect on the fact that many of us are “eclectic” in the technical sense; we are prepared to borrow tools from a variety of sources. But insofar as theoretical models provide a more or less coherent organizing structure to orient ourselves when contemplating the nature of human development, aetiology of psychological problems/illness, and the sources of healing and change, I would argue that very few are “a-theoretical” in this important sense.

removed from its psychodynamic theoretical roots, migrated to the Psychological Commons, and at once became more popular and more diffuse. It is important to note that the alliance construct has generated very little theoretical discourse since Bordin and Luborsky moved the idea on to the “Commons.” Instead, various groups developed measures that empirically and practically implemented a variety of conceptualizations of the alliance. This is to say, instead of a rigorous theoretical debate within the cognate community that was to use the concept — which would have yielded not only a definition of what the alliance is, but perhaps even more importantly, what it is not, and how it fits with other existing relationship constructs — we skipped right past the conceptual purgatory and went straight to “empirical bliss.” Or so it seemed.

As of last year, over 65 different methods of assessing the alliance have been documented (Elvins & Green, 2008). It is, of course, not unusual for a psychological construct to be assessed through a variety of means; there are different points of references (client, therapy is, observers), different contexts, and different age groups to consider. However, a plurality of over 60 assessment methods in English alone, should call our attention to the fact that something out of the ordinary might be happening. I believe that these many methods of assessment represents the current state of ‘de facto’ plurality of definitions of the alliance construct. Thus these alliances are pan-theoretical — in the plural, but unique to each assessment — in singular. This does not mean that these diverse assessment methods measure entirely different underlying constructs. There is good reason to believe that the most popular measuring instruments share, to a differing degree, a common focus on collaboration (Hatcher, Barends, Hansell, & Gutfreund, 1995). However, even these “core instruments,”<sup>5</sup> include much else beside the

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<sup>5</sup> The “core instruments” include the VPPS, CALPAS, HAQ and the WAI, These assessment tools are “core” in the sense of popularity of use as reported in the literature (Horvath & Bedi, 2002).



common collaborative element. In an earlier study (Horvath, 2009c) we found that less than 50% of the variance was shared among these most commonly used measures. Additionally, there is very little data available on the discriminant validity of the available tests; we have less than adequate evidence that the measures most of us have been using to measure alliance are measuring only “the alliance” and not something else in the relationship. The situation, of course, is even worse when researchers make inferences about the alliance on the basis of process measures developed for other concepts (e.g., empathy) or use subsets of alliance measures and assume that the variance captured is attributable to the alliance (Horvath 2009a, 2009b).

### **The impact of the “status quo”**

How serious is the impact of the ambiguity and mis-measurement of the alliance concept? Let us look at the alliance rupture research literature as an example: Bordin (1994) suggested that that the management of stresses in the alliance makes an important contribution to the therapy process. A significant body of research literature has built up in examining these “rupture-repair” cycles. Within this literature one can find some exceptionally useful fine-grained analysis of psychotherapy process. However, this significant body of work is also deeply fragmented. Some researchers use methods of detecting ruptures by analyzing therapy discourse at a single utterances or thought units level. Others use the sequence of events that may range from a single therapist-client exchange to a series of dialogical sequences within a session. Yet other researchers define ruptures as fluctuations between sessions or even phases of therapy (Lingiardi & Colli, 2009; Safran, Muran, Samstag, & Stevens, 2001; Stiles, Glick, Osatuke, Hardy, Shapiro, Agnes-Davies, et al., 2004). In each case the method of assessment “stands in” or assumes the role of defining alliance rupture and, in effect, brackets the important results

of the researcher's investigation within the constraints of this implied definition. Observations and conclusions about alliance ruptures made within each of these enclosures are not easily linked or extrapolated from one to another. Each type of investigation, each approach to measuring the alliance rupture, makes an important and significant contribution, but the insights uncovered by each project are marooned in a method-determined "definition island." As a consequence, knowledge gained about "alliance ruptures" does not aggregate easily, nor do the findings become more robust through independent corroboration.

Also, within this research literature, the kind of data that is interpreted as evidence that a rupture has taken place varies significantly with the researcher's method of assessment. At one end, almost any sign of momentary tension between therapist and client is assumed to signal some kind of rupture (Safran & Muran, 2000, 2006). Near the other end of the continuum, significant fluctuation in self reported alliance *between sessions* are the criteria that trigger the presence of a rupture (Stiles et al., 2004). It is difficult to know, and yet to be documented, whether these micro-tension ruptures lead to the session level disruptions. Both kinds of investigations identify processes that have potential practical and theoretical importance. But currently they only share the same label "alliance rupture" and leave clinicians adrift in trying to appreciate what alliance rupture is about.

I used a particular line of research — rupture repair cycles — to illustrate the consequences of fragmentation, but I would argue that to a lesser or greater extent the instrument based poly-definition of the alliance has similar effect on most if not all branches of alliance research at the present.

## **Conclusions**

Making the concept of alliance available to clinicians and researchers

across the spectrum of therapeutic orientation has achieved a great deal: It has brought into focus the importance of the relationship in general, and the value of a collaborative, responsive stance on the therapist part in particular. It has provided strong empirical support to Frank's insight that therapy is a "dance," a joint accomplishment arising from a special kind of engagement between therapist and client (Frank & Frank, 1991). This, in itself, has been a remarkable achievement coming as it did in the historical time when ever greater emphasis was being laid on method and technique. Research on the alliance has also provided strong support for moving away from the "medical model" and contextualizing therapy within a broader epistemological framework (Wampold, 2001).

Research on the alliance has also contributed to our knowledge about the importance and fragility of the first few sessions of treatment. We now know with greater certainty than ever before that if clients and therapist do not agree on certain key elements of treatment, feel in accord about what is needed to accomplish, and have a solid personal relationship and respect for one another, therapy may fail.

The aim and justification of studying therapy is to gain insights which will help us provide more effective and efficacious help to our clients. These are the same goals we must keep in sight in charting the course for future directions in alliance research. In order to keep bridging the world of researchers and that of therapists, we need to move beyond documenting the relation with the outcome, and to discover and document more clearly the kind of interactive processes that most likely foster the alliance. Likewise, we need to focus on studies designed to better understand both the direct and indirect affects off maintaining or repairing the alliance, and to better understand how the alliance functions in the mid-and late phases of therapy. In order to accomplish these goals we need to overcome some

of the fragmentations in our collective efforts and reduce the “fuzziness” around the alliance concept I have described earlier.

### **How can we reach these goals?**

It appears quite unlikely that a consensually excepted, universal, definition of the alliance is likely to emerge anytime soon. It seems equally unlikely that the research community will voluntarily give up many of the 60+ assessment methods to bring the alliance research literature into greater harmony. Therefore a practical first step to move us towards a more coherent research agenda, I believe, begins with the recognition of both the similarities and the *differences* among the constructs currently labeled alliance. Such “reclassification” need not to lead toward a diminishment of the importance of the construct, nor does it necessarily limit its universality, but it would help us to identify what is a common core amongst our different ways of understanding the alliance and at the same time permit the specification of components unique to certain perspectives/measures.

The second important step, which I believe is within practical reach, is a clearer classification of the relationship constructs currently in use. We need to develop a model of the relationship components that would facilitate the linking of the many relation constructs that are used in the research and clinical literature. There is strong evidence that many of these constructs make significant contributions to the therapy process (e.g., Norcross, 2002), but we lack a coherent schema that would help us appreciate how these concepts overlap, augment, or relate to one another. In a previous paper I have suggested that classifying relational constructs along a 3 layered hierarchy (feelings, relational inferences, and relational processes) would be a positive step in this direction (Horvath, 2009c).

My third suggestion is that the research community engage in a discourse directed toward clearing up the persistent “homogeneity

myth” that suggests that the alliance is realized via the same accomplishments throughout the course of therapy. Reaching consensus with respect to the tasks and goals of treatment seems much more relevant in the opening phases of treatment than in the mature or final phase of treatment. I would predict that the re-consideration of what informs the strength of the alliance in different points of treatment would likely facilitate the identification of the kinds of processes and accomplishments that contribute to alliance enhancing process.

Last, I recommend that we moderate our perspective in our search for the “common” or universal/pan theoretical therapy ingredient. As noted before, both logic and clinical wisdom support the idea that some core change processes are shared by all helping relations. However, these core ingredients manifest themselves only in the particular context of different therapies. As Bordin already noted in 1976, different therapies will have different alliances. It seems that we have paid most attention to what we assume to be the very broadly general aspects of the alliance at the expense of explicit notice and research on the different manifestations of the alliance in diverse kinds of treatments and at different stages of work. Universally common factors “live” at high level of abstraction (as opposed to particular manifestations). As therapy process constructs they are conceptually more akin to “change principles” than to concrete independent variables. Clear acknowledgement of both the “universality” and “manifest specificity” of alliance would likely help us more clearly define what it is and help to generate a research agenda that focuses on “alliance-in-context” that might better bridge the research/practice divide.

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