Abstract

Twenty one patients diagnosed with Cluster C, Personality Disorders were randomly assigned to Brief Relational Therapy (BRT) and their reflective functioning, in regards to the therapeutic relationship, was assessed with the Patient Relationship Interview, at termination, (PRI-T) and rated with the Reflective Functioning (RF) coding scale. The patients’ capacity for reflective functioning was assessed at termination as an outcome of a secure attachment relationship, an early alliance, and meaningful intersubjective negotiation with the therapist after 30 sessions of Brief Relational Therapy (BRT). Reflective functioning was also assessed in relation to symptomatic and interpersonal change at termination and follow-up of treatment. There was not a significant association between an early working alliance and RF at termination. There was a significant relationship between patient’s ratings of meaningful intersubjective negotiation in the last third of treatment, and RF at termination suggesting important internal change occurs with termination approaching. There was not a significant relationship between RF and symptomatic and interpersonal change, at termination or follow-up of treatment, yet there was an association approaching significance between reflective functioning and decreased symptoms at follow-up. Results suggest the need for research to focus more on the relationship between reflective functioning and intersubjective negotiation, as well as the unique internal changes that occur both at termination and follow-up of treatment.
Keeping a Mind in Mind:
The Role of Reflective Functioning
in the Process and Outcome of
Brief Relational Treatment

by

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Dedication

This dissertation is dedicated to the man who has supported me throughout the long and challenging process of graduate school and creating this piece of work. My confidante, my editor, my love, my husband soon-to-be, Michael this is for you.
Acknowledgements

I want to thank Jeremy Safran and Chris Muran for helping me grow as a researcher, clinician, and person over the past 7 years. You have both been wonderful mentors and have given me invaluable opportunities from the very beginning. I will be forever grateful for your support, understanding, and mentorship throughout this process. I want to thank Jeremy whose fostering of creativity and integration allowed for me to develop this idea and pursue it. I want to thank Chris for helping from the very beginning as a developing leader and curious researcher. I also want to thank Howard Steele who trained me in this innovative scale, and whose guidance and support were invaluable to me in reaching the finish line of this project.

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Finally, I want to thank my parents and sister for their unconditional love and steadfast support throughout this long road of graduate school. I would not have been able to get through this process without all of you.
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Part One: Experimental Study

With psychotherapy research increasingly showing that the quality of the therapeutic relationship or alliance is the strongest predictor of good outcome (Horvath & Symonds, 1991), many from the psychodynamic approach (Blatt & Auerbach, 2003; Shedler, 2010) are advocating for measures of therapeutic process and outcome that more fully tap into the rich internal experience of the patient over the course of treatment, and subsequent changes in patients’ abilities to negotiate interpersonal relationships. In turn, many (Holmes, 2010; Levy et al., 2006) have come to use the mother-infant attachment paradigm as a unique lens through which to study the therapist-patient relationship. Researchers are increasingly using a measure that assesses the quality of adult’s attachment to their parents, the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984, 1985, 1996) rated in terms of reflective functioning (RF; Fonagy, Target, Steele, & Steele, 1998), the ability to reflect on mental states in self and others, to examine therapeutic change in terms of shifts in patients’ internal representational worlds. Diana Diamond and her colleagues (1999; 2003) have developed the Patient Therapist Adult Attachment Interview (PT-AAI), which parallels the AAI and is rated on reflective functioning, to assess the quality of patient’s attachment to their therapist.

Diamond and her colleagues’ research (2003) has explored how patients’ attachment status and ability to reflect upon their attachment relationship with their therapist, on the PT-AAI, can function as a vehicle of therapeutic change for patients with Borderline Personality Disorder. Yet few studies have been conducted in this area with other personality disorders or in the context of short-term, relational treatment.
In line with this research, this study aims to examine patients’ Reflective Functioning (RF) when speaking about their therapist, on the Patient Relationship Interview at termination (PRI-T), an attachment-based interview adapted from the PT-AAI, as a way of assessing the quality of the patient’s attachment to their therapist. Consistent with research showing the strong association between attachment security and RF (Steele & Steele, 2008), this study hypothesizes that RF should strengthen over the course of treatment through the therapist functioning as a secure attachment figure for the patient. Further, an early strong therapeutic alliance and the therapist’s explicit focus on the negotiation of the therapeutic relationship, especially during moments of tension, should enhance the patient’s RF at termination. In addition, this study aims to explore whether patients’ reflective functioning at termination of short-term, Brief Relational Therapy (BRT) is associated with good outcome in terms of interpersonal and symptomatic change, at termination and at follow-up of treatment, in patients with Cluster C, personality disorders.

The Therapeutic Alliance

The concept of the therapeutic alliance has its origins in the psychoanalytic literature starting with Sigmund Freud (Freud, 1912, 1913; 1937) who emphasized the collaborative nature of the work, yet still viewed transference analysis and increased insight as most central to change. In contrast, theorists (Ferenczi, 1932; Greenson, 1967) increasingly emphasized the “real” experience of patients in psychoanalysis, and argued
that patients should actually re-experience their early conflicts in the present relationship
with the therapist.

Elizabeth Zetzel (1956; 1966) first articulated the terms “therapeutic alliance” and
“working alliance,” and proposed that the patient’s difficulty in developing trusting
relationships was rooted in earlier developmental failures, which could be repaired
through the real relationship with the therapist. Increased focus on the real aspects of the
therapeutic relationship rather than the transference aspects shifted the focus to the real
relationship with caregivers in childhood, and the ability to repair early developmental
difficulties through the therapeutic relationship.

In reaction to Melanie Klein’s object relations theory (1957) that emphasized the
infant’s primitive impulses and therapy’s need to analyze the adult’s early primitive
internal worlds, the British Object Relations School emerged. They (Fairbairn, 1952;
Winnicott, 1965) focused on infants', reality-based interactions with mothers as central to
the development of psychological health, and how these interactions become internalized
over time. They emphasized how, for those with unfavorable childhoods, therapy could
provide a safe, “holding environment” (Winnicott, 1965) in which patients could resolve
early developmental failures through the therapeutic relationship.

Within the Independent Group that formed, John Bowlby’s (1973) variant on
object relations theory, attachment theory, asserted that the child’s reality-based
interactions and attachment to the mother, and the emotional security that emerged was
central to later psychological health. Bowlby argued that children needed to be able to
turn to caregivers in times of distress, and be provided with the comfort of a “safe
haven,” and a “secure base” from which to safely explore. Caregivers’ real responses and interactions over time become internalized into mental schemata, internal working models (Bowlby, 1982), which come to characterize expectations for relatedness between self and others. Notably, he argued that maladaptive internal working models could be modified through other ongoing relationships such as with the therapist who could provide a “secure base” from which to explore feelings, and in which to work through unresolved conflicts associated with separation and loss.

Although many theorists wrote about the alliance, it was not until the 1970’s that researchers began to give notice to the therapeutic alliance. This focus was largely due to Edward Bordin’s (1979) reconceptualization of the therapeutic alliance. His model viewed a strong therapeutic alliance as central to the effectiveness of any kind of therapy. He operationalized the therapeutic alliance into several interrelated parts: the task, the goals, and the bond, and argued that the strength of the alliance was dependent upon agreement of these parts by both parties. These three dimensions influence each other in an ongoing and dynamic fashion as well as mediating each other. Further, Safran and Muran (2000) have built upon Bordin’s conceptualization by arguing that it is the ongoing negotiation between the patient and therapist over many of these components that is central to therapeutic change.

Safran and Muran’s conceptualization of the alliance (2000) comes out of the emergence of a more relational form of psychoanalysis in the past couple of decades (Mitchell & Aron, 1999), which has moved the therapeutic relationship into the forefront as the central driving force of treatment. Relational forms of psychotherapy promote the
use of transference and counter-transference as tools (Aron, 1999) to aid patients in acquiring a better understanding of their maladaptive relational schemas (Safran, 1998), which then can be modified.

**Reflective Functioning and Attachment as Qualities of the Therapeutic Relationship**

John Bowlby’s theory of secure attachment within mother-infant interactions promoting mental health and leading to internal representations, would be explored further through the research of Mary Ainsworth and her colleagues (Ainsworth, Blehar, Waters, & Wall, 1978), who found that the quality of nonverbal communication between mother and infant determined the infant’s attachment security and expectations of the mother’s availability. Building on this research, Mary Main (1985; 1991) designed the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985), which assesses the quality of adults’ attachment relationships to early caregivers. They found that securely attached adults had an internalized representation of a consistently responsive caregiver which led to an ability for “metacognitive monitoring” (Main, 1991), whereby they could be monitoring and reflecting upon their thoughts as they were speaking.

Inspired by Main’s (1991) notion of metacognitive monitoring, Fonagy and his colleagues (1991; 1998) elaborated upon this concept and named this capacity “reflective functioning” (RF). RF is the capacity to think about and understand behavior in one’s self and other’s in terms of intentional mental states – feelings, beliefs and desires. RF is a developmental achievement originating from the attachment relationship between infant and caregiver, and is specific to the unique relationship from which it develops. The
development of RF emerges from the caregiver’s ability to accurately and consistently perceive the mental states of the infant, respond in an attuned manner, and in turn, validate the intentionality driving the infant’s behavior. Through this process, the caregiver shows the infant that they are perceived as an intentional other with a mind of their own, which fosters the infant’s capacity to safely reflect upon his own and other’s minds.

Fonagy and his colleagues (1998) have operationalized this capacity by creating the RF scale in order to assess the quality of mentalization in the context of attachment relationships. Their extensive empirical work (1991; 1995) has shown that a parent’s RF is crucial to promoting security in their child, and can help explain the intergenerational transmission of attachment. Notably, reflective functioning has been shown to be the most widely recognized correlate of infant-parent attachment (Steele & Steele, 2008). Fonagy, Steele and Steele (1991) assessed the Adult Attachment Interviews of 100 expectant couples and found that there was an astounding association between mother’s and father’s RF on the AAI, and the quality of infant-mother attachment ($r = .58$) and infant-father attachment ($r = .64$). In addition, the mother’s RF rating most significantly predicted infant-mother attachment security (Steele & Steele, 2008). Notably, mothers classified as insecure on the AAI were more likely to have securely attached infants when their RF was high (Fonagy, Steele, Steele, Moran et al., 1991), which highlights how the capacity to reflect on mental states related to attachment “serves a protective, resilience-enhancing function” (Fonagy et al., 1995; p.255), which can buffer the impact of early adversity. Similarly, Arietta Slade and her colleagues (2005) have shown that mothers
who show high reflective functioning when discussing their relationships with their infants on the Parent Development Interview (PDI; Aber, Slade, Berger, Bresgi, & Kaplan, 1985) were more likely to have securely attached infants.

With this research in mind, many theorists and researchers (Holmes, 2010; Slade, 1999; Steele & Steele, 2008; Wallin, 2009) have argued that the therapist can function as an important attachment figure to whom the patient can develop a secure attachment bond and increased reflective functioning. The therapeutic relationship is “uniquely suited to evoke and illuminate the patient’s working models of attachment” (Diamond et al., 2003, p.128) by providing new internalized objects (Loewald, 1960) and altering old internal working models (Bowlby, 1973), in which early, maladaptive expectations can be disconfirmed and modified.

In line with research showing that caregivers’ strong reflective functioning is highly associated with security in their infants, it would make sense that the therapist’s enhancement of reflective functioning in the patient would promote attachment security. The therapist’s ability to accurately perceive the patient’s maladaptive behavior and reflect upon the mental states and intentions driving these acts, helps “put into words” (Holmes, 2010) what is being unconsciously enacted in the therapeutic relationship. This inherently fosters RF by helping the patient “evaluate oneself and one’s feelings from the outside and those of others [the therapist] from the inside” (Holmes, 2010, p.14). Further, “mentalization” or reflective function, whereby the other is kept in mind, is a crucial therapeutic skill in which the therapist reflects upon the patient as having a separate self and mind motivated by subjective thoughts and feelings (Holmes, 2010).
Jeremy Holmes (2003; 2010) argues that the therapist can function as a safe haven to which the patient can turn to for comfort in times of distress, and a secure base from which thoughts and feelings can be explored. He emphasizes the importance of therapists establishing an early alliance with patients from which a secure attachment relationship can develop, and attachment to the therapist has been shown to be positively associated with the alliance (Parish & Eagle, 2003). Thus it would make sense that a strong early alliance could foster attachment security to the therapist and stronger RF in the patient at termination.

Psychotherapy researchers have also become interested in whether the quality of attachment and RF of the patient when speaking about the therapist could be a driving force of therapeutic change whereby the therapist is internalized as a new, secure object. Similar to studies assessing adult attachment through the use of Adult Attachment Interviews (AAI) rated on the RF Scale, Diamond and her colleagues developed the Patient Therapist Adult Attachment Interview (PT-AAI; Diamond et al., 1999), adapted from the AAI and rated on RF, which assesses the quality of patients’ attachment relationship to their therapist.

Diamond and her colleagues (2003) used the AAI and PT-AAI rated with the RF Scale with 10 patients with Borderline Personality Disorder treated in year-long, Transference Focused Therapy (TFP), which focuses explicitly on transference and countertransference dynamics. They administered the AAI at 4 months and 1 year, and the PT-AAI at 1 year. Results showed that patients’ moved from insecurely to securely attached with strengthened RF on the AAI after 1 year. Notably, after 1 year, patients’
security status and RF with their parents on the AAI often overlapped with their security status and RF with their therapists on the PT-AAI. They concluded that the patient’s RF on the PT-AAI assesses transference and countertransference aspects of the therapeutic relationship, and suggested that internal working models are being activated and modified through the therapeutic relationship. Shifts to greater security and stronger RF, after one year, were associated with decreased suicidal acts. It is important to note that this study uses few self-report measures to assess the relationship between the patient’s RF and outcome, and the sample is small.

Use of the PT-AAI is difficult to use in research as it is challenging to give to patients prior to or early in treatment, which means that there is no baseline score with which to compare to later scores (Levy et al., 2010). Yet do patient’s RF ratings on the PT-AAI, when speaking about their therapist at termination, relate to therapeutic process in terms of an established alliance and the working through of ruptures? Does increasing security and RF in the context of the therapeutic relationship lead to symptomatic and interpersonal change at outcome in patients with Cluster C, Personality Disorders? This study seeks to explore and answer these questions.

**The Therapeutic Relationship, Brief Relational Therapy, and Ruptures**

The building and negotiating of the therapeutic relationship appears to be essential for the success of treatment (Safran, Muran, Samstag & Stevens, 2002). Safran and Muran (2000) argue that the alliance is an “ongoing process of intersubjective negotiation” (p.218) between the needs of both participants, which becomes most salient
during rupture moments, breakdowns in the collaborative process between the dyad. One could broaden this notion, as will be done in this study, and argue that the negotiation of shifts in the alliance is always implicitly occurring and that the continual working through of these strains is pivotal in the process of therapeutic change.

Safran and Muran (2000) assert that patients come into therapy with “relational” or “interpersonal” schemas, akin to internal working models (Bowlby, 1973), which are based on early and adaptive methods for finding relatedness, but now have become maladaptive in adulthood. They posit that these expectations are enacted in the therapeutic relationship, and thus the goal for the therapist is to attend to the patient’s maladaptive way of interacting, and disconfirm the expectations underlying their behavior.

At the Brief Psychotherapy Research Program at Beth Israel Medical Center, Safran and Muran (2000) have designed a relationally and experientially informed, 30 session treatment, Brief Relational Therapy (BRT). BRT focuses on interpersonal process and ways of repairing strains in the therapeutic relationship. In addressing ruptures, they advocate for the therapist to focus explicitly on the interaction, and disembed from this negative process through therapeutic metacommunication, which is an “attempt to step outside of the relational cycle that is currently being enacted by treating it as the focus of collaborative exploration” (Safran & Muran, 2000, p.108). Safran & Muran (2000) emphasize the therapist’s need to explore the patient’s experience, as well as self-disclose about their own experience. These moments require the therapist to reflect upon his own mind, keep the patient in mind, and speak about what is occurring in the moment between
both minds so that both participants can make sense of what is being enacted. This process of working through tensions inherently requires discussion of how each member’s mental states underlie their behavior and drive their reactions to each other, which should foster reflective functioning.

The exploration and negotiation of ruptures can provide the patient with a “corrective emotional experience” (Alexander & French, 1946) that can disconfirm and modify maladaptive interpersonal schemas or internal working models as these impasses “often. . . parallel the patient’s characteristic patterns, and it is the process of working one’s way out of this embeddedness that restructures the patient’s relational schemas” (Safran & Muran, 2000, p.90). This process could foster the patient to internalize a relational schema of self with therapist whereby the other is a responsive and available, a secure base, from which conflict can be worked through, and in which the self is capable of negotiating relatedness without having to disown a part of him or herself (Safran, 1998).

In addition, BRT’s time-limited nature of 30 sessions and the explicit discussion of termination is a unique opportunity to help patients work through unresolved issues regarding loss and separation (Bowlby, 1973) in the context of the therapeutic relationship.

In order to tap into the patient’s experience amidst rupture moments, Safran, Muran, & Winkleman (1998; 2006) developed a self-report measure, the Rupture Resolution Questionnaire (RRQ), which is conceptualized as a measure of the alliance as negotiation. The measure focuses on hypothesized “experiences associated and resulting
from the constructive negotiation of conflict between them” (Safran, Muran, & Proskurov, 2009, p.218). Items tap into ways in which the working through of tension has 1) led to a kind of resolution (“My therapist and I were able to work through a conflict and connect in a stronger way”), has helped the patient 2) feel stronger relatedness with the therapist (“I felt a closer connection with my therapist”), 3) become in touch with disconnected feelings or thoughts towards one’s self or others (“I became aware of ways in which I avoid creating conflicts and misunderstandings with my therapist”), 4) recognize the therapist’s subjectivity and separate mind (“I recognized and accepted my therapist’s limitations”), and 5) realize how one’s own behaviors drive responses in others (“I saw that I was doing something to distance myself from my therapist or push him/her away”). Identification with many of these items is likely to be the result of powerful intersubjective negotiation, which should foster patients’ reflective functioning.

The RRQ is positively related to patient and therapist ratings of session helpfulness, depth of therapeutic exploration, and strength of the alliance as measured by the working alliance inventory (Proskurov et al., 2006). Further, the RRQ has been shown to make a significant contribution above and beyond the working alliance inventory (WAI) in predicting improvement in the patient’s interpersonal and global functioning (Safran, Muran, & Proskurov, 2009). These findings highlight how the patient’s meaningful experience of intersubjective negotiation, as reported on the RRQ, can foster a stronger capacity in the patient to navigate interpersonal problems and relationships. Thus the patient’s ratings on the RRQ will be used in this study as a measure of intersubjective negotiation, throughout treatment, which is hypothesized to
strengthen the patient’s RF over the initial (sessions 1-10), mid-phase (sessions 11-20), and termination (sessions 21-30) stages of treatment, and be seen in the patient’s RF when speaking about the therapist at termination.

**Reflective Functioning and Outcome**

There is an increasing body of research showing the strong relationship between psychopathology and deficits in reflective functioning in individuals with Borderline Personality Disorder (Fonagy et al., 1996; Levy et al., 2006), Antisocial Personality Disorder (Bateman & Fonagy, 2004), and depression (Ivarsson, Broberg, & Gillberg, 1998). Further, Fonagy and his colleagues (1996) found that among patients reporting abuse, those who scored low on RF were more likely to be diagnosed with Borderline Personality Disorder compared with those who were abused but scored high on RF. In addition, treatments designed to foster RF in personality disordered patients, such as Transference Focused Therapy (Levy et al., 2006) and Mentalization Based Treatment (Bateman & Fonagy, 2004), have shown that increases in reflective capacities are associated with significant decreases in symptomatology and psychopathology (Bateman & Fonagy, 2004; Clarkin et al., 2001; Levy et al., 2006). Thus it would seem that RF should be used as an outcome measure in assessing attachment and rich internal representational change in conjunction with more conventional, self-report outcome measures. In addition, this study will use available follow-up data (between termination and follow-up) to try to assess the kinds of changes that continue following termination.
Overall, this study hypothesizes that improvements over the course of treatment and between termination and follow-up in symptomatology and interpersonal problems, should be associated with strong RF. This hypothesis is based on the theory that the therapist becomes an attachment figure who helps the patient learn to better reflect upon their behaviors as driven by thoughts and intentions, regulate their affect through being soothed from a safe haven, and learn to more adaptively negotiate interpersonal difficulties through greater interpersonal awareness and meaningful experiences.

**Methods**

**Design**

This study was conducted at the Brief Psychotherapy Research Program at Beth Israel Medical Center in New York City. Since the 1980’s, the program has been studying the therapeutic relationship in psychotherapy process and outcome within short-term (30 session) treatment of adults with personality disorders. Research focuses primarily on examining the therapeutic relationship and specifically the study of therapeutic alliance ruptures and their resolution through a short-term, manualized, relational treatment (Brief Relational Therapy; BRT; Safran & Muran, 2000).

Patients were recruited through advertisements in local papers such as Metro, AM, and the Village Voice as well as through referrals made by hospital staff. The criteria for participation in the study includes: (1) adults between the ages of 18 and 65, (2) no evidence of mental retardation, organic brain syndrome or psychosis, (3) no evidence of DSM-IV diagnoses of paranoid, schizoid, schizotypal, narcissistic, or
borderline personality disorders, (4) no evidence of current or recent substance abuse or
dependence, (5) no history of impulse control problems, (6) no evidence of current active
or recent suicidal behavior, (7) no use of anti-psychotic, anti-convulsant, or anti-
depressant medications within the past 3 months, (8) evidence of at least one close
relationship, (9) no concurrent psychotherapy treatment.

Patients who participated in the program were given an initial phone screening,
and, if eligible, were asked to come in and sign an informed consent to the research
protocol (See Appendix A). Patients were then assessed using the Structured Clinical
Interview for DSM-IV (SCID I and II; Spitzer, Williams, & Gibbon, 1987, 1994) to
identify diagnoses on DSM-IV Axes I and II. The SCID I and SCID II were administered
as part of the intake process by clinical psychology graduate students who had undergone
extensive training with the instruments. The graduate students were observed and
supervised by skilled diagnosticians.

Patients who were accepted into the program then participated in 30 session,
weekly Brief Relational Therapy treatment. Throughout treatment, patients completed
self-report measures at intake, mid-phase, termination and follow-up. After completing
treatment, patients were contacted and asked to come in for a semi-structured interview,
the Patient-Therapist Relationship Interview (PRI-T adapted from PT-AAI; Diamond et
al., 2003) that assesses their relationship with their therapist. Clinical psychology
graduate students administered these interviews to participants.
Participants

The participants in this study were 21 patients who completed thirty-session, Brief Relational Therapy at the Brief Psychotherapy Research Program at Beth Israel Medical Center in New York City. All patients lived within the New York Metropolitan area. The patients included 14 women and 7 men (N=21), ranging in age from 28 years to 56 (M=40.67, SD=9.7). In terms of marital status, 60% were single and never married, 25% married or remarried, and 15% divorced or separated. Forty-five percent had graduate degrees, 50% were college graduates, and 5% had some college. Ninety-nine percent were employed. Eighty percent were Caucasian, 15% Hispanic, and 5% African American. On Axis I, 38% met criteria for a primary diagnosis of mood disorder, 19% with anxiety disorders, 4% with an adjustment disorder, 19% with v-codes, and 9% without a diagnosis on Axis I. On Axis II, 43% were diagnosed with a Cluster C, Personality Disorder, 52% with Personality Disorder Not Otherwise Specified, and 5% with no diagnosis on Axis II.

Therapists

Therapists were recruited from the Department of Psychiatry at Beth Israel Medical Center. The therapists participated in didactic seminars and received weekly group supervision for BRT by licensed psychologists. Eighty-six percent of therapists had an MA degree, 5% had a PhD or PsyD, and 9% had an MD. Seventy-one percent of therapists were female and 29% were male. Ages ranged from 25 to 41 (M = 32, SD = 4.2). Eighty-one percent were Caucasian, 9% Asian or Pacific Islander, 5% Black, and
5% other. Sixty-two percent of therapists were single and never married, 33% were married or remarried, and 5% were divorced or separated.

**Treatment**

All patients included in this study were randomly assigned to Brief Relational Therapy (BRT; Safran & Muran, 2000). BRT is a set of therapeutic principles and techniques specifically designed to negotiate the therapeutic relationship and ruptures in the alliance. This model is grounded in relational psychoanalytic principles while also integrating principles from humanistic and experiential approaches. In the treatment, continual, moment to moment exploration into interactions and strains in the relationship function to disconfirm the patient’s maladaptive interpersonal schemas and provide corrective emotional experiences (Safran & Muran, 2000).

**Case Selection**

Cases were chosen on the basis of certain criteria. All patients had to have completed 30 sessions of Brief Relational Therapy, completed all self-report data, and been administered the Patient Therapist Relationship Interview (PRI-T) at termination.
Measures

Diagnostic Instruments

Structured Clinical Interview for DSM-IV for Axis I and Axis II (SCID I & II, Gibbon, Spitzer, & Williams, 1997). The SCID I and II are structured clinical interviews used for making DSM-IV Axis I and II diagnoses in patients older than 18 years.

Assessment of Attachment

Patient Relationship Interview at Termination (PRI-T adapted from Pt-AAI; Diamond, Clarkin, Levine, & Levy, 1999)(See Appendix B) The PRI-T is a semi-structured, attachment interview that was adapted from the Patient-Therapist Adult Attachment Interview. The PRI-T is designed to elicit information from participants regarding their feelings, thoughts, and memories about their attachment experiences with their therapist, and to examine the patient’s internal working model with regard to the therapeutic relationship. The format and structure of the PRI-T parallels the Adult Attachment Interview developed by George, Kaplan and Main (AAI; 1985) which was designed to elicit information from adults regarding their early attachment relationships. The PRI-T, like the AAI, asks patients to describe their relationship with their therapist, to give five adjectives that illustrate that relationship, and then to provide episodic memories to support these adjectives. Further, the PRI-T also asks patients questions about separation, loss, rejection, and the effects of the therapeutic experience upon their personality. In addition, the PRI-T asks about ruptures in the relationship and how they were addressed or resolved. PRI-T interviews were videotaped and then transcribed. Verbatim transcripts were used for coding verbalizations in this study.
Reflective Functioning Scale (RF; Fonagy, Steele, Steele, & Target, 1998) (See Appendix C). The RF scale was originally developed at the London Parent-Child Project for the purpose of coding Adult Attachment Interviews (AAIs) (Fonagy, Moran, Steele, Steele, & Higgitt, 1991; Fonagy, Steele & Steele, 1991a) and providing a model of intergenerational transmission of attachment. The RF scale assesses the quality of mentalization of an individual when speaking about attachment relationships, and ranges from negative one (-1, interviews which are devoid of mentalization) to nine (9, interviews which are exceptionally sophisticated in their reflective stance). Coders rate statements which demonstrate the presence or absence of a reflective stance in relation to self and other. Raters use the frequency, clarity, and quality of a subject’s response, over the course of the interview, to score the subject on the scale. Descriptions of the quality of reflection and narrative examples are given in the RF Manual to demonstrate the designation of points 1, 3, 5, 7, 9. The RF scale has strong interrater reliability (r = .91; Fonagy et al., 1996) and has been validated in numerous studies (Fonagy et al., 1998).

Procedure for Observer Rated Coding

The PRI-T interviews were videotaped, transcribed, and then coded using the RF scale. There were 6 coders who were all graduate students (M.A. level) including the Principal Investigator. All raters were trained for 5 months by Howard Steele, Ph.D., one of the creators of the scale and training manual. After coders achieved strong reliability (ICC = .82) with the creator of the scale, an additional 6 months of training was conducted by the Principal Investigator before coding for this study began. Interrater
reliability was strong (ICC = .89). All coders were familiar with the structure of the PRI-T interviews before coding began. Coders were blind to the modality of treatment and any identifying information of the patient. In making coding decisions, raters were trained to rate all the subject’s responses given to questions that explicitly demanded reflection (i.e., Why do you think your therapist behaved that way?”). Coders could also rate responses to permit questions if a reflective passage was given. Coders were trained to identify and code statements that were 1) explicit in attachment related narratives, 2) relevant to the question asked by the interviewer, and 3) specific to mental states. Raters were then required to give an overall score for each subject in regards to their reflective capacities illustrated through their narratives about the therapist and therapeutic relationship.

**Process Measures**

Both patient and therapist complete process measures after each session by filling out the *Post Session Questionnaire* (PSQ; Muran, Safran, Samstag, & Winston, 2002) (See Appendix D). The patient and therapist fill out the PSQ independently of each other and throughout the treatment they remained blind to how the other completed his or her PSQ. This self-report measure consists of several scales that assess the effect and impact of the therapeutic relationship upon the individual. The *Working Alliance Inventory* and the *Rupture Resolution Questionnaire* will be the two scales (on the PSQ) that are used in this study. Only the patients’ PSQs will be used in this study so as to assess processes of change from the patient’s perspective.
Working Alliance Inventory (WAI; Horvath & Rosenberg, 1986; Horvath & Greenberg, 1986; Tracey & Kokotovic, 1989) (Appendix D, Section C) is a well-established self-report measure of the therapeutic alliance between patient and therapist. It was derived from Bordin’s transtheoretical model and is comprised of three subscales measuring bond, agreement on tasks, and agreement on goals. This study used a 12-item version of the WAI and used the overall mean score. The 12 items are rated on a seven-point likert scale from 1 (“never”) to 7 (“always”) in response to statements such as “My therapist and I respect each other.” Both patient and therapist-rated versions have demonstrated high internal consistency (> .85) and robust predictive validity (Horvath & Symonds, 1991). For this study, the overall mean score of the first six sessions of treatment, as rated by the patient, will be used to examine the early alliance.

Rupture Resolution Questionnaire (RRQ; Winkleman, Safran, & Muran, 1996) (Appendix D, Section E) is an 18-item, self-report measure designed to identify the presence of experiences hypothesized to be associated with the process of alliance rupture resolution. This measure has a five-point likert rating scale from 1 (“not at all”) to 5 (“definitely”) in response to statements that are associated with different kinds of resolutions to strains such as “I felt able to disagree with my therapist” or “I felt a closer connection to my therapist.” This study used the means of each third of treatment (intake, mid-phase, termination). Means of intake (sessions 1-10), mid-phase (sessions 11-20) and termination (sessions 21-30) will be used in line with other studies (Bernbach et al., 2001), which have looked at unique stages of treatment. The RRQ has been shown to
measure a unitary construct of the alliance as negotiation and has a reliable internal consistency (Cronbach’s Alpha = .8) (Proskurov et al., 2006).

**Outcome Assessment Measures**

Both patient and therapist have to complete overall outcome assessments at intake, mid-phase, termination, and, for patients, at follow-up. Patient outcome measures include the Target Complaints Questionnaire, The Symptoms Checklist-90 Revised, and The Inventory of Interpersonal Problems. The therapist questionnaires consist of blind ratings of patients’ Target Complaints and the Global Assessment Scale at intake and termination.

The *Target Complaints Questionnaire* (TC; Battle et al., 1996) (See Appendix E) is a self-report measure developed to assess three presenting complaints of patients at intake, mid-phase, termination, and follow-up of treatment. Patients and therapists rate these complaints on a likert scale of 1 (“not at all”) to 13 (“could not be worse”). Patient’s overall mean ratings at intake, termination and follow-up will be used and therapist’s overall mean ratings at intake and termination will be used to assess change.

The *Symptom Checklist-90 Revised* (SCL-90; Derogatis, 1983) (See Appendix F) is a widely used measure of symptomatology among adult psychiatric and medical patients. It is a 90-item, self-report measure designed to assess general psychiatric symptomatology. Patients are asked to rate the extent to which symptoms have been experienced over the past week and they include questions about feeling annoyed, tense, or having trouble sleeping. Items are rated on a 5-point likert scale ranging from 0 (“not
at all”) to 5 (“extremely”). Derogatis (1983) reported strong test-retest reliability coefficients ranging from .78 to .90 and internal consistency coefficients ranging from .80 to .90. The overall mean scores computed form the SCL-90 will be used as a measure of general psychopathology in this study. Patient’s ratings on this scale at intake, termination and follow-up will be used.

The Global Assessment Scale (GAS; Endicott et al., 1976) (See Appendix G) is a clinician-rated scale for evaluating the overall mental health and adaptive functioning of a patient. Therapists provide a single rating on a continuum from 1 (hypothetically most symptomatic/poorly functioning) to 100 (hypothetically least symptomatic/highly functioning). Adequate psychometric properties have been reported for this instrument. This study will use the therapist’s overall rating for the patient at intake and termination.

The Inventory of Interpersonal Problems (IIP-64; Alden, Wiggins, & Pincus, 1990) (See Appendix H) is a revised version of the scale developed by Horowitz, Rosenberg, Baer, Ureno, & Villasenor (1988). The IIP-64 is a widely used, 64-item self-report measure designed to assess the severity and type of distress that develops in interpersonal situations. Patients are asked to rate items which begin with, for example, “It is hard for me to…” on a five point scale ranging from 0 (“not at all”) to 4 (“extremely”). An example of an item is “I argue with people too much.” The authors report high internal consistency and test-retest reliability coefficients. The patient’s ratings on this self-report at intake, termination, and follow-up will be used.

The Social Desirability Scale adapted from the Marlowe-Crowne Social Desirability Scale (MCSD; Crowne & Marlowe, 1964) (See Appendix I) is a 10 point,
likert-rated, self-report scale for measuring an individual’s desire to present themselves in a socially appropriate way. Patients provide a single rating on a 10 point likert scale from 1 (“never”) to 10 (“always”). The overall mean will be taken at termination in order to control for the possibility of the patient idealizing the therapist or the therapeutic relationship at termination of treatment.

Results

In this study, 21 patients’ capacity for reflective functioning (RF) was measured at termination on the Patient Relationship Interview (PRI-T) with patients who had completed 30 sessions of Brief Relational Therapy (BRT). The threefold aim of this study was to examine: 1) reflective functioning as a quality of a secure attachment relationship to the therapist, 2) the relationship between reflective functioning, the development of the alliance, and the negotiation of ruptures, and 3) the relationship between reflective functioning and therapeutic outcome at termination and at follow-up.

Reflective Functioning Scores

The overall RF mean ($M = 4.2, SD = 1.7$) was consistent with past studies, which assessed the RF of personality-disordered populations (Fonagy et al., 1996; Levy et al., 2006). The data was normally distributed with skewness ($S = .16, SE = .50$) and kurtosis ($K = -.82, SE = .97$) within normal limits. The range of RF scores ($R = 1-6.75$) was wider than in prior studies (Diamond et al., 2003) from questionable RF (1) to approaching marked RF (6.75).
Patient’s Demographic Variables and Reflective Functioning

A Pearson’s $r$ correlation coefficient was conducted between patients’ age and RF and no significant relationship was found ($r = 0.24, p = 0.28$). An independent ANOVA was also conducted and showed no significant relationship between patient’s RF and marital status, race, employment status or education level. Yet there was a significant relationship between patient’s RF and gender, $F(1,19) = 16.49, p = 0.001$) with males ($M = 5.77$) having significantly higher RF ratings over females ($M = 3.41$).

Process Measures

Table 1

<table>
<thead>
<tr>
<th>Table 1 Means, Standard Deviations, Skewness and Kurtosis for Process Measures</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Rupture Resolution Questionnaire (Sessions 1-10)</td>
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<tr>
<td>Rupture Resolution Questionnaire (Sessions 11-20)</td>
</tr>
<tr>
<td>Rupture Resolution Questionnaire (sessions 21-30)</td>
</tr>
<tr>
<td>Working Alliance Inventory (Sessions 1-6)</td>
</tr>
</tbody>
</table>

Table 1 shows descriptive statistics for the Rupture Resolution Questionnaire and Working Alliance Inventory. Skewness and kurtosis are within appropriate ranges and thus both scales are normally distributed. As stated earlier, the Rupture Resolution Questionnaire was broken down into thirds of treatment and means were calculated for the early, mid-phase, and approaching termination treatment phases. The overall mean of the working alliance inventory for sessions 1-6 was also calculated in order to assess the early alliance.
### Reflective Functioning and Process Measures

Table 2

**Correlational Analyses for Reflective Functioning and Process Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working Alliance Inventory (Mean of Sessions 1-6)</td>
<td>21</td>
<td>.15</td>
<td>.51</td>
</tr>
<tr>
<td>Rupture Resolution Questionnaire (Mean of Sessions 1-10)</td>
<td>19</td>
<td>.18</td>
<td>.46</td>
</tr>
<tr>
<td>Rupture Resolution Questionnaire (Mean of Sessions 11-20)</td>
<td>19</td>
<td>.30</td>
<td>.21</td>
</tr>
<tr>
<td>Rupture Resolution Questionnaire (Mean of Sessions 21-30)</td>
<td>19</td>
<td>.47</td>
<td>.04*</td>
</tr>
</tbody>
</table>

* p < 0.05

Table 2 shows the correlational analyses conducted between the patient’s RF score at termination and process measures. First the mean of the WAI of the first six sessions was calculated. A Pearson r correlation coefficient was then computed to assess whether an early working alliance could potentially foster attachment security, which would then be seen in high RF in the patient at termination. There was not a significant association between RF at termination and an early working alliance.

Further analyses were conducted to test the hypothesis that those patients who reported more meaningful experiences of intersubjective negotiation with their therapists, as assessed on the patient’s RRQ ratings, would show higher RF at termination as the working through of ruptures should theoretically foster RF. Treatment was broken down into thirds and means were calculated for the initial (1-10), mid-phase (11-20), and termination (21-30) stages of treatment. A Pearson r correlation was then conducted between these means and the termination RF score. There was no significant association between the patient’s RF score and the RRQ mean for the first or second third of treatment. Interestingly, there was a significant correlation (r = 0.47, p = 0.04) between patient’s RF scores at termination and the RRQ mean for the last third of treatment.
### Outcome Measures

**Table 3**

**Means, Standard Deviations, Skewness, and Kurtosis for Measures at Intake, Termination, Follow-Up**

<table>
<thead>
<tr>
<th>Measure</th>
<th>M(SD)</th>
<th>Skewness(SD)</th>
<th>Kurtosis(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptom Checklist-90</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake</td>
<td>0.73(.56)</td>
<td>1.49(.50)</td>
<td>2.62(.97)</td>
</tr>
<tr>
<td>Termination</td>
<td>0.48(.56)</td>
<td>1.85(.50)</td>
<td>2.99(.97)</td>
</tr>
<tr>
<td>Follow-up</td>
<td>0.68(.80)</td>
<td>1.27(.72)</td>
<td>0.31(1.4)</td>
</tr>
<tr>
<td><strong>Target Complaints (patient rated)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake</td>
<td>9.90(2.5)</td>
<td></td>
<td>-0.75(.50)</td>
</tr>
<tr>
<td>Termination</td>
<td>5.85(2.9)</td>
<td>0.82(.50)</td>
<td>0.16(.97)</td>
</tr>
<tr>
<td>Follow-up</td>
<td>6.40(3.9)</td>
<td>0.87(.71)</td>
<td>-0.96(1.4)</td>
</tr>
<tr>
<td><strong>Target Complaints (therapist rated)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake</td>
<td>9.20(1.8)</td>
<td>-0.89(.50)</td>
<td>0.84(.97)</td>
</tr>
<tr>
<td>Termination</td>
<td>5.70(2.1)</td>
<td>0.16(.52)</td>
<td>-0.30(1.0)</td>
</tr>
<tr>
<td><strong>Inventory of Interpersonal Problems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake</td>
<td>1.20(.53)</td>
<td>-0.32(.50)</td>
<td>-0.59(.97)</td>
</tr>
<tr>
<td>Termination</td>
<td>0.96(.55)</td>
<td>0.56(.50)</td>
<td>-0.50(.97)</td>
</tr>
<tr>
<td>Follow-up</td>
<td>1.10(.53)</td>
<td>0.24(.72)</td>
<td>-1.3(1.4)</td>
</tr>
<tr>
<td><strong>Global Assessment Scale (therapist rated)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake</td>
<td>66.40(9.7)</td>
<td>-0.45(.50)</td>
<td>1.6(.97)</td>
</tr>
<tr>
<td>Termination</td>
<td>69.70(8.9)</td>
<td>0.46(.52)</td>
<td>1.6(1.0)</td>
</tr>
<tr>
<td><strong>Marlowe-Crowne Social Desirability</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Termination</td>
<td>6.50(1.1)</td>
<td>-0.25(.50)</td>
<td>0.72(.97)</td>
</tr>
</tbody>
</table>

Table 3 shows the means and standard deviations of all outcome measures used.

Skewness and kurtosis of each measure was calculated and found to be within appropriate limits. Thus these measures can be deemed normally distributed.

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**Reflective Functioning and Outcome Measures at Termination and Follow-Up**

**Table 4**

**Correlational Analyses between Reflective Functioning and Residual Gain Scores on Outcome Measures**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptom Checklist-90</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake to termination</td>
<td>21</td>
<td>0.04</td>
<td>0.85</td>
</tr>
<tr>
<td>Termination to follow-up</td>
<td>9</td>
<td>-0.66</td>
<td>0.05</td>
</tr>
<tr>
<td><strong>Inventory of Interpersonal Problems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake to termination</td>
<td>21</td>
<td>0.21</td>
<td>0.36</td>
</tr>
<tr>
<td>Termination to follow-up</td>
<td>9</td>
<td>-0.17</td>
<td>0.67</td>
</tr>
<tr>
<td><strong>Therapist Rated Global Assessment Scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4 shows analyses conducted to test the hypothesis that higher RF at termination would be associated with good outcome and change over time between intake and termination, as well as between termination and follow-up. Residual Gain Scores were calculated by comparing the change from intake (pre-treatment) to termination (30 sessions), and termination to follow-up (approximately 6 months post-treatment) on self-report measures of symptomatology (Symptom Checklist-90), target complaints (Target Complaints; patient and therapist ratings), level of overall functioning (Global Assessment Scale), and interpersonal problems (Inventory of Interpersonal Problems-64).

A Pearson $r$ correlation coefficient was computed between the Residual Gain Scores and patients’ RF scores to assess whether patients’ changes in symptomatic and interpersonal domains were associated with higher RF at termination. There were no significant associations between magnitude of RF at termination and change between intake and termination. A Pearson $r$ correlation coefficient was also computed between the Social Desirability Scale and RF. There was a significant negative correlation ($r = -0.45$, $p = 0.04$), between RF and the social desirability scale suggesting that patients with higher RF were not making an effort to appear socially desirable to the therapist or program at termination.
There were no significant associations between RF and change between termination and follow-up. Yet there is a correlation with a large effect size (Cohen, 1992) reaching significance ($r = -0.656$, $p = 0.05$) between decreased symptoms (on the SCL-90), between termination and follow-up, and RF at termination. With a larger sample size, this correlation would likely be significant.

**Discussion**

The aim of this study was to examine reflective functioning as an assessment of the quality of the attachment relationship between patient and therapist which would be seen in the patient’s narratives when speaking about their therapist (on the PRI-T) at termination. Specifically, this study wanted to examine the relationship between reflective functioning at termination of Brief Relational Therapy and therapeutic process and outcome measures. It was theorized that patients who developed an early, strong working alliance with the therapist and who reported more meaningful experiences of intersubjective negotiation, over the course of treatment, would demonstrate higher RF at termination. Further, it was hypothesized that subjects who reported decreased symptomatology and interpersonal problems at termination and follow-up would exhibit higher RF at termination.

Firstly, the theory that an early, strong, working alliance could foster security which would then be seen in the patient’s RF, was not supported by results. Items on the working alliance measure might not have tapped enough into attachment related security to show a relationship to RF at termination.
Secondly, the hypothesis that the patient’s meaningful perception of intersubjective negotiation, as assessed on the RRQ over different stages of treatment, would be associated with high RF at termination was partially supported. Namely, findings showed that there was a significant relationship between the subject’s experience of intersubjective negotiation in the last third of treatment and high RF at termination. This striking finding highlights how the ongoing process of intersubjective negotiation can enhance RF through its explicit focus on shifts in the alliance and metacommunication in the moment.

In strained moments, the therapist’s ability to recognize, and draw attention to the interaction, through metacommunication, provides a space in which conflict can be safely explored and negotiated through a kind of meeting of minds, whereby the subjectivities, needs, and feelings of both participants can be recognized and understood. This inherently helps the patient see himself as reflected upon and recognized as a separate subjectivity through the eyes of an attuned other, which is central to the development of RF. “Metacommunication” can be conceptualized as the therapist “mentalizing” (Holmes, 2010) aloud to the patient about the current interaction at hand. In addition, the therapist’s feedback can also serve to disconfirm the patient’s expectations of how others will react to their behavior, and can help the patient internalize a more secure internal working model. Powerful moments of intersubjective negotiation likely result in the patient identifying with items on the RRQ that tap into a perceived sense of resolution, strengthened relatedness, connection with previously disconnected feelings, and a
recognition of the therapist’s subjectivity. All of these enhanced capacities are, in turn, fostering reflective functioning.

The strong relationship between termination RF and intersubjective negotiation in the last third of treatment could suggest many things. One notion is that towards the end of treatment, there is increased focus on the nature of the relationship and its upcoming end. This would be a theoretically opportune time to strengthen RF as the process of intersubjective negotiation would be more focused on both participant’s feelings and thoughts regarding termination. Explicit discussion about separation and the loss of the other provides an invaluable and unique opportunity to process leaving the other in the company of the other. The therapist’s responsive feedback to the patient’s needs and fears about termination also fosters a sense of how relationships can end, but still live on inside the mind. Subsequently, with the internalization of a mutually responsive and secure relationship in the final stage of treatment, the patient shows a stronger capacity for reflective functioning at termination.

The results regarding the third hypothesis showed no significant relationship between changes in symptomatic and interpersonal change at termination or follow-up and RF. This study hypothesized that a secure attachment relationship to the therapist could foster a secure base from which thoughts could be safely explored, and affect soothed in times of distress. This, in turn, would lead to higher RF due to patients learning how to better cope with their symptoms and navigate interpersonal relationships. Yet the internalization of the therapist and the patient’s subsequent capacities might not be evident until after treatment.
The Importance of Follow-Up Data

In terms of follow-up results, it is notable that there was a relationship approaching significance between RF at termination, and decreased symptoms between termination and follow-up of treatment. Although the sample size was small (N=9), there is a large effect size of 0.66 (Cohen, 1992) which could indicate that the capacities attained in therapy (perceived security, interpersonal awareness, negotiation of relatedness, and affect regulation), amidst a secure attachment relationship, are internalized and continue to be ‘kept in mind’ after treatment has ended. This finding is supported by Geller and his colleagues’ research (1993) which highlights that patients who have had a successful treatment experience, continue after termination to evoke representations of their therapist to cope with and process overwhelming feelings and needs in times of distress. This continuing therapeutic dialogue in the minds of patients has been found to be associated with decreased symptomatology and improved psychological well being (Arnold, 1998; Wzontek et al., 1995). This suggests the need for further psychotherapy research to use follow-up data to better assess how the internalization of the therapeutic attachment figure continues to be used and strengthened beyond termination of treatment.

It is important to note that giving the Patient Relationship Interview (PRI-T) at different intervals following treatment (1 year, 3 year, 5 year) in conjunction with these same self-report outcome measures could show more lasting, internal change. Psychoanalytic theory posits that the process of change and internal growth does not stop when therapy ends but continues within the “postanalytic phase” (Thoma & Kachele,
whereby patients use the internalized therapeutic figure and experience, as well as newly attained insight and skills, to continue to negotiate conflicts. Notably, Grande and his colleagues (2009) argue that “many [therapeutic] effects do not become apparent until later, when the patient has attained a higher level of autonomy and has acquired methods of independent self-regulation on the basis of . . . newly gained insights and . . . [thus an] interval of between 2 and 5 years is recommended as an adequate time frame” (p.346) for follow-up to detect internal change. Assessing observer-rated (RF ratings of interviews) and subjectively rated (self-reports) follow-up data in this fashion would tap into what psychoanalytic theory calls “structural change” (Grande et al., 2009) which is a lasting form of internal change. Grande and his colleagues (2009) argue that,

Structural changes are differentiated from more superficial changes, under which, for example, symptom reduction is subsumed. The term “structure” refers to the temporary stable organization of the personality and the habitual patterns that individuals adopt in an attempt to resolve their unconscious conflicts (Rapaport, 1960). It is assumed that changes at this deeper level of the personality are essential in attaining persistent therapeutic effects at all levels (e.g., also at the symptomatic level). (p. 344-345).

In fact, researchers are arguing (Levy et al., 2006) that psychodynamic therapies and the techniques employed are likely to promote structural changes and thus there is a continued need for research and, specifically the use of follow-up data, to explore this theory. Follow-up studies continue to show that after completion of successful psychodynamic psychotherapy, patients continue to struggle with their central
interpersonal conflicts driven by their relational schemas (Safran & Muran, 2000) or internal working models (Bowlby, 1973). Yet with time, patients become able to negotiate conflictual situations more adaptively with newly attained interpersonal awareness and cognitive and “emotion-based insight into their own . . . problems” (Grande et al., 2009, p.345). With this in mind, one might hypothesize that the patients in this study with acquired interpersonal awareness and meaningful experiences of working through ruptures would continue to have lasting “structural change” years after completing treatment. Three years after completing treatment, these same patients, might show a stronger capacity to negotiate conflict and tensions with others as a form of internal change that was experienced initially in the therapeutic relationship, and now has been extended to other relationships. Over a longer period of time, patients also might show a stronger capacity to regulate their affect, which could be evident in decreased symptomatology and interpersonal difficulties on the same outcome measures.

Further supporting the need for follow-up research is Grande and colleagues’ Heidelberg-Berlin Study (2009) which looked at psychodynamic therapies and the role of “structural change” as these kinds of changes “broadly impact many life domains and are associated with a change of self or the experience of the self” (p. 345) in contrast to more superficial symptomatic changes. They used pre-measures (intake) and post-measures (termination) of symptomatology and interpersonal problems as rated by patients, as well interviews (at termination and follow-up of 1 and 3 years) tapping into patient’s core problem areas. These interviews were then rated by coders to assess patients’ ability to negotiate these problematic areas and the kind of internal or “structural changes” that
strengthened their ability to navigate these core difficulties. Most importantly, patients were given retrospective outcome evaluations regarding therapy-related progress in various life domains, since completion of therapy, at follow-up of one-year and three-years. These retrospective evaluations were used to assess “structural change” or “shifts within a patient’s internal reference system in addition to manifest changes in symptoms and behaviour” (p.354). They found that structural changes, in contrast to symptomatic changes, achieved by completion of therapy significantly predicted retrospective outcome evaluations, completed by patients, at follow-up of 3 years after completion of therapy. Thus, as Grande and his colleagues (2009) note: “when patients are requested to evaluate their therapy-related progress in various life domains 3 years after finishing therapy, their evaluations are significantly better explained by the structural changes compared with the symptomatic changes achieved by the end of therapy” (p.354). Retrospective evaluations conducted years after completion of therapy enable patients to have the opportunity to reflect upon therapy and subsequent rich, internal changes that have occurred after a significant amount of time (Grande et al., 2009).

In regards to this study, conducting the Patient Relationship Interviews (PRI-T) with the patients in this study at follow-up of 3 years might show much stronger mentalization capacities in patient’s narratives about their therapist and the therapeutic experience. In fact, the Reflective Functioning Scale (Fonagy, Target, Steele, & Steele, 1998) would be a rich way of assessing patient’s structural change over time and would provide an important window into how lasting change can occur. This has numerous
implications for psychotherapy research in its ability to use the RF scale to assess internal change over time.

**Limitations of the Study**

Limitations of the study include the small sample size of 21 patients. With a larger sample, greater trends might have been detected and a wider range of reflective capacities might have been shown. In addition, another limitation is the lack of a baseline measure of RF on the PRI-T earlier in treatment so that it could be compared to the patient’s RF score at termination. Further, there is a need for more follow-up data in both administered interviews and collected self-report data. Specifically, “structural change” would be better assessed by giving the Patient Relationship Interview at 1, 3 and 5-year follow-up periods and then rating these interviews with the RF Scale. This would provide a way of exploring how the attachment relationship is internalized, lives on in the mind, and is used to negotiate continued interpersonal situations.

It is also important to note that the self-report measures, used in this study, of symptomatology and interpersonal problems might not have been best suited to assess the kind of rich internal or “structural change” that increased reflective capacities would seek to engender. Specifically, self-report measures that tap more into internal representations of self and other, and attachment related concepts (i.e., affect regulation, safe haven behaviors, and forms of mentalization) might have shown a stronger relationship with RF and with internal change at various stages of assessment.
Conclusion

The results of the present study are promising and suggest the need for continuing research to explore the use of alternative measures and rating scales to examine patients’ internalization of the therapeutic process and attachment relationship, as well as treatment outcome. This study suggests that the use of the RF scale with an attachment-based interview, focusing on the therapeutic relationship, allows for a richer window into the patient’s internal world and into mechanisms of therapeutic change. The significant finding that RF is associated with meaningful intersubjective negotiation, at the end of treatment, speaks to the need for more psychotherapy research to look at the relationship between reflective functioning, the working through of ruptures, and the effects of termination on the patient’s internalization of the therapist. Further research should focus on gathering follow-up data years after completion of therapy in order to assess the influence of reflective functioning and the therapeutic experience on lasting structural change.
Appendix A:

BRIEF PSYCHOTHERAPY RESEARCH PROGRAM CONSENT FORM
Beth Israel Medical Center
St. Luke's Roosevelt Hospital Center

CONSENT FOR PARTICIPATION IN RESEARCH

Name of Subject (Printed) J. Christopher Muran, Ph.D.
Principal Investigator

Brief Psychotherapy Research Program
Title of Project

IRB/COSA # 048-88

Attached to this form is a full description of the study in which we are asking you to participate. The description tells you about the reason for the study, the procedures, interviews, and drugs or devices which may be involved, the duration of the study, and any risks and benefits to you. The description also gives you information about other medical treatments you may receive if you do not want to participate in this study.

If you have questions concerning this research project or your rights as a research subject, or if you have a research-related injury, you may telephone the Principal Investigator

J. Christopher Muran, Ph.D. at (212) 420-4662 or the Patient Representative at (212) 420-3818.

CONSENT TO PARTICIPATE -- ADULT

I have read the attached study description. The purpose of the study, the risks of the study and what it means to participate in the study have all been explained to me, and my questions have been answered. I agree to participate in the study and agree to take all the tests or procedures mentioned in the study description. If I am injured in the study, I understand only immediate essential medical treatment will be provided free of charge. I understand that participating in the study is voluntary, that I can decline to participate, and that I can stop participating at any time. I also understand that my decision to participate in or to withdraw from the study will not affect the health care I receive, now or in the future. I have been told that records of this investigation will be kept confidential to the extent permitted by law but are subject to inspection by the U.S. Food and Drug Administration and study sponsors.

Signature of Subject or Legal Guardian Date Signature of Witness Date

Signature of Authorized Representative or Person Giving Consent Date Relationship to Subject

I, have clearly and fully explained to the above subject (or person giving consent) the nature, requirements, and risks of the study.

Signature of Researcher Date

INSTITUTIONAL REVIEW BOARD
JUN 10 2011

DISTRIBUTION: Original to Research Records, copies for Subject (or Person Giving Permission), Investigator, Hospital Chart and Pharmacy (when appropriate)
Brief Psychotherapy Research Program

Purpose and Nature of Program
You are being asked to participate in a study involving an integrative form of time-limited psychotherapy incorporating cognitive-behavioral and relational techniques. The techniques used in this integrative treatment have already been demonstrated to be significantly effective. We are now attempting to learn more about the relative contributions of these techniques in effecting overall change so that you and others like you can receive the benefit of the best available treatment approaches.

Treatment Condition
If you decide to participate, you will first complete a thorough assessment evaluation to determine if time-limited treatment is appropriate for you. If this type of time-limited psychotherapy is considered appropriate for you, you will then be assigned to a therapist based on schedule availability. The therapy will be conducted once per week (45-minutes sessions) for 30 weeks. This type of psychotherapy incorporates a generally high level of therapist activity with a focus on specific, targeted problem areas.

If you choose to participate in this study, you will be asked to do the following:
1. Not participate in other psychotherapy or take psychiatric medication while receiving treatment in this program.
2. Be available for 30 psychotherapy sessions and an relevant assessment evaluations.
3. Complete a package of questionnaires to evaluate your progress at four points in the treatment:
   a. Before beginning treatment
   b. Midway during treatment
   c. At termination of treatment
   d. Six months after treatment is completed
4. Complete a post-session questionnaire after each session.
5. Agree to have evaluation and treatment sessions videotaped.
6. Consent to have information obtained from videotaped recordings of sessions used for scientific purposes, such as a research study, professional publication, and educational presentations in transcribed, audiotaped, or videotaped format by the program staff.

Treatment Fees
There is no fee for any of the assessment evaluations. The fee for the 30 sessions of therapy is established on an income-sensitive scale, ranging from $10-$40 per session.

Possible Risks
We know of no inherent risks with these treatments. Each type of treatment may cause some emotional discomfort at times, but this is generally considered a natural part of the therapeutic process.

Confidentiality
Information that is obtained in connection with this study that can be identified with you, including evaluation materials and videotaped recordings, will be held in the strictest confidence.

Your study information will be identified with a code so that the study results are not linked directly to your name. The study results will be stored in a locked cabinet and any study information stored in a computer will be password protected. Only the study staff will have access to the study results. However, we cannot guarantee absolute confidentiality.

If you consent to participate in this research, your personal information will be kept confidential and will not be released without your written permission, except as described in this section or as required by law. The one exception to our ongoing efforts to protect your confidentiality is in the event that you may be in danger of harming yourself or someone else. In accordance with New York State laws, relevant individuals or authorities would be notified.

Your personal information may be shared, to the extent necessary, among the research staff, with the Institutional Review Board, and research oversight staff, and/or with your treating physician or your other health care providers.

Your personal information also may be used and disclosed in the same ways that it may be used and disclosed for regular hospital treatment, payment and healthcare operations; for example, with your insurance company so that, as appropriate, you may get reimbursed or covered for any medical services you receive.
The post-session questionnaire, which is not available to your therapist, will identify you solely by your confidential identification number provided at the outset. This provision is made because some of the material in this questionnaire pertains to your relationship with your therapist. While it is possible that at some point in the future selected excerpts from your sessions will be either presented or published for scientific purposes, adequate precautions will be taken to maintain complete confidentiality, according to the customary professional ethics of Beth Israel Medical Center.

If there is a sponsor for the study, that sponsor will be sent your study information on study report forms. Your name will not be reported in any publication; only the data obtained as a result of your participation in this study will be made public. If this study involves medications or devices regulated by the Food and Drug Administration (FDA), the FDA and other regulatory agencies, as well as the sponsor of the study, may inspect records identifying you as a subject in this investigation.

In addition, if your participation in this research is for treatment or diagnostic purposes, Beth Israel Medical Center or any other facility at which you are being treated, may ask you to sign a separate informed consent document for specific procedures or treatments. That informed consent may be included in the medical record of Beth Israel Medical Center or of that facility. Your medical record will be maintained by your treating physician or Beth Israel Medical Center as appropriate, and will be subject to state and federal laws and regulations dealing with the confidentiality and privacy of medical records.

If you decide to participate, the study staff will ask for your separate written permission, on a form called a "Research Authorization," for your permission to use and share your personal health information for purposes related to the study and as required by law.

Possible Benefits
The treatment offers possible therapeutic benefits to you because it follows clinical principles that have been tested and proven effective. We are attempting to study specific aspects of cognitive and relational techniques that contribute to, or detract from, their efficacy, particularly in terms of specific types of individuals and specific types of problems. While your participation in the research may be beneficial to you and other mental health treatment consumers in terms of contributing to the development of the most effective integrative, time-limited psychotherapy, there may also be no direct benefit for any individual participant.

Withdrawal
You may withdraw or cancel your participation at any time and you are under no obligation to participate. If you withdraw at a later date, you will not jeopardize your future care by doing so. In this event, you will be provided with standard Beth Israel care on the usual basis.

Alternative Treatment
Any person may receive psychiatric treatment at Beth Israel Medical Center without participating in this study. If you choose not to participate in this study, or if it is determined that the therapy is not appropriate for you, you will be provided with referrals for alternative forms of treatment.

In Case of Injury
If you are injured in the study, only immediate essential medical treatment will be provided free of charge by Beth Israel Medical Center. No funds have been set aside for any other purpose. By signing this consent form, you are not waiving any of your legal rights.

Questions
If you have any questions, you may contact J. Christopher Muran, Ph.D., Program Director, at (212) 420-3819. If you have any unsatisfied complaints, you may contact the Patient Representative at (212) 420-3818. You may request a copy of this consent form at any time. You may also request feedback regarding aspects of the study upon the termination of your treatment and the completion of the assessment protocol.
APPENDIX B:

PATIENT RELATIONSHIP INTERVIEW (PRI-T)
ADAPTED FROM THE
PATIENT-THERAPIST ADULT ATTACHMENT INTERVIEW
(PT-AAI; Diamond et al., 1999)
PRI-T
Patient Relationship Interview - Termination

Note: Interviewers should check the assessment log before making the PRI-T appointment to ensure that patients have returned termination data. When making the appointment – interviewers should follow up with patients if this data has not been received. **GENERAL NOTE TO INTERVIEWER: PLEASE FEEL FREE TO REPEAT LANGUAGE THAT PATIENT USED WHEN PROBING FOR CLARIFICATION. ALSO PLEASE FEEL AT LIBERTY TO PROBE AT ANY TIME FOR FURTHER DETAILS**

**THIS IS A CLINICAL INTERACTION, ONE NEEDS TO BE COMFORTABLE WITH AMBIGUITY AND CONFIDENT IN INFORMATION GATHERING WITH THE PATIENT.**

**INTRODUCTION**

In this interview, I’ll be asking you about your relationship with your individual therapist, and how you think different aspects of the relationship have influenced who you are today. Throughout the interview, I will be asking you a series of questions and I may ask you to change topics periodically so that we can cover all the questions in the interview. This interview should take approximately one hour.

1. **EMPHASIZE A BRIEF RESPONSE TO THIS QUESTION:**
   Could you start by helping me to get oriented to your work with your therapist?
   How did you address your therapist?
   INTERVIEWER MAY USE THE PATIENT’S NAME THROUGHOUT INTERVIEW.

   - When did you first start seeing your therapist?
   - How frequently have you seen your therapist?
   - Has the therapy been continuous?
   - Have there been any other treaters/therapists involved?

2. I’d like you to try to describe your **relationship** with your therapist going back to the beginning.

3. Now I’d like to ask you to choose five adjectives or words that reflect your relationship with your therapist. Then afterwards I’ll ask you why you chose them. I’ll write each one down as you give them to me.
   **ENSURE THAT PARTICIPANTS UNDERSTAND THEY ARE TO PROVIDE ADJECTIVES THAT REFLECT THE RELATIONSHIP, DO NOT PROVIDE ADDITIONAL PROMPTS.**

   Ok, let me go through some questions about your description. You say your relationship with your therapist was __________. Are there other any memories or incidents that come to mind with respect to __________?
   **IF YOU DO NOT GET A VIVID INCIDENT, REITERATE THE QUESTION AND PRESS MORE FIRMLY FOR A SPECIFIC EXAMPLE. AFTER TWO TRIES, GO ON TO THE NEXT WORD.**

   **CONTINUE THIS FOR ALL FIVE ADJECTIVES.**

   **EXAMPLES OF PROBES INCLUDE:**
   Can you think of a specific memory that would illustrate how your relationship is (_______)?
   Well that’s good general description, but I’m wondering if there was a particular time that happened, that made you think about is as (_______)?
4. When you were upset with something going on in your life, how would you handle or address it in therapy?
   Can you think of a specific time that happened?
   (IF SUBJECT DOES NOT SPONTANEOUSLY BRING UP THE THERAPIST’S REACTIONS
   PROBE: How did your therapist respond?)

   When you were upset in therapy, what would you do?
   Can you think of a specific time that happened?
   (IF SUBJECT DOES NOT SPONTANEOUSLY BRING UP THE THERAPIST’S REACTIONS
   PROBE: How did your therapist respond?)

   Were you ever ill during the course of your treatment?
   Do you remember what would happen?
   (IF SUBJECT DOES NOT SPONTANEOUSLY BRING UP THE THERAPIST’S REACTIONS
   PROBE: How did your therapist respond?)

5. What is the first time you remember being separated from your therapist?
   What was the nature of this separation (e.g., did therapist cancel appointment?)
   How did you respond?
   How did your therapist respond?
   Are there other separations that stand out in your mind?
   What were separations from your therapist like for you?

6. Have you ever felt rejected, pushed away, or criticized by your therapist?
   How did you respond?
   Are there any particular instances that stand out in your mind?
   What do you think the reason was that your therapist did those things?
   Do you think he/she realized he/she was being rejecting or critical?

7. In the course of your thirty-session treatment, did you ever think about ending the therapy? Did you ever worry that your therapist would end the treatment?

8. Were there many changes in your relationship with your therapist over the course of your treatment?
   PROBE: Did your feelings for your therapist change over the course of your treatment? FEEL FREE TO PROBE FURTHER FOR CLARIFICATION HERE.

9. Have you experienced any loss through death of a parent or other close loved one during the course of this treatment – for example, a sibling, or a close family member?
   Did this have an affect on your relationship with your therapist?

10. What do you think the reason is that your therapist behaved the way he/she did with you?

11. In general, how do you think your overall experiences with this therapist [that we have been discussing] have affected your personality/who you are now?
    POSSIBLE PROBE: IF ANSWER IS Vague OR GENERAL FEEL FREE TO PROBE WITH: “CAN YOU SAY A LITTLE BIT MORE ABOUT THAT?”
12. Is there any particular thing which you feel you learned above all from this therapy relationship? I'm thinking here of something you feel you may have gained from the experience.
   a.) Are there any aspects of this relationship that you feel have been a setback for your development?

Questions 15 - 21 are adapted from the Adult Attachment Interview (AAI, George, Kaplan & Main, 1999).

13. How do you think your therapist feels about you?
   How do you feel about your therapist?

14. If you met your therapist in ordinary life would you want to be his/her friend?

15. Do you think of your therapist outside of therapy?
   How often and in what ways?

16. Do you imagine having a different kind of relationship with your therapist outside of the therapy situation?

20. During the course of this treatment did you have any significant relationships that came to an end?
   Did you experience any loss through the ending of those relationships?
   What about the loss of a job?
   How did your therapist respond?

21. What were your feelings about your therapist during the concluding phase of your therapy?
   Can you describe how you felt about your therapist when your therapy ended?

Questions 22 - 27 are Rupture Resolution and Treatment items from the Brief Program

22. You mentioned/Did you experience any tension, problems, conflicts or misunderstandings in your relationship with your therapist.
   Can you describe a specific instance?

   IF APPLICABLE: When did the event occur in the course of treatment?
   What was your understanding of the cause of the event?
   What was your initial feeling or experience of it?
   Was this addressed or discussed?

   IF YES: Who first addressed it?
   What was the reason do you think it was addressed?
   What was it like to discuss it?

   IF NO: What was the reason this problem wasn't addressed?

To what extent was this resolved to your satisfaction?
To what extent do you feel this problem was resolved to your therapist's satisfaction? What do you think was most important for its resolution (e.g., what did you or your patient do that was critical?).
How did you feel upon its resolution?
Did you discover anything new or different about yourself in this process?  
Did you discover anything new about your therapist in this process?  
Did your understanding of the event change over the course of treatment?  
Did your therapist’s understanding of the event change over the course of treatment?  
How do you think the event affected the therapy?  

23. Do you think you changed over the course of treatment?  

24. What do you think were the most helpful aspects of the therapy experience?  
   Were there any aspects of the treatment that were not so helpful?  

25. How did you feel about the length of treatment?  
   Was it difficult to end after 30 sessions?  

26. What was your idea or fantasy about what would happen in the course of treatment with your therapist?  
   Did any aspects of this fantasy come true?  

27. Did your therapist remind you of someone significant in your life?  
   IF YES: Did you realize this early or late in the course of treatment?
APPENDIX C:

REFLECTIVE FUNCTIONING SCALE
(Fonagy, Target, Steele, & Steele, 1998)
## Chart of Overall Rating Criteria

<table>
<thead>
<tr>
<th>Overall Rating</th>
<th>Common Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>-1 Negative RF</td>
<td>A) Rejection of RF</td>
</tr>
<tr>
<td>• subject systematically resists taking a reflective stance throughout interview.</td>
<td>• there are some general indices of neg. RF (i.e., lack of participation, hostility, evasiveness, marked incongruences).</td>
</tr>
<tr>
<td>• no passages rated ‘5’ or above</td>
<td>• subject responds with hostile refusal to at least 3 demand questions.</td>
</tr>
<tr>
<td>• where some ‘1’ or ‘3’ passages exist, consider higher rating.</td>
<td>• if subject gives only one or two hostile refusals, but meets general criteria above, rate ‘0’.</td>
</tr>
<tr>
<td>1 Lacking in RF</td>
<td>B) Unintegrated, Bizarre or Inappropriate RF</td>
</tr>
<tr>
<td>• reflective functioning is totally or almost totally absent.</td>
<td>• mental state attributions are confused and hard to understand.</td>
</tr>
<tr>
<td>• mental states may be mentioned, but there is no picture of the subject’s or caregiver’s beliefs and feelings underlying behavior.</td>
<td>• at least 3 examples of inexplicable, bizarre or inappropriate attributions (may occur in response to demand or permit questions)</td>
</tr>
<tr>
<td>• mentalisation is absent in the narrative and awareness of the nature of mental states, if present, not explicit.</td>
<td>• must be shocking rather than simply odd.</td>
</tr>
</tbody>
</table>

A) Disavowal
- barren accounts, lacking in mentalising detail.
- at least 3 examples of assertion of ignorance concerning mental states or comparable examples of evasion (physicalistic, behavioral or sociological accounts and global and generalized statements concerning psychological states) in response to demand questions.
- no instance of reflective function rated above ‘3’

B) Distorted/self-serving
- interview does contain reflection, but reflection is flawed.
- reflective passages are egocentric, self-aggrandizing, and self-serving to the point where the accuracy of the representation of the mental state of the other may be reasonably called into question.
- at least 3 examples of such purposeful distortions in response to demand questions.
- no instance of reflective function rated above ‘5’, or
<table>
<thead>
<tr>
<th>3 Questionable or Low RF</th>
<th>Common Types</th>
</tr>
</thead>
</table>
| * Some evidence of consideration of mental states throughout the interview, but most references are not made explicit. *  
| * Will contain some elements of a reflective stance. *  
| * may contain more than 1 example of a rating of '5' or higher. *  
| * must contain at least 3 examples of a '3' or '4' rating. *  | A) Naive/simplistic  
| * interview shows a partial understanding of intentions of others, but this understanding is likely to be banal, clichéd, and excessively general and superficial. *  
| * normalization of experiences extends beyond what is culturally accepted. *  
| * interview does not inter into complexities of mental states (conflicts, ambivalence, etc. *  
| * naive/simplistic passages are the majority of low ratings. *  
| * fewer than 3 ratings of '5' or above. *  | B) Over-analytical/hyperactive  
| * The interview may have greater depth than might be expected in the interview context. *  
| * The interview is diffuse, however, and the insights are unintegrated. *  
| * There are at least 3 instances in which the subject is over-analytical. *  
| * If 1 or more of these includes statements that are bizarre, distorting/self-serving, consider '1' or '2' rating. *  | C) Miscellaneous low RF  
| * transcript is neither particularly naive nor overly analytic. *  
| * this rating may be a compromise between ratings for transcripts which show marked disavowal mingled with definite evidence of reflective functioning (or other such incongruities). *  |

<table>
<thead>
<tr>
<th>5 Ordinary RF</th>
<th>A) Ordinary Understanding</th>
</tr>
</thead>
</table>
| * There are a number of instances of reflective functioning (and these may be prompted, rather than spontaneous). *  
| * Speaker has a model of the mind (own and attachment figures) which may be simple but is |  
| * Subject shows an ordinary capacity to make sense of their experience in terms of thoughts and feelings. *  
| * Subject has a consistent model for thoughts and feelings of self and other which requires little or no inference from the rater. *  
| * This model is limited, and does not include understanding of conflict or ambivalence. *  |
relatively coherent, personal, and well-integrated.

Overall Rating

• There are at least 3 passages rated ‘5.’
• No breakthroughs of rejection, bizarre explanations, pervasive disavowal, etc.

Common Types

5 Ordinary RF (Cont.)

• Must have at least 1 or 2 clear ‘5’ passages. Most interviews with this rating will have responses in the ‘3’ to ‘7’ range.
• If any ‘-1’ or ‘1’ ratings, these are balanced by passages immediately following or elsewhere which indicate reflection.

B) Inconsistent Understanding

• One or two passages warrant a ‘7’ rating or even higher, but understanding cannot be maintained in relation to one or more problem areas (i.e., a conflictual relationship to one parent).
• Even problematic parts of interview do not fall below a ‘1’ or ‘2’ rating.

Overall Ratings for high RF (no sub-types)

7 Marked RF

• Numerous instances of full reflective functioning suggesting a stable psychological model of the mind (own and caregivers’) and reactions to mental states.
• Usually, passages where subject has arrived at an original reintegration of states of mind (own and/or others).
• Much detail about thoughts and feelings
• Implications of mental states explicitly spelled out.
• Usually able to maintain a developmental (interactional) perspective.
• In interview as a whole, subject is applying reflective stance fairly consistently to at least one context, or less consistently to a number of contexts.
• At least 3 instances, anywhere in interview, which rate ‘7’ or higher.
• No passages rated ‘1’ or lower, unless no relevant experiences to rate.
• No more than 3 passages where rating is less than ‘5’ in response to demand questions, where there are relevant life experiences.

9 Exceptional RF

• Transcript shows exceptional sophistication, is commonly surprising, quite complex or elaborate and consistently manifests reasoning in a causal way using mental states.
• Shows consistent reflective stance across all contexts.
APPENDIX D:

POST SESSION QUESTIONNAIRE
(PSQ, Patient Version; Muran, Safran, Samstag, & Winston, 2002)

Section C: WORKING ALLIANCE INVENTORY
(WAI; Horvath & Rosenberg, 1986; Horvath & Greenberg, 1986)

Section E: RUPTURE RESOLUTION QUESTIONNAIRE
(RRQ; Safran, Muran, & Winkleman, 2006)
PATIENT POST-SESSION QUESTIONNAIRE – Version 2006
Please complete immediately after session (or as close as possible) so that your memory of the session remains fresh.

Your initials: _________________________ Your therapist's initials: _________________________ Session number: _________________________ Date of session: _________________________

SECTION A: Please circle the appropriate number.

1. How helpful or hindering for you was this session overall?

<table>
<thead>
<tr>
<th>Extremely Hindering</th>
<th>Neutral</th>
<th>Extremely Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

2. To what extent are your presenting problems resolved?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Moderately</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Bad</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Dangerous</td>
</tr>
<tr>
<td>Difficult</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Easy</td>
</tr>
<tr>
<td>Valuable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Worthless</td>
</tr>
<tr>
<td>Shallow</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Deep</td>
</tr>
<tr>
<td>Relaxed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Tense</td>
</tr>
<tr>
<td>Unpleasant</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Pleasant</td>
</tr>
<tr>
<td>Full</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<td>Weak</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Powerful</td>
</tr>
<tr>
<td>Special</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Ordinary</td>
</tr>
<tr>
<td>Rough</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Smooth</td>
</tr>
<tr>
<td>Comfortable</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Uncomfortable</td>
</tr>
</tbody>
</table>

SECTION C: Please circle the appropriate number to indicate how you feel about your working relationship with your therapist based on this session.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Somewhat</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. My therapist and I agree about the things I need to do in therapy to help improve my situation.
2. What we are doing in therapy gives me new ways of looking at my problems.
3. I believe that my therapist likes me.
4. My therapist does not understand what I am trying to accomplish in therapy.
5. I am confident in my therapist's ability to help me.
6. My therapist and I are working toward mutually agreed upon goals.
7. I feel that my therapist appreciates me.
8. We agree on what is important for me to work on.
9. My therapist and I seem to trust one another.
10. My therapist and I seem to have different ideas on what my problems are.
11. We have established a good understanding of the kind of changes that would be good for me.
12. I believe the way we were working with my problem is correct.
13. My therapist and I respect each other.
14. I feel that the things I do in therapy will help me accomplish the changes that I want.
15. My therapist and I collaborate on setting goals for my therapy.
16. I feel my therapist cares about me even when I do things that he/she does not approve of.
17. As a result of these sessions, I am clearer as to how I might be able to change.
SECTION D: Please circle the appropriate number.

1. a) Did you experience any tension or problem, any misunderstanding, conflict or disagreement, in your relationship with your therapist during the session? Not at all Occasionally Constantly
   Mildly Moderately Extremely
   1 2 3 4 5

b) If yes, please rate how tense or upset you felt about this during the session.
   Not at all Somewhat Very much
   1 2 3 4 5

2. a) To what extent did you find yourself and your therapist overly accommodating or overly protective of each other? Or to what extent did you feel you were making nice or smoothing things over? Or to what extent did you feel you were holding back or avoiding something?
   Not at all Somewhat Extremely
   1 2 3 4 5

b) If yes, please rate how tense or upset you felt about this during the session.
   Not at all Somewhat Very much
   1 2 3 4 5

3. Please describe the problem:

4. To what extent was this problem addressed in this session?
   Not at all Somewhat Very much
   1 2 3 4 5

5. To what degree do you feel this problem was resolved by the end of the session?
   1 2 3 4 5

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

SECTION E: If you experienced any problems with your therapist during this session (any tension, misunderstanding, conflict, disagreement, over-accommodation or avoidance), please rate the extent to which the following statements reflect your experience in this session:

Not at all Somewhat Definitely

1. I felt a closer connection with my therapist.
   1 2 3 4 5

2. I discovered feelings toward my therapist that I had not been fully aware of.
   1 2 3 4 5

3. My therapist and I were able to work through a conflict and connect in a stronger way.
   1 2 3 4 5

4. I saw how I was contributing to the difficulties my therapist and I were having.
   1 2 3 4 5

5. I acted in a way that felt more authentic or genuine for me.
   1 2 3 4 5

6. I recognized and accepted my therapist's limitations.
   1 2 3 4 5

7. I felt less to make mistakes with my therapist.
   1 2 3 4 5

8. I became aware of ways in which I avoid creating conflicts and misunderstandings with my therapist.
   1 2 3 4 5

9. I saw that I can express my feelings and not be rejected or criticized by my therapist.
   1 2 3 4 5

10. I began to get the sense that I don't have to protect my therapist.
    1 2 3 4 5

11. I felt more comfortable with expressing vulnerability or anger towards my therapist.
    1 2 3 4 5

12. I told my therapist something I had been hesitant to say.
    1 2 3 4 5

13. I felt able to disagree with my therapist.
    1 2 3 4 5

14. I began to accept a part of myself, which I had not fully acknowledged before.
    1 2 3 4 5

15. I said something to my therapist that I had felt for a while and it left me with a sense of relief.
    1 2 3 4 5

16. I was doing something to distance myself from my therapist or push him/her away.
    1 2 3 4 5

17. I felt more trusting of my therapist.
    1 2 3 4 5

18. I was afraid something I said would upset or hurt my therapist but I found out that it did not.
    1 2 3 4 5
APPENDIX E:

TARGET COMPLAINTS-PATIENT RATED

TARGET COMPLAINTS-THERAPIST RATED
(Battle et al., 1996)
TARGET COMPLAINTS (P/I)

Name: ___________________________ Date: ___________________________

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

1. __________________________________________
   __________________________________________
   __________________________________________

In general, how much does this problem bother you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>a little</td>
<td>pretty</td>
<td>much</td>
<td>very</td>
<td>much</td>
<td>much</td>
<td>couldn't</td>
<td>be worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. __________________________________________
   __________________________________________
   __________________________________________

In general, how much does this problem bother you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>a little</td>
<td>pretty</td>
<td>much</td>
<td>very</td>
<td>much</td>
<td>much</td>
<td>couldn't</td>
<td>be worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. __________________________________________
   __________________________________________
   __________________________________________

In general, how much does this problem bother you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>a little</td>
<td>pretty</td>
<td>much</td>
<td>very</td>
<td>much</td>
<td>much</td>
<td>couldn't</td>
<td>be worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX F:

SYMPTOM CHECKLIST-90
(SCL-90; Derogatis, 1983)
## SCL-90-R

**Name:**
**Technician:**
**Location:**
**Visit No.:**
**Mode:**
**Age:**
**Sex:**
**Date:**
**Remarks:**

### INSTRUCTIONS

Below is a list of problems and complaints that people sometimes have. Read each one carefully, and select one of the numbered descriptors that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST MONTH, INCLUDING TODAY. Please that number in the open block to the right of the problem. Do not skip any items, and print your number clearly. If you change your mind, erase your first number completely. Read the example below before beginning, and if you have any questions please ask the technician.

### EXAMPLE

<table>
<thead>
<tr>
<th>HOW MUCH WERE YOU DISTRESSED BY:</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex. Body Aches</td>
<td>0 Not at all</td>
</tr>
<tr>
<td></td>
<td>1 A little bit</td>
</tr>
<tr>
<td></td>
<td>2 Moderately</td>
</tr>
<tr>
<td></td>
<td>3 Quite a bit</td>
</tr>
<tr>
<td></td>
<td>4 Extremely</td>
</tr>
</tbody>
</table>

### HOW MUCH WERE YOU DISTRESSED BY:

<table>
<thead>
<tr>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Not at all</td>
</tr>
<tr>
<td>1 A little bit</td>
</tr>
<tr>
<td>2 Moderately</td>
</tr>
<tr>
<td>3 Quite a bit</td>
</tr>
<tr>
<td>4 Extremely</td>
</tr>
</tbody>
</table>

1. Headaches
2. Nervousness or shakiness inside
3. Repeated unpleasant thoughts that won’t leave your mind
4. Faintness or dizziness
5. Loss of sexual interest or pleasure
6. Feeling critical of others
7. The idea that someone else can control your thoughts
8. Feeling others are to blame for most of your troubles
9. Trouble remembering things
10. Worried about stoppings or carelessness
11. Feeling easily annoyed or irritated
12. Pains in heart or chest
13. Feeling afraid in open spaces or on the streets
14. Feeling low in energy or slowed down
15. Thoughts of ending your life
16. Hearing voices that other people do not hear
17. Trembling
18. Feeling that most people cannot be trusted
19. Poor appetite
20. Crying easily
21. Feeling shy or uneasy with the opposite sex
22. Feelings of being trapped or caught
23. Suddenly scared for no reason
24. Temper outbursts that you could not control
25. Feeling afraid to go out of your house alone
26. Blaming yourself for things
27. Pains in lower back
28. Feeling blocked in getting things done
29. Feeling lonely
30. Feeling blue
31. Worrying too much about things
32. Feeling no interest in things
33. Feeling fearful
34. Your feelings being easily hurt
35. Other people being aware of your private thoughts
36. Feeling others do not understand you or are unsympathetic
37. Feeling that people are unfriendly or dislike you
38. Having to do things very slowly to ensure correctness
39. Heart pounding or racing
40. Nausea or upset stomach
41. Feeling inferior to others
42. Soreness of your muscles
43. Feeling that you are watched or talked about by others
44. Trouble falling asleep
45. Having to check and doublecheck what you do
46. Difficulty making decisions
47. Feeling afraid to travel on buses, subways, or trains
48. Trouble getting your breath
49. Hot or cold spells
50. Having to avoid certain things, places, or activities because they frighten you
51. Your mind going blank
52. Numbness or tingling in parts of your body
<table>
<thead>
<tr>
<th>HOW MUCH WERE YOU DISTRESSED BY:</th>
<th>Description</th>
<th>HOW MUCH WERE YOU DISTRESSED BY:</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53. A lump in your throat</td>
<td></td>
<td>71. Feeling everything is an effort</td>
<td></td>
</tr>
<tr>
<td>54. Feeling hopeless about the future</td>
<td></td>
<td>72. Spells of terror or panic</td>
<td></td>
</tr>
<tr>
<td>55. Trouble concentrating</td>
<td></td>
<td>73. Feeling uncomfortable about eating or drinking in public</td>
<td></td>
</tr>
<tr>
<td>56. Feeling weak in parts of your body</td>
<td></td>
<td>74. Getting into frequent arguments</td>
<td></td>
</tr>
<tr>
<td>57. Feeling tense or keyed up</td>
<td></td>
<td>75. Feeling nervous when you are left alone</td>
<td></td>
</tr>
<tr>
<td>58. Heavy feelings in your arms or legs</td>
<td></td>
<td>76. Others not giving you proper credit for your achievements</td>
<td></td>
</tr>
<tr>
<td>59. Thoughts of death or dying</td>
<td></td>
<td>77. Feeling lonely even when you are with people</td>
<td></td>
</tr>
<tr>
<td>60. Overeating</td>
<td></td>
<td>78. Feeling so restless you couldn't sit still</td>
<td></td>
</tr>
<tr>
<td>61. Feeling uneasy when people are watching or talking about you</td>
<td></td>
<td>79. Feelings of worthlessness</td>
<td></td>
</tr>
<tr>
<td>62. Having thoughts that are not your own</td>
<td></td>
<td>80. The feeling that something bad is going to happen to you</td>
<td></td>
</tr>
<tr>
<td>63. Having urges to hurt, injure, or harm someone</td>
<td></td>
<td>81. Shouting or throwing things</td>
<td></td>
</tr>
<tr>
<td>64. Awakening in the early morning</td>
<td></td>
<td>82. Feeling afraid you will faint in public</td>
<td></td>
</tr>
<tr>
<td>65. Having to repeat the same actions such as touching, counting, washing</td>
<td></td>
<td>83. Feeling that people will take advantage of you if you let them</td>
<td></td>
</tr>
<tr>
<td>66. Sleep that is restless or disturbed</td>
<td></td>
<td>84. Having thoughts about sex that bother you a lot</td>
<td></td>
</tr>
<tr>
<td>67. Having urges to break or smash things</td>
<td></td>
<td>85. The idea that you should be punished for your sins</td>
<td></td>
</tr>
<tr>
<td>68. Having ideas or beliefs that others do not share</td>
<td></td>
<td>86. Thoughts and images of a frightening nature</td>
<td></td>
</tr>
<tr>
<td>69. Feeling very self-conscious with others</td>
<td></td>
<td>87. The idea that something serious is wrong with your body</td>
<td></td>
</tr>
<tr>
<td>70. Feeling uneasy in crowds, such as shopping or at a movie</td>
<td></td>
<td>88. Never feeling close to another person</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>89. Feelings of guilt</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90. The idea that something is wrong with your mind.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX G:

GLOBAL ASSESSMENT SCALE
(GAS; Endicott et al., 1976)
Global Assessment Scale (GAS)

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

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

Name of Patient ___________________ ID No. ______________ Group code ____________

Admission Date ________________ Date of rating ________ Rater ______________

GAS Rating ________________

100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity.

91 No Symptoms.

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

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

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

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

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

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

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

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

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

INVENTORY OF INTERPERSONAL PROBLEMS
(IIP-64; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988)
Inventory of Interpersonal Problems

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

---

**EXAMPLE**

How much have you been distressed by this problem?

<table>
<thead>
<tr>
<th>It is hard for me to:</th>
<th>Not at all</th>
<th>Moderately</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. get along with my relatives.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

---

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

<table>
<thead>
<tr>
<th>It is hard for me to:</th>
<th>Not at all</th>
<th>Moderately</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. trust other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. say &quot;no&quot; to other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. join in on groups.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. keep things private from other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. let other people know what I want.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. tell a person to stop bothering me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. introduce myself to new people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. confront people with problems that come up.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. be assertive with another person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10. let other people know when I am angry.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11. make a long-term commitment to another person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12. be another person’s boss.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13. be aggressive with other people when the situation calls for it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14. socialize with other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15. show affection to people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Number</td>
<td>Item</td>
<td>Rating</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>get along with people.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>understand another person's point of view.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>express my feelings to other people directly.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>be firm when I need to be.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>experience a feeling of love for another person.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>set limits on other people.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>be supportive of another person's goals in life.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>feel close to other people.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>really care about other people's problems.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>argue with another person.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>spend time alone.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>give a gift to another person.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>let myself feel angry at somebody I like.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>put someone else's needs before my own.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>stay out of other people's business.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>take instructions from people who have authority over me.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>feel good about another person's happiness.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>ask other people to get together socially with me.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>feel angry at other people.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>open up and tell my feelings to another person.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>forgive another person after I've been angry.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>attend to my own welfare when somebody else is needy.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>be assertive without worrying about hurting the other person's feelings.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>be self-confident when I am with other people.</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
</tbody>
</table>
Part II. The following are things that you do too much.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>40. I fight with other people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41. I feel too responsible for solving other people's problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. I am too easily persuaded by other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43. I open up to people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44. I am too independent.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45. I am too aggressive toward other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46. I try to please other people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47. I clown around too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>48. I want to be noticed too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>49. I trust other people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50. I try to control other people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>51. I put other people's needs before my own too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>52. I try to change other people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>53. I am too gullible.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>54. I am overly generous to other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>55. I am too afraid of other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>56. I am too suspicious of other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>57. I manipulate other people too much to get what I want.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>58. I tell personal things to other people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>59. I argue with other people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>60. I keep other people at a distance too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>61. I let other people take advantage of me too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>62. I feel embarrassed in front of other people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>63. I am affected by another person's misery too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>64. I want to get revenge against people too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>
APPENDIX I:

MEASURE DERIVED FROM MARLOWE-CROWNE
SOCIAL DESIRABILITY SCALE
(MCSD; Crowne & Marlowe, 1964)
| Sometimes I feel incredibly irritable, and then suddenly the bad mood will just disappear and I feel fine. |
| No matter who I’m talking to, I’m always a good listener. |
| I have sometimes taken unfair advantage of another person. |
| I am always courteous, even to people who are disagreeable. |
| I sometimes try to get even, rather than forgive and forget. |
| I am quick to admit making a mistake. |
| I sometimes feel resentful when I don’t get my own way. |
| There have been occasions when I took advantage of someone. |
| I would never think of letting someone else be punished for my wrongdoing. |
| At times I have wished that something bad would happen to someone I disliked. |
| I am always willing to admit it when I make a mistake. |


Part Two: Literature Review

In the last couple of decades, attachment theory and research have received increased attention (Diamond, 2004; Slade, 1999; Steele & Steele, 2008) because of their large implications for exploring and better understanding the therapeutic relationship, as well as clinically treating patients in psychotherapy. Theorists and researchers (Holmes, 2010; Wallin, 2009) have now come to use the mother-infant attachment paradigm as a lens through which to examine the therapist-patient relationship.

This literature review will trace the history of the concept of the therapeutic alliance through its development within the history of psychoanalytic theory. This will lead to a discussion of attachment theory and reflective functioning as well as their implications for understanding the therapeutic relationship and exploring how relational therapy can enhance RF through intersubjective negotiation. Further this review will look at how psychotherapy researchers are using the concepts of attachment and RF to assess therapeutic change and outcome through alternative measures that tap into the patient’s internalization of the therapist.

History of the Therapeutic Alliance

During the past century of psychotherapy research, one of the central concerns has been to determine how people change over the course of therapy and to identify specific elements that contribute to that change. The most consistent finding in the literature has been that the quality of the therapeutic alliance, the relationship between patient and therapist, is one of the strongest predictors of successful outcome and change
in psychotherapy across a variety of treatment modalities (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

The concept of the therapeutic alliance has its origins in the psychoanalytic literature starting with Sigmund Freud (Breuer & Freud, 1885; Freud, 1912, 1913) who focused largely upon the transferential aspects of the relationship. In Freud’s “The Dynamics of Transference” (1912), he differentiated between the negative transference and the positive “unobjectionable” transference by which the patient came to consciously view the therapist as a supportive figure. He argued that the positive “unobjectionable” transference had great therapeutic potential in its ability to motivate the patient to collaborate effectively with the therapist and, in turn, function as “a vehicle of success in psychoanalysis” (Freud, 1912, p.105). Although Freud did not view non-transference elements as central to psychological change, with time he did suggest the importance of the real, collaborative relationship between analyst and patient. He argued they must “band together against the patient’s symptoms” (Muran & Safran, 2000, p.7) in an “analytic pact” grounded in the patient’s exploration and the analyst’s patient understanding (Freud, 1937, 1940).

In contrast to Freud’s emphasis on insight and the recalling of early experiences from childhood, Sandor Ferenczi (1932) emphasized the “real” experience of patients in psychoanalysis. Specifically, he argued that patients should actually re-experience their early conflicts in the present relationship with the therapist. His appreciation of the “real” aspects of the therapeutic relationship would inspire numerous theorists and lead to further focus on the real aspects of the relationship.
Within the school of ego psychology, Anna Freud (1936) and Hans Hartmann (1958) focused on the real aspects of the therapeutic relationship, which would later be called the therapeutic alliance. Richard Sterba (1934) posited the notion of the “ego alliance” which emphasized the importance of developing a positive relationship with the conscious parts of the patient’s personality, the ego, so that unconscious conflicts could be addressed. In this context, the alliance could function to encourage the patient to reflect upon himself by fostering a stronger ability in the patient to move between an experiencing and observing ego.

Elizabeth Zetzel (1956; 1966) was the first to formally articulate the terms “therapeutic alliance” and “working alliance.” She argued that the therapeutic alliance was crucial to the effectiveness of any intervention. The alliance described the patient’s ability to form a positive and trusting relationship with the analyst, which through the process of identification, would evoke the patient’s earlier developmental experiences. She argued that it was crucial for the analyst to meet the needs of the patient so as to provide a trusting relationship that led to an alliance in much the same way that a mother needs to fulfill the child’s needs so as to facilitate the emergence of safety and trust.

Increased focus on the real aspects of the therapeutic relationship rather than the transferential aspects enabled greater focus on the real relationship of patient’s with their caregivers in childhood rather than fantasized aspects of this early relationship. Zetzel (1956; 1966) proposed that the patient’s difficulty in developing trusting relationships, such as with the analyst, was an expression of earlier developmental failures. Notably, she argued that developmental difficulties could be repaired through the real relationship
with the therapist whereby a supportive and responsive environment was created.

Similarly, the theorists from the British Object Relations (Fairbairn, 1952; Winnicott, 1932) and the Independent School (Bowlby, 1969) emphasized how infant’s reality-based interactions with mothers are central to the development of psychological health, and how therapists could help patients work through developmental failures through the therapeutic relationship. Winnicott (1932) argued that mental health comes out of the mother’s responsiveness and containment within a physical and psychical “holding environment” whereby the child feels both protected and safe to playfully explore. For adults with unfavorable childhoods, the therapist could provide a similar “holding environment” within which developmental needs central to growth could be repaired.

Similarly, John Bowlby argued that the child’s attachment to the mother and the emotional security that emerges from this relationship are central to psychological wellbeing. He posited that attachment difficulties increase the vulnerability to psychopathology, yet could be modified and processed through the attachment relationship with the therapist.

Ralph Greenson (1967; 1971) continued theorizing on the therapeutic relationship by conceptualizing it as consisting of the transference configuration (Safran & Muran, 2000) and the real relationship. Although he emphasized that the boundary between these two parts was artificial, he posited that the real relationship between patient and therapist was made up of undistorted perceptions and their mutual respect for each other all of which enabled them to work together towards a common goal. He conceptualized all
these elements as making up the therapeutic working alliance with the essential core being the real relationship.

Although many theorists wrote about the alliance, it was not until the 1970’s that researchers began to give notice to the therapeutic alliance. This focus was largely due to Edward Bordin’s (1979) reconceptualization of the therapeutic alliance. He created a model that was not allied with any one psychological theory or technique. His model viewed a strong therapeutic alliance as central to the effectiveness of any kind of therapy. He operationalized the therapeutic alliance into several interrelated parts: the task, the goals, and the bond. His central assertion was that the strength of the alliance was dependent upon agreement of these parts by both parties.

Within Bordin’s model, the patient and therapist must agree upon the tasks and the goals of therapy in order for the therapy to be successful. There must also be a strong, relational bond between the patient and therapist whereby an environment of mutual understanding and respect is established. These three dimensions influence each other in an ongoing and dynamic fashion as well as mediating each other. This conceptualization of the alliance had numerous implications in that “it highlights the interdependence of relational and technical factors in psychotherapy [and] . . . suggests that the meaning of any technical factor can only be understood in the relational context in which it is applied” (Safran & Muran, 2000, p.14). Further, Safran and Muran (2000) have built upon Bordin’s conceptualization by arguing that it is the ongoing negotiation between the patient and therapist over many of these components that is central to therapeutic change.
Bordin’s reconceptualization of the alliance into multiple, atheoretical parts allowed for an aspect of the therapeutic relationship to be measured which led to a multitude of psychotherapy research projects (Horvath, Gaston, & Luborsky, 1993; Horvath & Symonds, 1991; Orlinsky, Grawe, & Parks, 1994) and the consistent finding that the quality of the therapeutic alliance is one of the strongest predictors of successful outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). As many theorists had intuited, the therapeutic alliance is an integral and crucial element in driving psychotherapeutic change. These findings as well as theoretical contributions will be explained further below as having an important connection to attachment theory and, specifically, reflective function.

**History of Attachment Theory**

John Bowlby’s attachment theory (1969; 1973; 1980) asserted that there was an “attachment behavioral system” in which the child and mother are bound by a biologically based, bi-directional relationship that functions to keep them in close proximity thereby serving, most basically, the function of physical safety. Further, his attachment theory proposes that infants engage in proximity seeking, attachment behaviors (i.e., crying) when distressed which are designed to evoke corresponding, responsive behaviors from the caregiver (i.e., soothing) so as to bring the child back to a state of security.

Bowlby (1988) also emphasized the importance of the caregiver functioning as a “safe haven” to which the infant could turn to for comfort in times of distress, and as a
“secure” base from which the infant could explore. If the attachment figure could provide protection and responsiveness to the needs of the infant, especially when distressed, then the infant could feel free to explore. Bowlby argued that without some sort of base, survival and development would be impossible for the infant and thus to survive the “infant must adapt to the caregiver, defensively excluding whatever behavior threatens the attachment bond” (Wallin, 2007, p.2). Bowlby’s (1988) notion of defensive exclusion described the ways in which unwanted feelings or needs are kept out of awareness, which leads to restrictions on the expectations of others. With time, the infant comes to internalize the kinds of behavioral responses given to his bids for proximity. These internal working models (IWM; Bowlby, 1973;1982) are modes of implicit relational knowledge about attachment relationships (Stern, 1985; Lyons-Ruth, 1991) that emerge out of early interactions with primary caregivers. These dynamic mental models represent patterns of interactional experiences in infancy and come to characterize the child’s expectations about self and others. These IWMs are active throughout the life cycle and thus come to critically shape future interpersonal relationships. In Bowlby’s conceptualization, IWMs could be open to modification through new experiences with other supportive figures, such as a therapist who could function as a secure base.

In the early 1960’s, Mary Ainsworth and her colleagues (Ainsworth, Blehar, Waters, & Wall, 1978) conducted research that would operationalize many of Bowlby’s theories regarding the attachment system. They found that infant’s attachment patterns were each associated with a correspondingly different pattern of mother-infant interaction. “Secure” infants could explore comfortably in the presence of the parent,
naturally display their distress at separation, and quickly turn to their mothers upon reunion with the expectation that they would be soothed. In contrast, insecure infants exhibited different coping strategies for regulating their emotional reactions. The anxiously/avoidantly attached infants over-regulated their affect and avoided situations that were potentially emotionally arousing which Holmes (2001) argues can lead to a tendency to gravitate towards autonomy over intimacy in adulthood. In contrast, the anxiously/resistantly attached infants under-regulated their affect and exaggerated their expressions and distress to elicit comfort from the caregiver thereby later embodying intimacy over autonomy (Holmes, 2001).

While Ainsworth’s research focused on the interpersonal interaction as a way of understanding the attachment system, Mary Main’s work would shift the focus from the external world of behavior to the internal world of mental representations underlying attachment behaviors. Main and her colleagues (George, Kaplan, & Main, 1985) sought to assess the relationship between parent’s early attachment experiences and their attachment status as adults. To this end, they designed a structured interview, the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985), which asked parents to reflect upon their relationships with their parents as well as past experiences of loss, separation, and rejection. This interview was designed to elicit attachment related representations through questions that “surprise the unconscious” (Main, 1991) and, in this way, could assess attachment in adulthood.

Through intensive analysis of language in these AAI narratives, Main and her colleagues (1984;1998) found that adult’s manner of discourse reflected specific patterns
of representation that were analogous to patterns of infant’s behavior in the strange situation. Specifically, mothers found as secure/autonomous on the AAI had children who were found to be secure in the strange situation procedure. Main and her colleagues’ finding that a mother’s representations of her relationship with her own parents is associated with the behavior of her child greatly illustrated Bowlby’s notion of IWMs and further that different patterns of attachment reflect different mental representations of the self to attachment figure (Main et al., 1985).

In research with the AAIs, Main and her colleagues (1991;1998) continued to find coherence in narratives as central in determining attachment status. They argued that those who can give a coherent narrative can consistently collaborate with the listener to make sure they are understood as well as be thinking and clarifying their thoughts as they are speaking. This ability to reflect upon one’s thinking spontaneously while speaking, *metacognitive monitoring*, is seen as a crucial illustration of coherence. This capacity allows one “to step back and consider his or her own cognitive processes as objects of thought or reflection” (1991, p.135). Thus secure individuals give descriptions that are clear, integrated, and open to reflection in the present.

Main (1991) described metacognition as the “regulation of cognition” that enables individuals to consider their own thinking as an object of reflection. She (1991) proposed that metacognition enabled individuals to appreciate that their thoughts could be devoid of validity, that their understanding of experiences, can change over time (representational change), and that different people may have thoughts and feelings different from one’s own yet equally valid (representational diversity). These abilities
enable one to differentiate between one’s internal and external world as well as see how
ythey can be related. In turn, this helps one make better sense of one’s internal affective
experience as well as to respond more adaptively to interpersonal situations. Most
especially, metacognitive monitoring enables individuals to freely observe, explore, and
be curious in understanding the facets of their own and other’s minds that continually
influence their experience of the world.

Main (1991) came to explain transgenerational transmission of attachment from
mother to child as having to do with the quality of metacognition and coherence of the
mother’s attachment narrative, which strongly predicted their infant’s pattern of
attachment. Main also argued most notably that metacognitive monitoring could function
as a protective factor early in life with the potential to diminish the effects of unfavorable
attachment experiences. This notion can also hold true for adults and has profound
implications for the utility of psychotherapy to increase metacognitive monitoring as a
way of conferring resilience.

**Reflective Functioning**

In the 1990’s, Peter Fonagy and his colleagues (1995, 1996, 1998) further
elaborated upon the notion of “metacognitive monitoring” (Main, 1991) through the
concept of “reflective functioning” (RF; Fonagy et al, 1998), which integrates ideas from
psychoanalytic theory, and developmental and cognitive psychology (Steele & Steele,
2008). Reflective functioning refers to mentalizing or the capacity to think about and
understand one’s self and others in terms of mental states – feelings, beliefs, intentions
and desires (Fonagy et al., 1998). This capacity requires the ability to appreciate mental states as propositional and intentional with underlying beliefs and desires. Reflective function involves the ability to reason and grapple in trying to understand one’s own and others’ behaviors in terms of underlying mental states. This capacity inherently enables one to be able to take another’s perspective into account as well as one’s own subjective stance. Thus RF enables people to anticipate and predict their own as well as other’s reactions and behaviors thereby endowing interpersonal interactions with meaning and predictability. Reflective function (RF) can be an adaptive capacity in many different ways. This reflective capacity can help organize experience by enabling one to see one’s own and other’s intentions, feelings, and behaviors as meaningful and predictable through an understanding of social causation. In addition, RF contributes to the ability to distinguish between appearance and reality, which endows one with the ability to view the world from different perspectives and interpretations. An ability to reflect upon one’s own and other’s minds also enhances communication by providing a means through which minds can be jointly explored and understood. In addition, studies (Fonagy, 1994) have shown that RF can function as a protective strategy to buffer the effects of past trauma and adversity.

Fonagy and his colleagues (1991;1998; 2002) conceptualize reflective functioning as a developmental achievement originating from the intersubjective processes and attachment relationship between infant and caregiver. It is notable that RF is specific to the unique attachment relationship from which it develops (Fonagy et al., 1991;1998).
Specifically, the development of RF emerges from the caregiver’s ability to accurately and consistently perceive the mental states of the infant, respond accordingly, and, in turn, validate the intentionality inherent in the infant’s states. As Target and Fonagy (1996) write, “Unconsciously and pervasively the caregiver ascribes a mental state to the child with her behavior, [and] this is gradually internalized by the child, and lays the foundations of a core sense of mental selfhood” (p.461). By empathically reflecting back to the infant an understanding of his or her own intentions, the caregiver shows the infant that they are perceived as an intentional other whose behavior is driven by thoughts, feelings and desires; through these moments of reflection, the caregiver is giving meaning to the child’s behavior. In turn, this process facilitates a sense of mental agency in the child who will then develop the capacity to experience a range of feelings later resulting in the ability to mentalize and understand his internal world.

Central to this theory is that the infant’s self-regulation and autonomy evolves out of coregulation and continued recognition by the caregiver. In contrast, the child who does not receive an accurate reflection of his thoughts and feelings will develop representations contradictory to his own experience. In turn, this child will have difficulty exploring mental states in himself or others as the act will not feel safe.

The notion of the self developing out of intersubjective interaction is rooted in Winnicott’s (1956;1971) developmental theory. His notion of mirroring posits that the mother’s reflection of the child’s experience fosters internalized representations of those interactions and the development of an authentic self embodied in the child feeling that “when I look I am seen, so I exist” (1971, p.134). Hence the mother’s recognition and
attunement fosters the child’s development of an autonomous self grounded in his own experiences.

In their conceptualization of RF, Fonagy, Target, Steele and Steele (1998; 2002) have integrated psychoanalytic notions of containment (Bion, 1962), mirroring (Winnicott, 1965), and internal representational worlds (Sandler, 1978; Loewald, 1960).

There are many notable similarities between attachment theory and psychoanalytic theory in terms of how the self develops out of the infant-caregiver relationship. Both view the caregiver’s attunement to the child as central to healthy self-development and affect regulation. Many psychoanalytic thinkers (Behrend & Blatt, 1985; Kernberg, 1985) have described how early developmental disturbances could result in unintegrated representations of self and other potentially leading to psychopathology.

Many psychoanalytic theorists wrote about the importance of early interactions in terms of how they influence the development of autonomy and affect regulation. Specifically, Fairbairn (1954) argued that from birth, humans are “object seeking” and the “loss of optimal intimacy will give rise to ‘splitting’ in the ego” leading to “conflicting multiple self-object systems [which] are the developmental roots of psychopathology” (Fonagy, 1999, p.608). Similarly, Winnicott (1956;1978) wrote extensively on how the child evolves out of early unity with the mother and through maternal sensitivity and “ego relatedness” (1965b) develops an authentic sense of self.

Loewald (1960) further built on these ideas by theorizing that people develop a sense of self and affect regulation by internalizing early interactions with caregivers. Specifically, he viewed the development of psychic structure as originating in the
maternal environment through the processes of introjection, or internalization, and
projection. Through this process, the child comes to understand the boundaries between
internal and external worlds as well as self and other. He emphasized how the mother
provides regulatory functions with which the child identifies and internalizes ultimately
becoming the basis of his own regulatory capacities.

In line with above theories, interpersonal and relational schools of psychoanalysis
view humans as essentially driven from birth to have and maintain relationships.
Contemporary relational psychoanalysis (Aron, 1996; Greenberg & Mitchell, 1983)
integrates American interpersonal theory, British object relations, self psychology,
feminist and postmodern theory. It also posits that early interactions with caregivers lead
to interdependent mental representations of self and other. It views the process of
negotiation between autonomy and relatedness as central to all interactions. The recent
focus on theories of intersubjectivity highlights that relationships are an ongoing
interplay between different subjectivities. Further, Safran and Muran (2000) argue that it
is the ongoing intersubjective negotiation between the needs and feelings of both patient
and therapist that is most central to therapeutic change.

Jessica Benjamin (1988;1990) has built upon Winnicott’s theory (1965) of how
the child develops healthy autonomy out of early unity with the mother. She (1988; 1990)
posits that the child must come to recognize the mother as having her own internal world
of needs, desires, and intentions. In turn, the child learns that she too has an internal
world and mind which leads to her ability to recognize the other as a separate subject.
Benjamin argues that this kind of recognition of the subjectivity of the other is a
developmental achievement crucial to the development of the self. Her notion of
intersubjectivity has many similarities to reflective function in its emphasis on how the
self develops out of interactions with other minds. Similarly, Fonagy and his colleagues
(1998; 2002) argue that the autonomous self develops out of the process of both figures
recognizing each other’s minds and subjectivities as separate yet connected.

Fonagy and his colleagues (1991; 1998) have operationalized this capacity by
creating the Reflective Functioning Scale (RF; Fonagy et al., 1998), which assesses the
mentalization of individual’s in the context of attachment relationships. Their body of
research (1991; 1998) has shown that RF is the most highly predictive correlate of
mother-infant attachment and can help explain the intergenerational transmission of
attachment. Based on Main’s assertion that metacognitive monitoring could serve as a
protective factor, Peter Fonagy, and Howard and Miriam Steele (1991) conducted a study
looking at the attachment classifications of 100 expectant couples from highly stressed,
deprived backgrounds. The study found that parents’ RF on the AAI could predict their
infant’s attachment security before the infants were born. Further, mothers who
experienced social stress and deprivation during their upbringing but showed high
reflective functioning on their AAIs had children with secure attachments to them. This
groundbreaking finding highlights how the capacity to reflect on ideas and mental states
related to attachment can serve a highly protective function and can help decrease the
likelihood of intergenerational transmission of security. One could theorize that it is the
parent’s ability to step back and put their own personal issues and needs aside, that allows
them to focus empathically on their children as separate beings with minds, feelings and needs of their own.

**Attachment Theory, Reflective Functioning, and the Therapeutic Relationship**

Theorists and researchers (Diamond, 1994; Fonagy, 1991; Holmes, 2001; Slade, 1999; Steele & Steele, 2008) have come to use the mother-infant attachment paradigm as a lens through which to understand and elaborate upon the therapist-patient relationship. Studies have shown that attachment status is associated with the quality and nature of the therapeutic alliance (Dozier, Cue, & Barnett, 1993; Eagle, 2003) and transference-countertransference dynamics (Diamond et al., 2003; Fonagy, 1991; Holmes, 1996; 2001). These findings highlight how the therapist can function as an important attachment figure for individuals in adulthood (Holmes, 2001) in which they can have a “secure base” and develop stronger reflective capacities. Within this context, the “therapist’s role . . . is to help the patient both to deconstruct the attachment patterns of the past and to construct new ones in the present” (Wallin, 2007, p.3) through the therapeutic relationship.

Jeremy Holmes (2001; 2003; 2010) has written prolifically on how therapists aim to create an environment similar to the early secure base by providing consistency, availability, reliability, attunement, and reflectiveness. Further, the therapist can function as a “safe haven” to which the patient can turn in times of distress and a safe “secure base” from which the patient can comfortably explore their thoughts and feelings. The therapist can both become a “secure base” in terms of his or her physical presence in
times of emotional distress, but also as “a [mental] representation of security within the psyche” (Holmes, 2001, p.7) which guides an ability to negotiate autonomy and relatedness. Patients can also turn to this internal secure base in order to find comfort and regulate their affect while outside of or following termination. Theoretically, ongoing interpersonal experiences with the therapist should become internalized over the course of treatment enabling the patient to develop a secure attachment to the therapist and positive expectancies of how his bids for relatedness will be met.

Holmes (2010) argues that the capacity for reflective functioning or “mentalizing” on the part of the therapist is crucial to developing a secure and resilience-promoting relationship. He argues that, particularly during rupture moments, mentalizing can be a “reparative activity [which] starts from the therapist’s capacity to mentalise his own mind, to reach out empathically to the patient, [and] to think and articulate about ‘we/us’” (p.86) and what is being enacted in the moment. The capacity of the therapeutic dyad to reflect upon the strained interaction together in the moment can strengthen the relationship and is “itself a change-promoting manoeuvre, enhancing the clients’ capacity for self-awareness and negotiating skills in intimate relationships” (Holmes, 2010, p.38).

Attachment theory’s focus on the self and its reflective capacities emerging from a process of both attachment and separation is in line with current relational psychoanalytic theory. It views development as a perpetual struggle between autonomy and relatedness (Greenberg & Mitchell, 1983) and sees the therapeutic relationship as a rich opportunity for the negotiation between these two needs. From a clinical perspective,
attachment theory provides a way of looking at how the therapeutic relationship can help patients negotiate struggles between autonomy and relatedness.

**Brief Relational Therapy, Ruptures, and Reflective Functioning**

Relational therapies can be particularly suited to enhance reflective functioning. Jeremy Safran and Christopher Muran (2000) have been conducting research on the therapeutic relationship since the 1980’s at the Brief Psychotherapy Research Program at Beth Israel Medical Center (Safran & Muran, 2000). Their research has focused on exploring and understanding ruptures in the therapeutic relationship and developing methods for repairing these strains. Their studies focus on thirty-session psychotherapy treatment for patients with Cluster C, personality disorders.

Safran and Muran (2000) argue that the process of negotiation between patient and therapist in a new, mutually collaborative relationship can provide corrective experiences to repair early developmental difficulties. Here the therapeutic relationship and the negotiation of autonomy and relatedness are seen as central vehicles of change. The working through of relational enactments is viewed in many ways as the therapy and as central to the alliance. In line with attachment theory, they emphasize the need for attunement early on because “the therapist’s ability to attune to the patient’s unarticulated emotional experience plays a critical role in the initial development of the alliance” (p.47). Hence one could argue that it is the development of this bond early on that makes secure attachment and reflective functioning possible for “without the alliance there can
be no secure base, and without the secure base there will be no exploration.” (Holmes, 2001, p.17).

Safran and Muran (2000) have written prolifically on how the relationship between patient and therapist is a process of continual intersubjective negotiation which provides rich potential for providing new relational experiences. They argue that patients come into therapy with “interpersonal” or “relational” schemas (Safran, 1998; Safran & Mura, 2000) which are based on early relationship patterns with others and guide one’s expectations for relatedness (Safran et al., 1990). These mental representations can be seen as akin to Bowlby’s internal working models (1973) or self-object representations (Behrend & Blatt, 1985). These schemas were developed out of early experiences in which they were adaptive but in adulthood have become maladaptive. Further, they argue that these generalizations are inevitably enacted in the therapeutic relationship and thus the goal for the therapist is to disconfirm these expectations by responding in a different way.

Safran and Muran (2000) have created a relationally and experientially informed therapy, Brief Relational Therapy (BRT), which is designed in many ways to help patients experience a new corrective relationship in which their interpersonal expectations can be explored and disconfirmed especially during ruptures, shifts in the alliance, or “breaches in relatedness” (Safran 1993a).

BRT’s emphasis on interpersonal process and the working through of ruptures provides fertile ground for the enhancement of RF. Firstly, there is an explicit focus on shifts in the relationship and in-depth exploration into the nuances of both participants’
experiences amidst these moments. During ruptures, they advocate for the therapist to metacommunicate or explicitly communicate about the communication occurring. Therapeutic metacommunication is “an attempt to step outside the relational cycle that is currently being enacted by treating it as the focus of collaboration” (p.108). The therapist’s ability to highlight what is being enacted and explore this interaction with the patient can provide the patient with a corrective emotional experience whereby conflict can be safely negotiated and understood. This process can foster the patient to internalize a relational schema, of self with therapist, which is secure and mutually responsive.

Further, these moments help patients see that they are capable of negotiating relatedness even amidst interactional tension. In other words, these moments entail an exploration and validation of both separateness and relatedness of patient and therapist whereby in treating the others as a potential object, the other may be found as a subject. As Safran and Muran (2000) write: “the therapeutic situation must invariably involve a dialectical tension between relating to the other as an object and relating to the other as a subject. This process continually involves both the recognition and negotiation of the other as a separate center of subjectivity” (p.54). In line with this notion, Fonagy (2004) asserts that through mentalization or RF, patients come to respond to the others “not as objects but as persons” (Wallin, 2009, p.56).

In order to tap into the process of rupture resolution, Safran, Muran, and Winkleman (2006) created the Rupture Resolution Questionnaire (RRQ) which is a unique self-report measure that is completed by patient and therapist after each session. The RRQ is conceptualized as a measure of the alliance as negotiation. In contrast to
most measures of the alliance that focus on agreement between patient and therapist, the RRQ focuses on the hypothesized “experiences associated and resulting from the constructive negotiation of conflict between them” (Safran, Muran & Proskurov, 2009, p.218). The RRQ taps into patient’s experiences of intersubjective negotiation and their feelings of resulting resolution, strengthened relatedness, connection with disavowed feelings or thoughts, and a new recognition of the subjectivity of the therapist. The finding from the empirical study that patients’ RF at termination is associated with intersubjective negotiation in the last third of treatment, highlights how the RRQ is a unique assessment measure that can tap into patients’ internal changes that occur as a result of intersubjective negotiation.

Attachment, Reflective Functioning, and Psychotherapy Research

There are numerous ways in which attachment theory can inform psychotherapy practice and research. Numerous studies have shown a strong association between reflective functioning and secure attachment (Fonagy et al., 1991; Slade, 2005), yet only recently has RF been explored in relation to psychotherapy process (Bernbach et al., 2001) and outcome (Diamond et al., 2003; Fonagy et al., 1996; Levy et al., 2006). Research has shown that patient’s overall attachment to the therapist is positively associated with the working alliance suggesting that the use of the therapist as a secure base is important (Parish & Eagle, 2003). Studies are also showing a strong relationship between deficits in RF, insecure attachment status, and borderline personality disorder (Diamond et al., 2003; Fonagy et al., 1996).
Researchers (Blatt & Auerbach, 2003) are increasingly creating measures for more richly assessing patient’s attachment to and internalization of their therapist, and how these factors can drive therapeutic change. Diana Diamond and her colleagues (1999; 2003) have conducted research exploring patients’ states of mind with regards to their attachment relationship with the therapist. To this end, they created the Patient-Therapist Adult Attachment Interview (PT-AAI), which parallels the Adult Attachment Interview (George, Kaplan, & Main, 1996) in format and structure, and have applied the RF scale to this interview. They argue that the PT-AAI “is designed . . . to explore the reflective function factor that might contribute to the transference-countertransference dynamic central to TFP, and the ways that they may vary depending on the dynamics of the specific patient-therapist dyad” (p.237). Diamond and her colleagues (1999) used the AAI and PT-AAI rated with the RF Scale with 10 patients with Borderline Personality Disorder treated in year-long, Transference Focused Therapy (TFP), a therapy that focuses explicitly on transference and countertransference dynamics. They administered the AAI at 4 months and 1 year, and the PT-AAI at 1 year. Results showed that patients’ security status and RF with their parents on the AAI, often overlapped with their security status and RF with their therapists on the PT-AAI. They concluded that the patient’s RF on the PT-AAI assesses “transference and countertransference aspects of the therapeutic relationship by capturing the patient’s and therapist’s capacities to represent each other in mental state terms, which then may be linked to the patient’s capacity to reflect on the mind of parents . . . as evidenced on the AAI” (p.254). Overall, their research also
highlights how psychoanalytic psychotherapies can serve to activate and modify the patient’s internal working models through the therapeutic relationship.

Studies are also emerging that view the internalization of the therapist and subsequent quality of internal representations as central to therapeutic change. Barry Farber and his colleagues (2004; 2010) have conducted ongoing research into the forms and functions of the patient’s internalization of the therapist. Through the Therapist Representation Inventory (TRI), they have looked at how patient’s internal representations of self with therapist function to help them through various contexts outside of session. They have shown that many patients continue to evoke representations of their therapists and themselves in the therapeutic relationship after treatment has ended. Further, they argue that after termination, the patient’s ability to keep an internal therapeutic dialogue continuing in their head of the therapeutic relationship, or in RF terms, to keep the therapist in mind, demonstrates optimal therapeutic treatment. This continuing therapeutic dialogue in the minds of patients has been found to be associated with positive therapeutic outcome and improved psychological well being (Arnold, 1998; Wzontek et al., 1995).

Further Farber and his colleagues (2010) argue that current and former patients “are most likely to evoke representations of their therapists when painful affects . . . are being experienced – an indirect indication that they seek the emotional proximity of their therapists, and that the therapy relationship provides a safe haven to turn to for comfort in times of need” (Farber & Metzger, 2010, p.52). Thus their research is tapping into patient’s internal representations of their therapists as secure attachment figures.
Conclusion

In summary, examining the therapeutic relationship through the attachment paradigm is highly useful in understanding patient’s difficulties rooted in childhood and informing how the therapist can function as a new, secure attachment figure. Further, the concept of reflective functioning is a rich concept which has enormous implications for fostering security and interpersonal change in therapy through “mentalizing” (Holmes, 2010), and through “metacommunication” (Safran & Muran, 2000) during ruptures. The operationalization of this concept (RF scale) also provides a unique assessment measure, which allows for research to tap into patient’s internal changes resulting from the intersubjective nature of the therapeutic relationship. Moving forward, research should continue to develop alternative measures that better tap into the effects therapy can have on shifts in patients’ internal worlds.
References


