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EVALUATING ALLIANCE-FOCUSED INTERVENTION FOR POTENTIAL TREATMENT FAILURES: A FEASIBILITY STUDY AND DESCRIPTIVE ANALYSIS

JEREMY D. SAFRAN
New School for Social Research and Beth Israel Medical Center

J. CHRISTOPHER MURAN
Beth Israel Medical Center and Albert Einstein College of Medicine

LISA WALLNER SAMSTAG
Long Island University and Beth Israel Medical Center

ARNOLD WINSTON
Beth Israel Medical Center and Albert Einstein College of Medicine

This article describes a pilot study evaluating the feasibility of an approach developed to test the efficacy of a therapeutic intervention (brief relational therapy) for patients with whom it is difficult to establish a therapeutic alliance. In the first phase of the study, 60 patients were randomly assigned to either short-term dynamic therapy (STDP) or short-term cognitive therapy (CBT), and their progress in the first eight sessions of treatment was monitored. On the basis of a number of empirically derived criteria, 18 potential treatment failures were identified. In the second phase of the study, these identified patients were offered the option of being reassigned to another treatment. The 10 patients who agreed to switch treatments were reassigned either to the alliance-focused treatment, referred to as brief relational therapy (BRT), or a control condition. For patients coming from CBT, the control condition was STDP. For patients coming from STDP, the control condition was CBT. The results provide preliminary evidence supporting the potential value of BRT as an intervention that is useful in the context of alliance ruptures.

Keywords: alliance ruptures, therapeutic impasses, brief relational therapy, treatment failures, treatment dropouts

Jeremy D. Safran, Department of Psychology, New School for Social Research, and Department of Psychiatry, Beth Israel Medical Center; J. Christopher Muran, Department of Psychiatry, Beth Israel Medical Center, and Albert Einstein College of Medicine; Lisa Wallner Samstag, Department of Psychology, Long Island University at Brooklyn, and Department of Psychiatry, Beth Israel Medical Center; and Arnold Winston, Department of Psychiatry, Beth Israel Medical Center, and Albert Einstein College of Medicine.

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Correspondence concerning this article should be addressed to Jeremy D. Safran, New School for Social Research, Department of Psychology, 65 Fifth Avenue, New York, NY 10003. E-mail: safranj@newschool.edu

This article is the first of a two-part series focusing on brief relational therapy (Muran & Safran, 2002a, 2002b; Safran, 2002a, 2002b, 2002b; Safran & Muran, 2000). Brief relational therapy (BRT) is an approach to treatment that is informed by recent developments in relational psychoanalytic thinking as well as by our own research

program on therapeutic alliance ruptures (e.g., Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996; Safran, Muran, & Samstag, 1994). In this approach, particular emphasis is placed on exploring and working through alliance ruptures, or what are referred to in psychoanalytic terms as transference/countertransference enactments.

In this article, we report the results of a pilot study conducted to evaluate the feasibility of a research design developed to test the effectiveness of this intervention with patients who have been determined to be at risk for treatment failure or premature termination. These patients are identified with an actuarial system developed specifically for this purpose. In addition, we provide a descriptive analysis of selected therapy sessions in order to enrich our understanding of the process through which alliance ruptures are resolved. In the second article (Muran, Safran, Samstag, & Winston, 2006) we evaluate the efficacy of BRT as a treatment intervention for personality disordered patients. The participants in the second study consisted of patients in our clinic who either were not identified by the actuarial system in the current study or who were identified but chose not to participate.

Although promising psychotherapeutic interventions have been identified for a range of different psychological disorders (e.g., Task Force on Psychological Intervention Guidelines, 1995), substantial numbers of patients fail to benefit from these treatments. There are a number of reasons for this. To begin with, dropout rates are relatively high. In the psychotherapy research literature, estimates of patient dropout rates average about 47% and range as high as 67% (Sledge, Moras, Hartley, & Levine, 1990; Wierzbicki & Pekarik, 1993).

Even without consideration of the issue of patient attrition, the evidence indicates that there is still considerable room for improvement. Asay, Lambert, Christensen, and Beutler (as cited in Lambert & Bergin, 1994) in their study of 2,405 community mental health center patients found that 66% of treated patients could be considered improved, 26% unchanged, and 8% worse. Howard, Kopta, Krause, and Orlinsky (1986) in their meta-analysis of 2,431 patients from published research over a 30-year period found that 75% of treated patients showed measurable improvement by the end of six months of weekly therapy, leaving 25% as either not improved or deteriorated.

The NIMH Treatment of Depression Collaborative Research Program (Elkin, 1994) found that at an 18-month follow-up interval, only 30% of the patients receiving cognitive therapy and 26% of patients receiving interpersonal therapy were considered improved. In their meta-analysis of methodologically sound treatment studies, Westen and Morrison (2001) found that of the patients who completed treatment, only 63% of panic disorder patients, 52% of generalized anxiety disorder patients, and 54% of depressed patients were considered improved at termination. These percentages decreased even further at follow-up.

Finally, it is important to remember that even these relatively low improvement rates are probably inflated by the fact that many patients are screened out of research treatment protocols because of the presence of complicated diagnostic pictures. Westen and Morrison (2001), for example, found that the average study screened out two thirds of patients initially assessed because of the presence of comorbid diagnoses. This practice of screening outpatients with comorbid diagnoses, while understandable from the perspective of research design considerations, may provide a distorted picture of clinical practice in the real world. Therapists in everyday practice are more likely to treat patients with comorbid diagnoses, and these patients may be more difficult to treat (Seligman, 1995).

Given the considerable evidence indicating that a significant proportion of patients fail to benefit from psychotherapy, it is important to identify those who are at risk for treatment dropout or poor outcome and to develop ways of improving the likelihood that they will complete the treatment protocol and benefit from the treatment intervention offered. One of the most consistent findings emerging from the psychotherapy research literature is that a good therapeutic alliance is related to positive treatment outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). There is also ample evidence that a poor alliance is correlated with unilateral termination (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1990, 1993, 1995, 1993, 1995). A related finding is that both weak alliances and poor outcome are associated with a pattern of negative interpersonal process in which

therapists respond to patient hostility with counterhostility (Coady, 1991; Henry, Schacht, & Strupp, 1986, 1990, 1990; Kiesler & Watkins, 1989; Samstag, 1999; Tasca & McMullen, 1992). There is also some evidence to indicate that it is particularly difficult to train therapists to avoid this type of negative process (Henry, Schacht, Strupp, Butler, & Binder, 1993; Piper et al., 1999).

Given these findings it would seem critical to develop ways of repairing strained alliances and training therapists to work through negative patient–therapist interactional cycles in a constructive fashion. A number of independent research programs have provided preliminary evidence regarding the factors involved in repairing alliance ruptures (Safran, Muran, Samstag, & Stevens, 2002), and the APA Divison 29 Task Force on Empirically Supported Therapy Relationships has identified this process as a "promising and probably effective" element of change (Norcross, 2002).

In our own research program we have identified two broad types of alliance ruptures, each with its own characteristic resolution processes (Safran, Crocker, McMain, & Murray, 1990; Safran et al., 1994; Safran & Muran, 1996, 2000, 2000). In *withdrawal ruptures* patients tend to deal with difficulties or misunderstanding in the therapeutic relationship by withdrawing, complying, or expressing negative feelings indirectly. In *confrontation ruptures* they tend to avoid the expression of underlying needs and to express negative feelings in a blaming or demanding fashion. In withdrawal ruptures the resolution process involves exploring the interpersonal fears, expectations, and internalized criticisms that interfere with the direct expression of negative feelings that are being avoided, and gradually progressing toward self-assertion and the expression of underlying wishes. In confrontation ruptures the resolution process involves exploring the fears and self-criticisms that interfere with the expression of underlying needs and gradually progressing toward the expression of more vulnerable feelings.

Building upon these findings as well as developments emerging from relational psychoanalysis (e.g. Aron, 1996; Benjamin, 1990; Ghent, 1992; Mitchell, 1988; Pizer, 1998), we developed a manualized treatment focusing on the therapeutic relationship, which should in theory be helpful for patients who are at risk for poor outcome or premature termination. This model, referred to as brief relational therapy (BRT), is designed to be administered as a stand-alone treatment modality, but the principles and interventions are also designed to be incorporated into other treatment modalities on an adjunctive basis (Muran & Safran, 2002a, 2002b; Safran, 2002a; 2002b; Safran & Muran, 2000).

Method

In a preliminary effort to evaluate the specific benefits of BRT as a treatment for alliance ruptures, we conducted a small-scale pilot study. This study consisted of a number of different phases. To best convey the relationship between these phases, we will depart somewhat from the conventional ordering of subsections within this section. The assumption guiding our research design is that a major obstacle to finding treatment differences is a lack of contextual specificity (Beutler, Moleiro, & Talebi, 2002; Greenberg, 1986). In the standard clinical trial study, clustering patients together on the basis of a standard diagnostic criterion and then administering a general therapeutic approach commits the error of subscribing to a uniformity myth (Kiesler, 1966). The sample is sufficiently heterogeneous with respect to important characteristics so that some will benefit, while others will not, thereby washing out treatment differences. To the extent, however, that patients can be grouped together on the basis of a variable that, in theory, is particularly relevant to a specific intervention, the possibility of finding treatment differences should be increased.

Following this line of reasoning we reasoned that selecting patients specifically on the basis of their difficulty in establishing a therapeutic alliance should increase the possibility that an intervention targeting ruptures in the alliance will have more impact than one that does not. By selecting patients on the basis of a relevant in-session performance variable, this strategy goes beyond the more traditional factorial design of clustering patients on the basis of a static or dispositional characteristic. This should increase the sensitivity of the design by reducing slippage resulting from selecting on the basis of a trait variable that may have limited consistency and predictive validity (Mischel, 1968). In order to

identify the relevant patients, we developed an actuarial system, which we describe below.

Developing an Actuarial System

In an attempt to establish criteria for identifying patients who are at risk for treatment failure, we examined a previously collected sample of 73 patients receiving short-term treatment in a variety of different modalities, including short-term cognitive therapy and short-term dynamic psychotherapy (see Samstag et al., 1998). In this sample, we compared the ratings of good outcome, poor outcome, and dropout cases from both patient and therapist perspectives on a postsession questionnaire (PSQ) administered after every session. The PSQ, which we have previously described in detail (Muran, 2002; Samstag et al., 1998) contains a number of items including the 12-item version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989), the Session Evaluation Questionnaire (Stiles, Reynolds, Hardy, & Rees, 1994), a short version of the Interpersonal Adjective Scale (IAS; Wiggins, Trapnell, & Phillips, 1988), a question rating the degree of tension experienced in the therapeutic relationship during the session, and a question asking to what extent this tension (if it occurred) was resolved by the end of the session. Classification into good and poor outcome groups was established by calculating reliable change indices (RCIs) on the basis of pre-to-post treatment changes on the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), and the Symptom Checklist−90 Revised (SCL-90R; Derogatis, 1983). The Reliable Change Index (RCI) scores of the two measures were averaged in order to provide a composite index. Patients with an RCI score of $< .5$ were classified as poor outcome cases, while patients with an RCI score of $\geq .5$ were classified as good outcome cases.

After using a MANOVA and subsequent univariate analyses to identify variables that distinguished among the good and poor outcome and the dropout groups, we used an iterative procedure to identify cutoff scores on those variables that would identify the highest number of dropout and poor outcome cases and the lowest number of good outcome cases. Our final actuarial system consisted of cutoff scores on three patient and three therapist dimensions (see Table 1). In order to be classified as a reassignment case, the dyad had to meet these cutoff scores on a minimum of 3 of these 6 dimensions (with at least one dimension from the patient perspective and one from the therapist perspective) for two consecutive sessions. A missing PSQ or missing data on a PSQ was included as a patient criterion, based on our finding that this was also predictive of outcome.

Having established these criteria, we then reexamined our initial sample of 73 patients for true positives (poor outcome and dropout cases classified as potential reassignment cases), false positives (good outcome cases classified as potential reassignment cases), and false negatives (poor outcome and dropout cases not identified). Using this system, we were able to identify 79% of the dropouts and 70% of the poor outcome cases (true positives). Thus 21% of the dropouts and 30% of the poor outcome cases went undetected (false negatives). Only 11% of the good outcome cases were mistakenly identified (false positives). Although the proportion of false negatives was relatively high, we decided that in

TABLE 1. Reassignment Criteria based on Patient and Therapist Postsession Questionnaire (PSQ) Ratings

Rating criteria	Cutoff score
Patient items	
WAI Total score	$M \leq 4.40$
WAI Task score	$M \leq 4.25$
Missing data	$\geq 25\%$ of a PSQ incomplete
Therapist items	
WAI Total score	$M \leq 4.10$
IAS: Patient hostility	$M \geq 6.00$
Degree of interpersonal tension with the patient	≥ 3.00

Note. WAI = Working Alliance Inventory (12-item version); IAS = Interpersonal Adjective Scale (8-item version).

order to reduce the possibility of unnecessarily interfering with a treatment, which might result in a positive outcome, it was better to err in the direction of increasing the number of false negatives rather than increasing the number of false positives. We felt that this was important both in terms of patients' welfare and therapists' willingness to participate in the study.

Procedures

The study consisted of two phases. In the first phase, patients who met the diagnostic criteria of Personality Disorder (PD) Cluster C or NOS on Axis II of *DSM-IV* were randomly assigned to 30 sessions of either short-term cognitive-behavioral therapy (CBT) or short-term dynamic psychotherapy (STDP). The patients were tracked over the first eight sessions of treatment, and on the basis of a number of empirically derived criteria for predicting treatment failure or dropout, a subgroup of patients was identified. These patients were then offered the option of transferring to another treatment condition.

In the second phase of the study, those who chose to be transferred were randomly reassigned to a 30-session protocol of either brief relational therapy (BRT) or a control treatment. For patients coming from CBT, the control treatment was STDP. For those patients coming from STDP, the control treatment was CBT. The control treatments were thus designed to control for the possibility that being switched to any viable alternative treatment would be of equal benefit. In other words, they were designed to test the hypothesis that BRT has unique benefits for patients with whom it is difficult to establish a therapeutic alliance.

Beginning in 1992, 146 patients meeting the inclusion criteria described below were randomly assigned to one of three treatments in our research program: STDP, CBT, or BRT. During a 4-year period between 1993 and 1996, all patients receiving either STDP (30 patients) or CBT (30 patients) were screened with our actuarial system. Those who met our reassignment criteria were offered the option of being transferred to another treatment condition. Those who did not meet these criteria or who met them but declined reassignment, were included as participants in the second study in this series (Muran et al., 2006).

Treatment Conditions

Short-Term Dynamic Psychotherapy. The short-term dynamic psychotherapy (STDP, also referred to as brief adaptive psychotherapy elsewhere: Pollack, Flegenheimer, Kaufman, & Sadow, 1992) is similar in many respects to the approaches of both Strupp and Binder (1984) and Luborsky (1984). The general approach to technique is one in which therapists help patients gain insight into maladaptive transactional patterns or core conflictual relationship themes through interpretation. The treatment process begins with the establishment of a case formulation. Based on what the therapist gathers in terms of developmental history and observes in the patient's behavior early in treatment, the therapist attempts to uncover and identify a major maladaptive pattern that indicates conflict and then contracts with the patient to make the pattern the focus of the treatment. The balance of treatment is marked by interpretation of patient transference material, exploring the details of the pattern, and making links to both in-session and extrasession material. The treatment goal is the resolution of the conflict inherent in the pattern. Training and supervision in this treatment model is primarily didactic in its orientation, teaching therapists to identify interactions of transference and countertransference.

Cognitive–Behavioral Therapy. The CBT condition (Turner & Muran, 1992) is a manualized treatment based on the approach of Beck, Rush, Shaw, and Emery (1979) and Beck and Freeman's (1990) adaptation of cognitive therapy to the treatment of personality disorders. It also incorporates Persons, Burn, and Perloff's (1988) perspective on cognitive therapy case formulation. It emphasizes the principles of Socratic dialogue and guided discovery. Patients are taught to monitor and identify automatic thoughts and dysfunctional attitudes and to modify them using standard cognitive and behavioral interventions. Like STDP, the treatment process begins with establishing a case formulation, which includes defining a problem list and clarifying core belief systems (Persons et al., 1988). The course of treatment then involves the application of various cognitive (e.g., Socratic questioning, thought records, imaginal exposure exercises) and behavioral (e.g., activity scheduling, in vivo exposure exercises, role-playing) tasks, including those assigned as homework, to challenge and correct the

patients' automatic thoughts and dysfunctional beliefs. The therapeutic relationship is based on the principle of "collaborative empiricism" (Beck et al., 1979), that is, the patient and therapist collaborate to test the validity and viability of the patient's beliefs. The ultimate goal is to teach the patient to approach his or her thinking as a scientist, submitting it to empirical analysis. The supervision process in CBT also has a didactic emphasis, instructing therapists on developing schema-focused change strategies.

Brief Relational Therapy. Brief relational therapy (BRT: Muran & Safran, 2002a; Safran & Muran, 2000; Safran, 2002a, 2002b is a model that synthesizes developments from contemporary relational psychoanalytic thinking with findings from our own research program on therapeutic alliance ruptures. It has also been influenced by other traditions, especially the experiential/humanistic tradition and mindfulness practice emerging from the Buddhist tradition. In addition it has been informed by contemporary theory and research on emotion (e.g., Greenberg & Safran, 1987). Its theory of change can be understood in terms of two principles: (a) the cultivation of mindfulness skills that facilitate the ongoing awareness of the way in which one's internal processes and actions contribute to self-defeating patterns, and (b) the emergence of new relational experiences with the therapist that challenge existing relational schemas. A central assumption is that therapists can never stand completely outside of the interpersonal field and look at the patient objectively and that to various degrees they unwittingly participate in relational scenarios with their patients. A key technical principle is therapeutic metacommunication, which is an attempt to disembed from the relational scenario that is being enacted by communicating about the communication process (Kiesler, 1996; Safran & Muran, 2000). It involves the use of collaborative inquiry to bring awareness to bear on what is going on in the therapeutic relationship.

BRT is distinct from the other two models in at least three noteworthy ways. First, the model emphasizes process rather than content. It is oriented toward cultivating the skill of mindfulness in relation to self and others rather than resolving a central conflict or challenging cognitive distortions. Since therapists inevitably become embedded in relational scenarios with the patient, case formulation is not the initial task of treatment, but rather a byproduct of the disembedding process. A primary focus of BRT is on tracking and exploring therapeutic alliance ruptures and treating them as opportunities for understanding and change. BRT is grounded in a constructivist and intersubjective model of the therapeutic relationship, in which the therapist is not considered to have a privileged understanding of reality. Rather, knowledge and understanding are considered to result from processes of both collaborative discovery and co-construction involving the patient and therapist. Finally, the supervision process in BRT includes the intensive exploration of therapist experience or countertransference and incorporates principles and practices from mindfulness meditation to cultivate greater self-awareness in therapists. This helps them to explore the way in which their own subjective experiences and actions contributed to therapeutic enactments. The training approach thus has an experiential and self-exploratory orientation that helps therapists to become aware of their own internal processes for purposes of facilitating metacommunication (which is conceptualized as a form of "mindfulness in action").

Participants

As discussed previously, standard practice in efficacy research involves studying patients who meet criteria for a single diagnosed disorder and screening outpatients with comorbid diagnoses. This reduces the ecological validity of the research and screens out those patients who are more commonly seen in real clinical practice and who are more difficult treat. For this reason, rather than restricting our study to the investigation of patients meeting criteria for a particular Axis I disorder, we decided to study patients with a range of different diagnostic pictures. Many had comorbid diagnoses on either Axis I or II or both. We were also particularly interested in focusing on patients with a personality disorder diagnosis, given the evidence that such patients are likely to present a difficult therapeutic challenge for clinicians. We reasoned that therapists' ability to negotiate a good therapeutic alliance in the face of personality disordered patients' inflexible and self-defeating interpersonal styles is likely to

be particularly important (e.g., Benjamin, 1993). Our principle inclusion criterion was thus a diagnosis of personality disorder (PD) Cluster C or Not Otherwise Specified (NOS). Exclusion criteria included evidence of psychosis, organicity, mania or bipolar disorder, substance abuse disorder, active suicidal or parasuicidal behavior, and history of severe impulse control problems. These patients were excluded since we reasoned that a longer treatment would be more appropriate for them. Patients who had begun psychotropic medication use within the last six months were also excluded in order to reduce the possibility that unstable medication regimens would moderate treatment effects. All patients were assigned a *DSM–IV* diagnosis on both Axis I and Axis II using the Structured Clinical Interview for *DSM* (First, Spitzer, Gibbon, & Williams, 1995), which was reliably administered by trained research assistants (see Muran, 2002; Muran et al., 2003). Figure 1 presents the de-

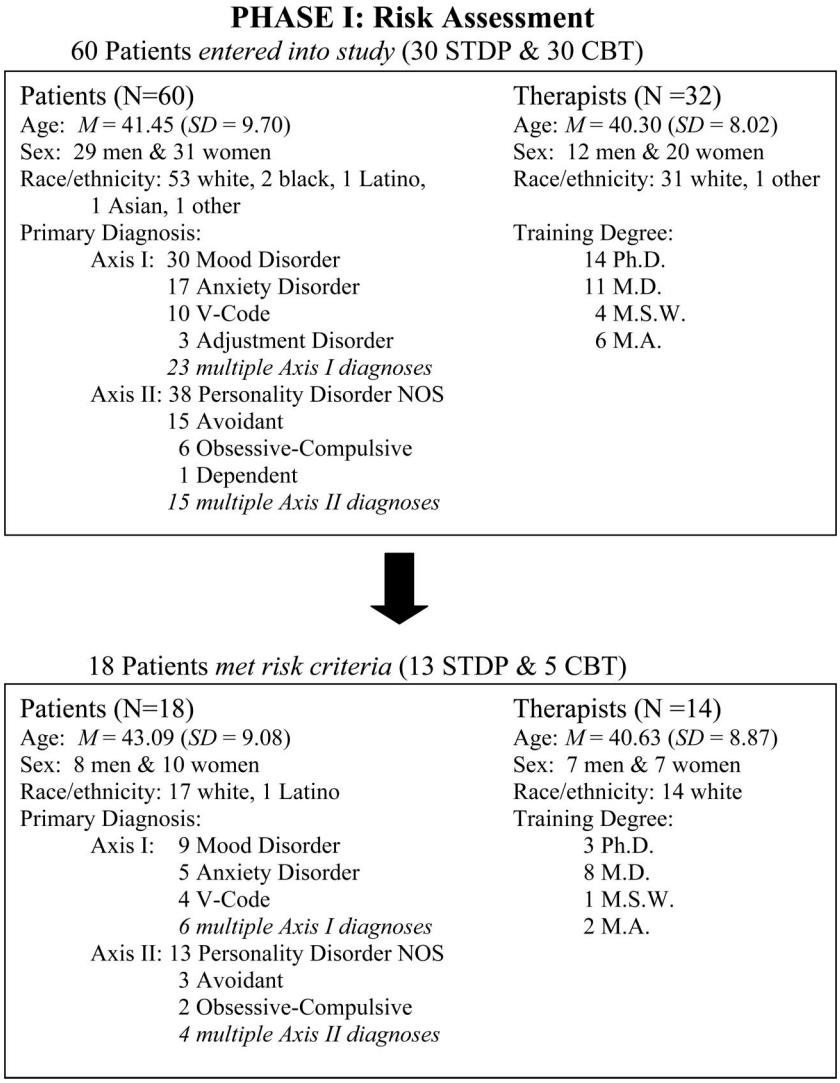

FIGURE 1. Study design and participant descriptives. STDP = Short-Term Dynamic Psychotherapy; CBT = Cognitive-Behavioral Therapy; BRT = Brief Relational Therapy.

scriptive data for the 60 patients (and their therapists) entered into the current study.

Treatment Reassignment

Eighteen (30%) of the 60 patients screened with the actuarial system were assessed as at risk for treatment failure and were offered the option of reassignment to another treatment. Figure 1 presents the descriptive data for this subset of patients and for the therapists who saw them. Of these 18 patients, 10 (56%) accepted the offer for reassignment to another treatment, and 8 declined and continued in treatment with their current therapists. We will discuss the outcome of these 8 patients in due course (see Figure 1 for descriptives of these patients and their therapists). The 10 patients accepting the offer to switch treatments were randomly assigned to either BRT or the control condition (see Figure 1 for descriptives).

Patients who met the reassignment criteria were contacted via telephone by the interviewer who had conducted the SCID and presented with the following rationale: "One of the features of this research program is that we monitor your treatment on an ongoing basis, in order to eval-

PHASE II: Treatment Reassignment

10 Patients *accepted reassignment*

5 Experimental Condition (BRT)	Control Condition (2 STDP & 3 CBT)
Patients (N=5)	Patients (N=5)
Age: *M* = 44.40 (*SD* = 9.73)	Age: *M* = 39.60 (*SD* = 6.62)
Sex: 2 men & 3 women	Sex: 2 men & 3 women
Race/ethnicity: 5 white	Race/ethnicity: 5 white
Primary Diagnosis	Primary Diagnosis
Axis I: 3 Mood Disorder	Axis I: 3 Mood Disorder
1 Anxiety Disorder	1 Anxiety Disorder
1 V-Code	1 V-Code
2 multiple diagnoses	*1 multiple diagnosis*
Axis II: 5 PD NOS	Axis II: 2 PD NOS
	1 Avoidant
	1 Obsessive-Compulsive
	2 multiple diagnoses
Therapists (N=4)	Therapist (N=5)
Age: *M* = 33.20 (*SD* = 3.97)	Age: *M* = 38.80 (*SD* = 3.31)
Sex: 3 men & 1 women	Sex: 1 man & 4 women
Training Degree: 2 Ph.D. & 2 MA	Training Degree: 3 Ph.D., 1 MD, & 1 MA

Patients *rejected reassignment* (7 STDP & 1 CBT)

Patients (N=8)	Therapists (N=8)
Age: *M* = 45.00 (*SD* = 8.75)	Age: *M* = 40.25 (*SD* = 10.05)
Sex: 4 men & 4 women	Sex: 5 men & 3 women
Race/ethnicity: 7 white, 1 Latino	Race/ethnicity: 8 white
Primary Diagnosis:	Training Degree:
Axis I: 3 Mood Disorder	6 M.D.
3 Anxiety Disorder	1 M.S.W.
2 V-Code	1 M.A.
4 multiple diagnoses	
Axis II: 6 Personality Disorder NOS	
1 Avoidant	
1 Obsessive-Compulsive	
1 multiple diagnosis	

uate how well things are progressing. Sometimes one form of treatment is more beneficial for a particular person than another. Based on your postsession questionnaires, it appears that you have some concerns about your therapy and that things are not going as well for you as they might. We are calling to offer you the option of being transferred to a different form of treatment with another therapist."

We reassured them that they were the best judges of what was right for them and that they should not necessarily switch if they felt hopeful about their current treatment. We also reassured them that their therapists were trained professionals who understood that this was part of the research program and were prepared for patients to switch treatments. We thus emphasized that they should not stay in their current treatment because of a concern about their therapists' reactions. Patients were given two sessions to make a decision and we left if up to them as to whether they wished to discuss the situation with their therapists.

All therapists participating in the first phase of the study were informed of the treatment design and knew that their patients would be offered the option of treatment reassignment if the postsession ratings met certain criteria. They were not, however, informed when a patient was offered the option of a treatment reassignment. We reasoned that to proceed otherwise could put patients in an awkward position because some might feel uncomfortable about a third party informing their therapists about their concerns, especially if they had not discussed them with their therapists. We anticipated that after being offered the option of treatment assignment, some might decide to discuss it with their therapists and some might not. We reasoned that differences of this type would reflect stylistic preferences in the patients and possibly the quality of the existing therapeutic alliance as well. We also anticipated that those patients who decided to stay in treatment with their original therapists might be the ones who had raised their concerns with their therapists and felt that their therapists responded to their concerns in a helpful fashion. We thus hypothesized that they would go on to become good outcome cases. If a patient elected to be reassigned, then the therapist was contacted and a debriefing interview was conducted by the program director.

Measures

Treatment effects were assessed using the following outcome measures:

Symptom Checklist-90 Revised (SCL-90R: Derogatis, 1983) is a self-report inventory developed to assess general psychiatric symptomatology. It consists of 90-items scaled in a Likert-type format on degree of severity. Normative data and adequate psychometric properties have been reported. In this study, the Global Severity Index (GSI), which is an overall mean score, was used. Patients filled out the SCL-90R at pretreatment, termination, and at a 6-month follow-up.

The Inventory of Interpersonal Problems (IIP: Horowitz, Alden, Wiggins, & Pincus, 2000) is an inventory developed to assess patient social adjustment and interpersonal difficulties. A short-form was developed from factor analytic procedures to be rated by the patient. It consists of 64 items scaled in a Likert-type format on degree of distress. Normative data and adequate psychometric properties have been reported. In this study, the overall mean score was used to determine outcome. Patients completed the IIP at pretreatment, termination, and 6-month follow-up.

Target Compaints (TC: Battle et al., 1966) is an idiographic self-report instrument developed to assess the particular presenting problems of the patients. Space is provided for three problems per patient, and each problem is rated on a Likert-type scale in terms of degree of severity. Both patients (PTC) and therapists (TTC) independently rated the severity of the problems. In this study, the ratings of the three problems was averaged for an overall index. Patients rated the PTC at intake, termination, and at 6-month follow-up. Therapists rated their patients' target complaints (TTC) after the third session of treatment and at termination. There were no follow-up ratings on the TTC.

Results

Treatment Fidelity

In order to assess for treatment fidelity, or to what extent therapists were conducting treatment according to their respective manuals, we applied the Beth Israel Fidelity Scale (BIFS), to our sam-

ple of cases which included the patients who accepted reassignment. The BIFS is a 44-item, observer-based scale comprised of four subscales: Brief Relational Therapy (BRT), Cognitive-Behavioral Therapy (CBT), Short-Term Dynamic Therapy (STDP), and Common Factors (Patton et al., 1998; Santangelo et al., 1994). The Common Factors subscale consisted of items believed to be common to all three approaches. Research assistants were trained to reliable standards (i.e., intraclass correlation .90) to conduct this assessment. In our analyses, we included a random sampling of sessions from cases before and after reassignment to increase the sample size. More specifically, we aimed to select one session before ($n = 10$) and one session after ($n = 10$) reassignment for a total of 20 sessions. In one case involving only two sessions, there was not a taped session available for rating, so our analyses were conducted on a sample of 19: 8 STDP, 6 CBT, and 5 BRT. The results of several one-way analyses of variance are presented in Table 2 and indicated adequate treatment fidelity.

Treatment Outcome

The comparison of experimental and control conditions is simplified by the fact that all patients in the control condition (CBT or STDP) dropped out of treatment unilaterally, one after each of the following sessions: 2, 5, 10, 15, and 23 (see Table 3).

In the BRT condition, 1 patient dropped out of treatment after session 2. A second patient left treatment after treatment midphase (Session 15) to accept a job that she had been offered in another country. This was a planned termination that both the patient and therapist worked toward in a constructive fashion during the last few sessions of treatment. A chi-square analysis indicated that BRT had significantly fewer dropouts than the control condition, $\chi^2\,(2, N = 10) = 6.67$, $p = .048$.

In order to evaluate the outcome status of the three BRT patients who completed the 30 session protocol, we assessed the extent to which they showed clinically significant and reliable change on the various outcome measures.

Clinically Significant Change. First we addressed the question of clinical significance or to what extent change indicated a shift to normal functioning. For the two measures for which we had normative data on a functional population, the Symptom Checklist-90R (SCL-90R) and the Inventory of Interpersonal Problems (IIP), we used the following formula: Patients were considered to have achieved clinically significant change when their level of functioning subsequent to therapy placed them closer to the mean

TABLE 2. Treatment Fidelity: Means, Standard Deviations, and Results from Four One-Way ANOVAs

	M	*SD*	*F*(2, 53)	Scheff ϑ Test *M* difference (*SE*)
STDP cases (N = 8)				
STDP Scale	2.03	0.58	10.49**	.11 (.24) BRT vs. CBT
CBT Scale	1.12	0.16		.91 (.22) STDP vs. CBT*
BRT Scale	1.23	0.16		.80 (.23) STDP vs. BRT*
CBT cases (N = 6)				
STDP Scale	1.12	0.13	5.51*	.50 (.17) CBT vs. STDP*
CBT Scale	1.61	0.52		.01 (.17) STDP vs. BRT
BRT Scale	1.10	0.08		.51 (.19) CBT vs. BRT*
BRT cases (N = 5)				
STDP Scale	1.45	0.29	4.39*	.42 (.19) BRT vs. STDP*
CBT Scale	1.30	0.32		.58 (.20) BRT vs. CBT*
BRT Scale	1.88	0.40		.15 (.18) STDP vs. CBT
Common Factor Scale				
STDP Cases	3.13	0.63	0.16	.01 (.33) STDP vs. CBT
CBT Cases	3.13	0.71		.19 (.37) CBT vs. BRT
BRT Cases	3.31	0.43		.18 (.35) BRT vs. STDP

Note. STDP = Short-Term Dynamic Psychotherapy; CBT = Cognitive-Behavioral Therapy; BRT = Brief Relational Therapy
* $p < .05$. ** $p < .01$.

TABLE 3. Results of Cases in Experimental and Control Conditions

Condition	Outcome Measures			
	PTC	TTC	GSI	IIP
Experimental condition				
Case 1				
Pretreatment	11.66	11.33	.42	.98
Termination	9.66	9.33	.21[a]	1.52
Follow-up	5.33[b]		.02[a]	.73[a]
Case 2				
Pretreatment	7.33	10.00	1.59	1.98
Termination	Unilateral Termination: Session 2			
Case 3				
Pretreatment	7.00	9.00	.52	.80
Termination	3.00[b]	5.67[b]	.22[a,b]	.72
Follow-up	3.33[b]		.30[a,b]	.66[a]
Case 4				
Pretreatment	9.00	9.33	.94	1.56
Termination	4.66[b]	4.33[b]	.88	1.64
Follow-up	3.33[b]		.45[a,b]	1.04[a,b]
Case 5				
Pretreatment	9.33	8.67	1.18	1.97
Termination	Planned Termination: Session 15			
Control condition				
Case 1				
Pretreatment	8.00	7.00	0.53	0.85
Termination	Unilateral Termination: Session 2			
Case 2				
Pretreatment	10.66	9.33	0.42	0.59
Termination	Unilateral Termination: Session 10			
Case 3				
Pretreatment	9.33	10.00	0.84	1.44
Termination	Unilateral Termination: Session 23			
Case 4				
Pretreatment	10.00	8.67	1.38	2.44
Termination	Unilateral Termination: Session 15			
Case 5				
Pretreatment	9.33	8.67	0.68	1.44
Termination	Unilateral Termination: Session 5			

Note. Reliable change indices (RCIs) could only be calculated on GSI and IIP. PTC = Patient Target Complaints; TTC = Therapist Target Complaints; GSI = Global Severity Index, Symptom Checklist—90 Revised; IIP = Inventory of Interpersonal Problems.
[a] Medium effect (RCI ≥ .50). [b] Clinically significant change.

of the functional population than it did to the mean of the dysfunctional population (Jacobson & Truax, 1991). We used Derogatis' (1983) reported mean score of .31 (*SD* = .31) on the GSI of the SCL-90R for a functional population (*N* = 974) and the pretreatment mean score of .83 (*SD* =.46) of our own sample (*N* = 60) of personality disordered patients who were entered into the first phase of the study, which yielded a cutoff score of .52.[1] We used Horowitz et al.'s (2001) reported mean score of .80 (*SD* = .54) on the overall mean of the IIP (64-item version) for a functional population (*N* = 800) and the pretreatment mean score of 1.44 (*SD* = .51) from our own sample (*N* = 60) for a dysfunctional population. This yielded a cutoff score of 1.13. Using this formula, one of the three cases evidenced clinically significant change on both measures at termination, and two had clinically significant change at follow-up (see Table 3).

In order for patients' change on Patient Target Complaints (PTC) and Therapist Target Complaints (TTC) to be considered clinically significant, their level of functioning subsequent to treatment was required to fall outside the range of the dysfunctional population, defined as extending two standard deviations (in the direction of functionality) beyond the mean for that population (Jacobson & Truax, 1991). This criterion was used since no norms on a functional population were available.

Again the dysfunctional population was defined by the pretreatment scores from our sample of 60 patients entering Phase 1 of the study (PTC: *M* = 9.81, *SD* = 1.62; TTC: *M* = 9.60, *SD* = 1.83). The derived cutoff scores were 6.57 for the PTC and 5.97 for the TTC. As indicated in Table 3, 2 of the 3 BRT cases completing the treatment protocol showed clinically significant change on PTC at termination, and all 3 showed clinically significant change on PTC at follow-up. On TTC, 2 out of 3 patients showed clinically significant change at termination; there were no TTC ratings at follow-up.

Reliable change. Next we calculated Reliable Change Indexes (RCIs; Jacoson & Truax, 1991) in order to establish statistically reliable criteria accounting for measurement error and indicating how much change has occurred. The RCI coefficient equals the difference between two test scores divided by the standard error of the difference between the scores, which is derived from test–retest reliability of a measure and standard deviation of pretreatment scores on the measure. Since test–retest reliability was not available for the Target Complaints measures, we

[1] Given the difference in variance between the functional and dysfunctional populations, the formula (SD1)(M2) + (SD2)(M1)/SD1 + SD2 was applied to determine the cutoff score (Jacobson, Follette, & Revenstorf, 1984).

were only able to calculate reliable change indexes for the SCL-90R and the IIP. The standard error of the difference (S_{diff}) scores used in the present study were .25 ($M = .83$, $SD = .46$, $N = 60$) for the GSI and .34 ($M = 1.44$, $SD = .51$, $N = 60$) for the IIP.[2] These were derived from the pretreatment scores of our 60 cases beginning Phase 1 and test–retest reliability coefficients reported by Derogatis (.84, $N = 94$) and Horowitz et al. (.78, $N = 60$).[3]

We initially followed the convention of considering an index (RCI) 1.96 ($p < .05$) to indicate reliable change. Using this criterion, none of the patients showed reliable change. Because our goal was not so much to establish a stringent criterion for determining whether change had taken place as it was to establish a statistical metric for determining the meaning of each subject's termination and follow-up scores relative to his or her pretreatment score, we established a more liberal criterion. For this purpose we used the criterion of RCI $\geq .5$, given that a difference of 0.5 standard deviations can be understood as corresponding to a medium effect (Cohen, 1988; Tingey, Lambert, Burlingame, & Hansen, 1996). On the GSI, two patients showed a medium effect by termination. All three showed a medium effect by follow-up (see Table 3). On the IIP, none of the three patients showed improvement at termination, but all three showed a medium effect by follow-up.

Although all 3 BRT cases completing the protocol did not consistently achieve clinically significant or reliable change (where it could be calculated) on all of the outcome measures, we reasoned that there was enough evidence of meaningful change at both termination and follow-up to consider them good outcome cases.

Validating the Actuarial System

In order to assess how well our reassignment criteria performed on this sample, the first step consists of examining the outcome of the 42 patients out of the original sample of 60 who were not offered a reassignment. Of these 42, 12 (or 20% of the original 60) dropped out of treatment unilaterally. These patients can be considered false negatives, insofar at they were dropouts who were not detected by our reassignment criteria. This proportion is very close to the proportion of dropouts who were not detected in our derivation sample.

To come up with a rough index of poor outcome for these patients, we calculated the proportion that obtained RCIs of $< .5$ at termination on the GSI of the SCL-90R and the IIP. Because two patients had missing data on the GSI and IIP at termination, a denominator of 58 was use to calculate the proportion of undetected poor outcome case. Seventeen percent met criteria for poor outcome on the GSI and 28% on the IIP. The number of poor outcome cases not detected (another type of false negative) thus compares favorably with the 30% of poor outcome cases who were not detected in the derivation sample.

In order to come up with an estimate of how effective our reassignment criteria were at accurately detecting dropout cases, we examined the 8 patients who had been identified by the actuarial system, but rejected the offer for reassignment. Seven of these patients dropped out of treatment unilaterally, after completing somewhere between 5 and 25 sessions. One of these patients completed the 30-session protocol with good outcome at termination. At termination, this patient showed reliable change on the GSI and the IIP and clinically significant change on the Patient Target Complaints (PTC) and Therapist Target Complaints (TTC). He did not, however, return for the follow-up assessment.

As another indication of the accuracy of our actuarial system at detecting dropouts, we considered the outcome status of the 5 patients who were identified by it and randomly reassigned to the control condition. Of course, the fact that these patients were reassigned to other treatments (and therapists) prevents this from being a naturalistic test of the predictive validity of the system. Nevertheless, the fact that all of these patients dropped out of treatment, even after exercising their option to be reassigned to different therapists, provides another form of evidence regarding predictive validity.

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[2] S_{diff} = square root of 2 (standard error of measurement $S_e)^2$. $S_e = SD$ (square root of $1 - r_{xx}$).

[3] This test–retest reliability coefficient represents an average of the coefficients reported for each of the nine SCL-90R subscales, because no such coefficient was reported for the GSI by Derogatis (1983).

Descriptive Analysis

In order to enrich our understanding of the rupture resolution process we decided to examine in detail videotapes of selected sessions from two patients who had been reassigned to BRT; we chose videotapes of sessions held both before and after their reassignment. We reasoned that this would also give us a rare opportunity to catch a glimpse of the way in which two different therapists with different approaches can work differently with the same patient. The 2 patients who we observed in this fashion were selected on the basis of having more complete postsession questionnaire (PSQ) data and a fewer number of missing videotapes of therapy sessions than the other patients. All patients had filled out the PSQ (described earlier) after every session, which contained a number of questions including: "Was there any problem or tension in your relationship with your therapist this session?" (Yes or No) and "If so, to what extent was it resolved by the end of the session?" (on a 5-point scale). For each of the four cases, we identified the rupture session (i.e., the session in which the patient had reported there was a problem or tension in the therapeutic relationship) with the highest rating on the resolution question. The two senior authors (JDS and JCM) examined videotapes of these sessions and combined their observations to develop consensually based narratives describing the most salient features of each session.

Patient 1: Cindy

Before Reassignment (cognitive–behavioral therapy, Session 5; Resolution rating: 3). Cindy is an angry, critical, single woman in her midthirties, with a dramatic manner. The therapist (a woman of approximately the same age) is five minutes late for the session and Cindy is upset that the therapist is "rattled about being late," because it indicates to her that "you get rattled like I do." The therapist denies being rattled and then attempts to explore Cindy's concerns about her in greater detail. Cindy admits to not having confidence in the therapist or the treatment. Throughout the session, the therapist has somewhat of an edge to her and Cindy seems to be alternately angry and cowed. She admits to attending a weight control clinic at the same time she is in treatment, and the therapist speculates that Cindy may be trying to undermine her treatment. When asked what her motivation for this might be, Cindy compliantly speculates that maybe she doesn't want to beat her father. The therapist says: "Don't speculate. . .what would happen if you took the next step?" Cindy responds: "I feel badly talking about this. I feel I'm making you angry at me. I feel like I'm being difficult." The therapist asks Cindy to think about how she might be able to test their relationship or experiment to see if there is some way that she can become more trusting about the therapy. "Why don't you experiment with putting aside your doubts? What would that be like for you?" Cindy suggests that she could try, but she appears compliant and subdued. The therapist suggests that it is important for them to actually start working and to adopt a problem-solving attitude. When asked what she is experiencing, Cindy replies that she is feeling reprimanded and that she feels like she is being difficult.

After Reassignment (brief relational therapy, Session 6; Resolution rating: 3). Cindy begins the session with an angry, demanding tirade: "I don't feel this is helping me. There's nothing short-term about this. There's nothing worthwhile about this." The therapist (a man of approximately the same age) responds: "I guess I'm feeling a little stuck. I understand there hasn't been the kind of progress you want. . .and I guess. . .watching the tapes, I'm aware that I've also been acting a little defensive. . .I guess feeling that you're questioning my competency. And it may be affecting my work a little." Cindy responds: " That's your problem. The bottom line is that I'm stuck. And I resent your implying that it's my fault." The therapist replies: "Well, we need to come up with a way of working together that's more profitable for you." Cindy responds: "That makes me feel there's no plan here. I feel we're directionless. You don't work with dreams. I want to feel you can handle me." The therapist attempts to empathize: "You're really feeling angry about not getting what you want here." This leads to a shift in Cindy's focus. She tells the therapist about a community meeting she participated in between sessions, during which she felt angry, powerless, humiliated and "like a child."

The therapist attempts to explore her feelings, and she vacillates between anger and tears in a somewhat histrionic style. She lists a litany of slights she has experienced in her life and then

returns the focus to therapeutic relationship by asking the therapist what he meant earlier when he said he "felt stuck." The therapist replies: "I want to apologize if it felt I was blaming you. I'm just trying to understand what's going on here." Cindy responds: " I think I'm being cooperative." The therapist says: "Did you hear me saying that you're not?" Cindy: "I guess I feel like I get the message that it's not okay to be angry." The therapist acknowledges that he may, at times, communicate this, but takes responsibility for his contribution: "When you get angry at me it gets to me sometimes. It's not that you shouldn't get angry. . .but I let it get to me sometimes."

Cindy softens, and suggests that she may in part be "dumping" on him because it feels like a "safe place." "I can act powerful here, but I can't in real life." She become tearful, lapses into hysterical crying, and then abruptly stops. The therapist says: "I feel like you're kind of asking me for help, and I'd like to take care of you. I'm just not sure how right now." At first Cindy denies asking for help, but later in the session she spontaneously suggests that maybe she's being overly dramatic, but that she really does want his help and sympathy. This request has an authentic flavor to it.

This session clearly contains some of the same themes as the session with the previous therapist: Cindy's anger at the therapist, her questions about the therapist's competence, and her concerns about being blamed for being uncooperative and for being angry. In contrast, however, the therapist responds less defensively. He acknowledges responsibility for his own feelings and his contributions to the interaction and attempts to explore the interaction between them. He attempts to empathize with her anger at him and the unmet needs underlying her anger. Cindy gradually moves from an angry, demanding, blaming stance to one in which she accepts some responsibility for her displaced anger and begins to acknowledge her more vulnerable feelings. This transition on the patient's part, from demanding and blaming to acknowledgment of underlying vulnerability, is characteristic of the resolution process in confrontation ruptures (Safran & Muran, 2000).

Patient 2: Ruth

Before Reassignment (short-term dynamic therapy, Session 4; Resolution rating: 3). Ruth is an unemployed, married woman in her midforties, who appears to have considerable difficulty accessing her feelings and is extremely sensitive to being misunderstood. Her communication style tends to be convoluted, obscure, and distancing. The therapist is a woman in her late twenties. Early in the session, the therapist picks up on a statement that Ruth had apparently made in the previous session and makes the following interpretation: "You were talking about being a fly in the web. . .feeling really trapped. I'm wondering if you experience me as the spider. . .kind of like your mother. . .and you need to keep me at a distance." Ruth rejects the interpretation and becomes quite obscure: "I'm not the fly. I'm the spider. I wove the web. It's my story. I wove it. It's very dense. I don't know if I feel trapped. The center was woven so long ago. I'm out here completing my activities. The spider keeps returning to the web." The therapist interrupts and asks her how the interpretation "felt" to her. Ruth replies: "It felt good. Not quite right. . .but good." The therapist attempts to explore the "not quite right" aspect of her communication, and Ruth eventually says: "I wonder if you understand me. I wonder if you hear me. I don't doubt your good will toward me, but I wonder if you understand what I'm saying?" The therapist responds: "Is there a fear I will hurt you?" Ruth denies this.

The session continues in this fashion with the therapist making transference interpretations that Ruth rejects. In general the therapist appears impatient with Ruth's rambling, convoluted style and frequently interrupts her. Eventually Ruth tells the therapist that she thinks she's "playing a role." She suggests that the therapist's interpretations sound like they "come from a textbook" and that they're "arrogant." Toward the end of the session the therapist suggests that perhaps Ruth is having difficulty being vulnerable because "I'm too invested in my agenda." Ruth seems to find this somewhat helpful. As the session progresses, the therapist slows down and becomes somewhat more responsive to Ruth, but her interpretations, although more attuned, are not deeply empathic.

After reassignment (brief relational therapy, session 11; resolution rating: 4). The therapist, a man in his late twenties begins the session by saying to Ruth: "I've been wondering where you're at, given where we ended last time." They establish that they had been talking about

whether the therapist could really understand Ruth's feelings of worthlessness. Ruth asks him, how he can help her if he's never felt worthless himself. She says: "there were times. . .not necessarily with you, but with the other therapist, where I felt like a cliché. . .you know. . . empty nest syndrome, menopause, and so forth" The therapist responds: "And you're not just these things." Ruth says: "Do you know what it feels like to feel worthless? Is it different for men than for women?" She tells a story in which her husband had said to her that she could find a job if she really wanted to. When she had gotten angry at him for this comment, he had not responded. The therapist asks Ruth if she had been angry when she left last week. Ruth responds: "I wanted something from you that I wasn't getting. I wasn't angry but I was aggressive."

The therapist attempts to explore what she had wanted from him and her responses tend to be somewhat obscure and metaphorical, for example, "I want to feel like the person I am. It's like the oil is still there, but the gasoline has been drained out." The therapist attempts to refocus things on the exploration of their relationship: "What I'm trying to do. . .so you can understand my logic. . .is to keep things focused on us for a moment because it's easier to grab onto." Ruth replies: "well, maybe I was a little angry, but then I thought. . .well it's not his fault he doesn't get it. How would he know what it feels like to be worthless. . .he's not a woman. . .and I didn't define worthless. . .and it's not his job." The therapist responds: "That's very rational. We can let some of that go here." Ruth responds: "That's right. As soon as I walked out, the rational side took over. Yeah. . .I started to assert myself- . . .and you backed off. . . just like my husband does." "So it felt like I was wimping out?" asks the therapist. "Yeah". . .replies Ruth, "wimping out." "Okay," she continues. "So why do people feel worthless? What does worthless feel like? Maybe if you could tell me, maybe I'd have some words. Maybe I'd have some feeling besides this deadness." There is a long pause and then the therapist says: "I'm not quite sure how to answer you because I feel unless I answer you I'm wimping out. . . .you know. . ." Ruth interrupts: "No. Come on. Don't wimp out." "I'm not quite sure how to answer," replies the therapist. Ruth gets angry: "Do you have any feelings? Do you feel? You're being very therapist-like. Why don't you just be feeling-like. You're asking me to be feeling-like, so why don't you be feeling-like?" Therapist: "Well (pause) worthless (he seems to be struggling) it's hard. . ." Ruth: "I'll do it with you. . .but you've got to do it." She closes her eyes and seems to be trying to feel along with him. Therapist: "Worthless to me feels like things are going so fast that I can't catch up with them. Or things are so complicated that I can't take it." Ruth: "So worthless sounds to me like you're out of control." Therapist: "Something like that." Ruth: "And what would you feel like if you lost control?"

The therapist continues to respond to her questions, and eventually Ruth spontaneously talks about her own feelings of worthlessness. She begins to look tearful, and the therapist asks her what she's feeling. She replies: "Sad. Like I've lost something. . .Like I'm missing myself. I feel deprived of my abilities and skills. . .like I should be going around with a cup." The therapist then asks her how it felt, when he self-disclosed about his own feelings of worthlessness. Ruth responds: "You felt like a real person. I felt connected to you. I felt grateful (she cries). When you think you're the only person experiencing something, you feel creepy and you feel much sicker than you are. So I feel really grateful. Thank you. Yeah. . . .it's important. Show me your feelings and I'll show you mine. Otherwise it's just talk."

As was true in Cindy's case, the session from Ruth's treatment with her therapist following reassignment contains several of the themes that were in the session with her previous therapist. She has difficulty putting her feelings into words and is sensitive to being misunderstood. At times she becomes obscure, although less often than in than in the session with the therapist prior to reassignment. It is possible that her obscurity serves a self-protective function and begins to decrease as she starts to feel safe. Once again, Ruth is concerned about being patronized by the therapist. And she continues to be concerned that the therapist is playing a role and is not present as a "real person." While this therapist, like the previous one, attempts to keep the focus on the exploration of the therapeutic relationship, he is less quick to make interpretations, and his interventions have a more exploratory and tentative quality to them. In response to his question, Ruth is able to begin acknowledging being angry at him last week, but then she equivocates: "I

wasn't angry but I was aggressive. . .Maybe I was a little angry, but then I thought. . .well it's not his fault if he didn't get it." The therapist draws her attention to the way she invalidates her own experience and then gives her permission to express her feelings more directly: "That's very rational. We can let some of that go here." This corresponds to the phase of the rupture resolution process we have referred to as the "exploration of the avoidance" (Safran & Muran, 2000). In response Ruth begins to assert herself. "Yeah. . .I started to assert myself and you backed off. . .just like my husband did." The therapist validates and explores her experience: "So it felt like I was wimping out?" This appears to embolden Ruth and she becomes more forceful. She acknowledges her feeling that he has been "wimping out" and then pressures him to earn her trust by stepping out of the therapist's role and disclosing vulnerable feelings. In a sense she "turns the tables" on him. Rather than interpreting her action, or in some way attempting to reestablish his role as the therapist, he struggles to accommodate her desire for more symmetry or mutuality in the relationship. Ruth clearly appreciates his struggle. She uses his self-exploration to stimulate her own self-exploration and begins to contact genuine feelings of sadness. She expresses gratitude to the therapist for his willingness to accommodate her by struggling to step out of the conventional therapist's role and speaks eloquently about why this has been important to her. With this patient, the progression from avoidance of tension in the therapeutic relationship to self-assertion and expression of underlying wishes is characteristic of the resolution process for withdrawal ruptures (Safran & Muran, 2000). The therapist's willingness to negotiate a change in the nature of the role relationship with her and to accommodate her need for greater mutuality appears to have played a particularly important role in this process.

Discussion

Overall, this study provides evidence regarding the feasibility of the patient reassignment design used as a general method for increasing the sensitivity of treatment comparison research and as a specific approach for evaluating the efficacy of an alliance-focused intervention. It also provides preliminary evidence regarding the validity of our criteria for identifying potential treatment failures. The actuarial system did as well and in some respects better in the validation sample than it did in the derivation sample at identifying dropout and poor outcome patients, and minimizing the number of false negatives. These findings should, however, be interpreted cautiously given the relatively small sample size. The finding that the proportion of false negatives in the validation sample continued to be relatively high (20%) warrants some discussion. As previously mentioned, we decided to accept a relatively high proportion of false negatives in order to reduce the possibility of interfering unnecessarily with treatments that might ultimately work out. It seems likely that this decision contributed to a situation in which only the most difficult of patients were offered treatment reassignment. This is certainly consistent with our clinical impression. On one hand, one could argue that this increased the likelihood of finding differences favoring BRT, because less difficult patients may have done better in the control treatments. On the other hand, it can be argued that this was a particularly (perhaps unnecessarily) difficult challenge for the BRT therapists. In future research it may be worth readjusting the actuarial system in a manner that decreases the false negatives, both as a way of reducing the difficulty of the challenge for therapists in all conditions, and reducing the amount of time that it takes to accumulate a reasonable sample size in the second phase of the study.

Our findings indicate very preliminary evidence regarding the value of BRT as a treatment for patients with whom it is difficult to establish a therapeutic alliance. This evidence is based on a small sample, and the findings must thus be interpreted cautiously. Nevertheless, in light of the rather dramatic finding that 5 out of 5 patients assigned to the control condition and 7 out of 8 of the identified patients who declined the offer for reassignment dropped out of treatment, the finding that 3 of the 5 BRT patients could be considered good outcome cases and that one appeared to be progressing towards good outcome prior to early termination due to extraneous factors, does seem promising. Of course it will be critical to evaluate whether these findings hold up in larger samples. The finding that 7 of the 8 patients who declined the reassignment dropped out of treatment ran counter to our hypothesis that these

patients would have good outcome and provides another indication of just how difficult it was to treat the 18 patients identified by our actuarial system.

Limitations and Conclusion

In addition to the small sample size, other potential limitations of the present study are the somewhat unconventional choices of focusing on an Axis II diagnosis of PD cluster C or PD NOS as the primary inclusion criteria, of including patients with a variety of different Axis I diagnoses, and of not screening out patients with comorbid diagnoses. It could be argued that these choices compromise the validity of the research insofar as they limit our ability to evaluate the efficacy of the treatment with a diagnostically homogeneous syndrome. On the other hand, we would argue that the focus on an Axis II diagnosis as a primary inclusion criterion and the decision not to screen out patients with comorbid diagnoses increased the likelihood of including the type of difficult-to-treat patients that are typically screened out of research and that we were interested in studying. Moreover, the inclusion of patients with a variety of different Axis I diagnoses and with comorbid diagnoses on Axis I and Axis II increased the ecological validity of the study. These are the kinds of patients who clinicians are likely to treat in everyday practice. Finally, whereas the patients admitted to the study were not diagnostically homogeneous, the patients admitted to the second phase of the study were homogeneous with respect to the dimension that was most relevant to our theoretical interests, that is, they were all patients with whom it was difficult to establish a therapeutic alliance and who were at risk for treatment failure.

Another limitation of the study is that although we controlled for the potential nonspecific effects of being reassigned to another treatment, we failed to control for the nonspecific effects of being reassigned to a new therapist administering the same treatment. It will be important for future research to control for this variable by, for example, adding a control condition in which patients are reassigned to therapists administering the same treatment or by using a multiple baseline design in which therapists augment their standard treatment approach with an alliance-focused intervention at different time intervals.

A final limitation to the study was that those patients who agreed to be reassigned to another treatment were a self-selected sample who may have differed in a systematic way from those deciding to stay with their therapists. This factor may limit the generalizability of the findings to the more general population of patients at risk for treatment failure or dropout.

A common finding in the literature is that treatments that focus intensively on the therapeutic relationship in the form of transference interpretations can actually contribute to poor outcome, especially for patients with poor object relations (e.g. Piper, Azim, Joyce, & McCallum, 1991; Hoglend, 1993) or poor interpersonal functioning (e.g. Connolly et al., 1999). A related finding by Piper et al. (1999) was that the last session conducted with patients who dropped out of treatment was characterized by a higher focus by therapists on the transference than was the case for matched sessions of treatment completers.

Given the fact that this type of intensive focus on the therapeutic relationship is a cardinal feature of BRT, it is worth speculating about the reasons underlying the apparent inconsistency between the above findings and our preliminary data suggesting that BRT may be helpful for patients with whom it is difficult to establish a therapeutic alliance. It seems to us that the critical issue here is what one means by "an intensive focus on the therapeutic relationship." As we indicated earlier, an important difference between BRT and STDP is that whereas STDP speculates about relational patterns that are common to the therapeutic relationship and other relationships in the patient's life, BRT emphasizes the collaborative exploration of both therapist's and patient's contributions to the relationship. Our experience has been that especially in the context of a poor therapeutic alliance, interpretations that speculate about the similarities between the therapeutic relationship and other relationships in the patient's life are often experienced by patients as blaming or critical; as an attempt to locate the problem in the patient rather than the relationship. Moreover, traditional transference interpretations delivered in the context of an alliance rupture have an increased probability of being, at least in part, defensively motivated by therapists who are feeling threatened, helpless, and incompetent. Although the type of collaborative exploration of both partners' contribution characteristic of BRT

does not guarantee that patients will not feel blamed or that the therapist will not blame them, it may offer some advantages in this respect.

Our perspective is not that traditional transference interpretations should never be used, and in fact we did observe instances in the study when they were helpful (even though neither of the BRT therapists used them in the sessions sampled). What is most important, regardless of the specific intervention used, is for therapists to attempt to respond flexibly to the needs of the situation and to reflect in an ongoing fashion on both the relational impact of one's interventions as well as one's motivations for intervening in a particular way.

The descriptive analysis of individual sessions sheds further light on the processes involved in resolving ruptures and on important differences between therapists' styles in the three different treatment conditions. Therapists in both the CBT and STDP conditions showed a certain rigidity of technique. For example, the CBT therapist continued to use cognitive interventions in a rigid fashion with Cindy (e.g., encouraging her to evaluate the evidence that the therapist is untrustworthy), rather than exploring her anger at the therapist. The STDP therapist continued to make interpretations even in the face of Ruth's nonresponsiveness. These interpretations, although not completely off the mark, had a sense of being forced or mechanical, rather than being responsive to the moment (cf. Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Henry et al., 1993; Piper et al., 1999). There was a sense in which both the CBT and STDP therapists were working from their formulations rather than engaging in what (Schon, 1983) refers to as reflection-in-action (i.e., modifying or refining one's understanding through an ongoing conversation with the situation).

In addition, both the CBT and STDP therapists focused exclusively on their patients rather than exploring both partners' contributions to the interaction. They seemed to be caught in enactments from which they could not disembed. The CBT therapist was angry and defensive and reprimanded the patient for being defensive. The STDP therapist maintained a certain distance and aloofness and a stance of authority. In contrast, both BRT therapists were tentative in their attempts to make sense of what was going on. Their exploration had a quality of genuine openness rather than one of imposing a preconception or agenda. They acknowledged responsibility for their feelings and contributions to the interaction and were willing to be personal and vulnerable. Although at times they may have become somewhat angry or defensive, they attempted to acknowledge when this happened rather than blaming their patients. And as illustrated in a striking way by Ruth's BRT therapist, they attempted to be flexible and accommodate to their patients' needs, even though at times this may have involved some emotional risk or discomfort on their own part.

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