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Therapist Intuitions, Measured by the ISQ, and Ability to Resist Hostile Process
In-Session

by

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Submitted to the Graduate Faculty of Political and Social Science of the New
School for Social Research in partial fulfillment of the requirements for the degree
of Doctor of Philosophy.

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This study investigated differences in therapist introjects and their effect on therapists’ ability to resist acting hostile toward patients in-session. An introject is defined as a self-representation that is based on the behavior of important others toward the self. Using data from the Brief Psychotherapy Research Project at Beth Israel Medical Center in New York, NY, therapist behavior toward patients was examined during “ruptures” in the therapeutic alliance (Safran & Muran, 1996). 24 therapists were differentiated on the basis of their expectations of affiliation (or friendliness) from significant others (mother, father, significant other/close friend), measured by Hill and Safran’s (1994) Interpersonal Schema Questionnaire (ISQ).

Therapists were separated into hostile and nonhostile groups based on evidence of hostility toward patients using SASB coding of two 15-minute rupture segments, one from the first half of therapy (sessions 1-15) and one from the second half of therapy (sessions 16-30).

Support was found for connections between hostile therapist introject and hostile behavior toward patients, using broad and specific measures that related to father affiliation expectations. Mother affiliation and significant other affiliation score were not related to hostile therapist behavior. Patient outcome was examined between hostile and nonhostile therapist groups, and between student and experienced therapist groups. Hostile therapists did not have worse patient outcome than nonhostile therapists. However, this is likely a function of the session samples studied. Student therapists had patients with significantly better outcome than experienced therapists, measured by the Inventory of Interpersonal Problems.
This study demonstrated that attention to therapist introject may be a crucial step in identifying therapists with vulnerabilities to hostile process. Attention to this variable through the use of introject inventories may make an important difference in the training of effective therapists.
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CHAPTER 1.

INTRODUCTION

In recent years, there has been a clear trend in clinical psychology theories away from an exclusive focus on the patient to one which incorporates therapist impact on the therapeutic process. This resulted from growing agreement that interaction between patient and therapist involves contributions from both parties. However, psychotherapy research has been slower to emulate this vision. Research on therapist variables has suffered from diverse notions about the process by which the therapist influences the patient, disagreement about which therapist variables are most crucial, and a lack of consensus about the appropriate method for studying these variables.

The adoption of new models for studying therapist variables may prove useful for unifying previous research. Such models would include finer-grain analysis of patient-therapist interaction (e.g., Kiesler’s Interpersonal Circle and Benjamin’s Structural Analysis of Social Behavior) and clearer definition of the therapist’s impact on the patient, arising from an integration of interpersonally-based theories. Using these improvements, Henry, Schacht and Strupp (1990) found strong support for connecting the therapist’s introject (as measured by Benjamin’s Intrex questionnaire), interpersonal process in-session, and outcome. They discovered that therapists with disaffiliative introjects engaged in a higher frequency of hostile behavior toward patients, as measured by Benjamin’s Structural Analysis of Social Behavior. They examined the third therapy
session because research supported this as the session in which alliance ratings become predictive of outcome (Marziali, 1984).

This study used data collected from Safran and Muran’s Psychotherapy Research Project at Beth Israel Medical Center. A major thrust of this project is the examination of “therapeutic alliance ruptures” (Safran & Muran, 1996), defined as periods of tension between therapist and patient. One way in which these ruptures are assessed is through therapist and patient post-session questionnaires. Instead of examining interpersonal process in the third therapy session, this study examined two fifteen-minute rupture segments. One rupture segment from the first half of therapy (sessions 1-15) and one rupture segment from the second half of therapy (sessions 16-30) was randomly chosen. Therapist introjects were differentiated using Hill and Safran’s (1994) Interpersonal Schema Questionnaire, instead of the Intrex questionnaire, due to the ISQ’s potentially superior precision in outlining the content of the relationship expectations that are likely involved in introject formation.

24 therapists who completed the ISQ were randomly selected, based on their sum affiliation scores from mother, father, and significant other. Eight were randomly selected from the top third of sum affiliation scores, eight from the middle third, and eight from the bottom third. Therapeutic dyads including the therapists used in this study were randomly selected from those dyads that have completed the full 30 session protocol. To test the hypothesis that therapists with disaffiliative introjects will engage in a higher frequency of hostile behavior toward patients than therapists with affiliative introjects, two rupture segments for each therapeutic dyad were scored by two independent teams of SASSB
coders who demonstrated reliability on this measure. Frequency counts of hostile process, as measured by the SASB, constituted the unit of analysis, and were correlated with the sum affiliation scores of the therapists. It was also hypothesized that therapists with affiliative introjects would show sharper decreases in the amount of hostile process from Time 1 (rupture segment from first half of therapy) to Time 2 (rupture segment from second half of therapy). This was examined by using difference scores between Time 1 and Time 2, which were correlated with the sum affiliation scores of the therapists. Finally, this study attempted to establish convergent validity between the Intrex questionnaire, also completed by therapists in this study, and the ISQ, because the ISQ has not yet been validated for use with therapists.

The assessment of therapist introjects may prove to be a critical development in the measurement and prediction of successful or unsuccessful process. Research findings suggest that the ability of the therapist to establish a positive relationship with the patient may be the most powerful therapist variable. Links have also been made between therapist introjects and interpersonal process. The current study may also demonstrate that attention to therapist introjects, though frequently neglected, is an important part of professional training.

Historical Background of the Therapeutic Alliance

Interest in therapist contributions to the therapeutic alliance varied in the previous century. Many theorists have pointed to Freud’s contradictory statements with regard to the importance of the personality of the therapist (e.g., McConaughy, 1987; Strupp,
1960). Freud’s 1913 paper, “On Beginning the Treatment”, recommended that the analyst allow the patient to see the “sympathetic understanding” and the “serious interest” with which the analyst views the patient. This stance allows the patient to view the analyst as one of the “people by whom he was accustomed to be treated with affection” (Standard Edition, Vol. 12, pp. 139-140). This seems to encourage the therapist to respond to the patient with friendliness and sympathy, at least in the beginning of treatment.

At the same time, Freud advised neutrality, that the therapist provide a blank slate upon which transferences can be examined, untainted by the personality of the therapist. Confusion about Freud’s prescriptions seems to stem from the interweaving of the “real” relationship and the transference, that is, expectations that the patient has about the relationship with the therapist, based primarily on prior experience with family members. Nonetheless, it was clear that Freud initially believed that the therapist’s self-analysis and later, formal analysis was required for effective work with patients, so that similar relationship expectations from the therapist’s past are not imposed on the patient. Freud states that countertransference is a covert obstruction to the analyst’s benign neutrality and that the analyst “must recognize this countertransference in himself and overcome it” (Standard Edition, vol. 12, pp. 144-145).

Zetzel (1956) was the first to call the relationship between the therapist and patient the “therapeutic alliance.” Her description of the alliance was based primarily on the mature capacities of the patient, and was distinguished from the transference neurosis. She believed that the capacity of the patient to enter into the relationship with the therapist required that the patient have a good object relationship in infancy. Overall, there is more
emphasis in her formulation on the qualities that the patient brings to the relationship, rather than the qualities of the therapist. Although she acknowledges the fact that the therapist’s individual personality will help determine the nature of the patient’s transference, she does not address the importance of successful object relationships in the ego development of the therapist. Her incorporation of object relations theory and understanding of the mother-child relationship as a model for the therapeutic relationship was an important turn in conceptualizing the therapeutic alliance and refocusing the therapeutic relationship to its attachment underpinnings (Fine, 1979; Kanzer, 1975; Zetzel, 1956).

Greenson’s efforts on the working alliance expanded upon Zetzel’s distinction between the working alliance and the transference neurosis in that he stressed the real, non-transference aspects of the alliance. He wrote, “The technique of ‘only analysing’ or ‘only interpreting’ transference phenomena may stifle the development and clarification of the transference neurosis and act as an obstacle to the maturation of the transference-free or ‘real’ reactions of the patient...It is also important to deal with the non-transference interactions between patient and analyst” (Greenson & Wexler, 1969, p. 28). His assertion was that the analyst has impact on the patient in a reality-based relationship and must respond to patient misfortunes or therapist mistakes, for example, with decency, openness, and a humane approach to the patient. He believes that the maintenance of a neutral attitude in such circumstances may have a detrimental effect on the relationship (Greenson, 1967). The distinction between the “real relationship” and the transference neurosis continued to dominate discussions of the therapeutic alliance for many years.
Broadly, it is conjectured that the pendulum began to swing from a Freudian-era attitude of psychoanalytic neutrality toward J.D. Frank's (1958, 1959) position that the technical ingredients of psychoanalysis are less crucial than the relationship between the therapist and patient (Strupp, 1960). Strupp believed that the revival of the interest in the person of the therapist began with the conceptualization of the "corrective emotional experience" (Alexander & French, 1946). This concept required that the therapist respond to the patient in ways different from important historical figures in the patient's life, so that faulty interpersonal interactions might be altered for the better. This idea has recently begun to gather attention in the field of psychotherapy research and clinical practice (Safran & Segal, 1990; Safran, 1993; Strupp & Binder, 1984).

With a few exceptions, interest in the personality of the therapist largely diminished in the 1960's through the 1970's. Speculation has been that the legacy of behaviorist principles led to a focus on therapist behaviors as opposed to therapist attitudes (McConnaughy, 1987; Safran & Segal, 1990). This encouraged emphasis on techniques within the therapeutic relationship. The importance of the therapeutic relationship was seen mainly as facilitating or impeding the patient's ability to work in the behaviorist framework.

An important deviation from this behavioral trend was a paper by E.S. Bordin (1979) in which he defined the elements of the therapeutic alliance as the bond, tasks and goals of treatment. The bond is the relationship between the therapist and the patient; tasks include the activities that the patient is expected to engage in to benefit from therapy; and the goals are specific aims of treatment. Bordin believed that treatment types vary in their
emphases on these elements; and the agreement, or lack thereof, between patient and therapist on these dimensions constituted the therapeutic alliance. This development in the definition of therapeutic alliance is crucial for understanding that therapy is a process of negotiation between therapist and patient about the form and aims of treatment. The alliance itself must involve interpersonal negotiation in order to be successful.

In the 1980's, the traditional clinical trials paradigm was dominant, incorporating treatment adherence and the use of control groups (Lambert, 1989; Waskow, 1984). At the same time, outcome studies redirected focus to the relatively ignored variable of the therapeutic alliance. These studies began to demonstrate that while treatment is more effective than no treatment (Smith, Glass, & Miller, 1980), treatment type and therapeutic techniques account for a smaller part of the variance in therapeutic improvement than previously believed (Lambert, Shapiro & Bergin, 1986). In their review, Lambert, Shapiro and Bergin found that approximately twice as much of the variance of specific treatment factors (15%) was due to “common factors,” factors common to all therapies, which included the therapist's interpersonal characteristics (30%). Another review of outcome studies from four major psychotherapy research projects found estimates of the variance accounted for by therapist factors ranging from 7-29% (Crits-Christoph, Baranackie, Kurcias, Beck, Carroll, Perry, Luborsky, McLellan, Woody, Thompson, Gallagher & Zitrin, 1991). Reviews such as these laid the groundwork for examining the alliance as the central mechanism of change in psychotherapy research. They revived interest in patient and therapist variables in the alliance.

It is noteworthy that there is far more literature on patient contributions to the alliance,
associated with successful psychotherapy process and outcome, than on therapist contributions. There are a number of reasons for this, including the greater research expediency of focusing on patients who far outnumber therapists. The lack of empirical data on therapists has been established in reviews (Najavits & Strupp, 1994). Kiesler (1966) discussed the "uniformity myth of therapists," which views therapists as interchangeable in research studies. Luborsky, Crits-Christoph, McLellan, Woody, Piper, Liberman, Imber, and Pilkonis (1986) found that treatment comparisons are made much more frequently than therapist comparisons.

Another explanation for the relative lack of study of therapists points to unquestioned assumptions that the therapist's adaptive functioning is superior on all dimensions to that of the patient. The function of therapist as role model is maintained by these myths, which has contributed to the relative lack of study of the personality of the therapist (Strupp, 1960). It has also been noted that there are considerable personal and professional risks if the identity of the individual therapists being studied is not kept confidential (Lambert, 1989; McConnaughy, 1987). Although these influences may have discouraged extensive study of therapist variables, research findings have both supported and disconfirmed various clinical suppositions about the therapist's contribution to the therapeutic process.

Research on Therapist Variables, Demonstrating their Impact on Therapeutic Process

Much of the existing data on therapist variables emphasizes specific therapist behaviors or attitudes toward the patient that are associated with outcome. While this makes for an
interesting laundry list of therapist characteristics, it is often difficult to make sense of the behaviors as they fit into a meaningful gestalt. Examination of the therapist’s contributions to the therapeutic process is rarely guided by clear theories which help organize the findings.

Since much of psychotherapy research has focused primarily on patient contributions to the alliance, many of the findings on therapist variables have followed from statistically insignificant patient findings (Strupp, 1980). This has led to the practice of presenting one or two therapist variables consisting of global behavior or attitude descriptors, which necessitates repeated redefinition of these global attributes, for example, empathy. Despite problems in the selection of relevant variables and methods of study, there are significant therapist effects on therapy process and outcome.

In one of the earliest series of experimental studies on therapists, evidence was found linking therapist attitudes toward patients and subsequent clinical decisions based on these attitudes. Strupp (1958) used a film of an initial interview with a psychiatric resident and a patient. Every so often, the tape was stopped, and the therapists were asked to write down the answer to the question, “What would you do?” This technique allowed the authors to gather responses from 200 therapists. Connections were discovered between the clinical observations of a therapist, the nature of his treatment recommendations, and his attitude toward the patient. The author was impressed by the heterogeneity contained in these factors, reflecting the diverse personalities among the therapists studied.

Strupp and Williams (1960) found corresponding evidence of a relationship between clinical evaluations, prognosis and therapists’ attitudes toward patients. Examining the
ratings of two psychiatrists who evaluated twenty inpatients, they found a high correlation between therapist’s liking for the patient and their ratings of the patient’s motivation for therapy, insight, and prognosis. When the therapist liked the patients, ratings of these patient factors were much higher than those of disliked patients. Using a different methodology and explanatory construct (i.e., countertransference distortion), McClure and Hodge (1987) found similar evidence linking therapists’ attitudes toward patients and their resultant beliefs about the patient. Therapists who strongly disliked patients were more likely to rate these patients as different from themselves. Therapists who professed strong like for a patient were more likely to rate the patient as being similar to themselves.

Other studies have made links between therapist characteristics and therapeutic outcome, usually defined by significant symptom relief from pre- to post-treatment. Lafferty, Beutler, and Crago (1989) grouped thirty psychotherapy trainees who had each seen two patients into groups based on their effectiveness upon case outcome. Data on the therapist and the patient were culled primarily from therapist self-report inventories. Analysis of both therapist and patient variables concluded that therapist variables extracted from in-session behavior best differentiated the groups of more effective and less effective therapists. The less effective trainees were perceived to have lower levels of empathic understanding, and they rated themselves as more supportive than the more effective therapists. Suh, O’Malley and Strupp (1986) examined therapist behavior, prognosis and outcome. Broadly, they found that good outcome cases were characterized by positive therapist behaviors; poor outcome cases were noted for negative therapist behaviors. This research was expanded in later studies by Henry, Schacht and Strupp (1986, 1990) to
include interpersonal theory-driven hypotheses about the nature of the process between patient and therapist.

Much of the data on therapists assumes that therapist effectiveness is a static trait, and that behaviors leading to good outcome are consistent within the individual therapist. Despite adherence to the clinical trials paradigm in which patient and therapist characteristics are intentionally minimized (the latter through the use of manualized treatments), others have found that the effectiveness of therapists may vary across patients. Luborsky, McLellan, Woody, O’Brien, and Auerbach (1985) discovered that the effectiveness of therapy with drug addicts depends heavily on the personal characteristics of the individual therapist. They concluded that both therapist personal adjustment and therapist desire to help patients were important variables in treatment outcome, and that the major instrument of change is the therapist’s ability to form a relationship with the patient. Also, in one of the first studies to empirically demonstrate that the individual therapist’s effectiveness is not constant, they found wide variations in outcome within the individual therapists’ caseloads.

Strupp’s (1980) study comparing two demographically and diagnostically similar cases (one poor outcome, one good outcome) treated by the same therapist, was a unique opportunity to study the finer differences between relationships in which positive change takes place and in which it does not. Although Strupp’s study is characterized by adherence to the clinical trials paradigm, it is clear that the patient and therapist characteristics could not be held constant across the two situations. Despite patient and therapist factors which were intentionally minimized, it was clear that interpersonal
process between two patients deemed demographically similar and the same therapist
could never be the same. This was confirmed by radically different interpersonal process
in the two dyads. Strupp points to many of the patient factors distinguishing the good
from poor outcome patient, with some subtle criticism of the therapist for failing to make
an adaptation to the poor outcome patient’s deficits. However, the impact of the
therapist’s personality on the interpersonal process in these two cases is not explored as
thoroughly as the impact of the patients’ characteristics.

Other studies evaluated therapist characteristics based on examination of highly
experienced or “expert” therapists. This seems to be a variant of studies examining
therapists on the basis of outcome; experience is assumed to contribute positively to
outcome. Mahoney and Norcross (1993) discuss the characteristics of expert therapists,
who are described as more interpersonally flexible than less experienced therapists. The
difficulty with this focus on experience as an important moderator variable affecting
outcome is that, while this is clinically intuitive and supported by some research (Orlinsky
& Howard, 1986), there are other reviews that have suggested that experience may not
have measurable effects on patient change (Stein & Lambert, 1984).

Additionally, some studies including meta-analyses have questioned whether formal
psychological training makes a significant difference in ability to effect positive change.
These studies have compared professionally trained therapists with “paraprofessionals”,
that is, those who work as therapists with no formal training (Durlak, 1979; Hattie,
Sharples & Rogers, 1984). The results of these studies suggested that professional
training may be a hindrance to effective work with patients. Struck by these provocative
findings, Berman and Norton (1985) reanalyzed Hattie et al.'s findings, removing 11 of 
the original 39 studies which they deemed problematic. These defects were as follows: 
1. Inadequate definition of clinical experience. 2. Studies including treatments not of a 
specifically psychotherapeutic nature. Berman and Norton concluded that while the 
paraprofessionals were not more effective than the professionally-trained therapists, there 
was largely no difference between the two groups in terms of outcome. They found some 
suggestion that professionally-trained therapists were more effective with short term 
therapies and older patients. The paraprofessionals were found to be slightly more 
effective with patients their own age, specifically younger patients, and in longer term 
therapies. These results call into question the assumption that professional training is 
sufficient to enable therapists to effect change within the therapeutic relationship. This 
finding presses the question of how, if not through formal education, therapists learn to 
engage in successful therapeutic relationships. Successful therapeutic relationships was the 
remaining commonality between both groups of these therapists. 

Another study, in which similar questions about the relationship between outcome and 
training were examined (Strupp & Hadley, 1979) compared professionally trained and 
experienced therapists with college professors, selected for their ability to engage in good 
relationships. The results of Strupp and Hadley’s study suggest that the professionally- 
trained therapists were more effective in working with patients who had high motivation 
and few characterological disturbances, but the effectiveness of professionally-trained 
therapists did not differ from the college professors in treating less motivated and more 
disturbed patients. This produced further evidence supporting Luborsky et al.'s findings
that the crucial therapist variable is the ability to engage in a positive relationship with the patient. In fact, the professionally-trained therapists responded to the hostile patients with the same amount of counterhostility as the college professors. It is interesting that the college professors were selected specifically because of their ability to engage in successful interpersonal relationships; this adds further power to the argument that the therapist’s pattern of relating interpersonally is a crucial moderator variable determining the success of therapy.

Theoretical Background of Interpersonal Introjection and The Interpersonal Circle

Sullivan (1953) theorized that interpersonal behavior exerts a pull on others to respond reciprocally. His theory of interpersonal introjection describes the process by which people learn to treat themselves as other important people in their lives have treated them. Adoption of the behavior of others toward the self in making up the self-image results in an introject. This introject is thought to remain relatively stable, in part by exerting a pull from others to act toward the self in a way which confirms the truth of this introject. The introject can be altered by disconfirming behavior from others. Thus, if a person’s introject is that of a loved person, the person will act toward others in a way that elicits love from others. These pulls for specific behavior from others may operate on an unconscious or conscious level.

The interpersonal circle was first outlined by Leary (1957). He expanded Sullivan’s theory and proposed that interpersonal acts could best be described as falling somewhere on a circle, with the horizontal axis depicting a continuum of affiliative behavior and the
vertical axis depicting a continuum of controlling behavior. Individual behaviors can be plotted on Leary's circumplex model according to degrees of affiliation and control. This allows for predictions about the specific location of reciprocal behavior. This was named the "principle of reciprocal interpersonal relations" (1957).

Kiesler (1983, 1992) integrated interpersonal theory, complementarity theory, and interpersonal circle methodology. This union lends itself nicely to the study of therapist contributions to therapeutic process without removing these variables from the context in which they occur, that is, the relationship. His version of the Interpersonal Circle depicts the control dimension as moving from submissive behavior down the horizontal axis to controlling behavior. The affiliation dimension moves from left (hostile) to right (friendly). Kiesler (1992) stated,

Interpersonal communications theory (Kiesler, 1979, 1982a,b, 1983, 1986a,b, 1998, 1991) considers relationship to be inevitable and pervasive in all human interactions, including those in psychotherapy... Any interpersonal act is designed to elicit from an interactant reactions (complementary responses) that confirm, reinforce, or validate a person's self-representation, and cause that person to repeat similar interpersonal acts (Kiesler, 1979, 1983, 1988).... One central way to measure interpersonal behavior is through use of inventories designed to measure the comprehensive array of interpersonal acts found on the interpersonal circle. (p. 78).

This highlighting of complementarity within the interpersonal circle is useful for predicting behavior that will be elicited interpersonally. According to this concept, like behaviors on the affiliation dimension and opposite behaviors on the control dimension are thought to be complementary. For example, friendliness elicits friendliness, and hostile behavior
elicit hostility. On the control dimension, controlling behavior evokes submissive behavior, and vice versa.

**Empirical Application of Interpersonal Circle Methodology**

Henry, Schacht and Strupp (1986) used the interpersonal circle in their application of Benjamin’s (1974, 1983) Structural Analysis of Social Behavior to a study of therapeutic process in differential psychotherapeutic outcomes. Benjamin’s model is similar to Kiesler’s interpersonal circle, with two exceptions. First, the control dimension is reversed in Benjamin’s Circle (1974) so that control is at the top of the vertical axis and submission is at the bottom of this axis. Second, her model is a system of three interrelated circumplex surfaces. Each surface presents 36 interpersonal behaviors that represent degrees of affiliation and control which are commonly collapsed into octants, each containing four or five statements reflecting the range of affiliation and dominance within each octant. Codes are assigned to each transcribed “thought unit” (or speech act containing one thought); the first number reflects the surface and the second number indicates the octant (Benjamin, 1981). The first surface is organized around a focus on the other. For example, the SASB code 1-2 indicates **Surface 1**: focus on the other; this is traditionally the therapist speaking to the patient. **Octant 2: (115)**: Affirming and Understanding. “S (Subject) really hears O (Object), acknowledges O’s views even if they disagree.” The second surface focuses on the self. For example, the SASB code that is complementary to a 1-2 is a 2-2. **Surface 2**: focus on the self, this is traditionally the patient speaking to the therapist. **Octant 2 (215)**: Disclosing and Expressing. “S (Subject)
freely and openly talks with O (Object) about his or her innermost self.” The third surface allows for assessment of intrapsychic beliefs about the self. For example, the SASB code 3-2 indicates Surface 3: focus on the self. Octant 2 (315): Self-Accepting and Exploring.” S (Subject, in this case, the self) comfortably lets him or herself hear and go by his or her own deepest feelings.”

Henry et al. examined therapeutic process in eight cases involving one good outcome and one poor outcome case, each seen by four therapists. Using SASB categories of interpersonal behaviors, they discovered correlations between affiliative therapist behaviors (specifically, octant 2: helping and protecting, and octant 4: affirming and understanding) and good outcome cases. They also found correlations between disaffiliative therapist behaviors (specifically, octant 6: belittling and blaming) and poor outcome cases. The authors propose that SASB offers the following advantages for studying psychotherapy process research: “a) It provides a research method congruent with the theoretical premises about interpersonal process in psychotherapy; b) it permits extremely fine-grained analysis of virtually any interpersonal event, and c) it uses small rating units judged by methods requiring relatively low inference and permitting high specificity.” (p. 27).

Similar findings connecting disaffiliative therapist behaviors with poor process and outcome have been found by others using the SASB method of assessing the interpersonal process in-session. Correlations between belittling and blaming behavior on the part of the therapist and poorer alliance ratings have been further validated (Coady & Marziali, 1994). Low frequency of therapist statements coded as attacking (including belittling and
blaming) have been related to therapist effectiveness as defined by patient's outcome scores and length of stay in treatment (Najavits & Strupp, 1994).

**Application of Interpersonal Circle Methodology to Therapists’ Introjects**

The impact of the therapist's introject, or internalized self-representation, is implicit in the discussion of the interpersonal process, given that interpersonal theory posits a bidirectional field of influence. However, empirical examination of the impact of therapist introject is rare and is a crucial area for further study. Explicit examination of this impact is critical because it can potentially explain the therapist’s contribution to productive and counterproductive interpersonal process in-session. Further, interactions between the individual therapist's introject and the varying introjects of patients in the therapist's caseload may explain why the interpersonal process among the patient-therapist dyads is rarely the same.

Henry, Schacht, and Strupp (1990) explicitly examined patient and therapist introjects, interpersonal process, and differential psychotherapy outcome. They grouped seven dyads into a poor outcome group and seven dyads into a good outcome group, based on the amount of change (positive or negative) in the patients’ introjects as measured by Benjamin’s Intrex introject questionnaire (Benjamin, 1988). This questionnaire contains 36 items (clustered by octants) corresponding to the introject behaviors from the third surface of the SASB. Subjects were asked to rate themselves on these behaviors on a scale of 0-100 twice, once with the instruction to “describe yourself at your best” and once with the instruction to “describe yourself at your worst.” This yields two measures:
"introject at worst" and "introject at best," which are scored along three dimensions: attack, control and conflict. Therapists in this study completed this instrument prior to meeting with the patients in the sample, in order to test the hypothesis that therapists might also treat patients in accord with their introjects. The authors had raters code the third therapy session according to SASB in each of the fourteen dyads to look at interpersonal process. As previously noted, they chose the third session of therapy because research suggested that the third session of treatment is when alliance ratings become predictive of overall alliance (Marziali, 1984).

The results of this study were striking in that strong support was found for connections between the therapist's introject state, interpersonal process in-session, and outcome. Specifically, it was discovered that,

(a) Poor outcome cases (no introject change) were typified by interpersonal behaviors by the therapist that confirmed a negative patient introject; (b) the number of therapists' statements that were subtly hostile and controlling was highly correlated with the number of self-blaming statements by the patients; (c) therapists with disaffiliative introjects tended to engage in a much higher level of problematic interpersonal processes that have been associated with poor outcome. (p. 768)

Therapists with disaffiliative, or hostile, introjects engaged in hostile interactions in 17.7% of the coded transcript units as compared to 5.6% of the therapists with affiliative introjects. The authors point to these results as confirming that disaffiliative therapist introjects may serve as a vulnerability marker for poor interpersonal process in therapy.

Referring to these results in later work, Henry and Strupp (1994) conclude that "these findings describe a theoretically coherent link between early actions by parents toward the
therapist, the therapists' adult introject state, vulnerability to counter-therapeutic interpersonal processes with their patients, and differential outcome." (p. 24). This type of explanation relating interpersonal interactions to positive and negative therapist introjects seems to be the most parsimonious and cohesive for linking research findings on therapist variables. The following findings are compelling: 1. Therapist attitudes toward the patient affect subsequent treatment decisions; like or dislike of the patient may enhance or impede positive change. 2. Professionally-trained therapists may be no better than paraprofessionals in effecting therapeutic change. 3. Experience may be insufficient to lead to positive outcome. 4. Negative therapist behaviors are likely to lead to poor outcome. 5. Positive relationship-enhancing qualities are associated with good outcome. 6. Some therapists are more effective than others, and there is wide variation among individual therapists' caseloads.

Therapist introject may be a filter for processing interactions with patients, and may vary with interactions that activate the introject or its components. Henry, Schacht and Strupp (1990) elegantly demonstrate the utility of knowledge about therapist introject states, and provide clear direction for the impact of therapist personality on therapeutic interpersonal process. Empirical study of another introject measure is warranted. It would be helpful to be able to avoid the potential pitfalls of Intrex's reliance on self report introjects, using descriptors that are removed from the interpersonal context. These descriptors are feeling states that are not related to specific interactions with others. Hill and Safran's (1994) Interpersonal Schema Questionnaire approaches the introject concept from a different theoretical perspective, offering an alternative method for accessing
similar data.

**Interpersonal Schema Questionnaire (ISO) as an Alternate Method for Studying the Therapists' Contribution to Interpersonal Process**

The interpersonal schema is defined as a "generalized representation of self-other relationships. The interpersonal schema is initially abstracted on the basis of interactions in a way that increases the probability of maintaining relatedness with these figures. In theory, an interpersonal schema contains information of the form: If I do X, others do Y."

(Hill & Safran, 1994, p. 367). Hill and Safran's use of the term "interpersonal schema" hints at its theoretical grounding in cognitive psychology. They point to Markus' (1977) original definition of self-schemas as "cognitive generalizations about the self, derived from past experience, that organize and guide the processing of self-related information contained in the individual's social experience."

The similarities between interpersonal schemas and related constructs from developmental psychology (e.g., Bowlby's internal working models, Stern's Representations of Interactions that have been Generalized [RIGs]) cohere around the idea that human beings are intrinsically designed to seek attachment to others. They will develop expectations regarding interpersonal interaction that will maximize opportunities for relatedness, based on interpersonal experience (Hill & Safran, 1994). Thus, interpersonal schemas are defined as generalized representations of self-other relationships, or programs for maintaining relatedness (Safran, 1986, 1990; Safran & Segal, 1990; Safran, Segal, Hill & Whiffen, 1990). An example of such a representation
would be that of someone whose early interpersonal experience was with caretakers who forbade direct expressions of anger by threatening abandonment or loss of love. We anticipate that such a person would believe that overtly angry feelings are too threatening, and banishes these feelings from conscious awareness.

The therapist version of the questionnaire is designed to assess expectations about how three important people (i.e., mother, father and significant other/friend) will respond to the therapist in sixteen different situations, corresponding to the 16 major positions on Kiesler’s (1982) Interpersonal Circle. (See Appendix A). For each scenario, the therapists are asked to imagine themselves behaving in a way that matches the description from the Interpersonal Circle. Following this, the therapists are asked how they think the three important others (mother, father, significant other) would respond to their behavior, and choose from the eight responses (collapsed from the original 16 parts of the circle to simplify the choice process.). Therapists also rate the desirability of the responses of these important others on a scale of 1 to 7. For example, situation 1 is as follows: “Imagine that you and your mother are collaborating on something. You have more knowledge and expertise in this area than your mother, so you take the lead in making decisions. How do you think your mother would respond to this?” Examples of responses include: “Would go along with me and act unsure.”, “Would take charge or try to influence me.”, “Would respect or trust me.”, etc. The chosen response would then be rated on its desirability.

The method used to assess the interpersonal schema in the ISQ is distinct from the method of assessing introjects in the Intrex in important ways. The first difference is that “the focus is on schematic processing of events in the real world, rather than on the
processing of static adjectives or trait information" (Safran & Segal, 1990). This grounding in real life situations may produce important, specific information about interactions with close family members/friends which may be critical in the therapist’s introject formation. In contrast, Sullivan’s theory of interpersonal introjection does not elucidate the precise steps by which significant others contribute to the formation of introjects, apart from the child’s broad understanding of aspects of the self that are avowed or disavowed (“me” vs. “Not me”).

Another important advantage to this method is that it is not entirely dependent on the self report of potentially negative descriptives in referring to the self. The focus is ultimately on the other because the behavior of the therapist is held constant, according to the positions of the Interpersonal Circle. This contrasts with the focus on the behavior of the self, in the Intrex. The self report of dysfunctional attitudes is likely affected by social desirability (Edwards, 1957), resulting in therapist reluctance to admit to hostile and/or controlling behavior, for example. The focus on the behavior of the other in the ISQ may sidestep some of these concerns. Negative behaviors of the self are provided by situation descriptions.

Both the ISQ and the Intrex share a questionnaire format which allows for expedient measurement of the individual’s expectations regarding the responses of self and other. Less expedient are more time-intensive, though similar formulations, such as Luborsky’s (1984) Core Conflictual Relationship Scheme, or individually-generated dynamic formulations. The ISQ has never been validated for use with therapists. However, given that this measure possesses good research and clinical utility with patients and students
(Hill & Safran, 1994; Soygut, Nelson & Safran, 2001a, 2001b), further exploration of its applicability to therapist patterns of interpersonal interaction and connection with process and outcome measures may allow for a powerful way of predicting positive and negative interpersonal process in-session. Given that the ability of the therapist to establish a positive relationship with the patient seems to be the most powerful therapist variable, and it is not necessarily moderated by professional training or experience, accurate assessment of the relationship predilections and vulnerabilities to poor process of the individual therapist may prove to be critical in the measurement and prediction of successful therapeutic process and outcome.

Examining Interpersonal Process in Multiple Rupture Segments

This study used data from the Beth Israel Brief Psychotherapy Research Project at Beth Israel Medical Center in New York, NY. (See further description of this research project in the methods section) A key feature of this research program is the extensive investigation of “ruptures in the therapeutic alliance” led by Muran and Safran (Safran & Muran, 1996; Safran & Segal, 1990; Safran, Crocker, McMain & Murray, 1990.). Safran et al. (1990) defined the alliance rupture as “an impairment or fluctuation in the quality of the alliance between the therapist and client. Alliance ruptures vary in intensity, duration, and frequency, depending on the particular therapist-client dyad.” (p. 154). These ruptures have been examined using a multitude of process measures.

Safran and Muran (1996) suggested that these episodes of tension may reflect pathogenic interpersonal patterns of the patient, which may pull for complementary, albeit
inadvertent, responses from the therapist. Examination of interpersonal process during rupture segments may allow for a more powerful elucidation of the ways in which therapists may resist or succumb to interpersonal pulls for hostility. Additionally, these ruptures may reflect varying parts of the therapists’ own systems for maintaining relatedness.

Analysis of session segments from more than one point in time may allow for a dynamic assessment of the therapists’ ability to resist negative interpersonal process, determined by SASB codes. It is possible that variation in the therapists’ introjective states may allow for corresponding variation in the amount of hostile communications expressed in-session.

Treatment and Training Implications of Introject Assessment

The ability of the therapist to establish a positive relationship with the patient may be the most powerful therapist variable for positive process and outcome. It is not necessarily moderated by professional training or experience. Thus, accurate assessment of the relationship predilections and vulnerabilities to poor process of the individual therapist may prove to be critical in the measurement and prediction of successful therapeutic process and outcome. While past studies have questioned the utility of professional training in altering the therapist’s ability to engage in a positive relationship with the patient, this study may specifically point to the importance of professional training that attends to introjects. Despite Freud’s (1913) suggestion that all therapists be analyzed so as to remove the obstructions created by their own relationship expectations,
this recommendation is incompletely followed and is not a national standard of training in clinical psychology programs. In addition, those clinical psychology trainees who do receive individual therapy are not assured quality therapy, nor is it certain that their therapy will involve attention to their introjects, or the impact of their relationships with significant others on their self-representation. Because this impact may be either conscious or unconscious, specific attention to these processes may be crucial for the training of effective therapists.

Hypotheses

This study proposes to study differences in therapist introjects and how these differences may affect the therapists’ ability to resist hostile interpersonal process in-session. Interpersonal process will be rated using SASB coding procedures. Groups of therapists will be differentiated on the basis of their expectations of affiliation (or friendliness) from significant family members, measured by the ISQ. Thus, those who have introjected high expectations of affiliation from significant family members would have fewer hostile interactions with patients in-session than therapists with lower expectations of affiliation from significant others. It is also anticipated that therapists in the positive introject group will be more successful in “unhooking” (Kiesler, 1988) themselves from negative interpersonal process with patients, through sharper decreases in hostility from Time 1 to Time 2.

Therapeutic outcome will be examined. Therapists with high affiliation expectations (friendly introjects) are predicted to effect more positive change with their patients than
therapists with low affiliation expectations.
CHAPTER 2.

METHOD

Participants

Therapists

24 therapists were included in this study. All therapists who participate in the Brief Psychotherapy Research Project provide informed consent and complete questionnaires related to therapist demographics and other measures prior to meeting their first patient. Due to the pressing demand for therapist confidentiality, all therapist questionnaires were double coded to ensure the privacy of the individual therapists. There were 20 white therapists and 4 nonwhite therapists; eighteen were women and six were men. Experience ranged from zero to 30 years of experience, the mean was 5.52 years. Therapist ages ranged from 27 to 57 years, with a mean age of 36.6. There were eight psychologists (Ph.D.), one psychiatrist (M.D.), three clinical social workers (M.S.W.), six psychology interns (MA), five psychology externs (MA), and one psychiatry resident (M.D.). Of this group, 6 therapists provided Cognitive Behavioral Therapy (CBT), 8 therapists provided Brief Adaptive Psychotherapy (BAP), and 10 therapists provided Brief Relational Therapy (BRT).

Cognitive-Behavioral Therapy (CBT) focuses on discovery of the patients’ dysfunctional beliefs about themselves, other people and the world at large. Patients are taught to examine their thinking using rational principles (from which it is believed emotional understanding will follow) and to test their beliefs consciously both within and
outside treatment (Turner & Muran, 1992).

Brief Adaptive Psychotherapy (BAP) is a psychodynamically-oriented treatment based on ego-psychology. A primary focus of this treatment is the uncovering and working-through of major maladaptive patterns of behavior, which are presumed to originate in childhood experiences with important attachment figures. It is believed that these patterns are maintained by current habits of relating to others (Pollack, Flegenger, & Kaufman, 1988).

Brief Relational Therapy (BRT) is an integrative model that borrows concepts from relational and humanistic psychology. A primary emphasis is the use of the therapeutic relationship as a key to the patient's problems of relatedness. The patient and therapist are viewed as both simultaneously contributing to interpersonal process. The subjective states of the patient and therapist are considered with a focus on the “here and now” (Safran & Muran, 2000).

All therapists attended group supervision for 1 ½ hours per week, to foster supportive learning and to facilitate adherence to Beth Israel treatment manuals (Pollock et al., 1988; Safran & Muran, 2000; Turner & Muran, 1992). Unlicensed psychology trainees and the psychiatry resident were closely supervised in weekly individual supervision by licensed psychologists and psychiatrists, in addition to group supervision.

Therapists were selected for this study from a pool of 48 therapists who had completed the therapist version of the Interpersonal Schema Questionnaire (ISQ) from 1990 to 1999. All therapist ISQs were scored according to the main dimensions of affiliation and control as well as on the desirability ratings of each item. A scoring key devised by Hill and
Safran (1991, revised 1992) was used to structure an Excel coding program at Beth Israel. This program weighted each response on the main dimensions of the ISQ, affiliation and control. Both the affiliation score and the control score operate in a positive direction. Higher scores on the affiliation dimension indicate a friendlier response, while higher scores on the control dimension indicate that more dominant behavior is expected from the significant other. Given that the affiliation dimension was of interest, each ISQ yielded three affiliation scores by adding the relative affiliation weights of all 16 responses. This generated a mother affiliation score, a father affiliation score, and a significant other/close friend affiliation score. The three scores were added to get a composite affiliation score for each therapist ISQ. This composite of the three affiliation scores yielded an expanded range of scores, from -3 to 29. Therefore, it was chosen first, instead of ranking the therapists on individual ratings of mother, father, and significant other affiliation.

Of this pool of 48 therapists, 16 could not be used in this study for the following reasons: 1. Those who treated patients using two treatments that had been discontinued in the Brief Psychotherapy Project prior to this study. 2. Those who had not completed the full 30 session protocol. This removed therapists who had patients drop out of treatment prematurely, or who had to terminate the treatment for other reasons such as job relocation of the patient. 3. Therapeutic dyads in which neither the patient nor the therapist indicated a rupture on the PSQs, in the first half and the second half of treatment. Either member of the therapeutic dyad had to indicate a rupture on a PSQ from the first and second halves of treatment to be included in this study. 4. The demands of archived videotapes made some cases ineligible for inclusion if pertinent videotapes were missing.
or the video or audio portions of the videotapes were not recorded.

Of the remaining 32 therapeutic dyads, therapists were randomly sampled for inclusion. Composite affiliation scores were ranked from highest to lowest. Eight therapists were sampled from the top third affiliation scores; eight therapists were sampled from the middle third; and eight were sampled from the bottom third, yielding 24 therapists. Because of the time-intensive nature of gathering the data, preparing it, and coding it by SASB analysis, random sampling of the original 32 therapists was used to make the scope of this study manageable. By chance, this study ended up with 12 therapists with experience beyond the training level, and 12 trainee therapists. All therapists were given Benjamin's (1988) Intrex questionnaire. This was useful in attempting to establish convergent validity between the ISQ and the Intrex.

Patients

There were 24 outpatients included in this study; all patients were seen between January 1992 and March 2001. Each had completed the 30 session protocol. One patient had completed 40 sessions of therapy, from a previous treatment protocol design of the Brief Psychotherapy Project. This person was included to substitute for a therapeutic dyad with missing data. The patient population was recruited by advertisement in local New York newspapers (e.g., The New York Times and The Village Voice) and met the inclusion criteria outlined by the Brief Psychotherapy Research Project at Beth Israel Medical Center.

The principal criterion for patients included in NIMH grant-funded studies is the
presence of a DSM-III-R or DSM-IV Axis II Personality Disorder diagnosis on Cluster C or NOS. However, some patients were included in this study who were not simultaneously included in the NIMH grant-funded studies. These patients had subthreshold Axis II personality disorders which could not be diagnosed at intake.

Patients seen in the Brief Psychotherapy Project may also carry diagnoses on Axis I, the most frequent being Mood Disorders or Anxiety Disorders. Exclusion criteria for all NIMH-grant patients and non-grant patients include: evidence of psychosis, organic brain syndrome or mental retardation, mania or bipolar disorder, severe Obsessive-Compulsive Disorder or eating disorders, serious dissociative disorders, current substance abuse, active suicidal ideation or behavior, history of serious impulse control problems or violence, psychotropic medications within the past six months, and no evidence of current important relationship (Muran, 2001). The patients in this study received the following Axis I primary diagnoses: Dysthymia 30%, Generalized Anxiety Disorder 21%, v codes 17%, Depressive Disorder NOS 12%, Adjustment Disorder 12%, Obsessive Compulsive Disorder 4% and Major Depression 4%. They received the following Axis II primary diagnoses: None 33%, Personality Disorder NOS 30%, Avoidant 17%, Negativistic 8%, Self Defeating 4%, Depressive 4%, and Dependent 4%.

Patients included in this study consisted of 14 females and 10 males. There were 21 white patients and 3 nonwhite patients. The range of age was from 24 to 58 years; their mean age was 41.8. Marital status was as follows: 12 were single, 6 were divorced or separated, and 6 were married. Of this pool of patients, 21 were employed, and 3 were unemployed.
Although attempts were made in this study to equalize the numbers of patients in each treatment category, the need for adequate therapist sampling across the ISQ affiliation dimension did not allow this. Of the 24 patients included in this study, ten were randomly assigned to Brief Relational Therapy, eight were randomly assigned to Brief Adaptive Psychotherapy, and six were randomly assigned to Cognitive-Behavioral Therapy.

Raters

Four graduate students, who are currently enrolled in clinical psychology programs, coded the videotape and transcript data using SASB surfaces one and two. The Brief Psychotherapy Project does not use the third surface of the SASB for research purposes. The coders’ mean age was 33.8 years (range 24-44). Prior to this study, the coders had participated in a minimum of one academic year of a SASB coding process group conducted at the Brief Psychotherapy Project at Beth Israel. Then they met with this writer, who has extensive training and experience with SASB, biweekly for approximately six months, to re-establish reliability. Once the raters met a minimum reliability standard, they were grouped in two groups of two raters each, because of the time-intensive nature and complexity of SASB coding. All coding was done by the same two teams, and by consensus. Half of the data (12 cases) were coded by each rating team, with four cases (two from each team) coded by both teams, to establish ongoing reliability. This overlapped data was also used during recalibration meetings to guard against rater drift. Recalibration meetings occurred every four to six weeks. Raters were blind to the nature of the cases under study and the hypotheses of this study.
Materials

Interpersonal Schema Questionnaire

The therapist version of the questionnaire is designed to assess expectations about how three important people (i.e., mother, father and significant other/close friend) will respond to the therapist in sixteen different situations, corresponding to the 16 major positions on Kiesler’s (1982) Interpersonal Circle. (See Appendix A). For each scenario, the therapists are asked to imagine themselves behaving in a way that matches the description from the Interpersonal Circle. Following this, the therapists are asked how they think the three important others (mother, father, significant other) would respond to their behavior, and choose from the eight responses (collapsed from the original 16 parts of the circle to simplify the choice process.). Therapists also rate the desirability of the responses of these important others on a scale of 1 to 7. For example, situation 1 is as follows: “Imagine that you and your mother are collaborating on something. You have more knowledge and expertise in this area than your mother, so you take the lead in making decisions. How do you think your mother would respond to this?” Examples of responses include: “Would go along with me and act unsure.”, “Would take charge or try to influence me.”, “Would respect or trust me.”, etc. The chosen response would then be rated on its desirability.

Post Session Questionnaire (PSQ)

The PSQ was developed by Muran, Safran, Samstag and Winston (1990) as a suboutcome measure, designed to assess links between in-session changes and outcome. These questionnaires are administered to both patient and therapist after each therapy session. Each PSQ contains multiple scales and questionnaires. One item on the
questionnaire asks the person to indicate whether there were any problems or tension in
the relationship during the session. If the answer is “yes”, they are asked to rate the
intensity of the problem or tension using a scale from 1 to 5. They are also asked to
indicate where in the session the rupture occurred: in the beginning, middle or end of the
session. (See Appendix B).

Interpersonal Adjectives Scale (IAS)

The IAS (Wiggins, Trapnell, & Phillips, 1988; IAS-16: Muran, Samstag, Jilton,
Batchelder, & Winston, 1997) is a self-report inventory that is contained in the therapist
and patient versions of the PSQ. It is designed to assess the interpersonal behavior of the
self and other. It contains eight lists of adjectives that correspond to the major points of
the interpersonal circle, which are then rated on a scale of 1-7. (See IAS contained in part
E of the PSQ in Appendix B).

Structural Analysis of Social Behavior (SASB)

As noted in the previous chapter, the SASB is a system of three interrelated
circumplex surfaces. Each surface presents 36 interpersonal behaviors that represent
degrees of affiliation and control which are commonly collapsed into octants, each
containing four or five statements reflecting the range of affiliation and dominance within
each octant. Codes are assigned to each transcribed “thought unit” (or speech act
containing one thought); the first number reflects the surface and the second number
indicates the octant (Benjamin, 1981). The first surface is organized around a focus on the
other. For example, the SASB code 1-2 indicates Surface 1; focus on the other; this is
traditionally the therapist speaking to the patient. Octant 2: (15); Affirming and
Understanding. “S (Subject) really hears O (Object), acknowledges O’s views even if they disagree.” The second surface focuses on the self. For example, the SASB code that is complementary to a 1-2 is a 2-2. **Surface 2:** focus on the self, this is traditionally the patient speaking to the therapist. **Octant 2 (215):** Disclosing and Expressing. “S (Subject) freely and openly talks with O (Object) about his or her innermost self.” The third surface allows for assessment of intrapsychic beliefs about the self. For example, the SASB code 3-2 indicates **Surface 3:** focus on the self. **Octant 2 (315):** Self-Accepting and Exploring.” S (Subject, in this case, the self) comfortably lets him or herself hear and go by his or her own deepest feelings.” The third surface is not used in the Brief Psychotherapy Research Project for research purposes. (See Appendix C).

**Intrex Questionnaire**

This questionnaire contains 36 items (clustered by octants) corresponding to the introject behaviors from the third surface of the SASB. Subjects were asked to rate themselves on these behaviors on a scale of 0-100 twice, once with the instruction to “describe yourself at your best” and once with the instruction to “describe yourself at your worst.” This yields two measures: “introject at worst” and “introject at best”, which are scored along three dimensions: attack, control and conflict. (See Appendix D).

**Data Preparation**

Therapists were randomly sampled across the range of composite affiliation scores, as described in the Participants section above. When therapists had seen more than one patient for a complete 30-session treatment, one of these completed cases was randomly chosen. Because therapist hostility expressed in-session is of utmost interest in this study,
it was decided that patient-indicated ruptures (from patient PSQs) would receive first priority. This was based on speculation that therapists might be uncomfortable in reporting ruptures that resulted from their own socially undesirable behavior; therefore, patient PSQs may more accurately reflect therapist behavior. Ruptures indicated on the PSQs were rated on a Likert scale of 1-7 indicating the intensity of the rupture. Ruptures of 3+ (indicating medium to high intensity) were randomly chosen. If the patient did not mention a rupture in the first or second half of therapy, available ruptures from the therapist PSQs were used.

The rupture session segments chosen for this study were 15 minutes in length, which seemed brief enough to allow SASB coders to complete the coding in a timely manner. Yet it was not too short a period for the coders to find the appropriate context for understanding the interpersonal process. When the pertinent ruptures were selected for inclusion, the locations of these ruptures were guided by the PSQ section where respondents indicated in which third of the session the rupture occurred, that is, beginning, middle or end. Each session’s total length was calculated in order to determine the precise location of this session third. There was some variation in length of therapy sessions; a few sessions were slightly less than 45 minutes and many were longer than 50 minutes. Each therapy session was divided into thirds, based on number of minutes.

Sessions in which the ruptures were noted at the beginning were sampled from the start of the session to minute 15. Mid-session ruptures began at the start of the second third and lasted for 15 minutes; end-session ruptures began 15 minutes from the end of the session. With the sessions that lasted longer than 45 minutes, it is possible that the rupture
was not adequately sampled. This did not appear to be a problem based on inspection of each rupture segment. All session segments included in this study appeared to contain a rupture in the alliance. Rupture segments were transcribed according to the accepted standards at the Brief Psychotherapy Project. These standards include the transcription of verbal utterances, paraverbal utterances, and noises occurring in the situational context. Pauses noted in the transcript were rated subjectively by the transcriptionist as exceeding the speaker’s baseline rate of pausing, and were not timed. The transcripts were unitized per “thought unit” (Benjamin, 1974) to facilitate the SASB coding. Raters were given copies of the videotaped rupture segments and the transcripts for coding (two per therapeutic dyad).
CHAPTER 3.
RESULTS

Reliability of SASB coders

Reliability of the SASB coders was calculated from four complete cases (for a total of eight rupture segments); two cases from each team were coded by both teams. Ten minutes of the rupture segment were randomly selected for reliability calculations. The mean weighted kappa estimate (Cohen, 1968) across the eight segments was .73 (range: .58 to .84). The one case which did not meet accepted minimum standards (.58) was recoded by one rating team; and the resulting mean weighted kappa was .74 (range: .67-.84). The primary difficulty in achieving higher reliability estimates between the two coding teams had to do with the generally neutral/affiliative codes. For example, the Freeing and Forgetting Octant (Octant 1) and the Affirming and Understanding Octant (Octant 2) are adjacent. Thus, subcategories of each octant that were adjacent were used differently by each coding team. Despite focused attention to this problem during recalibration meetings, these differences between the coding teams persisted. They were more reliable in identifying hostile therapist behavior.
ISO and SASB codes

The transcripts were tabulated to yield frequency counts of all possible SASB codes on surfaces 1 and 2. The SASB codes were tabulated for both therapist and patient for each transcript. Since therapist SASB codes were the unit of analysis for this study, patient SASB codes were not analyzed. The total number of therapist utterances for all 48 session segments were added together and then divided by 48 to yield a grand mean of speech utterances. Frequency of therapist SASB codes per segment was weighted by this grand mean, to compare across therapists, acknowledging individual differences in amount of speech.

The first analysis was a series of correlations between the therapist composite affiliation scores and each hostile SASB code, for Time 1 (first rupture) and Time 2 (second rupture). Since rupture segments were coded, it was expected that there might be a fairly continuous, if low, frequency of hostile therapist behavior. It became quickly apparent that the dependent variable (SASB hostility codes) was skewed; only 11 of the 24 therapists displayed any hostility toward their patients. Data transformation was not possible due to the excessive number of zeroes in the dependent variable, so nonparametric tests were used. The Mann-Whitney U test and the Chi Square were most useful, because of the lack of distribution assumptions and the ability of these tests to handle uneven numbers in the groups. In a few instances, correlations were used, but not regarding the main hypothesis that low affiliation therapists will be more likely to be hostile toward their patients.

The results of the Mann-Whitney U test which ranked hostile and nonhostile therapists
by composite affiliation scores were difficult to interpret, that is, the hostile therapists were clustered around the middle of the range of composite Affiliation scores (See Pictorial Representation A). This led to the decision to break down the composite affiliation into their parts, that is, father affiliation scores, mother affiliation scores, and significant other affiliation scores.

Using the composite affiliation scores, the only statistically significant relationship was a correlation between the composite affiliation scores and the number of speech utterances per therapist ($r = .36, p = .04$). This had been found by Henry, Schacht & Strupp (1990) but was not of particular interest for this study.

A Mann-Whitney U test was used to explore whether there was a significant difference between therapists who were hostile during both rupture sessions and therapists who were hostile during one rupture session. Therapists were ranked on their composite affiliation scores. There was no significant difference between these two groups. Thus, the presence of therapist hostility, or the lack thereof, was used as the grouping variable in exploring the main hypothesis about therapist hostility.

Other analyses using Mann-Whitney U and Chi Square tests were done to determine if other therapist factors (such as experience, treatment type and student status) were related to SASB hostility and ISQ affiliation scores. Therapist experience did not have a measurable effect on therapist hostility (Mann-Whitney U, using hostility as a dichotomous variable and ranking experience by number of years). Treatment type (BAP, BRT, and CBT) was not related to either therapist composite affiliation scores or Affiliation scores broken down by mother, father and significant other (Chi Square, using
a split in affiliation scores at their relative medians). Student status did not appear to have an effect on therapist hostility (Chi Square, using dichotomous categories or student and nonstudent, hostile and nonhostile). Therapist gender was unrelated to hostility in-session (Chi Square, using dichotomous gender and hostility categories).

**Breakdown of the composite ISQ affiliation scores**

As mentioned above, the results of the Mann-Whitney U test that ranked hostile and nonhostile therapists by composite affiliation scores were difficult to interpret. In order to better understand this finding, the composite affiliation scores were broken down by mother affiliation, father affiliation and significant other affiliation. This yielded three separate affiliation scores for each therapist. The presence or absence of hostility was used as the grouping variable since there was no significant difference between therapists who were hostile during one rupture session or during both rupture sessions, using a Mann-Whitney U test.

A series of Mann-Whitney U tests were used to assess the relationship between therapist hostility and the three affiliation scores. The first significant finding of this reanalysis was that father Affiliation is significantly related to expressed hostility toward patients. That is, the group of therapists that was hostile toward their patients had a significantly higher median rank, indicating lower affiliation of father, than the non-hostile therapist group. Hostile therapist group (N = 11, rank sum = 200); nonhostile therapist group (N = 13, rank sum = 100); p = .029. Father affiliation: range = -5 to 11.5, mean = 3.21, median = 2.25, SD = 4.24.
The Statistical Bootstrapping method (Efron, 1993) was used for further clarification of the confidence levels of this significant result. Using 500 subsampling with 24 observations (random seed = 67442110), the Bootstrap Confidence Interval at 95% for the reported Z score of -2.1807 was [-2.2344, -0.0292]. Through interpolation, the obtained Z score is at an approximate p = .065.

Neither mother affiliation, combined mother and father affiliation, nor significant other affiliation were significantly related to therapist hostility.

**Exploration of the Interaction Between the Affiliation and Control Dimensions**

To explore a possible interaction between the affiliation and control dimensions for mother, father and significant other, a scoring system was used that was developed by Kiesler and Schmidt to code their Impact Message Inventory (1991). (See Appendix E). This scoring system was easily translated for use with the ISQ since both measures are based on Kiesler’s Interpersonal Circle. This method yielded quadrant scores, allowing for the precise location within the Interpersonal Circle of the highest weighted expected responses of other. The quadrants are: Hostile-Dominant, Hostile-Submissive, Friendly-Submissive and Friendly-Dominant.

This scoring method calculates the numbers of the possible eight ISQ responses for all of the sixteen situations for mother, father, and significant other, generating 16 responses for each person. Each of the eight ISQ responses has varying weights of dominance, submission, friendliness and hostility. The highest weighted score in these quadrants is used to determine the location within the interpersonal circle of mother, father and
significant other. The quadrant scores of these three important figures were tallied separately for the hostile therapist group and the nonhostile therapist group, and examined using a Chi Square for each important figure.

Essentially, there were no significant differences between the hostile and the nonhostile therapists, using separate Chi Square calculations for mother, father and significant other quadrant scores. However, there were three results worth mentioning. First, in the examination of father quadrant scores, there was a total of three fathers who were Hostile-Dominant. These Hostile-Dominant fathers were exclusively in the hostile therapist group, that is, all three therapists who had Hostile-Dominant fathers expressed hostility toward their patients. Second, all five therapists who were hostile toward their patients at both Time 1 and Time 2 had fathers who fell in the Hostile quadrant. Additionally, the therapist who was hostile toward her patient only at Time 2, but was the most hostile outlier (interactions with her patient were hostile approximately 45% of the second rupture segment) had a father in the Hostile quadrant. These five therapists also had father affiliation scores of < 2.0. This compares with four therapists who were not hostile toward their patients at Time 1 or Time 2, whose father affiliation scores were < 2.0. Of these nonhostile therapists with low father affiliation scores, three of them had fathers who were in the Hostile quadrant. One nonhostile therapist with a father affiliation score of < 2.0 had a father in the Friendly quadrant. This may be because the expected responses of her father did not contain any purely hostile responses (most heavily weighted for Hostile quadrant scores). Instead, the hostile responses of this father were Hostile-Dominant or Hostile-Friendly.
Third, none of the therapists (hostile or nonhostile) reported having a significant other with a Hostile quadrant score. This compares with rates of Hostile quadrant mothers (21%) and Hostile quadrant fathers (37%) across both groups of therapists.

Examination of the Interaction Between Hostile Father Quadrant Scores and Patient Diagnosis

Further scrutiny of the four nonhostile therapists mentioned in the previous section, who had hostile father quadrant scores and low father affiliation scores, pointed to patient diagnosis as a potentially important moderator variable. Of the group of six therapists with hostile fathers (five were hostile at Time 1 and 2; one was hostile at Time 2 but was quantitatively the most hostile therapist), all six treated patients with Axis II Personality Disorder diagnoses at intake. In the group of four nonhostile therapists with hostile fathers, three treated patients with no Axis II Personality Disorder diagnosis at intake.

Examination of the ISQ by Friendly and Hostile situations

The last ISQ-specific analyses examined the responses of mother, father and significant other for each Hostile situation on the ISQ (situations 2, 6 and 13) and each Friendly situation (situations 4, 8, and 15). Complementarity, affiliation and desirability scores were calculated for each response to each situation, for mother, father and significant other.

Complementarity scores indicate how complementary the response was to the situation, based on the principle that friendliness evokes friendliness, and dominance
evokes submission. These complementarity scores (+1 or -1, based on the quality of the expected response of other) were tabulated for mother, father and significant other, collapsed separately across the Hostile and Friendly situations. For example, if the three responses expected from mother are complementary (friendly) in all three Friendly situations, the therapist’s score for mother in Friendly situations would be +3.

**Expected Father Responses**

Situation 13 ("Imagine that you have had a terrible day and are feeling peeved off with the whole world. You are definitely not feeling affectionate or cordial toward anyone") was statistically significant in terms of the frequency of hostile and nonhostile responses expected by hostile and nonhostile therapists. The hostile therapists expect significantly more hostile responses from Father in this Hostile situation than the nonhostile therapists. \( \chi^2 (1, N = 24) = 5.38, p < .025. \)

Desirability of fathers’ responses to the Hostile situations varied between the groups of therapists, as well. There was a significant difference between the hostile and nonhostile therapist groups, based on desirability of father’s response to situation 13. The hostile therapists’ fathers’ responses were rated as much less desirable than the nonhostile therapists’ fathers’ responses. In the hostile group, 18% of the desirability scores were above 5 (on a scale of 1-7) and 82% were below 5. In the nonhostile therapist group, 77% of the desirability scores were above 5, and 23% of scores were below 5. This between group difference was confirmed by a Mann-Whitney U Test. Hostile therapist group (\( N = 11, \) rank sum = 188); Nonhostile therapist group (\( N = 13, \) rank sum = 112),
\[ p < .005. \]

Using complementarity scores collapsed across the Hostile situations, with +1 indicating a complementary response for each situation, and -1 indicating a non-complementary response for each situation, we find similar results. The complementarity sums were dichotomized into negative (range = -1 to -3) and positive (range = 1 to 3) categories. Nonhostile therapists expected their fathers to respond more frequently in a non-complementary manner to situations in which the therapist is acting hostile. That is, the nonhostile therapists expect a higher degree of friendliness from fathers in Hostile situations than the hostile therapists. \( \chi^2(1, N = 24) = 5.38, p < .025. \)

While there were no significant findings related to father and friendly situations, there was one situation which was very close to statistical significance. The desirability of father's response to situation 4 ("Imagine yourself being friendly and helpful with your father") was lower for the hostile therapist group using a Mann-Whitney U test. Hostile therapist group (\( N = 11, \) rank sum = 166); Nonhostile therapist group (\( N = 13, \) rank sum = 134); \( p < .05. \) However, rank sum = 167 for the hostile therapist group gives a \( p = .05. \)

**Expected Mother Responses**

The only significant finding relating to mother was the desirability of mother's response to situation 2 ("Imagine you are feeling angry and argumentative towards your mother."). While both therapist groups expected almost unanimous counterhostility from mother, the hostile therapist group found mother's response more desirable. Hostile therapist group (\( N = 11, \) rank sum = 103.5); Nonhostile therapist group (\( N = 13, \) rank sum = 196.5); \( p < .05. \)
Expected Significant Other Responses

There were no significant findings related to Significant Other.

Outcome

Outcome was compared between the hostile and nonhostile therapist groups, and between the group of therapists who were students (psychology interns, psychology externs, and one psychiatry resident) and the group of experienced therapists (licensed therapists with a Ph.D., M.D., or M.S.W.). The comparison between the students and experienced therapists was facilitated by equal numbers in both groups, by chance.

One-third of the patients included in this study did not receive an Axis II diagnosis at intake. They were treated by three psychology externs, two psychology interns, two psychologists with Ph.D.s, and one M.S.W. Because there is not an even split between these therapists who treated patients with no Axis II diagnosis, the outcome picture is somewhat clouded.

Outcome was calculated using the Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988) and the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1975). The IIP is a self-report measure designed to assess social adjustment and interpersonal distress. The SCL-90-R is a self-report inventory which rates general psychiatric symptoms. Both measures are completed by Brief Psychotherapy Research Project patients at multiple stages in the treatment. For outcome in this study, difference scores between intake and termination were used. The standard deviation was calculated for each measure for this subject group. Positive change was defined by a decrease in IIP and SCL-90-R scores at
termination, beyond one standard deviation. Negative change was defined by an increase in IIP and SCL-90-R scores at termination, beyond one standard deviation. No significant change was defined by increases or decreases in IIP and SCL-90-R scores that fell within one standard deviation.

There was not a significant relationship between outcome and therapist group in the expected direction, that is, the hostile therapists did not have worse outcome than the nonhostile therapists. Using IIP difference scores and a $SD = .48$ (calculated for this sample), there were three poor outcomes and four good outcomes. The other 17 patients did not show change on this measure, below or above one standard deviation. Of the three patients with poor outcome, one had a hostile therapist and two had nonhostile therapists. Of the four patients with good outcome, three had hostile therapists and one had a nonhostile therapist. The SCL-90-R difference scores yielded similar results. Using a $SD = .34$, there were four patients with poor outcome, and three patients with good outcome. Of the four poor outcome patients, two had hostile therapists and two had nonhostile therapists. Of the three good outcome patients, two had hostile therapists and one had a nonhostile therapist. Using a composite score, $E = (\text{Intake IIP-termination IIP}) + (\text{Intake SCL-90-R - termination SCL-90-R})$, with an $SD = .68$, there were four poor outcome patients and five good outcome patients. Of the four patients with poor outcome, two had hostile therapists and two had nonhostile therapists. Of the five patients with good outcome, four had hostile therapists and one had a nonhostile therapist.

There was a significant difference between the student therapists and the experienced therapists on the basis of IIP difference scores. The difference scores were ranked and a
Mann-Whitney test was used. The student group had a significantly higher rank, indicating greater positive change in IIP scores, than the experienced therapist group. Student therapist group ($N = 11$, rank sum = 156); Experienced therapist group ($N = 11$, rank sum = 97); $p < .05$. This approach to comparing students and experienced therapists seemed useful, given the low numbers of poor and good outcome using the more conservative method outlined above. Examination of SCL-90-R difference scores demonstrated a similar trend in the data that approached statistical significance.

Convergent validity between the ISQ and the Intrex

Analyses were conducted with the aim of establishing convergent validity between the ISQ and the Intrex, since the ISQ has not yet been validated for use with therapists. The Intrex has been used empirically in the study of therapists (Henry, Schacht & Strupp, 1990; Henry, Schacht & Strupp, 1986). In this study, correlations were made between the ISQ composite Affiliation scores and a number of different Intrex scores, based on two different scoring methods. The method advocated by Benjamin (1983, 1988) yields three scores: attack, control and conflict for “when you are at your worst” and “when you are at your best”. The attack score corresponds most closely to the Affiliation dimension of the ISQ and was used for a correlation with the ISQ Affiliation dimension.

Another method of scoring the Intrex advocated by Pincus, Newes, Dickinson and Ruiz (1988) was used to explore the relation between the ISQ and the Intrex. These authors note that Benjamin’s scoring method consists of pooled correlations that resample related relationships over four curves, yielding bimodal distributions that “[mirror]
dichotomous social perceptions and internal object representations” (p. 150). Pincus et al. promote the use of a scoring procedure that uses weighted scale scores and linear transformation of item responses. They argue that nondichotomous and noncategorical dimensions of relational experience may be more adequate for assessing this domain. Their method yields two measures of Affiliation, “Affiliation at best” and “Affiliation at worst”. For further exploration of this scoring method, these two measures were correlated with the ISQ.

Convergent validity between the two measures could not be established using Benjamin’s ATK (Best Attack and Worst Attack) score or Pincus et al.’s Affiliation at Best and Affiliation at Worst scores. As mentioned before, because the dependent variable (SASB hostility scores) was skewed, these Intrex-generated scores could not be directly correlated with the SASB data. Correlations were made between both ISQ composite and father Affiliation scores and Best Attack, Worst Attack, and Affiliation at Best and Affiliation at Worst. None of these correlations were statistically significant. Separate Mann-Whitney U tests were calculated, ranking each of the four Intrex scores and placing them into categories of hostile and nonhostile. These tests yielded no significant results.

There was a statistically significant relationship between negative Affiliation at Worst scores and student status. $\chi^2(1, N = 24) = 8.03, p < .005$. The experienced therapists scored almost exclusively in the positive direction, and the student therapists almost exclusively scored in the negative direction. This suggests that the students assess their introjects when they are at their worst as being more hostile than the nonstudents, using
this scoring method.

Convergent validity between SASB hostility and the Interpersonal Adjective Scale (IAS)

The IAS (Wiggins et al., 1988; IAS-16; Muran et al., 1991) is one of the inventories contained in the patient and therapist versions of the Brief Psychotherapy Project PSQ. The IAS lists a series of adjectives clustered according to the poles of the interpersonal circle. Respondents are asked to rate themselves and the other on these adjectives, on a Likert scale of 1 to 7, based on in-session behavior. The IAS portion of the PSQs used in this study was examined to see if there was a significant relationship between therapist hostility identified by the SASB coders and therapist hostility reported in the IAS by patients. When patient PSQs were unavailable for examination, the IAS portion of the therapist PSQs were used for self ratings. Ratings of hostility were deemed congruous if the patient (or therapist) rated the therapist as hostile during the rupture session noted in the IAS portion of the PSQ, and if the SASB coders found evidence of therapist hostility in that same session.

Convergent validity of therapist hostility measured by SASB and the IAS could not be established. The relationship between the two was essentially the same as chance. One major reason for this finding involves the differing lengths of session samples. The IAS is a global measure that rates the entire therapy session. The rupture session segments lasted for 15 minutes and were intensively analyzed by the SASB coders. It is possible that the IAS respondents had different thresholds for recognizing hostile behavior than the SASB coders. Another possibility is that there were instances of hostility achieving a higher
threshold in-session which were not coded by SASB and were missed. Additionally, the IAS is a self-report inventory, whereas SASB codes are rated by third party observers. These different systems for assessing in-session behavior may not allow for precise comparison. Finally, there were problems in these data in that there were sufficient numbers of patient PSQs that were missing, necessitating the use of therapist ratings of the self. Comparison between patient ratings of therapist behavior and therapist ratings of their own behavior may be inappropriate; social desirability may discourage therapists from acknowledging their own unpleasant behavior.
CHAPTER 4.

DISCUSSION

Interpretation of Results

This study proposed to study differences in therapist introjects and their effect on the therapists' ability to resist hostile interpersonal process in-session. Groups of therapists were differentiated on the basis of their expectations of affiliation (or friendliness) from significant family members, measured by the ISQ. It was predicted that those who introjected high expectations of affiliation from significant family members would have fewer hostile interactions with patients in-session than therapists with lower expectations of affiliation. Interpersonal process was rated using SASB coding procedures. It was also anticipated that therapists in the positive introject group would be more successful in extricating themselves from negative interpersonal process with patients, and would show sharper decreases in hostility from Time 1 to Time 2.

Therapeutic outcome was examined. Therapists with high affiliation expectations (friendly introjects) were predicted to effect more positive change with their patients than therapists with low affiliation expectations.

The results of this study support the hypothesis that therapists with low expectations of friendly behavior from important others will tend to act in a hostile way toward their patients. However, the three relationships sampled in the therapist ISQs do not appear to be equally salient. The relationships with mother and significant other do not appear to be related to therapist hostility. Rather, the relationship with father seems directly related to
therapist hostility expressed toward patients. This was demonstrated by both broad and specific measures that differentiated hostile from nonhostile therapists. Broad measures included the father affiliation scores. The specific measures included the content and desirability scores of Hostile ISQ situation 13, Hostile-Dominant quadrant scores, and complementarity scores collapsed across the three Hostile ISQ situations. The near significant result that hostile therapists find their fathers' responses undesirable in the Friendly situation 4 ("Imagine yourself being friendly and helpful with your father") lends some credence to the idea that the hostile therapists may not like the behavior of their fathers in either Friendly or Hostile situations. This finding occurs even though there is no significant difference in response content across both therapist groups.

According to this study, the two most powerful items that differentiate hostile from nonhostile therapists are as follows:

1. The desirability score of father's response to situation 13 ("Imagine that you have had a terrible day and are feeling peeved off with the world. You are definitely not feeling affectionate or cordial toward anyone."). On a scale of 1-7, 82% of the hostile therapist group rated the desirability of their fathers' response to situation 13 as falling below 5. This compares with 23% of the nonhostile therapist group.

2. Having a father in the Hostile-Dominant quadrant. All three therapists with fathers in the Hostile-Dominant quadrant were hostile toward their patients at Time 1 and Time 2. However, this is a very low number. It would be useful to re-examine this result in studies involving larger numbers of therapists.

There are different ways of interpreting these data. One view is that the relationship
with father holds special prominence in the introject formation of therapists and that the father’s behavior toward the therapists is introjected at levels exceeding the behavior of mother and significant other. Although this therapist sample contained 75% women and 25% men, it may be that these therapists identified more strongly with their father and consciously and unconsciously adopted similar behaviors. While it is a stereotype in flux, historically fathers have been more likely to be involved in professional careers. Given the educational and training demands involved in becoming a therapist, it is not a likely course of study and training for those who do not intend to engage in a professional career. Another possibility is that the father is more central in the development of the child’s attitudes and behavior than previously believed.

An alternate explanation is that, relative to father, the reporting of relationships with mother and significant other are affected more by the social desirability limitation of self-report inventories (Edwards, 1957). The principle of social desirability suggests that respondents may alter the image that they present, to place themselves in a desirable light. It is possible that the therapists did not think that their relationship with their father had as much impact on them, or they deemed it less important than the other two relationships, thus resulting in more accurate reporting. There is solid reason to believe that social desirability may operate in the reporting of relationships with significant others on the ISQ. The finding that not one therapist reported a significant other with a hostile quadrant score may be accurate; but given the distributions of hostile mother quadrant scores (21%) and hostile father quadrant scores (37%) across both groups of therapists, 0% of hostile quadrant significant others seems low.
Safran and Hill's (1994) study of college students similarly found responses from friend to be more desirable than responses from mother and father. One explanation for friend responses being more desirable is that friends are consciously chosen, unlike parents. However, because significant others/friends are chosen, these choices may need internal defending if the significant other acts in undesirable ways. If there is a social desirability factor operating in the ISQ, direct assessment by a social desirability scale would be optimal to reduce the added error variance.

There are significant limitations in generalizing findings from studies of college students from Canada (Hill & Safran, 1994) and Turkish college students (Boyacioglu & Savasir, 1995) to this study of American therapists with an average age of 36 years. However, there are some similarities worth mentioning. Hill and Safran found that their student sample expected fewer friendly responses and more hostile responses from father, relative to mother and friend. This is somewhat consistent with the expected responses of the hostile therapists’ fathers. Looking at the interaction between depression and expected responses on the ISQ, Boyacioglu and Savasir found that their high depressive symptomatology group expected more hostile responses from fathers in hostile situations than the middle and low depressive symptomatology groups. Low, middle and high depressive symptomatology was measured by the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979). They also found far more expected dominant responses from father, across all situations. While the control dimension was not used in this study, Boyacioglu and Savasir speculate that the expectation of dominant responses from father may reflect cultural differences. They refer to research findings that Turkish adolescents
find their parents more controlling than American adolescents. Further exploration of the control dimension and the potential impact of cultural differences on the ISQ would be useful.

The one significant result related to mothers was the therapists' desirability ratings of mother's response to situation 2 ("Imagine you are feeling angry and argumentative towards your mother"). Hostile therapists' mothers' responses to situation 2 were rated as significantly more desirable than the nonhostile therapists mothers' responses, even though the mothers' expected responses were hostile across both groups of therapists. It may be that hostile therapists are more comfortable with a higher threshold of hostility from others, given their hostile tendencies. Nonhostile therapists may have higher expectations of their mothers, and thus do not find hostile responses desirable.

The hypothesis that affiliative introject therapists will show sharper decreases in hostility from Time 1 to Time 2 was disconfirmed; however, this lack of "improvement" is misleading. This hypothesis stemmed from the inaccurate belief that, since rupture segments were analyzed, there would be a continuous, if low, level of hostility expressed by most therapists. This did not occur. Therapist hostility became the grouping variable, and the ensuing design of this study did not allow for further exploration of this hypothesis.

One unexpected finding related to outcome was that student therapists were significantly more effective with their patients, as demonstrated by difference scores on the Inventory of Interpersonal Problems (IIP). Patient diagnoses were not completely similar for these two groups: three experienced therapists treated patients with no Axis II
Personality Disorder diagnosed at intake; five student trainees treated patients with no Axis II Personality Disorder diagnosed at intake. However, these diagnoses are based on relatively unenduring interactions with research assistants who diagnose based on SCID (Structured Clinical Interview for the DSM) Axis II questionnaires during the intake process. This does not guarantee that aspects of an Axis II Personality Disorder will not emerge over the course of 30 therapy sessions.

Patients treated by student therapists tended to improve their interpersonal relations, measured by the difference between intake and termination, on the IIP. This finding is somewhat surprising, given that improvement in patterns of interpersonal functioning is infrequently found in brief psychotherapy outcome, as opposed to improvement in psychiatric symptomatology. It may be that the student therapists have more time to devote attention to their patients because of the relatively low numbers of patients treated by these therapists. It is also possible that this finding relates to a reporting bias by patients, who are aware of their therapists' trainee status.

The hypothesis that affiliative therapists will have better outcome with patients was not confirmed. A fairly conservative method of estimating outcome on the SCL-90-R and the IIP showed results in the opposite direction. Patients with significantly better outcome tended to be treated by hostile therapists, although the numbers of these patients was very low. Using a composite index of both outcome measures, the five good outcome patients had four hostile therapists and one nonhostile therapist. This finding is in direct contradiction with studies demonstrating that even a small amount of therapist hostility leads to poor patient outcome (Coady & Marziali, 1994; Henry et al., 1986; Henry et al.,
1990; Najavits & Strupp, 1994). These studies selected therapy sessions for SASB analysis based on theoretical/practical decisions; for example, the third therapy session, following research suggesting that this session is when alliance ratings become predictive of overall alliance (Marziali, 1984). It may be that hostile therapist behaviors found in a relatively neutral session; that is, a therapy session that is not selected specifically because of reported ruptures, may be more related to poor outcome.

Additionally, it may be that there was exploration and resolution of the rupture segments involving therapist hostility following the segment sampled, either in the same session or in subsequent therapy sessions. Safran, Muran, and Wallner Samstag (1994) propose that the resolution of therapeutic alliance ruptures may “provide an important corrective emotional experience for the patient---an experiential disconfirmation of core maladaptive beliefs” which may presumably lead to better patient outcome. Unfortunately, such a determination exceeded the scope of this study.

**Treatment/Training Implications**

This study has demonstrated that attention to therapist introject may be a crucial step in identifying those therapists with vulnerabilities to hostile process. Therapists who report hostile relationships with fathers on the ISQ may be prone to acting hostile toward their patients. In particular, therapists with fathers who fall in the Hostile-Dominant quadrant scores (determined by Kiesler and Schmidt’s IMI quadrant score formula, adapted for use with the ISQ), and therapists who rate their fathers’ expected responses to ISQ situation 13 as being less desirable than 5 (on a scale of 1-7) are especially liable to
hostile process in-session. This relationship vulnerability seems particularly strong when the therapist treats patients with Axis II Personality Disorder diagnoses.

While national standards requiring personal therapy have not been enacted for clinical psychology training programs, personal therapy that does not attend to introjected hostile behavior may be insufficient for reducing hostile therapist behaviors. Attention to this variable through the use of introject inventories such as the ISQ may make a difference in training effective therapists.

Limitations of the Current Study

The limitations of the current study involve selection procedures, coding procedures and constraints of some measures used. First, the primary focus of this study was on therapists who had completed the ISQ. At the time this study was initiated, this pool was relatively limited, which did not allow for selection of patients matched on diagnosis. Such selection would have been preferable, so that conclusions about outcome differences between student and experienced therapists could be made with more certitude. While the absence of an Axis II diagnosis at intake does not preclude the emergence of personality disorders over time in therapy, it makes outcome findings less clear.

Another limitation of this study involved the use of completed treatments, to allow for assessments of hostility over time. This need for complete treatments may have screened out compelling data on hostile therapist introjects and subsequent hostile behavior that leads patients to drop out of treatment prematurely. Research designs might be conceived that could use length of stay in treatment as a dependent variable in research on therapist
introject.

It may be preferable to study therapist introject in either a group of experienced therapists or a group of student therapists, rather than a mixed group. The significant difference between experienced therapist and student therapist introjects on Pincus et al.'s Intrex measure Affiliation at Worst likely reflects a limitation in the scoring method. Such a limitation cannot be conclusively determined by using a group of therapists with varying levels of training and/or experience.

Restrictions of the procedure used for SASB coding involves the use of two teams of graduate student coders. This was the most practical solution, given the extensive time demands of coding with SASB and the nature of this study. Half of the data were coded by one team; and half, by the other team. As mentioned in the section on coder reliability, the teams developed habits of coding therapist utterances in adjacent nonhostile SASB octants. These habits were remarkably resistant to change over the duration of the coding, despite specific attention paid to this problem during recalibration meetings. Henry et al.'s (1990) study used two clinical psychologists with extensive experience in SASB coding who resolved differences in codes through discussion, to arrive at one set of consensus codes. This use of fewer, more experienced, SASB coders may be optimal. The comparison of nonhostile SASB codes was not required by this study, because the focus was on hostile SASB codes. Future use of SASB coding that requires consistent coding of the nonhostile codes would be advised to consider the coding limitation of this study.

Finally, there were limitations in the measures used for establishing convergent validity with the ISQ and SASB. The Intrex was used for comparison with the ISQ. Straight
examination of the Intrex scores used by Benjamin, in particular, the Attack scores were of little use alone. Although these scores theoretically closely resembled the affiliation dimension of the ISQ, they were insufficient to provide correlations with any other variables. The limitations of using these scores as static variables may be indicated by the different approach of Henry et al. (1990). These authors used change in these scores to determine outcome, depending on the direction of the change. Movement toward friendly octants indicated positive change, while movement toward hostile octants indicated negative change.

Pincus et al.'s scoring methods for calculating Affiliation at Worst and Affiliation at Best are more straightforwardly calculated, but a major problem seemed to be in the significant relationship between student therapist status in this study and negative Affiliation at Worst scores. This may reflect both a difficulty in the scoring method and a difficulty in the Intrex, in which introject descriptions are not tied to actual behavior, but rather, to therapist ability to imagine worst and best states of being.

The IAS did not appear to be an adequate measure for establishing convergent validity with the SASB, due to the differing scope of assessment. It is likely that the difference between observer rated measures of hostility (SASB) and self-report measures of hostility (IAS) do not allow for adequate comparison. The IAS was, at times, inconsistent when compared with rupture narratives from part B of the post-session questionnaire. In a few instances, patients were articulate about describing their therapists' unpleasant behavior in the rupture narrative, but did not give their therapists any hostility ratings on the IAS.

While the ISQ was useful in this study for finding differences between hostile and
nonhostile therapists, there are limitations with this measure, as well. First, although it is a questionnaire that can be completed in a reasonable amount of time, it is lengthy. Second, while the descriptions of the situations are somewhat specific, there is potential variation in individual interpretation of the content of the situations. Many therapists report that they can imagine multiple possibilities for these situations, depending on further distinguishing context. Thus, the situations may not provide enough detail for precise assessment of the behavior of the other. Third, the responses themselves may at times be difficult to distinguish. There are similarities in the descriptors that may make the choice process more difficult. Fourth, there may be an impact of an ordering effect on the reporting of others' responses. The questionnaire requires assessment of mother's responses, father's responses, and significant others' responses, in that order. It may be that assessment of father's responses is affected by prior assessment of mother's responses.

Future Directions

The ISQ appears to be a promising measure of therapist introject. There are a multitude of ways in which it can be scored, depending on the aims of studies in which it is used. Examination of therapist introjects and their relation to therapy process and outcome is a useful expansion of the neglected area of research on therapist variables. Despite research and therapist concerns which have limited research on therapist variables, this is a critical area for future study.

Although this study was loosely based on Henry et al.'s (1990) study, there are clear differences. One major difference is the use of rupture segments for study, as opposed to
the third therapy session. This attempt at matching negative therapist introjects with their sequelae, i.e., hostile behavior toward patients, may be a useful direction for further research on therapist introjects. Given that patient behavior during rupture segments may pull for hostile behavior from therapists, the connection between negative therapist introjects and hostile therapists may be further clarified by studies with this type of design.

Attention to various measures of psychological health and interpersonal functioning, as well as psychiatric symptomatology, may be useful for further understanding variables that impact therapist behavior toward patients. It may be that in addition to therapist introjects, psychological well-being of therapists may moderate their behavior toward patients.

Garfield and Bergin (1971) found that therapists with less disturbed MMPI profiles were more effective in reducing their patients’ defensiveness and depression. Beutler, Crago, & Arrizmendi (1986) discovered that therapists with objective and peer ratings of psychological health were deemed more effective. Boyacioglu and Savasir’s (1995) found correlations between levels of depressive symptomatology and expectations of hostility from significant others on the ISQ, as previously mentioned. It is possible that depressive symptomatology in therapists is related to desirability ratings of fathers’ responses.

In conclusion, more research focused on therapist measures of psychological health and relationship tendencies is warranted. These variables have been thoroughly studied in patients, and many of the same conclusions (i.e., patients with better psychological well-being and successful relationships do better in therapy) are likely applicable to therapists. Clinical psychology theories have moved toward an understanding that therapeutic process involves contributions from both therapist and patient. Psychotherapy research ought to
continue moving in tandem with this trend.
REFERENCES


scores from the eight scales of the IMI: IIA octant version. Unpublished.


PICTORIAL REPRESENTATION A: Composite Affiliation Scores

29
22
19
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16.5 •
16 •
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9 •
6 •
4.5 •
4.5 •

* = hostile therapist
Therapist Instructions

This questionnaire calls for you to imagine yourself in various situations. We will ask you to imagine yourself in several different situations with three people in your life: your mother, your father, and a significant other. (If you have a spouse equivalent, refer to this person as your significant other. Otherwise, refer to a good friend or other important person in your life.) Please close your eyes and imagine yourself in each of the situations, and imagine how the person you are with would respond to you. In order to get accurate answers it is important that you try to imagine the event rather than just answering the question "off the top of your head."

At the top of each page is a list of possible responses. For each situation please circle the letter of the response that SEEMS CLOSEST to how you think the person in question would react. Please note that each response contains two or more descriptions of the other person's feelings or behavior. It is only necessary that the person fit ONE of the descriptions. For instance, if the person would be "disappointed" but not "resentful" or "critical", you would choose response B.

Then, on the next scale, indicate how much you like or dislike the other person's response. If the other person's response would make you feel good circle a number toward the desirable end of the scale. If it would make you feel unhappy, uncomfortable, or if it is something you would prefer to avoid, circle a number toward the undesirable end of the scale. If you are completely neutral about the response circle number 4.

**EXAMPLE:**

Imagine yourself feeling frightened about something and turning to your "significant other" for reassurance.

If you think your significant other would be unresponsive to your need for reassurance, circle D, the letter corresponding at the top of the page to the response "would be distant or unresponsive."

A B C D E F G H

Then indicate how desirable this response would be for you on the numbered scale provided. If you would be, say, mildly disappointed if this person were unresponsive when you turned to him or her for reassurance when frightened, you would mark 3.

1-----2-----3-----4-----5-----6-----7
Undesirable Desirable

Some of the questions may ask you to imagine situations that have never actually happened between yourself and the other person. If this happens, please try to imagine the described situation anyway and answer the best that you can.
RESPONSES:  A Would take charge or try to influence me.
B Would be disappointed, resentful, or critical.
C Would be impatient, or quarrelsome.
D Would be distant or unresponsive.
E Would go along with me, or act unsure.
F Would respect me or trust me.
G Would be warm or friendly.
H Would show interest, or let me know what he/she thinks.

For the following situations please imagine yourself with your mother.

1. Imagine that you and your mother are collaborating on something. You have more knowledge and expertise in this area than your mother so you take the lead in making decisions.

   How do you think your mother would respond to this?  A B C D E F G H

   This response would be:  1----2----3----4----5----6----7
                          Undesirable Desirable

2. Imagine yourself feeling angry and argumentative towards your mother.

   How do you think your mother would respond to this?  A B C D E F G H

   This response would be:  1----2----3----4----5----6----7
                          Undesirable Desirable

3. Imagine yourself feeling weak or passive and wanting your mother to take the lead.

   How do you think your mother would respond to this?  A B C D E F G H

   This response would be:  1----2----3----4----5----6----7
                          Undesirable Desirable

4. Imagine yourself being friendly and helpful with your mother.

   How do you think your mother would respond to this?  A B C D E F G H

   This response would be:  1----2----3----4----5----6----7
                          Undesirable Desirable
**RESPONSES:**  
A Would take charge or try to influence me.  
B Would be disappointed, resentful, or critical.  
C Would be impatient, or quarrelsome.  
D Would be distant or unresponsive.  
E Would go along with me, or act unsure.  
F Would respect me or trust me.  
G Would be warm or friendly.  
H Would show interest, or let me know what he/she thinks.

For the following situations please imagine yourself with your mother.

5. Imagine yourself in a game of (tennis, scrabble, etc.) with your mother. You act very competitive and work hard to win the game.

   How do you think your mother would respond to this? A B C D E F G H

   This response would be: 1----2----3----4----5----6----7
   Undesirable Desirable

6. Imagine yourself being preoccupied with your own thoughts and detached from your mother.

   How do you think your mother would respond to this? A B C D E F G H

   This response would be: 1----2----3----4----5----6----7
   Undesirable Desirable

7. Imagine yourself in an unmotivated or lazy mood where you feel like just going along with whatever your mother is doing.

   How do you think your mother would respond to this? A B C D E F G H

   This response would be: 1----2----3----4----5----6----7
   Undesirable Desirable

8. Imagine yourself expressing genuine interest and concern for your mother.

   How do you think your mother would respond to this? A B C D E F G H

   This response would be: 1----2----3----4----5----6----7
   Undesirable Desirable
RESPONSES:
A. Would take charge or try to influence me.
B. Would be disappointed, resentful, or critical.
C. Would be impatient, or quarrelsome.
D. Would be distant or unresponsive.
E. Would go along with me, or act unsure.
F. Would respect me or trust me.
G. Would be warm or friendly.
H. Would show interest, or let me know what he/she thinks.

For the following situations please imagine yourself with your mother.

9. Imagine a situation where you feel your mother has disappointed you.

How do you think your mother would respond to this?  A B C D E F G H

This response would be: 1 2 3 4 5 6 7
Undesirable    Desirable

10. Imagine yourself in a serious mood where you are reserved and not sociable with your mother.

How do you think your mother would respond to this?  A B C D E F G H

This response would be: 1 2 3 4 5 6 7
Undesirable    Desirable

11. Imagine yourself confiding in your mother something that is important to you.

How do you think your mother would respond to this?  A B C D E F G H

This response would be: 1 2 3 4 5 6 7
Undesirable    Desirable

12. Imagine feeling uninhibited and spontaneous with your mother.

How do you think your mother would respond to this?  A B C D E F G H

This response would be: 1 2 3 4 5 6 7
Undesirable    Desirable
RESPONSES:  A Would take charge or try to influence me.
B Would be disappointed, resentful, or critical.
C Would be impatient, or quarrelsome.
D Would be distant or unresponsive.
E Would go along with me, or act unsure.
F Would respect me or trust me.
G Would be warm or friendly.
H Would show interest, or let me know what he/she thinks.

For the following situations please imagine yourself with your mother.

13. Imagine that you have had a terrible day and are feeling peevish off with the whole world.
You are definitely not feeling affectionate or cordial toward anyone.

How do you think your mother would respond to this?  A B C D E F G H
This response would be:  1----2----3----4----5----5----7
Undesirable  Desirable

14. Imagine feeling not very confident or sure of yourself and feeling dependent on your mother.

How do you think your mother would respond to this?  A B C D E F G H
This response would be:  1----2----3----4----5----6----7
Undesirable  Desirable

15. Imagine yourself feeling warm and affectionate towards your mother.

How do you think your mother would respond to this?  A B C D E F G H
This response would be:  1----2----3----4----5----6----7
Undesirable  Desirable

16. Imagine yourself acting independently and confidently about something you have never done before and not feeling that you need assistance from your mother.

How do you think your mother would respond to this?  A B C D E F G H
This response would be:  1----2----3----4----5----6----7
Undesirable  Desirable
RESPONSES:  
A Would take charge or try to influence me.  
B Would be disappointed, resentful, or critical.  
C Would be impatient, or quarrelsome.  
D Would be distant or unresponsive.  
E Would go along with me, or act unsure.  
F Would respect me or trust me.  
G Would be warm or friendly.  
H Would show interest, or let me know what he/she thinks.

For the following situations please imagine yourself with your father.

1. Imagine that you and your father are collaborating on something. You have more knowledge and expertise in this area than your father so you take the lead in making decisions.

How do you think your father would respond to this?  A B C D E F G H
This response would be:  1----2----3----4----5----6----7
Undesirable Desirable

2. Imagine yourself feeling angry and argumentative towards your father.

How do you think your father would respond to this?  A B C D E F G H
This response would be:  1----2----3----4----5----6----7
Undesirable Desirable

3. Imagine yourself feeling weak or passive and wanting your father to take the lead.

How do you think your father would respond to this?  A B C D E F G H
This response would be:  1----2----3----4----5----6----7
Undesirable Desirable
RESPONSES:
A Would take charge or try to influence me.
B Would be disappointed, resentful, or critical.
C Would be impatient, or quarrelsome.
D Would be distant or unresponsive.
E Would go along with me, or act unsure.
F Would respect me or trust me.
G Would be warm or friendly.
H Would show interest, or let me know what he/she thinks.

For the following situations please imagine yourself with your father.

4. Imagine yourself being friendly and helpful with your father.
   How do you think your father would respond to this?  A B C D E F G H
   This response would be:  
   Undesirable     Desirable

5. Imagine yourself in a game of (tennis, scrabble, etc.) with your father. You act very competitive and work hard to win the game.
   How do you think your father would respond to this?  A B C D E F G H
   This response would be:  
   Undesirable     Desirable

6. Imagine yourself being preoccupied with your own thoughts and detached with your father.
   How do you think your father would respond to this?  A B C D E F G H
   This response would be:  
   Undesirable     Desirable

7. Imagine yourself in an unmotivated or lazy mood where you feel like just going along with whatever your father is doing.
   How do you think your father would respond to this?  A B C D E F G H
   This response would be:  
   Undesirable     Desirable
RESPONSES:  
A  Would take charge or try to influence me.  
B  Would be disappointed, resentful, or critical.  
C  Would be impatient, or quarrelsome.  
D  Would be distant or unresponsive.  
E  Would go along with me, or act unsure.  
F  Would respect me or trust me.  
G  Would be warm or friendly.  
H  Would show interest, or let me know what he/she thinks.

For the following situations please imagine yourself with your father.

8. Imagine yourself expressing genuine interest and concern for your father.

How do you think your father would respond to this?  A B C D E F G H

This response would be:  
1----2----3----4----5----6----7

Undesirable  Desirable

9. Imagine a situation where you feel your father has disappointed you.

How do you think your father would respond to this?  A B C D E F G H

This response would be:  
1----2----3----4----5----6----7

Undesirable  Desirable

10. Imagine yourself in a serious mood where you are reserved and not sociable with your father.

How do you think your father would respond to this?  A B C D E F G H

This response would be:  
1----2----3----4----5----6----7

Undesirable  Desirable

11. Imagine yourself confiding in your father something that is important to you.

How do you think your father would respond to this?  A B C D E F G H

This response would be:  
1----2----3----4----5----6----7

Undesirable  Desirable
| RESPONSES: | | |
| A | Would take charge or try to influence me. |
| B | Would be disappointed, resentful, or critical. |
| C | Would be impatient or quarrelsome. |
| D | Would be distant or unresponsive. |
| E | Would go along with me, or act unsure. |
| F | Would respect me or trust me. |
| G | Would be warm or friendly. |
| H | Would show interest, or let me know what he/she thinks. |

For the following situations please imagine yourself with your father.

12. Imagine feeling uninhibited and spontaneous with your father.

How do you think your father would respond to this?  A B C D E F G H

This response would be:  1-2-3-4-5-6-7

Undesirable  Desirable

13. Imagine that you have had a terrible day and are feeling peeved off with the whole world. You are definitely not feeling affectionate or cordial toward anyone.

How do you think your father would respond to this?  A B C D E F G H

This response would be:  1-2-3-4-5-6-7

Undesirable  Desirable

14. Imagine feeling not very confident or sure of yourself and feeling dependent on your father.

How do you think your father would respond to this?  A B C D E F G H

This response would be:  1-2-3-4-5-6-7

Undesirable  Desirable

15. Imagine yourself feeling warm and affectionate towards your father.

How do you think your father would respond to this?  A B C D E F G H

This response would be:  1-2-3-4-5-6-7

Undesirable  Desirable

16. Imagine yourself acting independently and confidently about something you have never done before and not feeling that you need assistance from your father.

How do you think your father would respond to this?  A B C D E F G H

This response would be:  1-2-3-4-5-6-7

Undesirable  Desirable
RESPONSES:  
A Would take charge or try to influence me.  
B Would be disappointed, resentful, or critical.  
C Would be impatient, or quarrelsome.  
D Would be distant or unresponsive.  
E Would go along with me, or act unsure.  
F Would respect me or trust me.  
G Would be warm or friendly.  
H Would show interest, or let me know what he/she thinks.  

For the next set of situations, refer to your significant other. If you have a spouse or spouse equivalent, please refer to this person. If you do not have a spouse equivalent, choose another important person in your life and imagine that person in the situations. This person can be a spouse, family member, co-worker, friend, or anyone you wish. Use the same person for each situation. Remember to close your eyes when you imagine the situations in your mind. 

Fill in the line below with the person you have chosen.  

For the following situations I will imagine myself with my _________.  
(Please indicate Male ______ or Female ______).  

For the next set of situations, replace the blank space with the person you have chosen. You do not have to fill in the blanks.  

1. Imagine that you and your ________ are collaborating on something. You have more knowledge and expertise in this area than your ________, so you take the lead in making decisions.  

How do you think your ________ would respond to this?  
A B C D E F G H  

This response would be: 1---2---3---4---5---6---7  
Undesirable  Desirable  

2. Imagine yourself feeling angry and argumentative towards your ________.  

How do you think your ________ would respond to this?  
A B C D E F G H  

This response would be: 1---2---3---4---5---6---7  
Undesirable  Desirable  

3. Imagine yourself feeling weak or passive and wanting your ________ to take the lead.  

How do you think your ________ would respond to this?  
A B C D E F G H  

This response would be: 1---2---3---4---5---6---7  
Undesirable  Desirable
For the following situations I will imagine myself with my ________.

4. Imagine yourself being friendly and helpful with your ________.

   How do you think your ________ would respond to this?  A B C D E F G H
   This response would be: 1----2----3----4----5----6----7
                           Undesirable           Desirable

5. Imagine yourself in a game of (tennis, scrabble, etc.) with your ________. You act very competitive and work hard to win the game.

   How do you think your ________ would respond to this?  A B C D E F G H
   This response would be: 1----2----3----4----5----6----7
                           Undesirable           Desirable

6. Imagine yourself being unoccupied with your own thoughts and detached with your ________.

   How do you think your ________ would respond to this?  A B C D E F G H
   This response would be: 1----2----3----4----5----6----7
                           Undesirable           Desirable

7. Imagine yourself in an unmotivated or lazy mood where you feel like just going along with whatever your ________ is doing.

   How do you think your ________ would respond to this?  A B C D E F G H
   This response would be: 1----2----3----4----5----6----7
                           Undesirable           Desirable
RESPONSES:  
A Would take charge or try to influence me.
B Would be disappointed, resentful, or critical.
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G Would be warm or friendly.
H Would show interest, or let me know what he/she thinks.

For the following situations I will imagine myself with my ________.

8. Imagine yourself expressing genuine interest and concern for your ________.

How do you think your ________ would respond to this?  A B C D E F G H

This response would be: 1-2-3-4-5-6-7
Undesirable Desirable

9. Imagine a situation where you feel your ________ has disappointed you.

How do you think your ________ would respond to this?  A B C D E F G H

This response would be: 1-2-3-4-5-6-7
Undesirable Desirable

10. Imagine yourself in a serious mood where you are reserved and not sociable with your ________.

How do you think your ________ would respond to this?  A B C D E F G H

This response would be: 1-2-3-4-5-6-7
Undesirable Desirable

11. Imagine yourself confiding in your ________ something that is important to you.

How do you think your ________ would respond to this?  A B C D E F G H

This response would be: 1-2-3-4-5-6-7
Undesirable Desirable
RESPONSES: A Would take charge or try to influence me.
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H Would show interest, or let me know what he/she thinks.

For the following situations I will imagine myself with my ……..

12. Imagine feeling uninhibited and spontaneous with your ……..

How do you think your …….. would respond to this?  A B C D E F G H

This response would be: 1-2-3-4-5-6-7
Undesirable Desirable

13. Imagine that you have had a terrible day and are feeling peeved off with the whole world. You are definitely not feeling affectionate or cordial toward anyone.

How do you think your …….. would respond to this?  A B C D E F G H

This response would be: 1-2-3-4-5-6-7
Undesirable Desirable

14. Imagine feeling not very confident or sure of yourself and feeling dependent on your ……..

How do you think your …….. would respond to this?  A B C D E F G H

This response would be: 1-2-3-4-5-6-7
Undesirable Desirable

15. Imagine yourself feeling warm and affectionate towards your ……..

How do you think your …….. would respond to this?  A B C D E F G H

This response would be: 1-2-3-4-5-6-7
Undesirable Desirable

16. Imagine yourself acting independently and confidently about something you have never done before and not feeling that you need assistance from your ……..

How do you think your …….. would respond to this?  A B C D E F G H

This response would be: 1-2-3-4-5-6-7
Undesirable Desirable
Appendix B: Post-Session Questionnaire

BRIEF PSYCHOTHERAPY RESEARCH PROJECT
BETH ISRAEL MEDICAL CENTER, ROOM 5F-04
NEW YORK, NY 10003

THERAPIST POST-SESSION QUESTIONNAIRE
V2001

Complete immediately after session. Please answer all questions.
Your patient’s initials ______  Session number ______
Your initials ______  Date of session ______

PART A
1. Please rate how helpful or hindering to your patient this session was overall by circling the appropriate number below.

   1  2  3  4  5  6  7  8  9
   Extremely helpful  Neutral  Extremely hindering

2. Please rate to what extent your patient’s problems are resolved.

   1  2  3  4  5  6  7  8  9
   Not at all  Moderately  Completely

PART B
1. Did you experience any problem or tension in your relationship with your patient during the session?
   Yes____ No____

2. If so, about where in the session did this problem begin?
   Beginning____ Middle____ End____

3. Please rate the highest degree of tension you felt during the session as a result of this problem.

   1  2  3  4  5
   Low  Medium  High

4. To what extent was this problem addressed in this session?

   1  2  3  4  5
   Not at all  Somewhat  Very much

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

   1  2  3  4  5
   Not at all  Somewhat  Very much

6. Please describe the problem briefly:

H:\briefFORMS\Questionnaire\psqph2001.doc
7. Please rate the extent to which each of the following statements reflects your experience during this session.

a. I felt a closer connection with my patient.

1 2 3 4 5
Not at all Somewhat Definitely

b. I found myself talking about feelings I didn’t know I had.

1 2 3 4 5
Not at all Somewhat Definitely

c. My patient and I were able to work through a conflict and connect in a stronger way.

1 2 3 4 5
Not at all Somewhat Definitely

d. I saw how I was contributing to the difficulties my patient and I were having.

1 2 3 4 5
Not at all Somewhat Definitely

e. I acted in a way which felt more authentic or genuine for me.

1 2 3 4 5
Not at all Somewhat Definitely

f. I recognized and accepted my patient’s limitations.

1 2 3 4 5
Not at all Somewhat Definitely

g. I felt freer to make mistakes with my patient.

1 2 3 4 5
Not at all Somewhat Definitely

h. I became aware of ways in which I avoid creating conflicts and misunderstandings with my patient.

1 2 3 4 5
Not at all Somewhat Definitely

i. I saw that I can expose risky feelings and not be rejected/criticized by my patient.

1 2 3 4 5
Not at all Somewhat Definitely

j. I began to get the sense that I don’t have to protect my patient.

1 2 3 4 5
Not at all Somewhat Definitely

k. I felt more comfortable with expressing vulnerability or anger towards my patient.

1 2 3 4 5
Not at all Somewhat Definitely

l. I told my patient something I had been hesitant to say.

1 2 3 4 5
Not at all Somewhat Definitely
m. I felt able to disagree with my patient.

   Not at all  Somewhat  Definitely
   1          2          3          4          5

n. I began to accept a part of myself which I had not fully acknowledged before.

   Not at all  Somewhat  Definitely
   1          2          3          4          5

o. I said something to my patient which I had felt for a while and it left me with a sense of relief.

   Not at all  Somewhat  Definitely
   1          2          3          4          5

p. I saw that I was doing something to distance myself from my patient or push him/her away.

   Not at all  Somewhat  Definitely
   1          2          3          4          5

q. I felt more trusting of my patient.

   Not at all  Somewhat  Definitely
   1          2          3          4          5

r. I was afraid something I said would upset or hurt my patient but I found out that it did not.

   Not at all  Somewhat  Definitely
   1          2          3          4          5

PART C

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

This session was:

   Bad 1 2 3 4 5 6 7 Good
   Safe 1 2 3 4 5 6 7 Dangerous
   Difficult 1 2 3 4 5 6 7 Easy
   Valuable 1 2 3 4 5 6 7 Worthless
   Shallow 1 2 3 4 5 6 7 Deep
   Relaxed 1 2 3 4 5 6 7 Tense
   Unpleasant 1 2 3 4 5 6 7 Pleasant
   Full 1 2 3 4 5 6 7 Empty
   Weak 1 2 3 4 5 6 7 Powerful
   Special 1 2 3 4 5 6 7 Ordinary
   Rough 1 2 3 4 5 6 7 Smooth
   Comfortable 1 2 3 4 5 6 7 Uncomfortable
PART D
The following items reflect your working relationship with your patient based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.

1. My patient and I agreed about the things he/she needs to do in therapy to help improve his/her situation.

   1  2  3  4  5  6  7
   Never  Sometimes  Always

2. My patient believed that what we are doing in therapy gave him/her new ways of looking at his/her problem.

   1  2  3  4  5  6  7
   Never  Sometimes  Always

3. My patient believed that I like him/her.

   1  2  3  4  5  6  7
   Never  Sometimes  Always

4. My patient believed that I did not understand what he/she is trying to accomplish in therapy

   1  2  3  4  5  6  7
   Never  Sometimes  Always

5. My patient was confident in my ability to help him/her.

   1  2  3  4  5  6  7
   Never  Sometimes  Always

6. My patient and I worked toward mutually agreed-upon goals.

   1  2  3  4  5  6  7
   Never  Sometimes  Always

7. My patient felt appreciated by me.

   1  2  3  4  5  6  7
   Never  Sometimes  Always

8. We agreed on what is important for him/her to work on.

   1  2  3  4  5  6  7
   Never  Sometimes  Always

9. My patient and I seemed to trust one another.

   1  2  3  4  5  6  7
   Never  Sometimes  Always

10. My patient and I seemed to have different ideas on what his/her problems are.

    1  2  3  4  5  6  7
    Never  Sometimes  Always

11. We have established a good understanding of the kind of changes that would be good for him/her.

    1  2  3  4  5  6  7
    Never  Sometimes  Always

12. My patient believed the way we were working with his/her problem was correct.

    1  2  3  4  5  6  7
    Never  Sometimes  Always
PART E

Please rate how well each of the following sets of four adjectives, taken all together, describes YOUR PATIENT in the session just completed.

<table>
<thead>
<tr>
<th>Adjectives</th>
<th>Least</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Most</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ASSERTIVE-FORCEFUL-PERSISTENT-INDUSTRIOUS</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. TRICKY-BOASTFUL-CONCEITED-CRAFY</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. UNSOCIAL-INTROVERTED-DISTANT-SHY</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4. MEEK-INCONSISTENT-UNPRODUCTIVE-UNAUTHORITATIVE</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. UNDECEPTIVE-UNARGUMENTATIVE-HONEGOTISTICAL-UNDEVIOUS</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
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PART F

Please check any of the following adjectives to describe how you felt in this session with your patient. A check beside the word means “Yes.” You may check as many or as few adjectives as you would like.

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31. To what extent do you feel uncomfortable or badly about having any of these feelings in the session?

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<th>Extent</th>
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32. To what extent did any of these feelings emerge as new or different for you in this session?

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<thead>
<tr>
<th>Extent</th>
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PART G

The following items reflect your working relationship with your patient based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.

1. I liked my patient.
   1 2 3 4 5 6 7
   Never Sometimes Always

2. I struggled to understand my patient.
   1 2 3 4 5 6 7
   Never Sometimes Always

3. I felt appreciated by my patient.
   1 2 3 4 5 6 7
   Never Sometimes Always

4. I felt uncomfortable with my patient.
   1 2 3 4 5 6 7
   Never Sometimes Always

5. I felt confident in my ability to help my patient.
   1 2 3 4 5 6 7
   Never Sometimes Always

6. I felt that I am not totally honest about my feelings toward my patient.
   1 2 3 4 5 6 7
   Never Sometimes Always

Progress Note: Please write a few sentences about the session.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature: ____________________________
Figure 11-3  The SASB model at levels of increasing complexity. (1) The quadrant version appears at the center of the figure. (2) The middle section provides names for 8 subdivisions or clusters. (3) The outer ring shows boxes corresponding to each of the clusters and containing specific model points from Figure 11-1. Model points in the figure present tests from the INTREX questionnaires, to give clients a highly specific description of each model cluster. Cluster names and questionnaires are copyright 1962 and 1983, respectively, by INTREX Institute, Inc. From L. S. Barthes, Principles of prediction using structural analysis of social behavior (SASB), in R. A. Zuckier, J. Aronoff, & A. J. Ruben (Eds.), Personality and the prediction of behavior (New York: Academic Press, 1984, Reprinted by permission.
Appendix D: Intrex Questionnaire

YOURSELF

Rate yourself twice: at your best, and at your worst. First, try to remember a specific time a few months ago when you were at your best, and while thinking of that time, rate the best version. Then think of a specific time a few months ago when you were at your worst, and rate the worst version. Please do not go back in time further than one year. A rating of less than 50 indicates “false”; a rating of 50 or more indicates “true.”

YOURSELF AT YOUR BEST (Circle the appropriate number after each answer)

1. Without concern or thought, I let myself do and be whatever I feel like. 0--10--20--30--40--50--60--70--80--90--100
2. Without considering what might happen, I hatefully reject and destroy myself. 0--10--20--30--40--50--60--70--80--90--100
3. I tenderly, lovingly cherish myself. 0--10--20--30--40--50--60--70--80--90--100
4. I put energy into providing for, looking after, and developing myself. 0--10--20--30--40--50--60--70--80--90--100
5. I punish myself by blaming myself and putting myself down. 0--10--20--30--40--50--60--70--80--90--100
6. Aware of my personal shortcomings as well as my good points, I comfortably let myself be “as is.” 0--10--20--30--40--50--60--70--80--90--100
7. I am recklessly neglectful of myself, sometimes completely “spacing out.” 0--10--20--30--40--50--60--70--80--90--100
8. To make sure I do things right, I tightly control and watch over myself. 0--10--20--30--40--50--60--70--80--90--100

Now change to rating: YOURSELF AT YOUR WORST

1. Without concern or thought, I let myself do and be whatever I feel like. 0--10--20--30--40--50--60--70--80--90--100
2. Without considering what might happen, I hatefully reject and destroy myself. 0--10--20--30--40--50--60--70--80--90--100
3. I tenderly, lovingly cherish myself. 0--10--20--30--40--50--60--70--80--90--100

Copyright: University of Utah, 1995
4. I put energy into providing for, looking after, and developing myself.
   0-10--20--30--40--50--60--70--80--90--100

5. I punish myself by blaming myself and putting myself down.
   0-10--20--30--40--50--60--70--80--90--100

6. Aware of my personal shortcomings as well as my good points, I comfortably let myself be "as is."
   0-10--20--30--40--50--60--70--80--90--100

7. I am recklessly neglectful of myself, sometimes completely "spacing out."
   0-10--20--30--40--50--60--70--80--90--100

8. To make sure I do things right, I tightly control and watch over myself.
   0-10--20--30--40--50--60--70--80--90--100

You have just described yourself in what you consider to be your best and worst states. Think back on these states and answer the following:

1. What percent of the time in the past month have you found yourself at your:
   Best _______  Worst _______

2. Where are you right now on the best-worst scale?
   Worst 1 2 3 4 5 6 7 8 9 10 Best

3. To what extent are you able to move yourself from worst to best?
   Not at all able 1 2 3 4 5 6 7 8 9 10 Very Able
FORMULAS FOR CALCULATING QUADRANT AND AXIS SCORES FROM THE EIGHT SCALES OF THE IMI:IIA OCTANT VERSION

Donald J. Kiesler and James A. Schmidt
Virginia Commonwealth University
June 1, 1991

Quadrant Scores

\[ \begin{align*}
\text{HOS-DOM} &= .707 \ D + .707 \ H \\
\text{HOS-SUB} &= .707 \ H + .707 \ S \\
\text{FRI-SUB} &= .707 \ S + .707 \ F \\
\text{FRI-DOM} &= .707 \ F + .707 \ D
\end{align*} \]

Axis Scores

\[ \begin{align*}
\text{CONTROL} &= D - S + .707 \ (H + F) - .707 \ (H + S) \\
\text{AFFILIATION} &= F - H + .707 \ (F - F) - .707 \ (H + H)
\end{align*} \]

Quadrant Names

- HOS-DOM = Hostile-Dominant
- HOS-SUB = Hostile-Submissive
- FRI-SUB = Friendly-Submissive
- FRI-DOM = Friendly-Dominant

Octant Scale Names

- D = Dominant
- HD = Hostile-Dominant
- H = Hostile
- HS = Hostile-Submissive
- S = Submissive
- FS = Friendly-Submissive
- F = Friendly
- FD = Friendly-Dominant