The Effects of Alliance Focused Training on Patient and Therapist Interpersonal Process

Anthony P. DeMaria

ABSTRACT: Research has consistently shown the therapeutic alliance to be one of the most robust predictors of outcome in individual psychotherapy. Safran and Muran (2000) propose a treatment model with an intensive focus on the therapeutic relationship, interpersonal process, and training in how to resolve moments of therapeutic impasse and alliance ruptures called Alliance Focused Training (AFT). The present study uses a simplified version of the SASB rating system to measure change in patient and therapist interpersonal process as a result of this training. Based on a power analysis, 132 therapy sessions (2 early, 2 midphase, 2 late) from 22 different dyads in a multiple baseline study design were selected. Therapy cases were time limited (30 session) CBT on cluster C personality disordered patients. AFT was implemented to augment CBT supervision at either session 8, or session 16 in multiple baseline design to control for therapist maturation and time effects. Change in interpersonal process as a result of AFT was assessed using Generalized Estimating Equations. Results indicate significant change in patient and therapist interpersonal process as a result of AFT, and are discussed.

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by

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DEDICATION

I would like to dedicate this dissertation to my family, friends, and loved ones who have always supported the pursuit of my interests.

ACKNOWLEDGEMENTS

I would like to thank Drs. Safran, Muran, Eubanks-Carter, and Christian. Their research mentorship, guidance, clinical expertise and supervision have undoubtedly influenced my academic, clinical, and professional trajectory. Finally, I thank the Brief Psychotherapy Research Program and all of its members. I am indebted to you all.

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Chapter 1: Theoretical Basis

Psychotherapy research has undergone much change in recent years. One that is notable for the present investigation is the trend not to exclusively focus study on patient factors in isolation, but to incorporate both therapist and patient impacts on therapeutic process. Prior to this trend, the primary aim of most psychotherapy research studies was to investigate the effectiveness of specific therapies via outcome focused research. One of the primary impetuses for this movement in the field has been recommendation by the American Psychological Association that clinicians utilize empirically derived and/or supported therapies for the treatment of psychiatric disorders and psychological distress (APA, 1995). Following such recommendations made by professional associations and political trends in the field, the United States dramatically increased its research funding as an attempt to further develop new and existing forms of treatment that are empirically supported (APA, 2006). To operationalize this, Chambless & Hollon (1998) describe "empirically supported treatments" as clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population.

To demonstrate this efficacy, the majority of outcome studies utilized a research design borrowed from medicine, the randomized clinical trial (RCT). The RCT paradigm is a group designs in which patients are randomly assigned to the treatment of interest or one or more comparison conditions (Chamless & Hollon, 1998). Treatment efficacy is typically assessed via change in symptom, or other outcome based ratings from pre to post treatment. Persons (Persons and Silberschatz, 1998) states that evidence from RCT's is considered to be the gold standard of evidence of treatment efficacy. Furthermore,

proponents of this manner of research purport that practitioners have an ethical and legal obligation to integrate research from RCT's into their practice (AHCPR, 1993).

Despite the commonality of RCT's, and their status as a "gold standard", many are critical of their utility. Silberschatz (Persons & Silberschatz, 1998) points out that in clinical practices, diagnostic co-morbidity is the rule, rather than the exception. This, however, is not often captured in RCT's that tend to limit their samples to patients with singular diagnoses. Further, many speak to limitations of pre-posed based methods of assessing therapeutic outcome. The results of the Grande et. al study (2009) indicate that structural change in psychotherapy is not amenable to being studied by re-rating 'outcome' measures at termination or follow-up. Rather, this longitudinal study contends that, since patients are not aware of the elements of their psychology, behavior, thinking, and other abilities to function adaptively are problematic, they cannot be considered accurate at treatment onset. In other words, information about pre-treatment problems and functioning on some levels can only be examined retrospectively after such structural changes have taken place.

Consistent with conceptual critiques to outcome based research, a consistent finding when surveying psychotherapists about the perceived relevance of sources of information, clinicians tend to not see research as particularly meaningful (Morrow-Bradley and Elliot, 1978, Safran, et. al, 2010.) Perhaps explaining this phenomenon, Keisler (1966) asserts that practitioners will benefit from knowing what types of treatments work best for the specific constellations of symptoms and dysfunctions of their clients and patients, particularly when they can clearly see what change mechanisms are

at play within interventions. He posits that clinicians can work best when able to drawn upon various specific techniques that are established by research as effective for specific problems.

This is more often than not absent in psychotherapy outcome trials, leading consumers of research to having difficulty finding utility in research findings, and integrating them into practice. The longstanding gap between research and practice is mirrored by a gap between treatment type and specific mechanism for change. Kazdin states that, "It is remarkable that after decades of psychotherapy research we cannot provide an evidence based explanation for how or why even our most well studied interventions produce change." He concludes that:

> *"The scientific study of mechanisms of change is certainly not an easy path on which to embark. A given treatment might work for multiple reasons. Just as there is no simple and single path to many diseases, disorders, and social, emotional, and behavioral problems, there may be analogous complexity in mechanisms for a conceivably could respond for different reasons. The complexities are critically optimal variation of treatment is provided. Understanding mechanisms of treatment is the path toward improved treatment"* (Kazdin, 2009).

Luborsky (1997) notes that when we are looking at 'outcome' in psychotherapy, we are inextricably speaking about *change*. Departing from RCT based investigations of patient change, contemporary psychotherapy researchers have trended towards investigating therapeutic change *processes* themselves. This shift in focus from outcome to process, follows assertions from multiple psychotherapy researchers, notably

Greenberg. Les Greenberg (1999) posits that rigorous scientific research follows a progression of observation, measurement, explanation, and finally prediction. He argues that little work has been done on the early stages of this progression, stating, "intensive rigorous observation of how change takes place probably has been the most sorely neglected (area of research)." Essentially, the psychotherapy process becomes the variables to be measured for 'outcome'. Change, this way, is seen, rather than inferred or abstracted. Accordingly, based on this change of focus, an increased amount of attention has been paid to in-session, therapeutic process.

To date, despite the fact that the majority of psychotherapy research has used symptom-based measures of therapeutic success (Goldfried, 1994), interpersonal process is one of the most well supported predictors of treatment outcome (Orlinsky, Ronnestad & Wllutzki, 2004). Patient and therapist interpersonal process refers to the transactional quality and manner in which the two are interacting. Where as the content refers to what patients and therapists are talking about in session, process refers to what they are doing in the therapy session, and how they are doing it.

While finding factors that compellingly predict therapeutic outcome is difficult and often disappointing (Norcross, 2002), interpersonal process consistently plays an integral role in the course of therapeutic change (Benjamin & Critchfield, 2010). In some studies, as much as 65% of the variance in therapeutic progress has been attributed to interpersonal process and reflexive social behavior (Rudy, McLemore & Gorsuch, 1985) indicating that it is not only a consistent predictor of therapeutic outcome, but also one

that is robust. Both empirical research and theory indicate that social behavior and interactions play an important role in the process of psychotherapeutic change.

This sentiment, which in imbedded in interpersonal theory, was held by early psychoanalysts such as H.S. Sullivan, who suggested that one must understand recurring patterns in social relations to understand one's personality. This view stems from theory and research suggesting that the formation of one's personality is inextricably tied to the social realm and interactions (Sullivan, 1953). Accordingly, Henry, Schact & Strupp (1986) call for the fundamental unit of psychotherapy process analysis to be interpersonal transactions in the therapy dyad. Following Kiesler (1982), they argue against the studying of patient and therapist variables in isolation, as doing so would not account for the interaction between a patient's self-defeating communication patterns that compose an interpersonal evoking style, and a therapist's manner of responding to this style. Kiesler (1982) notes that these two styles join together in an irreducible pathway that *is* the therapeutic relationship.

One of the major constructs through which this emphasis on therapeutic process has been investigated in psychotherapy research is the therapeutic working alliance (Norcross, 2002). The quality of the relationship between patient and therapist was discussed as a critical factor in psychotherapy from its inception. Although his view on the subject is relatively contradictory, Freud made early reference to the importance of the interpersonal bond in his technical writings. In his discussions, Freud (1913) recommended that the analyst show the patient "sympathetic understanding" and a "serious interest". Further, he made mention to colleagues that "the secret of therapy is to

cure through love" (Grotjahn, 1967). Although Freud's intention was to indicate that it was the patient's love of the therapist that was necessary, he nevertheless indicates in this statement the fundamental necessity of positive affect within the therapeutic relationship. These contributions were dissimilar to others made at the time, which stressed the dynamic structures of the mind, focused primarily on the patient, and noted how the analyst should remain neutral, abstinent, and objective. Early mentions of the importance of the therapeutic relationship and bond between patient and therapist like Freud's served as precursors to later investigations of what would become the therapeutic working alliance.

The term therapeutic alliance was first used by Zetzel (1956) as a patient's identification with a therapist, which becomes formed and encouraged by that therapist's behavior. Building upon the aforementioned statements by Freud, Zetzel's definition acknowledged the role of therapist behavior and contributions to the therapeutic relationship. This and other early views of the therapeutic working alliance, however, are theory specific, and claim that a distinction can be made between aspects of the therapeutic relationship that are transferential, or distorted by past experiences, and those which are not (Safran and Muran, 2006). Indeed for Freud, the therapeutic relationship was better understood as a positive transference, which was not necessarily important to interpret and analyze, than any other concept. Because of the multitude of perspectives on the topic, precursory discussions of the importance of "non-specific" factors, that is to say aspects of therapy that were not related to any specific theory or technique such as the therapeutic relationship were fraught with contention and acrimony. Freud, and other early analysts discussing the therapeutic relationship viewed negative relational

experiences and strains in the emotional bond between patient and therapist as something to be worked through, resolved or cleared away so that the "real work of analysis", transference interpretation, could be done. At most, a strong therapeutic working alliance was seen as a necessary condition for meaningful transference interpretations that would lead to insight and a successful analysis (Messer & Wolitzky, 2010). This view was to evolve over time, as analysts such as Greenson (1965) began making the claim that the therapeutic working alliance was as important to therapeutic action as transference analysis itself. Further, Greenson (1965) suggested that this alliance could be based on non-distorted object relations.

At this time, the concept of the therapeutic working alliance was predominantly discussed by psychoanalysts, and not more broadly by psychotherapists. This, however, changed in the second half of the 20th century when Bordin (1979) began discussing the therapeutic alliance in pantheoretical terms. His understanding of the therapeutic alliance had three operationalized parts: agreement between patient and therapist on the tasks of therapy, agreement on the goals of therapy, and the quality of the emotional bond between patient and therapist. Hatcher (2010) emphasizes Bordin's thinking on the alliance when he summarizes that "work is an activity toward a goal- it is purposeful. Two people working together for a goal require collaboration. Thus, this work is anchored in agreement on goals, collaboration on tasks, and supported by an appropriate bond." Bordin, by making use of pantheoretical language and avoiding theory specific understandings of the significance a strong alliance, was able to broaden the scope of alliance discussions. This marked a significant change, as his conceptualization of the therapeutic working alliance emphasized the collaborative element of the patient-

therapist relationship in a language that could be incorporated into psychotherapy research and practice more largely than previous theory specific definitions. (Horvath, 1994).

Bordin's conceptualization of the therapeutic working alliance has been incredibly influential within the field of psychotherapy research. His tripartite conceptualization stresses mutuality between patient in therapist that emphasizes their interdependence and how this contributes to the quality of their interactions and relationship. In a somewhat fortuitous manner, Bordin's conceptualization of the therapeutic alliance became popular at a time when researchers began to recognize that therapeutic techniques from a multitude of treatment modalities produced remarkably similar therapeutic outcomes (Strupp & Hadley, 1979). This lead to the proliferation of psychotherapy research investigating generic or common factors that contribute to success in psychotherapy. To date, the quality of the therapeutic alliance has been one of the better predictors of therapy outcome across different types of treatment (Horvath & Symonds, 1991).

As in any relationship, moments of tension, impasse, disagreement and conflict are common to the therapeutic working alliance. While many studies show that a strong alliance is predictive of outcome (Martin et al., 2000), Safran and Muran posit that it is more relevant to focus on the reconstruction of the therapeutic working alliance following deterioration in alliance quality. These therapeutic working alliance deteriorations, also called ruptures (Safran and Muran, 1996), can be seen as a period of difficulty in establishing a therapeutic relationship necessary for therapeutic progress, or a discrete and acute instance of alliance weakening. Consistent with Bordin's conceptualization,

ruptures can be related to therapy tasks, therapy goals, and the emotional bond between patient and therapist, and any combination of these elements. Alliance ruptures, much like any conflict, can range from minor misunderstandings and misatunements to major fundamental disagreements that lead to termination of treatment. Rupture moments, like Keisler's (1982) description of the therapeutic relationship, are always interdependent and involving contributions from both patient and therapist. Safran (1993) illustrates that the phenomenology of rupture moments, specifically the weakening of an emotional bond *between* the patient and therapist, makes them interpersonal events, and not simply the result of the patient's characterological dysfunction or maladaptive patterns of behavior.

The ubiquitous nature of alliance ruptures in psychotherapy, and the potential for psychological transformation in successful rupture resolution, leads alliance negotiation and rupture resolution to be an important skill for therapists of all orientations (Safran, 1993b). Safran and Muran's focus on alliance ruptures and resolution processes has lead to a growing area of research and theoretical discussion calling for alliance studies to track fluctuation in relationship quality over time. (Stiles & Goldsmith, 2010). Following this, an emergent research finding is that changes in alliance strength, particularly those indicating that rupture moments were expediently repaired, are crucial to the therapeutic change process (Strauss et al., 2006).

Accordingly, Safran and Muran (2000) posit that a specialized training which focuses on an intense exploration of therapeutic process, and increasing awareness and skills for dealing with moments of deterioration of the therapeutic relationship (alliance ruptures) would have effects on treatment outcome. They contend that not only is a

strong therapeutic working alliance useful to psychotherapeutic process, but an intensive negotiation of the therapeutic alliance that includes drawing attention to moments of rupture, exploring their significance and, finally, resolving them can be a transformative experience in psychotherapy (Muran, Safran, Eubanks-Carter, 2010). This specialized training, which is focused on alliance ruptures and their resolution, called Alliance Focused Training (AFT), is modeled from Safran and Muran's (2000) Brief Relational Therapy (BRT), and its design allows for it to be integrated into a multitude of treatment orientations.

Borrowing from BRT, Alliance Focused Training contains several orienting principles (Safran, 2002): First, it assumes a "two-person" psychology and constructivist epistemology that acknowledges both patient and therapist contributions to the therapeutic situation (Hoffman, 1998). This epistemological stance informs a particular therapeutic sensibility in which therapy is seen as an ongoing collaborative process between two subjectivities (Aron, 1996). This is consistent with the view of the therapeutic working alliance construct and alliance ruptures as interpersonal in nature, and not something that results strictly from patient pathology and psyche. In Alliance Focused Training, the ongoing, collaborative therapeutic process involves an intensive focus on the "here and now" of the therapeutic relationship, and acknowledges therapist contributions to the quality of the therapeutic working alliance (Safran and Muran, 2000) Consequently, Alliance Focused Training encourages therapists to adopt a stance of "skillfull tentativeness." This tentative position, which serves the purpose of letting patient's be the arbiter of their own experience and acknowledging that therapists' perceptions are subjective, is grounded in contemporary relational psychoanalytic theory

stressing that the therapist's conceptualization of the patient is never objective (Renik, 1993). Accordingly, a technique often employed in AFT is therapeutic metacommunication, which can be described as a process of stepping out and commenting *on* the therapeutic process itself. That is to say, therapeutic metacommunication becomes a collaborative exploration about the transaction that is taking place, as it is taking place. An example of therapeutic metacommunication in an instance of a patient speaking in a monotone, emotionally removed voice might be "I'm beginning to feel like there is a distance between us, and that we are not as connected as we were before. What's your sense of that?" With a growing literature indicating that patient and therapist mindfulness is important to therapeutic process and outcome, Safran and Muran's (2000) therapeutic metacommunication can be considered a mindfulness in action, requiring both patient and therapist to disembed themselves from what they are currently thinking, feeling and doing, and having them comment on it.

Despite notable debate over the theoretical and research utility of the therapeutic working alliance (Safran and Muran, 2006), ongoing empirical research leads one to surmise that the resolution of moments of conflict, disagreements, misunderstandings, and moments of tension and/or strain in the therapeutic relationship (rupture moments) is important to psychotherapy outcome (Safran, Muran, Samstag, & Stevens, 2001, Strauss, et al. 2006). To date, even though there is significant evidence to indicate that the resolution of ruptures is an significant component to treatment success, and a wide body of literature pointing to the importance of investigating therapy at the process level (Greenberg, 1999), little is known about what effects a specialized training focused on

repairing therapeutic working alliance like Alliance Focused Training would have on patient and therapist interpersonal process.

Amongst the different ways to quantify, categorize and assess interpersonal behavior, circumplex models are some of the more frequently used. These models consist of an array of descriptors that describe interpersonal behavior arranged around a circle so that its organizing dimensions have no beginning or end. The location of categories on polar ends of the circumplex model denotes behavioral and semantic opposites. Commonly, these circumplex models are divided into the dimensions of control (vertical axis), and affiliation (horizontal axis). Theorists argue that all interpersonal behavior can be categorized as a location on such circumplexes (Leary, 1957, Wiggins, 1982). Consistent with the premises of interpersonal theory, these circumplex theories propose predicative principals that seek to explain how people influence each other's behavior in expected ways through their respective behaviors (Carson, 1969), making them particularly useful for psychotherapy research.

Benjamin's (1974) Structural Analysis of Social Behavior, or SASB, is one of the more detailed, conceptually rigorous and empirically validated models of interpersonal process, making it a useful tool for the investigation of therapeutic processes (Schaffer, 1982, Benjamin, 1994). The SASB is a circumplex model of interpersonal relations that consists of surfaces that specify the interaction's "Focus", two of which correspond to interpersonal transactions: focus on self & focus on other. Focus on self refers to "what is going to be done to, for and about the self", while focus on other refers to "what is going to be done to, for, or about the other person" (Benjamin, Rothweiler, & Critchfield,

2006). A patient disclosing feelings of sadness and depression would be categorized as an interpersonal behavior focused on the self, while a therapist conveying a sense of understanding and empathy to this patient would be considered to be focused on the other.

These two interpersonal surfaces contain two orthogonal dimensions of affiliation, defined as the degree to which an individual is behaving friendly or hostile, and interdependence, or the extend of which an interpersonal act is dominant or submissive. The affiliation and interdependence dimensions can be used to describe a full array of systemic and interpersonal events such as psychotherapy sessions (Humphrey & Benjamin, 1986). Although the orthogonal dimensions of the SASB remain constant across surfaces, the way in which they are expressed change with the focus. The affiliation axis ranges from Active Love to Attack when considering the focus on other dimension, while it runs from Reactive Love to Recoil on focus on self. On the vertical axis of interdependence, the poles of the SASB model differ according to the interpersonal focus of the interaction. On focus on other, opposite points on the circumplex of the interdependence dimension are 'Emancipate' and 'Control', illustrating a freeing or controlling *of* the other. Opposites on the interdependence dimension of the focus on self surface are 'Assert/Separate' and 'Submit', illustrating a respective freeing or control of the self in relation *to* the other. This complexity and intricacy makes the SASB a more comprehensive model than circumplexes that only make the distinction between dominant and submissive behaviors (Benjamin, Giat & Estroff, 1981).

Like other circumplex models, the SASB contains several predictive principles used to suggest what may precipitate and follow a given interpersonal event. With respect to the dimensions and reactions they pull for, affiliation tends to elicit congruent affiliative responses. That is to say, when someone is hostile, he likely elicits hostility from the other. In contrast, with respect to the axis of interdependence, the interpersonal compliment is semantically opposite, with enmeshment in one being harmonious with differentiation in the other. This predicts that when someone is dominant, the complementary response back is submission. In therapy, a common example of this would be a directive therapist teaching skills in a friendly dominant way to the patient (which would be categorized as 'Nurturing and Protecting on the focus on other dimension) receiving back the friendly submission of looking to the therapist for guidance and help (which would be categorized as 'Trusting and Relying' on the focus on self surface). The principle of complementarity, refers to moments in which participants are focused on the same person. In therapy, a common occurrence of this would be a patient talking about himself, while the therapist also comments on and interprets the patient's experience. Further, as described by Benjamin, Giatt, & Estroff (1981), "Interpersonal behaviors 'pull for' a complementary response." They describe that if one individual Belittles and Blames (focus on other, hostile, dominant), the behavior being pulled for from the other is to Sulk and Scurry (focus on self, hostile, submissive). Interpersonal complementarity can be described as the goodness of fit of the interpersonal behavior in which the two participants encourage each other's self-presentations. A final important predictive principle is of antithesis. In this, one's interpersonal behavior is used to elicit behavior from the other that is opposite from what is being shown by delivering

the compliment to the other's opposite. This is described in the following example: A patient becomes angry with his/her therapist and is 'Belittling and Blaming' on the SASB (focus on other, hostile, dominant). To bring the patient to a position of being more emancipating and affiliative, the therapist may be 'Disclosing and Expressing' (focus on self, friendly, dominant) which, give the previously described predictive principles, encourages the patient to be more friendly and submissive.

This comprehensive and rigorous system provides and in depth look at interpersonal interactions, and their significance on future behavior. Although it has incredible clinical and research utility, it's complexity makes the implementation and use of it as a research tool cumbersome and difficult. Wetzler (2005) comments that "the SASB is an intriguing foreign language, but not terribly practical; and I never did learn the language." This presents a significant limitation to the progression of psychotherapy research, as the SASB's utility clashes with the measure's difficulty of implementation and use, potentially limiting its use and impeding process based research.

Currently, a grant funded research study is investigation the effects of Safran and Muran's Alliance Focused Training on the therapeutic relationship when added to time limited Cognitive Behavioral Therapy (CBT) cases for Cluster C Personality Disordered Populations (Avoidant, Dependent, Obsessive-Compulsive, PD-NOS) in a multiple base line design. In this design, after demonstrating competency in a 30 session long Cognitive Behavioral Therapy treatment case, therapists are assigned another 30 session long CBT case. In this second case, Alliance Focused Training begins at either session 8, or session 16. This design then allows for the investigation of therapeutic process changes and

outcome analyses while controlling for therapist maturation and increasing experience with clinical work. Cognitive therapy, which has become the dominant tradition in the United States, has been shown to be an effective treatment for a multitude of psychological disorders (Beck, 1995). This treatment focuses on teaching patient's skills to more realistically evaluate their interpreting of situations and events, with hopes to correct maladaptive styles of thinking that lead to psychological distress. This treatment modality, which often requires therapists to adopt a didactic, teacher-like role, is distinct from the more tentative approach called for in AFT. One would expect that this specialized training would have effects on the interpersonal behavior of therapists when added to, and integrated into ongoing CBT cases.

Although specialized trainings to improve fidelity of psychotherapy are often grounded by theory and empirical research, their ability to positively influence therapeutic interpersonal process is inconclusive, and often unpredictable (Henry, Strupp, Butler, Schacht & Binder, 1993). In an era where evidence based practices are encouraged and even privileged, it would follow that training programs in psychotherapy would be the subject of much investigation. To date, the surprising reality is that research on the process and effectiveness of psychotherapeutic training is strikingly limited (Rock, 1997). This has remained true despite the fact that the little research conducted on the effects of training has been inconsistent, counterintuitive, and unsettling (Binder, 1993). Binder and Henry (2010) state that, "Without a solid foundation of empirical findings, the belief that our typical psychotherapy training methods are effective is no more than a myth." That withstanding, specialized training such as Safran and Muran's Rupture Resolution training are commonly implemented at psychotherapy training institutions.

Further studies should investigate their effects on in session variables such as patient and therapist interpersonal process

Chapter 2: The Empirical Study: The Effects of Alliance Focused Training on Patient and Therapist Interpersonal Process

Interpersonal Process

Psychotherapy research has undergone much change in recent years. One that is notable for the present investigation is the trend not to exclusively focus study on the patient, but to incorporate both therapist and patient impacts on therapeutic process. To date, despite the fact that the majority of psychotherapy research has used symptom-based measures of therapeutic success (Goldfried, 1994), interpersonal process is one of the most well supported predictors of treatment outcome (Orlinsky, Ronnestad & Wllutzki, 2004). While finding factors that compellingly predict therapeutic outcome is difficult and often disappointing (Norcross, 2002), interpersonal process consistently plays an integral role in the course of therapeutic change (Benjamin & Critchfield, 2010). In some studies, as much as 65% of the variance in therapeutic progress has been attributed to interpersonal process and reflexive social behavior (Rudy, McLemore & Gorsuch, 1985) indicating that it is not only a consistent predictor of therapeutic outcome, but also one that is robust. Both empirical research and theory indicate that social behavior and interactions play an important role in the process of psychotherapeutic change.

Accordingly, Henry, Schact & Strupp (1986) call for the fundamental unit of psychotherapy process analysis to be interpersonal transactions in the therapy dyad. Following Kiesler (1982), they argue against the studying of patient and therapist variables in isolation, as doing so would not account for the interaction between a

patient's self-defeating communication patterns that compose an interpersonal evoking style, and a therapist's manner of responding to this style. Kiesler (1982) notes that these two styles join together in an irreducible pathway that *is* the therapeutic relationship.

The Therapeutic Working Alliance

One of the major constructs through which this emphasis on therapeutic process has been investigated in psychotherapy research is the therapeutic working alliance (Norcross, 2002). The quality of the relationship between patient and therapist was discussed as a critical factor in psychotherapy from its inception. At this time, the concept of the therapeutic working alliance was predominantly discussed by psychoanalysts, and not more broadly by psychotherapists. This, however, changed in the second half of the 20th century when Bordin (1979) began discussing the therapeutic alliance in pantheoretical terms. His understanding of the therapeutic alliance had three operationalized parts: agreement between patient and therapist on the tasks of therapy, agreement on the goals of therapy, and the quality of the emotional bond between patient and therapist. Hatcher (2010) emphasizes Bordin's thinking on the alliance when he summarizes that "work is an activity toward a goal- it is purposeful. Two people working together for a goal require collaboration. Thus, this work is anchored in agreement on goals, collaboration on tasks, and supported by an appropriate bond." Bordin, by making use of pantheoretical language and avoiding theory specific understandings of the significance a strong alliance, was able to broaden the scope of alliance discussions. This marked a significant change, as his conceptualization of the therapeutic working alliance emphasized the collaborative element of the patient-therapist relationship in a language

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like any conflict, can range from minor misunderstandings and misatunements to major fundamental disagreements that lead to termination of treatment. Rupture moments, like Keisler's (1982) description of the therapeutic relationship, are always interdependent and involving contributions from both patient and therapist. Safran (1993) illustrates that the phenomenology of rupture moments, specifically the weakening of an emotional bond *between* the patient and therapist, makes them interpersonal events, and not simply the result of the patient's characterological dysfunction or maladaptive patterns of behavior.

Alliance Focused Training

The ubiquitous nature of alliance ruptures in psychotherapy, and the potential for psychological transformation in successful rupture resolution, leads alliance negotiation and rupture resolution to be an important skill for therapists of all orientations (Safran, 1993b). Safran and Muran's focus on alliance ruptures and resolution processes has lead to a growing area of research and theoretical discussion calling for alliance studies to track fluctuation in relationship quality over time. (Stiles & Goldsmith, 2010). Following this, an emergent research finding is that changes in alliance strength, particularly those indicating that rupture moments were expediently repaired, are crucial to the therapeutic change process (Strauss et al., 2006).

Two of the most notable endeavors to investigate whether therapist's can be trained to better negotiate the therapeutic alliance and respond to negative interpersonal process are the Vanderbilt II study, (Bein et al, 2000; Henry et al,1993; Strupp, 1993) and Crits-Christoph et al. (2006). In both of these training studies, therapeutic outcomes obtained by the same therapists with different cohorts of patients in a pre/post-training

design were evaluated. The design of studying therapists both over time and with different patient's allows to control for variance in outcome attributable to factors attributable to the particular therapist, thus making results of aggregate analyses more likely to be due to the effects of training. Both studies yielded disappointing results, with the Vanderbilt II study showing a decrease in positive therapeutic process and outcome as a result of training, and Crits-Crisoph et al. (2006) showing only modest improvement.

Similarly to the aforementioned studies, Safran and Muran (2000) posit that a specialized training which focuses on an intense exploration of therapeutic process, and increasing awareness and skills for dealing with moments of deterioration of the therapeutic relationship (alliance ruptures) would have effects on treatment outcome. They contend that not only is a strong therapeutic working alliance useful to psychotherapeutic process, but an intensive negotiation of the therapeutic alliance that includes drawing attention to moments of rupture, exploring their significance and, finally, resolving them can be a transformative experience in psychotherapy (Muran, Safran, Eubanks-Carter, 2010). This specialized training, which is focused on alliance ruptures and their resolution, called Alliance Focused Training (AFT), is modeled from Safran and Muran's (2000) Brief Relational Therapy (BRT), and its design allows for it to be integrated into a multitude of treatment orientations.

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between two subjectivities (Aron, 1996). This is consistent with the view of the therapeutic working alliance construct and alliance ruptures as interpersonal in nature, and not something that results strictly from patient pathology and psyche. In Alliance Focused Training, the ongoing, collaborative therapeutic process involves an intensive focus on the "here and now" of the therapeutic relationship, and acknowledges therapist contributions to the quality of the therapeutic working alliance (Safran and Muran, 2000) Consequently, Alliance Focused Training encourages therapists to adopt a stance of "skillfull tentativeness." This tentative position, which serves the purpose of letting patient's be the arbiter of their own experience and acknowledging that therapists' perceptions are subjective, is grounded in contemporary relational psychoanalytic theory stressing that the therapist's conceptualization of the patient is never objective (Renik, 1993).

Accordingly, a technique often employed in AFT is therapeutic metacommunication, which can be described as a process of stepping out and commenting *on* the therapeutic process itself. That is to say, therapeutic metacommunication becomes a collaborative exploration about the transaction that is taking place, as it is taking place. An example of therapeutic metacommunication in an instance of a patient speaking in a monotone, emotionally removed voice might be "I'm beginning to feel like there is a distance between us, and that we are not as connected as we were before. What's your sense of that?" With a growing literature indicating that patient and therapist mindfulness is important to therapeutic process and outcome, Safran and Muran's (2000) therapeutic metacommunication can be considered a mindfulness in

action, requiring both patient and therapist to disembed themselves from what they are currently thinking, feeling and doing, and having them comment on it.

Despite notable debate over the theoretical and research utility of the therapeutic working alliance (Safran and Muran, 2006), ongoing empirical research leads one to surmise that the resolution of moments of conflict, disagreements, misunderstandings, and moments of tension and/or strain in the therapeutic relationship (rupture moments) is important to psychotherapy outcome (Safran, Muran, Samstag, & Stevens, 2001, Strauss, et al. 2006). To date, even though there is significant evidence to indicate that the resolution of ruptures is an significant component to treatment success, and a wide body of literature pointing to the importance of investigating therapy at the process level (Greenberg, 1999), little is known about what effects a specialized training focused on repairing therapeutic working alliance like AFT would have on patient and therapist interpersonal process.

Measuring Interpersonal Process

Amongst the different ways to quantify, categorize and assess interpersonal behavior, circumplex models are some of the more frequently used. These models consist of an array of descriptors that describe interpersonal behavior arranged around a circle so that its organizing dimensions have no beginning or end. The location of categories on polar ends of the circumplex model denotes behavioral and semantic opposites. Commonly, these circumplex models are divided into the dimensions of control (vertical axis), and affiliation (horizontal axis). Theorists argue that all interpersonal behavior can be categorized as a location on such circumplexes (Leary, 1957, Wiggins, 1982). Consistent with the premises of interpersonal theory, these circumplex theories propose

predicative principals that seek to explain how people influence each other's behavior in expected ways through their respective behaviors (Carson, 1969), making them particularly useful for psychotherapy research.

Benjamin's (1974) Structural Analysis of Social Behavior, or SASB, is one of the more detailed, conceptually rigorous and empirically validated models of interpersonal process, making it a useful tool for the investigation of therapeutic processes (Schaffer, 1982, Benjamin, 1994). The SASB is a circumplex model of interpersonal relations that consists of surfaces that specify the interaction's "Focus", two of which correspond to interpersonal transactions: focus on self & focus on other. Focus on self refers to "what is going to be done to, for and about the self", while focus on other refers to "what is going to be done to, for, or about the other person" (Benjamin, Rothweiler, & Critchfield, 2006). A patient disclosing feelings of sadness and depression would be categorized as an interpersonal behavior focused on the self, while a therapist conveying a sense of understanding and empathy to this patient would be considered to be focused on the other.

These two interpersonal surfaces contain two orthogonal dimensions of affiliation, defined as the degree to which an individual is behaving friendly or hostile, and interdependence, or the extend of which an interpersonal act is dominant or submissive. The affiliation and interdependence dimensions can be used to describe a full array of systemic and interpersonal events such as psychotherapy sessions (Humphrey & Benjamin, 1986). Although the orthogonal dimensions of the SASB remain constant across surfaces, the way in which they are expressed change with the focus. The affiliation axis ranges from Active Love to Attack when considering the focus on other

dimension, while it runs from Reactive Love to Recoil on focus on self. On the vertical axis of interdependence, the poles of the SASB model differ according to the interpersonal focus of the interaction. On focus on other, opposite points on the circumplex of the interdependence dimension are 'Emancipate' and 'Control', illustrating a freeing or controlling *of* the other. Opposites on the interdependence dimension of the focus on self surface are 'Assert/Separate' and 'Submit', illustrating a respective freeing or control of the self in relation *to* the other. This complexity and intricacy makes the SASB a more comprehensive model than circumplexes that only make the distinction between dominant and submissive behaviors (Benjamin, Giat & Estroff, 1981).

Like other circumplex models, the SASB contains several predictive principles used to suggest what may precipitate and follow a given interpersonal event. With respect to the dimensions and reactions they pull for, affiliation tends to elicit congruent affiliative responses. That is to say, when someone is hostile, he likely elicits hostility from the other. In contrast, with respect to the axis of interdependence, the interpersonal compliment is semantically opposite, with enmeshment in one being harmonious with differentiation in the other. This predicts that when someone is dominant, the complementary response back is submission. In therapy, a common example of this would be a directive therapist teaching skills in a friendly dominant way to the patient (which would be categorized as 'Nurturing and Protecting on the focus on other dimension) receiving back the friendly submission of looking to the therapist for guidance and help (which would be categorized as 'Trusting and Relying' on the focus on self surface). The principle of complementarity, refers to moments in which participants are focused on the same person. In therapy, a common occurrence of this would be a

patient talking about himself, while the therapist also comments on and interprets the patient's experience. Further, as described by Benjamin, Giatt, & Estroff (1981), "Interpersonal behaviors 'pull for' a complementary response." They describe that if one individual Belittles and Blames (focus on other, hostile, dominant), the behavior being pulled for from the other is to Sulk and Scurry (focus on self, hostile, submissive). Interpersonal complementarity can be described as the goodness of fit of the interpersonal behavior in which the two participants encourage each other's self-presentations. A final important predictive principle is of antithesis. In this, one's interpersonal behavior is used to elicit behavior from the other that is opposite from what is being shown by delivering the compliment to the other's opposite. This is described in the following example: A patient becomes angry with his/her therapist and is 'Belittling and Blaming' on the SASB (focus on other, hostile, dominant). To bring the patient to a position of being more emancipating and affiliative, the therapist may be 'Disclosing and Expressing' (focus on self, friendly, dominant) which, give the previously described predictive principles, encourages the patient to be more friendly and submissive. This comprehensive and rigorous system provides and in depth look at interpersonal interactions, and their significance on future behavior. Although it has incredible clinical and research utility, it's complexity makes the implementation and use of it as a research tool cumbersome and difficult (Nagy, 2005).

The Present Study

Although specialized trainings to improve fidelity of psychotherapy are often grounded by theory and empirical research, their ability to positively influence therapeutic interpersonal process is inconclusive, and often unpredictable (Henry, Strupp,

Butler, Schacht & Binder, 1993). In an era where evidence based practices are encouraged and even privileged, it would follow that training programs in psychotherapy would be the subject of much investigation. To date, the surprising reality is that research on the process and effectiveness of psychotherapeutic training is strikingly limited (Rock, 1997). This has remained true despite the fact that the little research conducted on the effects of training has been inconsistent, counterintuitive, and unsettling (Binder, 1993). Binder and Henry (2010) state that, "Without a solid foundation of empirical findings, the belief that our typical psychotherapy training methods are effective is no more than a myth." That withstanding, specialized training such as Safran and Muran's Alliance Focused Training are commonly implemented at psychotherapy training institutions. To date, no research has been conducted investigating change in patient and therapist interpersonal process as a result of Alliance Focused Training.

To investigate the effects of Alliance Focused Training on patient's that present high potential for treatment failure and dropout, Safran and Muran have developed a research-training program funded by the NIMH. This program utilizes a design created in order to control for variance attributable to patients, therapists, and patient-therapist interactional sources. In order to evaluate whether changes taking place after the implementation of AFT were attributable to the AFT or to other factors such as therapist maturation over time and changes in the therapeutic relationship due to natural treatment progression, etc., this program employed a multiple baseline design. In this design, all therapists began treating a case with CBT and then at predetermined points (either 8 sessions or 16 sessions) began augmenting the CBT treatment with AFT principles. By introducing AFT training at different points of time, we were able to control for

maturation effects. This allows for testing for differences within, rather than only between patient-therapist dyads, thus allowing for control of both patient and therapist individual differences, as well as differences specific to each dyad.

Within this study, training consisted of two discrete phases. In the first phase therapists received one year of didactic training in CBT, and completed one CBT case while attending weekly CBT supervision sessions lasting each 1 ½ hour. After completing 30 sessions of CBT treatment with a first case and demonstrating adherence to the CBT protocol and competence with the modality, therapists were assigned a second treatment case and entered the second phase of the study. In this phase, therapists began treating a second case with CBT, while continuing to attend CBT supervision. All therapists were randomly assigned to begin augmenting CBT with AFT principles after either 8 or 16 sessions, and transferred form the CBT supervision group to an AFT supervision group.

The present study is an examination of the effects that this training has on patient and therapist interpersonal process. To assess for differences between CBT and AFT in therapist and patient interpersonal process, we employed a simplified version of the SASB coding system (described in method section below) that allowed us to code videotapes of sessions as a whole in terms of the octant versions of surface 1 (Focus on Self) and surface 2 (Focus on Other) of the SASB. The following differences in interpersonal process emerging from training between CBT and AFT were hypothesized:

1. Given the more directive nature of CBT relative to AFT it is hypothesized that therapists in AFT training would display less evidence of controlling interpersonal process than they did in CBT training. It is also hypothesized that a

complementary pattern of patients displaying less evidence of submissive interpersonal process in AFT than in CBT. .

2. Because AFT tends to be more exploratory and process oriented in nature than CBT, the present study hypothesizes that therapists in AFT training would display interpersonal styles which were more friendly- autonomy granting in nature than they did in CBT training. For patients, it is hypothesized that a complementary shift in the direction of more friendly-autonomy taking process.

3. Because therapeutic metacommunication (which involves therapist self-disclosure) plays an important role in AFT the present study hypothesizes more evidence of therapist self-disclosure in AFT than in CBT phases of training. For patients, a complementary shift in the direction of more self-disclosure was anticipated.

4. Because AFT places an emphasis on detecting alliance ruptures and on encouraging patients to explore any concerns they have about the therapy or therapeutic relationship and to express wishes or needs that they feel are not being met by the therapist, it was hypothesized that therapists in AFT training would be more encouraging of patient autonomy than they were during CBT training. It was further hypothesized that this would be reflected in both a decrease in therapist controlling interpersonal process and an increase in autonomy granting process. For patients, a complementary shift in AFT towards a greater degree of self-assertion (in context of the therapeutic relationship) than in CBT training was anticipated.

5. Finally, since AFT emphasizes the importance of therapists reflecting on and making constructive use of their own countertransference rather than expressing it unconsciously through their actions, the present investigation anticipated that they would display less hostile interpersonal process in AFT than in CBT. It was also hypothesized that patients would show a complementary decrease in hostile interpersonal process during AFT training.

These specific hypotheses were described as a series of specific shifts in therapist interpersonal stance, each followed by a specific shift in patient interpersonal stance for purposes of clarity. It is important to bear in mind, however, that in reality anticipated links between shifts in therapist and patient interpersonal stance were assumed to operate in a more holistic and organic fashion. For example, the present study hypothesizes that patients in AFT would show increased levels of self-disclosure as a function of a number of shifts in therapist process including decreases controlling process, increases in friendly–autonomy encouraging process, and increased levels of therapist self-disclosure.

Method

Participants

Based on the results of a power analysis, twenty-two patients who have consented to participation in a psychotherapy research study at Beth Israel Medical Center's Brief Psychotherapy Research Program were included in this study. Participants had to meet the following inclusion criteria: age ranging from 18-65, the presence of an Axis I diagnosis and Cluster C Axis II diagnosis (Avoidant, Dependent, Obsessive Compulsive,

and PD-NOS) using the DSM-IV-TR, no recent psychiatric hospitalizations, no active suicidality, no apparent severe instability, no history of conduct disorder, are stabilized on psychiatric medications if taking them, have no history or signs of mania or psychosis, are not currently abusing substances, and consent to compliance with assessment measures and being videotaped in weekly psychotherapy sessions with trainees.

The twenty-two patients selected for study were chosen based on availability of video data (eleven receiving AFT at session 8, and eleven at session 16). Of these patients, twelve were male and ten female with a mean age of 45.13 (standard deviation of 10.23). Seventeen patients included in the present study were Caucasian (77.2%), two African-American (9.1%), and two of Asian-Pacific Island descent (9.1%). Regarding primary Axis I diagnoses, seven patients had a diagnosis of Major Depressive Disorder (45.2%), three met for a diagnosis of Dysthymia (13.6%), one Panic Disorder with Agoraphobia (4.5%), one Panic Disorder without Agoraphobia (4.5%), one Social Phobia (4.5%), and three had no Axis I diagnosis (13.6%). All patient's in the study had a Cluster C or PD-NOS diagnosis on Axis II. Nine patients (40.9%) met for PD-NOS (two with Negativistic PD, 1 with Depressive PD), seven Avoidant PD (31.8%), and six with Obsessive-Compulsive PD (27.2%).

Therapists were twenty-two psychology externs enrolled in doctoral level clinical psychology programs treating patients in Beth Israel Medical Center's Brief Psychotherapy Research Program for training. Of these therapists eighteen were female (82%) and four were male (18%), with a mean age of 29.55 (Std. Dev. 3.42) and an average of 1.70 years of clinical experience (Std. Dev. 3.42). Eighteen of the study's

therapists were Caucasian (82%), two Hispanic (9%), and two of Asian-Pacific Island descent (9%).

Treatment Modalities and Training

Cognitive-Behavioral Training (CBT: Beck, 1995).

Within Beth Israel Medical Center's Brief Psychotherapy Research Program, cognitive-behavioral therapy training was designed to treat patients presenting with anxious, fearful, introverted personality disorders and with personality disorders "not otherwise specified" according to DSM-IV in a 30-session, one 45-minute session/week protocol. It is largely based on Beck, Freeman, and associates' (1990) adaptation of cognitive therapy to the treatment of personality disorders, and incorporates Persons' (1988) case formulation approach. According to this treatment model, personality and behavior are understood as organized by underlying belief systems or schemas. The treatment process involves the application of various cognitive and behavioral strategies, including in-session therapeutic tasks such as the examining of automatic thoughts, and extra-session tasks in the form of homework assignments.

Training consisted of a weekly 90-minute group supervision format., a didactic component, observation of videotapes of skilled cognitive therapists, feedback on videotapes of trainees' therapy cases, and role-playing exercises to help therapists develop basic skills such as agenda setting, eliciting automatic thoughts and abstracting underlying schemas, and the use of various cognitive and behavioral strategies for challenging cognitive distortions and dysfunctional attitudes.

Alliance Focused Training (Safran & Muran, 2000).

Training was conducted in a weekly 90-minute group supervision format, consisting of a didactic component, videotaped demonstrations, and experiential exercises, and review of videotaped therapy sessions. The didactic component involved readings and lectures provided by supervisors regarding the definition and identification of ruptures and the various principles of metacommunication. Safran and Muran's (2000) Negotiating the Therapeutic Alliance: A Relational Treatment Guide as a training manual was used as the primary treatment manual. There was an important emphasis on experiential learning and self-exploration. Therapists were trained to attend to and explore their own feelings as important sources of information about what is going on in the therapeutic relationship. AFT makes use of role-playing exercises to provide them with the opportunity to develop the skill of exploring their own feelings and internal conflicts as they emerge during alliance ruptures. Supervisors monitored the role-plays carefully and intervene at critical moments to direct therapists' attention to their inner experience, and encourage them to put unarticulated feelings and intuitions into words.

Supervision sessions also employed mindfulness training for purposes of helping therapists refine their capacity to observe their own inner experience as well as the nature of their own contributions to alliance ruptures. All supervision sessions devoted some time to mindfulness training, and therapists were encouraged to develop an ongoing mindfulness practice on their own between training sessions. Metacommunication is conceptualized as a type of "mindfulness in action" (Safran & Muran, 2000). In other words therapists are taught to view metacommunication as a type if mindfulness in action, with the goal of paying attention to what is happening in the here-and-now both in

the therapeutic relationship and their own emerging internal experience with an attitude of curiosity and nonjudgmental acceptance.

Once therapists transitioned into the AFT training, they were instructed to begin incorporating principles of AFT into their work with their patients in a fashion that felt appropriate for their particular case. The precise pace and extent to which they used specific AFT interventions (e.g., metacommunication), was worked out collaboratively with their supervisor. In cases were patients appeared to be benefiting from the use of cognitive behavioral interventions, therapist were encouraged to continue using these interventions, while at the same time becoming more mindful of relational patterns that might be playing out between them and their patients in sessions. In other cases where the use of cognitive interventions appeared to be problematic, therapists were encouraged to modify their approach more dramatically, in some cases actually abandoning the use of cognitive behavioral interventions, and focusing more intensively on the use of relational interventions.

Measures and Materials

Video data of psychotherapy sessions collected at Beth Israel Medical Center's Brief Psychotherapy Research Program was utilized. research program will also be included in the present study's analysis. To make use of the multiple baseline design, 6 sessions were coded for each dyad. Two sessions were selected from each of the following phases of treatment: the early phase, (defined as sessions 6-8), mid-phase (defined as sessions 14-16), and late phase (defined as sessions 22-24) to allow for an analysis of both within group differences (i.e. changes attributable to training modality), and between group differences (i.e. change attributable to the time factor) The two

sessions for each phase were selected within a range of 3 sessions to allow for enough flexibility to accommodate missing data (see Figure 1).

The SASB is typically used to code process at the level of thought units (i.e. portions of speech corresponding to one complete thought). An important advantage of this procedure is that it allow for a fine-grained analysis of turn-by-turn shifts in interpersonal process. This coding process is, however, relatively labor intensive and time consuming. Consequently, researchers often restrict themselves to coding samples of process presumed to be representative (e.g. 15-30 minutes of the third session (Henry et al., 1986). For purposes of the present study it was posited that global codings of entire sessions would be a meaningful and adequate unit of analysis. This rendered SASB coding less labor intensive, thus allowing us to code more sessions of potential interest and to code entire sessions (rather than samples of sessions). The modifications therefore traded off the potential value of a more fine-grained analysis for the gain of being able to increase the degree of representativeness of the material coded (i.e. being able to code entire sessions rather than session samples, and multiples sessions per dyad.

Using a working group of 10 graduate student coders, a number of videotapes of psychotherapy sessions were viewed, and the team gradually refined its sense of how best to code these videotapes at a global level. Ultimately the decision was made to code using the octant level of the SASB for both Surface 1 (Focus on Self) and Surface 2 (Focus on Other). This resulted in 16 possible codes or dimensions that raters were instructed to rate on a 5 point scale modeled after Baranackie and Crits-Cristoph's QUAINT (1992), with 1 meaning not present, 3 moderately present, and 5 meaning very present. Each SASB octant was rated on this scale for both patient and therapist in 5-minute intervals (See

Appendix B for scoring sheet). The ratings for each 5-minute interval were then averaged into global scores for sessions, yielding an overall score of the presence of each of the SASB Surface 1 and Surface 2 octants. Reliability was then calculated at the session level. Scores for each item were thus averaged, creating 32 mean scores to be used for analysis. Approximately 15 weeks of coding training were required to attain inter-rater reliability. Additionally, patient demographic information was collected via confidential intake forms included with initial informed consent form (Appendix C).

Procedure

To control for non-independence of observations, a Generalized Estimating Equations (GEE) analysis and repeated measures design was utilized for octant of Surfaces 1 & 2 of the SASB. A formal power analysis was conducted using G-Power Statistical Software (Faul, F., Erdfelder, E., Lang, A.G., & Buchner, A., 2007). Specifying a repeated measures GLM design or 6 observations with a moderate effect size, 22 dyads were selected for analysis, giving the study's principle analysis a power of .81. It was hypothesized that any differences between CBT and AFT in interpersonal process would be evident regardless of whether AFT was implemented at session 8 or 16. In others words, any differences in interpersonal process would be attributable specifically to training modality rather than the number of sessions that had taken place in the treatment. Moreover, no training modality X time interval (8 or 16) interactions were anticipated.

Results

SASB coder reliability was assessed using single measures Intraclass Correlation Coefficients (ICC) specifying absolute agreement. Coding groups were judged to be

reliable following 5 consecutive ICC scores above .70. Following this, paired codings of video sessions included in the study were conducted. Composite scores of pairs were retained if raters received ICC's above .70. One session in the present study's data set received an ICC below .70 (.67). This session was coded by a 3rd coder, and the two most reliable scores were retained for the session's composite SASB scores. The present study's average ICC score for all sessions included was .78.

Given no reliable statistical correction exists for analyses using multiple correlated dependent variables, to decrease the likelihood of Type-I error, items with minimal variance were eliminated from the present study's analyses. These items largely corresponded to "Focus on Self" items for therapists, and "Focus on Other" items for patients. This is not surprising given the fact that because of the nature of the therapeutic relationship; therapist's focus more on patient's during sessions, while patient's remain more self focused. Descriptive data of SASB items included in this study can be seen in Table 1.

Several significant shifts in both therapist and patient interpersonal process emerged after CBT was augmented with AFT training (See Tables 2 & 3 for statistical results). All significant differences in therapist interpersonal process (with one notable exception) emerged on the "other" or "transitive" surface of the SASB (Surface 2). All significant differences in patient interpersonal process emerged on the "self-focused: or "intransitive" surface of the SASB (Surface 1). For simplicity and clarity, specific results presented below correspond accordingly to the aforementioned study hypotheses:

1. Consistent with hypothesis 1, therapists in AFT training showed significantly less evidence of both *Watching & Controlling* (Cluster 5, Surface 2) and

Nurturing & Protecting (Cluster 4, Surface 2) interpersonal process than they did in CBT training. Complementing this shift in therapist interpersonal process, patients in AFT showed significantly less evidence of *Trusting & Relying* (Cluster 4, Surface 1) *process* , than they did in CBT. Further, patients in AFT displayed significantly less evidence of *Deferring & Submitting* process (Cluster 5, Surface 1) than they did in CBT.

2. Consistent with hypothesis 2, therapists in AFT training showed less evidence of both *Watching & Controlling* (Cluster 5, Surface 2), and *Nurturing & Protecting* (Cluster 3, Surface 2) process that they did during CBT training. In a complementary fashion, patients showed more evidence of *Disclosing & Expressing* (Cluster 2, Surface 1) process in AFT than in CBT.

3. Consistent with hypothesis 3, therapists in AFT training showed more evidence of *Disclosing & Expressing* (Cluster 2, Surface 1) process than they did in CBT training. And as indicated above this was true of patients as well.

4. Consistent with hypothesis 4, therapists in AFT training showed more evidence of *Affirming & Understanding* (Cluster 2, Surface 2) process than they did in CBT training. Also, consistent with hypothesis 4, patients in AFT showed more evidence of *Disclosing & Expressing* (Cluster 2, Surface 2) process than they did on CBT. And as previously indicated therapists also showed a decrease in both *Watching & Controlling* (Cluster 5, Surface 2), and *Nurturing & Protecting*

(Cluster 3, Surface 2) process. Also consistent with hypothesis 5, patients in AFT showed more evidence of *Asserting & Separating* (Cluster 1, Surface 1) process than they did in CBT.

5. Findings did not support the first part of hypothesis 5, with therapists in AFT training not showing fewer instances of hostile interpersonal process than they did in CBT training. Consistent with the second part of hypothesis 5, however, patients in AFT did show a decrease two forms of hostile interpersonal process. First they showed a decrease in *Walling off & Distancing* (Cluster 8, Surface 1). In addition they showed less evidence of *Sulking & Scurrying* (Cluster 6, Surface 1) in AFT than in CBT.

As hypothesized, there were several changes in patient and therapist interpersonal process, with the majority significant differences between training modalities in both therapist and patient interpersonal processes emerging regardless of time of implementation of AFT (session 8 or session 16). Moreover, there were, for the most part, no training modality X time interactions. The one exception (noted earlier) was on the dimension of patient A*sserting & Separating* (Cluster 1, Surface 1) Here we found that patients whose therapists switched to AFT training in session 8 displayed significantly more evidence of *Asserting & Separating* process than patients whose therapists switched to AFT training in session 16.

Discussion

The majority of the findings were consistent with study hypotheses. Although this investigation's results were presented sequentially and in a fashion that corresponds to our hypotheses, it may be useful at this point to discuss their implications as a whole. Therapists in AFT were less likely to display controlling interpersonal process than they were during CBT training. They showed less evidence of both *Watching & Controlling* process (controlling interpersonal process that is neutral with respect to the affiliation dimension) and less evidence of *Nurturing & Protecting* process (controlling process that is friendly in nature). Therapists in the AFT phases were also more *Affirming & Understanding* (a friendly autonomy-granting behavior) than they were in CBT training. Finally, therapists in AFT tended to self-disclose (*Disclosing & Expressing)* more than they did in CBT training.

Patients in the AFT phases tended to display complementary shifts in interpersonal process. First, they displayed less submissive interpersonal process, both 1) less friendly-submissive process and 2) submissive process that is neutral with respect to affiliation (*Deferring & Submitting*). They also displayed more interpersonal process of a self-disclosing nature. Finally (although not one of the study's original predictions), consistent with therapists' shift towards a less controlling and more autonomy-encouraging stance, patients displayed an increase in *Asserting & Separating* interpersonal process.

It is worth noting that some previous studies (e.g., Henry et al, 1986) found that patient interpersonal process that is coded as *Asserting & Separating* on the SASB was associated with poor outcome. In this particular context, however patient movement in the direction of greater self-assertion is consistent with the goals of AFT. There are two reasons for this: first, facilitating patient self-assertion in relationship to the therapist is considered to be an important component of the rupture resolution process (Safran & Muran, 2000). Especially in the context of alliance ruptures, it is considered important for patients to have the experience of telling their therapists what they want from them and from the treatment, rather than hiding their feelings and concerns for fear of alienating their therapists. Second, it is important to bear in mind that the patients in this study were primarily cluster C patients who tend to present with problems with excessive compliance, deference, and avoidance. For this particular subgroup of patients, movement in the direction of increased self-assertion is likely to be a desirable outcome of therapy.

The finding that this difference was even more pronounced when AFT commenced at the earlier time interval (session 8), while not anticipated, is also not surprising. It stands to reason that the process of being able to assert oneself in relationship to the therapist may take more time, especially with this population. A possible explanation is that, while therapists may be able to change their interpersonal stance in a direction that encourages greater patient self-assertion after as few as fourteen sessions of AFT (i.e., when AFT begins at session 16), and while patients may be able to begin to shift their stances in corresponding fashion,

additional time may help to strengthen or facilitate patients' ability to assert themselves.

As previously stated, although these changes have been described separately for simplicity, in actuality they occurred in a more holistic fashion. This type of process can be illustrated with the following clinical example. In one session in the CBT phase, the patient expressed difficulty with the previous session's homework assignment and apprehension toward therapy tasks. The therapist adopted a friendly yet dominant stance, and explained the rationale for the homework and therapy tasks, indicating how they would help alleviate the patient's symptoms. The therapist's stance was coded as *Nurturing & Protecting*. The patient, who loudly sighed and expressed both doubts and anxiety with therapy tasks, ultimately complied. The patient's reluctant submission was captured through a code of *Sulking & Scurrying.*

In contrast, during the AFT phase, when the patient experienced a similar apprehension about therapy tasks, the therapist metacommunicated the following: "I'm getting the sense that this feels really difficult. Almost like I'm asking you to face what you fear the most." This utterance, coded as therapist *Disclosing & Expressing,* was not dominating of the other as in the previous example. The patient did not submit or display self-directed hostility as in the previous example, but rather disclosed her experience in a friendly and autonomous way, which was coded as *Disclosing & Expressing*: "Yeah...I don't know...it is like, I can hold onto the fact that I know that it'll be helpful, but it really is tough for me."

Finally, while the present study did not find that therapists in the CBT phases were more likely to display hostile interpersonal process than they did in AFT, more evidence of hostile patient interpersonal process in CBT phases was observed. It is possible, however, that the therapist dominance seen in CBT (as in the clinical example above), represented a subtle form of hostility that was difficult to detect using the SASB, which requires that codes be made purely based on observable behavior. It was not uncommon for therapists in the AFT phases to retrospectively report in supervision groups that they had been experiencing subtle feelings of frustration and irritation towards their patients during CBT phases of treatment that they had not discussed extensively with their CBT supervisors. It is possible that such feelings had been leaking out in the form of subtle nonverbal manifestations of hostility which were sensed at some level by their patients, thus contributing to their tendency towards hostility (albeit of a self-focused or intransitive nature).

It is worth noting that these patients did not show the type of other-focused hostility (*Belittling & Blaming, Attacking & Rejecting, Ignoring & Rejecting*) that has been found to be associated with poor outcome (e.g., Henry et al, 1986; 1990). However, both *Walling Off & Distancing* and *Sulking & Scurrying* acts are still forms of hostile patient interpersonal process that are associated with poor outcome (Henry et al, 1986; 1990). In this respect, it is important to bear in mind that the distinction between hostility coded on the *self-focused* versus the *other-focused* surfaces of the SASB is not one of intensity, but rather one of directionality. In other words, hostile interpersonal behavior coded on the other-focus surface is directed

at the therapist, whereas hostility on the self-focused surface of the SASB tends to be less direct (examples will be given in the final discussion). Another way of looking at it is that this form of hostility is more likely to manifest as what we have termed a withdrawal rupture, in which the patient moves away from the therapist, than a confrontation rupture, in which the patient moves against the therapist**.** Again, this is not surprising given this particular population of patients.

This study represents a preliminary investigation on the effectiveness of Alliance Focused Training on patient and therapist interpersonal process. Future investigation should be done with increased sample size, utilizing other appropriate statistical methodologies for studying change over time on aggregate data, and multiple methods for operationalizing interpersonal process. The results of this study give evidence for the efficacy of AFT for improving interpersonal process with patient's likely to experience difficulty forming and maintaining positive therapeutic relationships. Future directions of research include investigating the relationship of interpersonal process change to the therapeutic alliance, and treatment outcomes.

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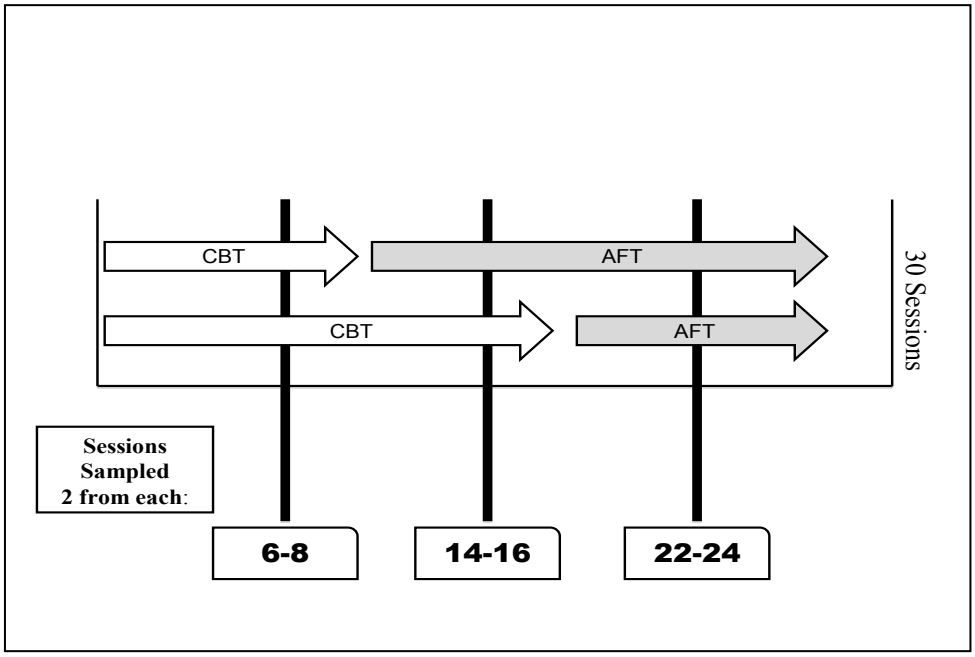


Figure 1. Study design, showing CBT and AFT (Alliance-Focused Training) phases for the group that switched at session 8 (top row of arrows) and the group that switched at session 16 (bottom row of arrows).

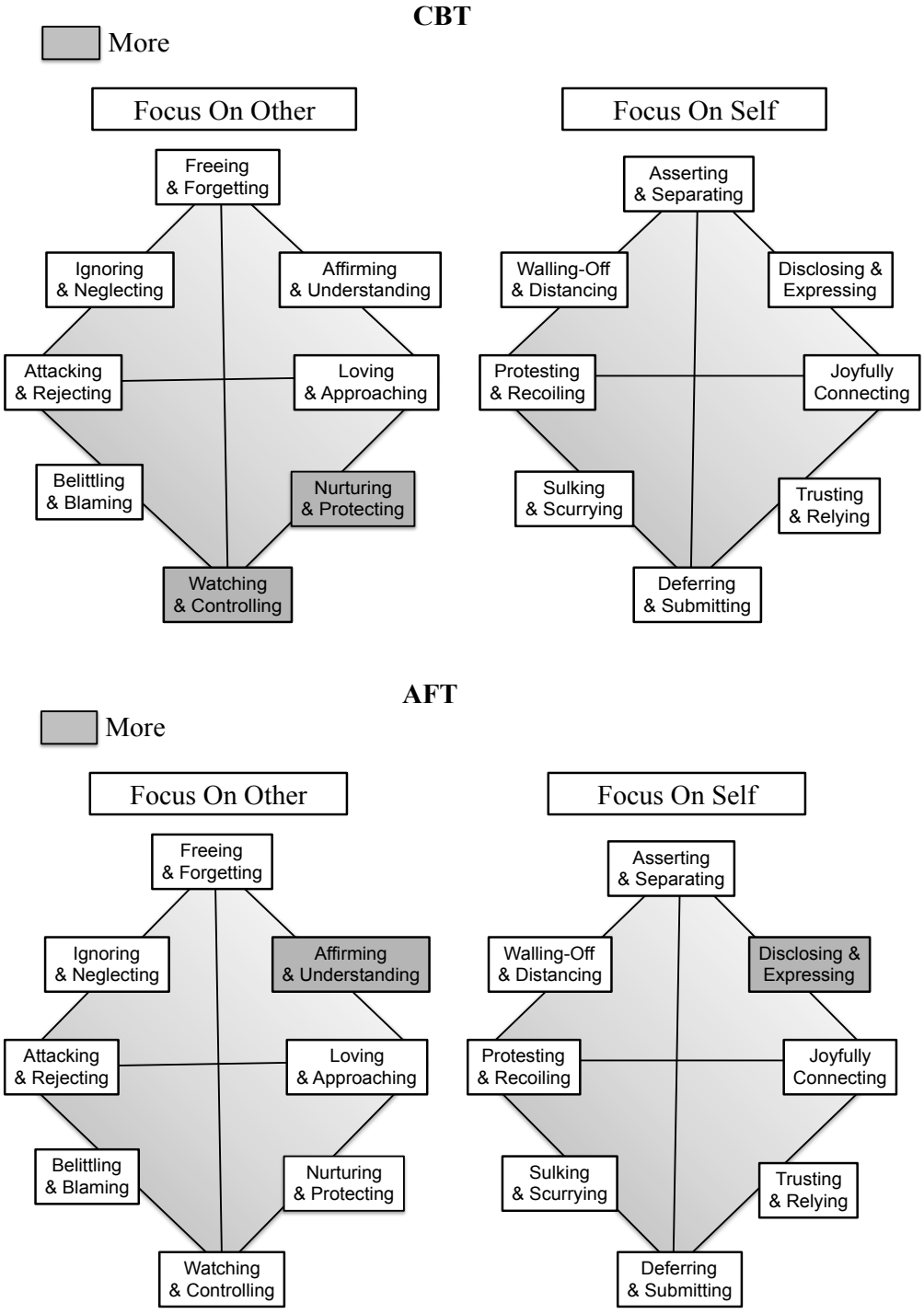


Figure 2. Therapist results on the Focus on Other and Focus on Self surfaces of the SASB. Shaded items in the top two figures were rated significantly higher in the CBT phase relative to the AFT phase of treatment. Shaded items in the bottom two figures were rated significantly higher in AFT than CBT.

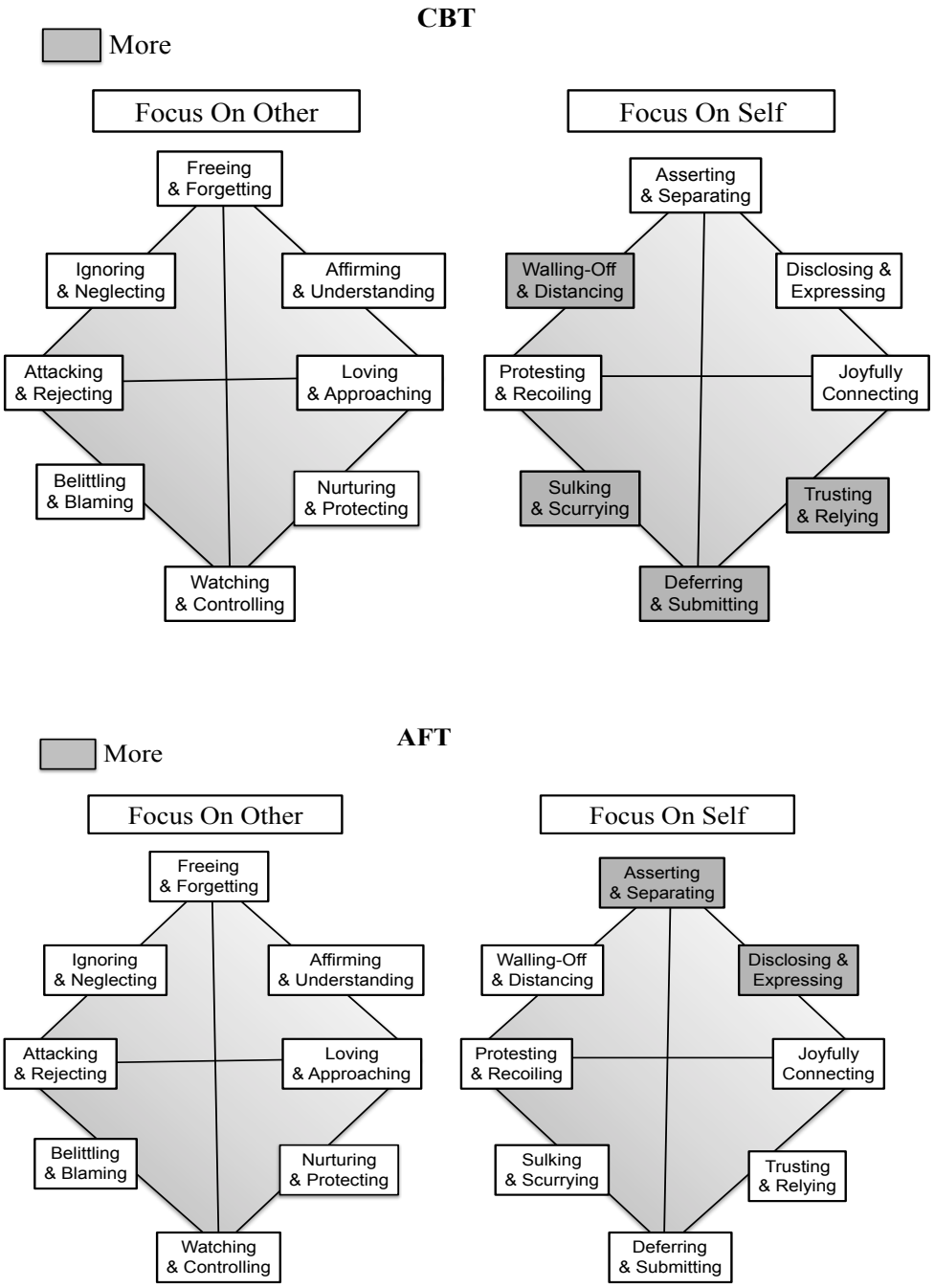


Figure 3. Patient results on the Focus on Other and Focus on Self surfaces of the SASB. Shaded items in the top two figures were rated significantly higher in the CBT phase relative to the AFT phase of treatment. Shaded items in the bottom two figures were rated significantly higher in AFT than CBT.

SASB Item	Therapist Mean (SD)	Patient Mean (SD)
Surface 1: Focus on Other		
Freeing & Forgetting	1.00 (.00) [i]	1.00 (.00) [i]
Affirming & Understanding	2.67 (.77)	1.00 (.00) [i]
Loving & Approaching	1.07 (.13)	1.00 (.00) [i]
Nurturing & Protecting	2.18 (.84)	1.00 (.00) [i]
Watching & Controlling	1.23 (.37)	1.02 (.07)
Belittling & Blaming	1.02 (.06)	1.05 (.18)
Attacking & Rejecting	1.00 (.00) [i]	1.00 (.00) [i]
Ignoring & Neglecting	1.00 (.00) [i]	1.00 (.00) [i]
Surface 2: Focus on Self		
Asserting & Separating	1.02 (.03)	1.28 (.50)
Disclosing & Expressing	1.31 (.38)	2.93 (.80)
Joyfully Connecting	1.00 (.00) [i]	1.20 (.16)
Trusting & Relying	1.00 (.00) [i]	1.65 (.67)
Deferring & Submitting	1.00 (.00) [i]	1.20 (.34)
Sulking & Scurrying	1.00 (.00) [i]	1.12 (.21)
Protesting & Recoiling	1.00 (.00) [i]	1.00 (.00) [i]
Walling off & Distancing	1.00 (.00) [i]	1.20 (.41)

[i] Not included in analyses due to lack of variance.

Table 2. *Analysis of Changes in Therapist SASB scores from CBT to AFT phases*					**95% Wald CI (Grand Mean)**	
SASB Item	**Significant Model Effect**	**Wald x^2**	**CBT Mean**	**AFT Mean**	**Lower**	**Upper**
Affirming & Understanding	Training Condition	169.29**	2.12	3.23	2.54	2.81
Nurturing & Protecting	Training Condition	106.34**	2.78	1.59	2.04	2.31
Watching & Controlling	Training Condition	47.88**	1.48	1.02	1.17	1.32
Disclosing & Expressing	Training Condition	39.35**	1.09	1.51	1.24	1.36
Asserting & Separating	N/A	1.10	1.01	1.00	0.09	1.00
Loving & Approaching	N/A	1.97	1.04	1.08	1.03	1.08
Belittling & Blaming	N/A	2.90	1.03	1.00	0.99	1.03

* p=<.05
** p=<.05
Note: No significant findings had interaction effects.

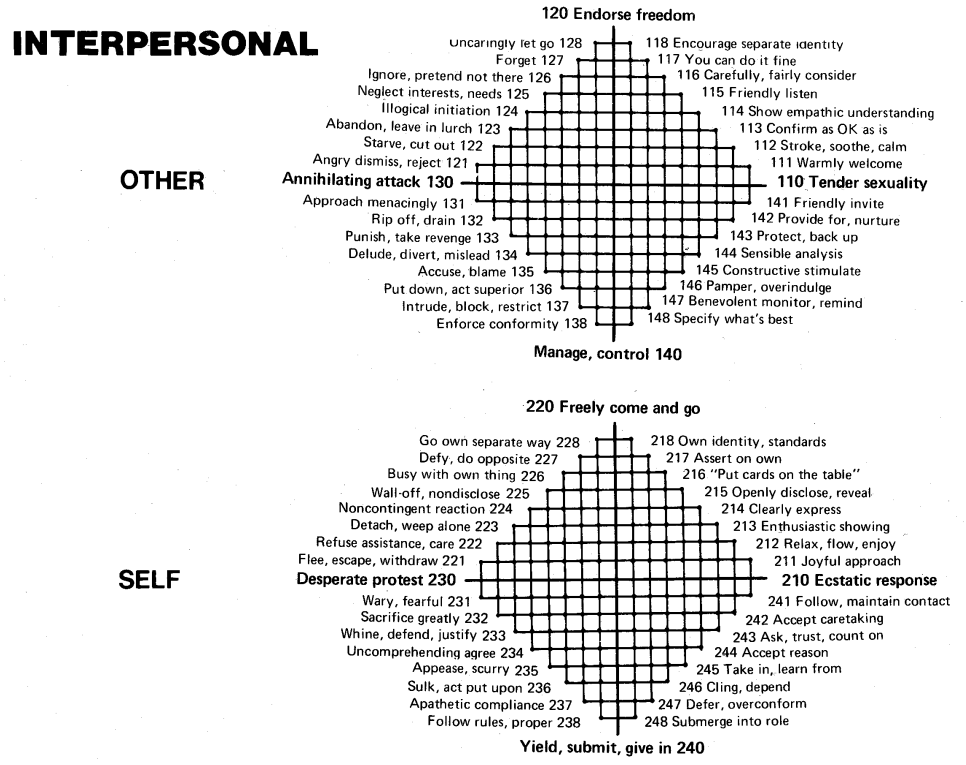
Table 3. ***Analysis of Changes in Patient SASB scores from CBT to AFT phases***

SASB Item	Significant Model Effect	Wald x^2	CBT Mean	AFT Mean	Lower	Upper
Disclosing & Expressing	Training Condition	149.91**	2.27	3.52	2.78	3.01
Trusting & Relying	Training Condition	51.96**	2.07	1.21	1.52	1.76
Deferring & Submitting	Training Condition	33.60**	1.33	1.01	1.11	1.22
Sulking & Scurrying	Training Condition	21.22**	1.20	1.02	1.07	1.15
Walling Off & Distancing	Training Condition	4.16*	1.29	1.04	1.05	1.28
Joyfully Connecting	N/A	0.29	1.07	1.08	1.04	1.10
Belittling & Blaming	N/A	0.53	1.08	1.04	1.01	1.12
Watching & Controlling	N/A	1.96	1.02	1.00	0.99	1.03

SASB Item	Significant Model Effect	Wald x^2	Time of AFT	Modality	Mean	95% Wald CI	
						Lower	Upper
Asserting & Separating	Interaction	4.46*	8	CBT	1.17	0.99	1.36
	(Condition x Time			AFT	1.38	1.13	1.63
	of Implementation)		16	CBT	1.04	.99	1.09
				AFT	1.63	1.29	1.95

* p=<.05
** p=<.05
Note: No significant findings but Asserting & Separating had interaction effects.

Appendix A. SASB Model, Surface 1 & Surface 2



Appendix B. Simplified SASB Scoring Sheets

Rater:		Patient ID:			Session #			Date Rated:					
Response of Patient					Rate from 1 to 5. 1= not present, 3= moderately present, 5= strongly present.								
	Item	**Segment**											
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**		
1	Is freeing and forgetting.												
2	Is afirming and understanding.												
3	Is loving and approaching.												
4	Is nurturing and protecting.												
5	Is watching and controlling.												
6	Is belittling and blaming.												
7	Is attacking and rejecting.												
8	is ignoring and neglecting.												
9	Is asserting and seperating.												
10	Is disclosing and expressing.												
11	Is joyfully connecting.												
12	Is trusting and relying.												
13	Is deferring and submitting.												
14	Is sulking and scurrying.												
15	Is protesting and recoiling.												
16	Is walling off and distancing.												

Rater:		Patient ID:			Session #			Date Rated:					
Response of Therapist					Rate from 1 to 5. 1= not present, 3= moderately present, 5= strongly present.								
	Item	**Segment**											
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**		
1	Is freeing and forgetting.												
2	Is afirming and understanding.												
3	Is loving and approaching.												
4	Is nurturing and protecting.												
5	Is watching and controlling.												
6	Is belittling and blaming.												
7	Is attacking and rejecting.												
8	is ignoring and neglecting.												
9	Is asserting and seperating.												
10	Is disclosing and expressing.												
11	Is joyfully connecting.												
12	Is trusting and relying.												
13	Is deferring and submitting.												
14	Is sulking and scurrying.												
15	Is protesting and recoiling.												
16	Is walling off and distancing.												