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UMI
NARRATIVES OF TENSION EVENTS AND
PSYCHOTHERAPY OUTCOME

A Microanalysis of Statements on Post-Session
Questionnaires Given by Therapists and Patients in Brief Relational Therapy

by

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May 2000

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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ABSTRACT

This dissertation examined short narratives written by 39 patient-therapist dyads about tension between them in Brief Relational Therapy (BRT). Linguistic characteristics in the narratives were hypothesized to be predictive of session effectiveness, as rated by patients and by therapists, and overall treatment outcome. The characteristics were inspired by existing literature and by principles of metacommunication used in BRT. They were (1) variables reflecting the degree to which participants returned Post-Session Questionnaires, and wrote narratives when they reported tension about the session, (2) levels of “Concreteness” and “Specificity” in the narratives, (3) attribution of blame, (4) use of the name of the other person in the dyad, (5) use of third person to refer the oneself, (6) use of “we” to express more inclusiveness, and (7) the ratio of “Other-referents” to “I-referents.” Paired t-tests examined differences between patients and therapists on the predictor variables regarding the participants’ engagement in the therapy process. Regression analyses using a generalized estimating equations approach tested for relationships between the predictor and criterion variables. The main findings were that therapists reported tension and wrote about it more frequently than patients, and that several
linguistic characteristics present in the narratives were significantly associated with
session effectiveness ratings by therapists, by patients, or by both, and only one
predictor variable, the level of blame patients attributed to their therapist for the
tension in the session was associated with poorer overall treatment outcome. To be
able to generalize from the present findings to the process in the actual sessions,
narratives including the predictor variables studied could be used to examine the
corresponding session transcripts.
This work is dedicated to my beloved mother. I wish she had lived to see this day. I am very indebted to her and my father for believing in me and for making it possible for me to pursue graduate studies.
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CHAPTER I

INTRODUCTION

After approximately four decades of conducting psychotherapy research, there has been a recent effort by researchers to reassess what has and has not been successful in their methodology approaches intended to determine treatment effectiveness. Some investigators have suggested that studies examining the microlevel of psychotherapy process and progress reveal more about treatment effectiveness than do traditional outcome studies. There seems to be a consensus among psychotherapy researchers that, theoretically, the psychotherapy process is a bidirectional process (meaning that there is a flow of action and reaction between participants, the therapist and the patient, during the psychotherapy). Therefore, these researchers suggest that investigation of psychotherapy process needs to include the study of both participants. Another point of consensus is that smaller units of change need to be examined to shed light on that bidirectional process. Several research
methods have been proposed for this purpose. Among them are the strategies which call for mapping out the process and for marking noticeable shifts occurring in psychotherapy. Shifts may occur along a variety of dimensions, depending on which theory is being tested and depending on the type of change processes hypothesized to underlie a particular psychotherapy.

In the present dissertation, both the notion of bidirectionality and the idea that studying small change units is an effective means of examining progress in psychotherapy will be tested, using data collected at the Brief Psychotherapy Project at Beth Israel Medical Center in New York. This project will focus on data gathered during the provision of one method of psychotherapy called Brief Relational Therapy (BRT).

First, I will review the broader theoretical background underlying this dissertation and will present: (1) several current approaches to psychotherapy research and how they guide this study, and (2) the rationale for the idea that the psychotherapy process can be viewed as a bidirectional process that includes both participants: the therapist and patient. I will then present Jeremy Safran’s and Christopher Muran’s Brief Relational Therapy approach, which represents the focus of the present dissertation. The BRT “rupture resolution” model will be presented as it provides the framework on which BRT is based for negotiating interpersonal tension experienced in the moment during psychotherapy sessions. This model advocates that addressing such breaches in the relationship and trying to resolve them
may enhance corrective interpersonal experiences and therefore benefit the patient seeking help for his or her relational problems. I will present the BRT principles that will constitute the specific theoretical rationale for this study and that led to the formulation of the hypotheses. After presenting the theoretical background, I will review those studies in the existing literature which have tracked psychotherapy change through the analysis of the language used either in the psychotherapy sessions themselves or in post-session accounts of the participants. Such microanalysis has focused on the description of “important events,” “significant events,” “tension,” or “helping or hindering events” in the psychotherapy sessions.

The information presented in the above mentioned sections will serve as the theoretical rationale for this dissertation. The focus of this study will be the linguistic microanalysis of short written narratives, that are included as items on the Post-Session Questionnaires (PSQ) that are completed by therapists and patients participating in BRT after each session. The participants have described in written accounts the kind of “tension” that occurred between them in a particular session. A series of brief written post-session accounts for each of the 39 patient-therapist dyads will be analyzed. The aim is to examine how linguistic shifts in the narratives might be predictors of session effectiveness as rated by both, therapist and patient, and overall treatment outcome.

The type of linguistic microanalysis conducted on the post-session accounts was partly inspired by the principles of metacommunication of BRT and by a review
of existing literature. Examining aspects of language change over time in brief
written post-session answers by both patients and therapists, instead of extensive
post-session accounts or session transcripts, is believed to be a new way to feel the
"pulse" of the psychotherapy process. This dissertation is intended to contribute to
the ongoing Brief Psychotherapy Research Project at Beth Israel Medical Center, as
well as to the body of literature in psychotherapy research.
CHAPTER II

LITERATURE REVIEW

1. Broader theoretical background

Investigators in psychotherapy research have suggested that psychotherapy research move away from assessing psychotherapy as something which comprises “active ingredients” supplied by the therapist towards the client, and where the presence or absence of such ingredients would lead to correlations between process and outcome (Stiles, Shapiro and Harper, 1994). They argue instead for an alternative approach which focuses on smaller in-session interpersonal changes between therapist and patient on the one hand, and within subject changes on the other hand. It is suggested that such investigation be conducted on various pertinent dimensions which may more or less influence the outcome of a particular session and/or the overall outcome of the psychotherapy.
Such alternative approach to conducting psychotherapy research has been used recently in many studies conducted on the psychotherapy process, one of which is “the assimilation model” (Stiles, Elliott et al., 1990). This model

dissects “outcome” into changes in specific ideas, attitudes, or themes... [and] traces changes in clients’ ideas across a series of psychotherapy sessions to test the hypothesis that the assimilation of problematic experiences follows a predictable path. Episodes dealing with a common theme or problem are extracted from session tape recordings and examined intensively for movement along the predicted path. By studying change in specific ideas, this new approach circumvents the vagueness and the methodological problems of assessing global long-term change, and may make it more feasible to link changes with specific in-therapy processes (Stiles, Shapiro and Harper, 1994, p.45).

Leslie Greenberg (1994) has suggested further specific methods to capture the change process itself. He proposed to study change by shifting the focus away from specifying or manualizing therapist interventions as a primary research endeavor and toward specifying the process between therapist and client and within the client himself. Greenberg elaborated that it would be helpful to study variables such as “interactional stances, the content and manner of verbalizations, nonverbal aspects of communication, and shifts in cognitive, emotional and interpersonal states” (Greenberg, 1994, p.120). Robert Elliott (1986) suggested that the focus of study can be about particular “episodes” or particular specified types of events. He stated that participant’s views of the situations as reported by them can be obtained to define “episodes.” He also suggested that meaningful episodes can be identified through for example “marking an event by a shift in a particularly relevant variable or by the
occurrence of a particular performance relevant to a clinical or theoretical formulation."

Leslie Greenberg outlined five ways of isolating such “episodes” which have been already used by some investigators: (1) in session events are identified by client’s markers and therapist’s interventions (Rice & Greenberg, 1984; Greenberg, 1986); (2) clients identify events based on in-session impact (e.g. Elliott, 1986); (3) shifts in a variable are used to identify an event (e.g. Luborsky, Singer et al., 1984); (4) a clinical formulation of such variables as the core issue is used to track certain episodes; and (5) a theoretical formulation is used to derive the occurrence of certain phenomena which are identified and investigated (Greenberg, 1994, p.124).

The development and refinement of BRT (the framework of the present dissertation) designed and studied by Safran, Muran and colleagues at the Brief Psychotherapy Project (BRT) follows a similar approach in two ways: it has a method of identifying interactions between patient and therapist which enhances “locating key episodes.” Secondly, it involves marking key events and recurrent episodes of change from tapes and transcripts of psychotherapy sessions and inspecting them for regularities across sessions. Using this method, a “rupture resolution” model and a means for identification of therapeutic interaction sequences was gradually developed. BRT will be reviewed in more detail in section 3 of this chapter. Before that, the idea of bidirectionality in the therapy process will be briefly reviewed.
2. **Bidirectionality of psychotherapy**

Many researchers of psychotherapy process have suggested that investigators “get inside” the counseling experience by using clients’ self-reports. Toukmanian & Rennie (1992) and Elliott (1986) stated that clients be viewed as authorities on their own experiences in therapy and that what they have to report about the process is valuable information. This approach stems from psychotherapy theories moving from a one-way psychology, influenced typically by classical psychoanalysis, to a two-way psychology influenced by interpersonal traditions (e.g. Sullivan, 1953). The latter support the idea that the therapist is embedded in the therapeutic situation, is often unconsciously participating in the dynamics at work, and is rarely an impartial observer of events (Mitchell, 1988). This “relational” perspective has developed and refined how interactional processes between participants in the psychotherapy situation can be viewed as a reflection of patterns of interpersonal difficulties stemming from early object relations with parental figures (e.g. Luborsky, 1984; Strupp & Binder, 1984).

Safran and colleagues sought to extend this approach and have been developing BRT which makes extensive use of the therapist’s feelings and reactions about the patient as a “source of information” about the processes at work in the therapy dyad. Further it encourages therapists to intervene actively but non-judgmentally to probe for what might be happening in the therapy dyad (Safran & Muran, 1999).
3. **Brief Relational Therapy (BRT)**

Safran & Muran (1995, 1996, 1999) have gradually built and refined a model of "rupture resolution." "Rupture" is defined as "a deterioration in the quality of the relationship between patient and therapist; ... an interpersonal marker that indicates a critical opportunity for exploring and understanding the processes that maintain a maladaptive interpersonal schema" (Safran & Muran, 1996).

The resolution of ruptures in the session is meant to increase patients’ ability to "acknowledge disowned parts of themselves and to learn to negotiate the dialectically opposed needs for self-agency and relatedness in a constructive fashion" (Safran, 1993). Signs that a rupture may have occurred between the participants are: (1) confrontation in which the patient expresses directly negative statements and, (2) avoidance of confrontation in which the patient withdraws, distances him/herself, or avoids the therapist (Safran et al., 1990). Sometimes the patient can present with a mixture of these two types of ruptures.

In BRT, a rupture resolution is when a patient is in a particular negative state and the therapist intervenes until they reach resolution of what is blocking the process. The rupture resolution is facilitated through "metacommunication," a term used originally by Kiesler (1996) and has been defined in BRT as "an attempt to disembend from a relational matrix when there is a therapeutic impasse... an attempt to step outside of the relational cycle that is currently being enacted by treating it as
the focus of collaborative exploration: that is, communicating about the communication that is taking place” (Safran & Muran, 1999, p.97). Unlike a traditional transference interpretation, efforts at metacommunication attempt to decrease the degree of inference on the part of the therapist and are as much as possible grounded in the therapist’s immediate experience of some aspect of the therapeutic relationship. When rupture is properly addressed in the therapy dyad with the help of such efforts at metacommunication, patient and therapist go through four stages of interactional sequences. The four patient states are: (P1) patient withdrawal, (P2) patient expression of negative feelings, (P3a and P3b) patient disclosure and exploration of avoidance and (P4) patient exploration of interpersonal schema. The therapist’s interventions include: (T1) therapist focuses patient on immediate experience, (T2) therapist empathizes or accepts responsibility, and (T3) therapist probes for fears. Some of the key features of BRT are as follows (as reported in Safran, 1998, p.4):

1) BRT assumes a two person psychology and a constructivist epistemology
2) there is an intensive focus on the here and now of the therapeutic relationship
3) there is an ongoing collaborative exploration of both patient’s and therapist’s contributions to the interaction
4) it emphasizes in-depth exploration of the nuances of patient’s experience in context of unfolding therapeutic enactments and is cautious about making transference interpretations that speculate about generalized relational patterns
5) it makes intensive use of countertransference disclosure
6) it emphasizes the subjectivity of the therapist’s perceptions
7) it assumes that the relational meaning of interventions is critical.

Under “Principles of Metacommunication,” numerous categories and subcategories of principles serve as guidelines to train therapists in the particular form of metacommunication used in BRT. Out of an extensive number of principles, three belonging to the subcategory “Participation and Orientation,” and two belonging to the category “Attention and Focus,” were selected for this project. The reason those five metacommunication principles were taken out of the larger context is: first, because in contrast to several other BRT principles (see Safran & Muran, 1999), it was felt that if used in the interpersonal communication between therapist and patient, these five principles could be more readily captured in the written self-report accounts which were analyzed linguistically in the present study, and second, they therefore could constitute a more specific theoretical background for the present study and inspire the formulation of the hypotheses to be tested here.

Out of the first subcategory “Participation and Orientation,” principles 2, 4 and 8, and out of the second category “Attention and Focus,” principles 2 and 3 were used. In the following section, these principles will be summarized (see Safran, 1999, pp.102 for a more extensive presentation).

From the category “Participation and Orientation:”
Principle #2: Establish a sense of "we-ness." This principle calls for inviting the patient to join the therapist in an attempt to understand any shared dilemma. In order to reduce a feeling of demoralization or isolation on the part of the patient particularly in times of tension/rupture, the therapist is encouraged to deal with the impasse as a "shared experience," and work collaboratively with the patient to untangle the situation.

Principle #4: Emphasize one's subjectivity. This principle calls on emphasizing how subjective the perceptions of the therapist are, and that it is important to engage in an ongoing collaborative effort to clarify what is taking place. It is suggested that by using simple strategies like beginning one's comments with phrases such as "What occurs to me..." or "I'm thinking that..." to one's communications, such subjectivity can be communicated and this would give room to the patient to feel on more equal grounds and allow the patient to express his or her disagreement, instead of perceiving the therapist as controlling or assaultive and hence act defensively in strained situations.

Principle #8: Accept responsibility for one's own contribution to the interaction. By following that principle, therapists can help patients become aware of feelings they are having difficulty articulating, in part, because of a fear of interpersonal repercussions. This helps validate patients' conscious and unconscious perceptions of what is taking place and help them trust their judgment. It can also reduce patients' self-doubt, thereby decreasing the need for defensiveness and paving
the way for the exploration and acknowledgment of the patient’s contribution to the interaction.

From the category “Attention and Focus,” the following two principles were borrowed:

**Principle #2: Focus on the concrete and specific.** This principle calls for the focus on the concrete and specific, rather than the general. It is suggested that this promotes experiential awareness, rather than abstract, intellectualized speculation and that his type of concreteness and specificity helps them become observers of their own behavior and their own reality. It thus promotes the type of mindfulness that fosters change.

**Principle #3: Gauge intuitive sense of relatedness.** This principle calls on therapists to monitor continuously their intuitive sense of the variations in emotional closeness with or distance from patients. It is suggested that the quality of the relatedness reflects an ongoing interplay between interpersonal and intrapsychic dimensions.

To the extent that patients feel safe, accepted and validated by the therapist, they will find it easier to access their inner experience in a genuine fashion. Conversely, to the extent that they are in contact with their inner experience, therapists will experience a greater sense of relatedness to them. A sudden shift in the direction of decreased relatedness may signal that the therapist’s intervention has been hindering, rather than facilitative, and indicate the need to explore the way in which the patient has construed or experienced the intervention. Conversely, a sudden shift in the direction of increased relatedness may signal that the therapist has developed a more attuned understanding of the patient’s internal experience (Safran & Muran, 1999, p.104).
These selected principles of metacommunication will guide the hypotheses formulation which will be presented later in the method section of this paper. A review of some studies focusing on the analysis of accounts of patients and therapists will be presented next.

4. Studies on accounts of therapists and patients

Within the Brief Psychotherapy Project at Beth Israel Medical Center, open-ended questions have been used in addition to structured rating measures, to get post-session feedback from patients and therapists. This has been done also in other research projects which merit some attention. Some studies focused on what participants felt were “important events” during the session (Cummings et al., 1992, 1993, 1994). Others studies screened “significant events” (Elliott & Shapiro, 1992; Stephenson, 1997), “helping or hindering events” (Litaer, 1992), “problematic” (Watson, 1996) or “tension provoking” ones (Safran et al., 1990). In all these studies it was suggested that the content analysis of such accounts provides insight into what might have contributed to the change process for the patient seeking help in psychotherapy as well as what might be helpful in remediating poor alliance between therapist and patient and help achieve better outcome.

Most literature focused on aural feedback for example from post-session interviews, or on parts of dialogue from the sessions. Written post-session accounts on the other hand have rarely been examined microlinguistically. One possible
explanation is that spontaneous speech reveals more about the thought process leaving little time for censoring, whereas written accounts can be monitored more carefully by the writer. It is the question whether the microanalysis of written accounts in response to open-ended questions from post-session questionnaires may also reveal some information about the nature of what is occurring in psychotherapy for the patient as well as between the patient and the therapist.

The linguistic characteristics of narratives and how linguistic variables might correlate with session outcome and/or overall treatment outcome, as well as variables like alliance in the psychotherapy dyad have been based on quantitative approaches to analyze the narratives and have used specific rating scales for that purpose (e.g., Bucci, 1985), including at times word-by-word based computer software (Stephenson et al., 1997). Some have argued also for qualitative analyses of narratives (Polkinghorne, 1991), and some have used a qualitative approach in addition to quantitative rating scales (Cummings et al., 1994).

The following review will encompass studies on “important events,” “significant events,” or “tension events” where change was captured through linguistic microanalysis of patients’ and therapists’ narratives.

Anne Cummings and her colleagues (1992a, 1992b, 1993, 1994) and Jack Martin and his colleagues (1991, 1992) did a series of studies in which events believed to be “important” by the participant, were described on post-session
Important Events Questionnaires (IEQ; Cummings et al., 1992)\textsuperscript{1} by both therapists and patients. Their research was based on Martin’s (1991) description of the social-cognitive construction of therapeutic change, which hypothesized that change results from: (a) the elaboration of client memories and the co-construction of new insights based on such elaborations, and (b) the retention of these new insights in clients’ episodic memories of therapy to facilitate ongoing client self-change following counseling interventions.

Using psychotherapy transcripts the above investigators located the important events reported on the questionnaires by identifying these events using tapes of the sessions. They then examined whether there was a match between patients’ and therapists’ recall of these events, and further how that correlated with patients’ and therapists’ ratings of the effectiveness level of the session (Cummings, Hallberg, Slemen, & Martin, 1992a). In another study, memory for "important events," session effectiveness and working alliance were investigated in short-term counseling (Cummings, Martin, Hallberg & Slemen, 1992b). Results indicated that therapists exhibited greater specificity of recall of important events for sessions rated as more effective and showed greater specificity of recall than did clients. In the line of study

\textsuperscript{1} The Important Events Questionnaire (IEQ) contains five different questions: 1) What was the most important thing that happened in this session? (e.g. what stood out for you). Please be as specific as you can; 2) Why was it important and how was it helpful or not helpful? 3) What thoughts and feelings do you recall experiencing/having during this time in the session? 4) What did you find yourself thinking about or doing during the time in between sessions that related in any way to the last
by Cummings and her colleagues, therapists evidenced an increase in the bond aspect of the working alliance over time but there was no relationship between specificity of recall and the working alliance. It is the question whether therapists do better in the beginning of treatment in terms of recall and whether patients catch up later, once they are further involved in the treatment.

In those early studies Cummings and colleagues emphasized that the activity of completing the IEQ and describing in writing important events after each session may have influenced the change process for participants in a positive way. They suggested that writing about important events may have potential for embedding these events in client’s memories and enhancing good outcome. By comparing those who write about specific types of events with those who don’t, it would be possible to further investigate whether writing helps the change process.

Martin and colleagues focused more specifically on the type of language use in reported “important events” and any changes in this area over the treatment period. Here, the participants’ memories for therapeutic events were examined in terms of what contributed to their memorability (Martin and Stelmaczonek, 1988; Martin, Paivio, and Labadie, 1990). They examined dialogue during client-recalled important events, as compared with control events in the same interview by using a coding method developed by Mc Carthy and colleagues (1986) and including the following five information-processing dimensions: (1) Deep-Shallow; (2) Elaborative-

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session? and 5) Are you experiencing any change in yourself? If so, what? (see instrumentation section Cummings, Hallberg & Slemon, 1994).
Nonelaborative; (3) Personal-Impersonal; (4) Clear-Vague; (5) Conclusion Oriented-Descriptive Oriented. The authors found that language was deeper, more specific, more metaphorlic and more conclusion oriented in memorable events rated as “important.” The investigation of language use seems also to shed light on the nature of the therapy process as well as the developing relationship between participants.

Cummings, Halberg, Martin and Slemon (1994) examined the relationship between accuracy of recall for important events and session effectiveness ratings. They found that clients had greater specificity of recall of important therapeutic events after sessions that were rated as more effective. They also found that clients and their therapists tended to recall the same therapeutic events as important during sessions that were rated as more effective.

Other investigators studied similar events in different psychotherapy modalities and expanded this type of research in a different direction, mainly methodologically. Germain Litaer’s (1992) conducted a content analysis on “helping and hindering processes” in client-centered/experiential psychotherapy as perceived by therapists and clients. During the course of long-term client-centered/experiential psychotherapy treatment, patients and therapists were asked to fill in a post-session questionnaire after every other session for a maximum of 10 sessions. In addition to an effectiveness likert scale rating measure (1-7) on how poor or good the session was, and an extensive rating scale referring to different relational and task-oriented aspects of the therapeutic process, the investigator used four open-ended questions to
capture participants responses\textsuperscript{2}. He investigated differences arising from each one’s vantage point and found that clients and therapists had often two at times vastly differing views on “hinder ing processes.” Litaer and his team decided to develop separate taxonomies to conduct content analyses of therapists’ and clients’ reports on such events. Not only differences between clients and therapists were noted but there were also considerable differences between clients. He also found that sometimes patients as well as therapists gave numerous blank answers to the open questions about the session’s “hinder ing” moments in contrast to their descriptions of “helping” moments. Sometimes they gave brief answers while some of them tended to give lengthy ones comprising several response segments. Litaer investigated what processes most discriminate between “very good” and “rather poor” session and found that in terms of “helping” ingredients, clients seemed to indicate, more strongly than therapists, that self-exploration and experiential insight were more likely achieved in a safe relationship with an accepting and empathic therapist. When asked to report “hinder ing” processes, therapists did not seem to talk or write easily about impasses in psychotherapy, or about the things that go wrong in their work, and clients experienced their sessions in general as less negative than did their therapists (the clients gave half as many negative answers than therapists, hence they seemed to have been more lenient in their judgment). What seemed “hinder ing”

\textsuperscript{2} 1) What feelings and expectations did you have coming to this session? 2) What was mostly discussed in this session? 3) Did things happen in this session that you felt were really helpful to you? and 4) Did things occur in this session that you feel were not helpful at all?
according to both participants were the same interventions categories as “helping” ones, but supplied in the wrong dosage and timing. For example, the therapist being too passive or too active, too confronting or not confronting enough, too interpretive or insufficiently interpretive. Although patients tended to see the negative as well as the positive coming mainly from themselves, therapists tended to present an intrapunitive reaction, that is they attributed the “helpful” events to the patients and the “hinderling” ones to their own defective interventions. Litaer and his team used mainly a qualitative approach to design the content taxonomies they based the research on.

Another method to capture characteristics and content of post-session accounts is to classify the types of responses by way of a cluster analysis. Within the Brief Psychotherapy Project at Beth Israel Medical Center, Jilton (1998) used in her dissertation project this approach to identify therapeutic misalliances reported by patients. She examined the brief statements of patients given in one of the research cells, Brief Adaptive Therapy, a therapy modality inspired by Ego Psychology, and conducted a cluster analysis on the content of those statements to provide a classification of “rupture events.” She found eight categories of ruptures which were named: “Feeling judged and incompetent,” “Feeling attacked and defensive,” “Patient is assertive and challenging toward therapist,” “Feeling frustrated and angry,” “Feeling misunderstood,” “Difficulty trusting and being open,” “Confusion
about how to respond and express feelings in therapy,” and “Feeling pressured to accept therapist’s task or agenda.”

Watson’s work on the relationship between vivid description, emotional arousal, and in-session resolution of problematic reactions (Watson, 1996) in which the author investigated how difficult moments in the therapy can be resolved provides an additional example of an attempt to examine psychotherapy changes captured in language. Watson examined “systematic evocative unfolding” believed to be effective in facilitating the resolution of problematic reactions and in enhancing clients’ in-session process (e.g. Rice & Saperia, 1984). Systematic evocative unfolding requires patient and therapist to vividly and concretely evoke the situation in which clients’ reactions were triggered. Therapists help clients to represent nonverbal representations in words to facilitate access to their emotional experiences. This approach is also based on findings by a number of theorists that imagery plays an important role in producing affect insofar as it may enable individuals to experience emotions that were inhibited from overt expression (e.g. Bucci, 1985-Referential Activity Theory). It is believed that there is a relationship between vividness and affect and between vividness and conscious awareness so that as the vividness of an image or memory increases so does the intensity of affective experience and conscious awareness (Tower & Singer, 1981 cited in Watson 1996).

Watson found that so-called resolution sessions in contrast to non-resolution sessions, were characterized by high levels of referential activity when clients and
patients were actively reevoking the problematic situations, and these segments were followed immediately by a progression in the depth of experiencing level in the clients in resolution sessions. The work of Watson presents another tool to capture and rate language use, namely Bucci’s Referential Activity Scale which captures four dimensions: Concreteness, Specificity, Clarity and Imagery. It also in various ways converges towards other findings mentioned above, about the specificity and the depth of language and participants’ experience of the therapy and its effectiveness.

The above review leads to several questions: (1) Does the microanalysis of short written accounts in response to open ended questions also reveal some information about the nature of what is occurring in psychotherapy for the patient as well as between the patient and the therapist? (2) Does writing about a difficult process indicate more involvement in the process, and enhance better outcome? (3) How would the investigation of language changes and shifts over time in a particular psychotherapy context, in this case Brief Relational Therapy, shed light on the nature of the therapy process as well as the developing relationship between participants?

5. Statement of purpose

This project will be based upon suggestions arising from recent psychotherapy research (reviewed above). The focus of the research will be placed on examining smaller in-session changes during difficult moments in therapy (rupture events), on the tracing of certain linguistic shifts (present in post-session accounts about
impasses in the treatment), and on examining the psychotherapy dyad. It will be also based on the theory of Brief Relational Therapy and some of the principles of metacommunication used to foster negotiation of interpersonal tension. This study explores the question of whether the repetitive use of the principles of metacommunication used by therapists in BRT enhances “assimilation” (Elliott, 1986) of the BRT way of negotiating interpersonal tension in the therapeutic situation. The BRT principle about establishing a sense of “we-ness” could be captured in shifts in the language used from a subjective stance towards a more inclusive stance as in the use of “we, us, together…” in the narratives of the participants in their report on tension in the session. The BRT principle about emphasizing one’s subjectivity could be captured in the ratio of “Other-referents” to “I-referents” in the language use to measure the levels of objectivity and subjectivity of the speaker/writer. The BRT principle about accepting one’s own contribution to the interaction could be tested in the levels of blame attribution for the tension in the session. The BRT principle about focusing on the concrete and specific could be traced in rating the narratives on their levels of “Concreteness” and “Specificity” by using the Referential Activity Scale by Bucci (1985), also used in Watson’s (1986) study mentioned above. The BRT principle about gauging an intuitive sense of relatedness could be captured in the tracing of shifts in relatedness: An increase in relatedness could be captured in the use of first name, name, or initials of the partner in the therapy dyad, and a decrease in relatedness or distancing could be captured in
the use of third person instead of first person to refer to oneself, and in the shift back to a more formal reference to the treating clinician as “therapist” or to the patient as “patient” after having used their name.

Can the brief statements on tension be considered representative of how difficulties have been negotiated in the treatment and how some of the principles guiding BRT were assimilated? Do these narratives contain the linguistic markers mentioned above that might be indicative of the change process itself? Finally, do within treatment changes in language use predict outcome both on the session level and at the end of treatment?

6. **Hypotheses**

The following hypotheses will be examined in this study:

1) Having engaged in tension reporting and writing will reflect on being actively involved in the therapy process. The more tension reporting and writing about tension, the better the session as well as the overall treatment outcome.

2) The statements about tension as reported by patients and therapists will be relatively higher in “Concreteness” and “Specificity” in sessions rated as more effective by the participants.

3) The more evenly distributed the blame for the tension between self and other, the better the session as well as the overall treatment outcome.
4) The presence of shifts in the narratives from an impersonal to a personal stance over time will predict greater levels of relatedness and better session as well as overall treatment outcome. This will be true mainly for patients.

5) The presence of shifts in the narratives to an impersonal stance to describe oneself will indicate decrease in the relatedness level and predict poorer session as well as overall treatment outcome.

6) The presence of shifts from first person to a “We” stance will indicate a greater level of inclusiveness in the negotiation process and predict better session as well as overall treatment outcome. This will be mainly true for therapists.

7) The more evenly distributed the “I-referents” to “Other-referents,” the better the session effectiveness and overall treatment outcome.
CHAPTER III

METHOD

1. Participants

This study is based on a sample of 39 patient-therapist dyads and 768 narratives from the self-report questionnaires which were completed after the sessions.

1.1 Patients

Patients were 21 females and 18 males. 28 (71.2%) of them completed the 30 sessions of the BRT treatment. 11 (28.2%) dropped out after an average 11.2 sessions. The mean age of the patients involved was 42.51 years (SD = 12.12), 19 were single, 11 were married, 8 were divorced and 1 was widowed. All patients had a high school diploma, and 33 (83%) held at least a college degree. 30 were employed, 8 were unemployed and 1 was retired. There were 36 Caucasians, 1 Hispanic and 2 Asian patients. Using the DSM-III-R and the current version, the DSM-IV criteria
(Diagnostic and Statistical Manual of Mental Disorders 3rd. ed. rev. and 4th ed.; DSM-III-R and DSM-IV; American Psychological Association, 1987 and 1997), 29 (74%) of the patients received Axis I diagnoses (including unipolar mood disorders without psychotic features, anxiety disorders, and adjustment disorders), and 23 (58%) received Axis II diagnoses (including avoidant, dependent, obsessive-compulsive, passive-aggressive personality disorders and personality disorders NOS [not otherwise specified]).

Exclusion criteria included: 1) organic brain disorders and mental retardation; 2) symptoms of psychosis; 3) a diagnosis of bipolar disorder; 4) active substance abuse; 5) active Axis III medical diagnosis; 6) history of violent behavior or impulse control disorder; and 7) use of psychotropic medication within the last year.

All study patients were treated with Brief Relational Therapy as one of three brief psychotherapy modalities offered at the Brief Psychotherapy Project at Beth Israel Medical Center. The other two modalities offered were Brief Adaptive Psychotherapy (BAP) which is influenced by Ego Psychology, and Cognitive Behavioral Therapy (CBT), which is based on various cognitive and behavioral theories and methods. Patients were initially randomly assigned to one of the treatment modalities or cells. Patients may be switched from one treatment modality to another, based on a set of clinical decisions and research protocol. The majority of patients assigned to a particular modality remain in that cell for the duration of the treatment. If completed, treatment in all cells consists of 30 sessions.
At intake, patients were evaluated in a Structured Clinical Interview (SCID I & II) to establish the presence or absence of diagnostic criteria according to the Diagnostic Manual for psychiatric conditions, the DSM-III-R or the DSM-IV upon which diagnoses are assigned. Patients completed the revised version of the Symptom Checklist-90 (SCL-90-R: Derogatis, 1983), the Patient Target Complaint questionnaire (PTC: Battle et al., 1965) and the Inventory of Interpersonal Problems (IIP: Horowitz et al., 1988) at intake, midphase, and termination, and at six month follow-up.

1.2 Therapists

Treatment was provided by 27 therapists (16 females and 10 males; 1 therapist omitted gender information on the data sheet). Mean age was 33.3 years (SD = 5.39). 4 of the therapists held Ph.D. degrees, the remaining 23 were Ph.D. candidates in Clinical Psychology. Therapists completed the Therapist Target Complaint questionnaire (TTC), and the Global Assessment Scale (GAS: Endicott et al., 1976) at intake, midphase and termination.

Patients and therapists were asked to complete a Post-Session Questionnaire (PSQ) after each session.

2. Measures

2.1 Psychotherapy process measure: The Post-Session Questionnaire (PSQ)
The Post-Session Questionnaire (PSQ) includes the Interpersonal Adjective Scale (IAS-16); the Working Alliance Inventory-12 items (WAI-12); the Session Evaluation Questionnaire (SEQ); five questions targeting “tension” between patient and therapist which might have emerged in the session; and two questions about session helpfulness. The components of the PSQ are described next: (1) the IAS-16 is a 16-item shortened version of the Interpersonal Adjective Scale (IAS: Wiggins et al., 1988; IAS-16: Muran et al., 1991) and is a measure of interpersonal process. The original scale (Wiggins et al., 1988) was designed as a 128-item adjective checklist derived from an octant version of the interpersonal circumplex which then was shortened by its authors (Wiggins et al., 1985) to a 64-item, 8-point likert scale version of the original scale. The IAS-16 used in the Brief Psychotherapy Project is a 16-item, 7-point likert scale. It is comprised of two sections having eight items each. One section is used for the participant to rate themselves and the other section to rate the other person in the interaction (for further detail, see Muran & Safran, 1989; Rozmarin, 1998); (2) the WAI-12 is a 12-item version of the Working Alliance Inventory (WAI: Horvath & Greenberg, 1989; WAI-12: Tracey & Kokotovic, 1989) which captures Bordin’s (1979) tripartite concept of therapeutic alliance: bond, task, and goal. This instrument yields alliance ratings specific to each category, and also one total alliance score; (3) the Session Evaluation Questionnaire (SEQ: Stiles, 1980) consists of 9-point likert-type items assessing session helpfulness, one of the
dimension being the perceived "depth" of the session (Safran & Muran, 1990); (4) two items assessing whether the session was helpful or hindering to the patient and to what extent the presenting problems of the patient seem to be resolved; and (5) five questions targeting "tension" which might have emerged in the session. These questions assess the approximate temporal location of the tension in the session (beginning, middle, or end), the degree of severity experienced (on a 1-5 likert scale), an open-ended question to describe the problem or tension briefly, a 5 point likert scale rating on whether the tension was addressed in the session, and one question on whether the person felt that the tension was resolved by the end of the session.

2.2. Instruments and raters rating the narratives

2.2.1 Referential Activity Scale (RA)

The Referential Activity Scale (RA; Bucci & Freedman, 1978; Bucci, 1984, 1985) is intended to measure the degree of vividness of a person’s statements relating to how close a person’s statements are to his or her deeply felt, non-verbal experience. It measures the narrative quality and complexity on four dimensions: Concreteness Specificity, Imagery, and Clarity. These dimensions are scored on a scale of 0-10 points each and an average score is computed to obtain an RA score.

The following are definitions of the Referential Activity subscales as reported in the RA coding manual (Bucci & Mc Kay, 1992, pp.45):
**Concreteness:** This dimension reflects perceptual or sensory quality (of the communication), specifically the extent to which verbal expressions refer to sensate properties of actual things or events or to anything that is experienced as a sensation or feeling. This may include reference to imagery in any sense modality; somatic or visceral experience; or representations of motoric activity, e.g. any components of the nonverbal representation and processing systems... (Examples and levels are described in the manual).

**Specificity:** This dimension refers to a highly specific text that is detailed and informative, that refers to particular objects, persons, place, times; that specifies precise quantities; describes the subject or object of the discourse, whatever they may be, in detail.

**Clarity:** In general, this dimension may be understood as reflecting the speaker’s awareness of the communicative intent of discourse; the degree to which the speaker appears to be aware, on some level, of the perspective of the listener, and to be attempting to bring the listener where he or she is. There are two separate components, transition and focus, which the rater needs to keep in mind in scoring this dimension. If you think of a person’s narrative as frames or “shots,” the concept of focus concerns the clarity of the individual frame; the clarity of an image as seen through the language; the effectiveness with which the speaker’s imagery, ideas or feelings, whatever they may be come through the language... The concept of transition refers to the signaling of the sequential connection between one frame and
the next; the degree to which the speaker attempts to make sense of this sequencing, so you can follow him or her.

**Imagery:** This dimension refers to an overall impression of the vividness and effectiveness with which the speaker’s language is reflecting and capturing imagery or emotional experience, in any sense modality. The rater judges the degree to which the experience is present and immediate for the speaker and likely to be experienced as immediate by the listeners.

Only the subscales of “Concreteness” and “Specificity” from the Referential Activity scale ultimately were used in the present study, due to the lack of improvement by raters on tests of interrater reliability for the “Clarity” and “Imagery” dimensions, even after several weeks of scoring trials. The shortness of the narratives being rated seemed to interfere with the raters’ obtaining adequate interrater reliability on the “Clarity” and “Imagery” dimensions. The decision was made to drop them from use in the study. As a result, the RA scale had to be taken out of its global theoretical context (an RA score was not computed). The instrument was used in this study simply as a tool to measure dimensions of “Concreteness” and “Specificity” in the narratives.

For the Referential Activity subscales, two raters, trained at Wilma Bucci’s laboratory at Adelphi University, reached the following interrater reliability, which was computed by using the intraclass correlation (ICC; 3,k) on a random third of the coded material. The following reliability initially was obtained for “Concreteness”

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.64 and for “Specificity” .58. After the raters scored one coding sheet (44 narratives) and reached extremely low interrater reliability, they rescored the narratives under the supervision of a third trained rater and improved their reliability ratings to the upper .50s levels. After further extensive training sessions and discussions, the raters reached reliability at .81 on “Concreteness” and at .79 on “Specificity,” and were instructed to continue scoring. At the end of rating all narratives, consensus scores were agreed upon by the two raters for all items which had a two or greater point difference on either dimension. The mean scores between the two raters were the scores used in the study, unless the raters established a consensus score which would override the mean score.

2.2.2 The Blame Attribution Scale (BAS)

A two-dimensional rating scale was designed specifically for the purpose of the study. After a thorough literature search and review of existing research, it was determined that no existing instrument would capture the dimension of blame attribution in written self-report statements as short in nature as the ones used in this study. These narratives furthermore answered a precise question about tension in the session that could not be adequately addressed by existing measures. To capture the movement by patient and therapist towards sharing the blame for the tension, a two dimensional likert scale (1-7) was designed. The first dimension indicated the extent to which the narrative is a reflection of “Self-blame,” and the second dimension
considered the extent to which the narrative is a reflection of "Other-blame" for the tension/rupture occurring during the session. The two dimensions were scored independently from each other. Blame was not to be confused with "responsibility," as blame usually implies a hostile quality that responsibility does not connote.

Three raters who were trained on the Structural Analysis of Social Behavior (SASB; Benjamin, 1979) and were sensitized to the idea of attribution of blame (it is one of the dimensions on the SASB) and how it might pertain to the resolution of rupture coded the narratives on the two dimensional Blame Attribution Scale (BAS). The raters were furthermore guided by a list of illustrative examples which were actual examples from the subjects studied. Fourteen examples were provided to illustrate the seven levels for each of the two dimensions of the BAS, "Self-blame" and "Other-Blame" (see Appendix I). After a few scoring trials, the raters stopped referring to that list and used their knowledge base of the SASB to rate the two simplified dimension of the BAS on blame attribution. The raters reached on interrater reliability, computed using the intraclass correlation (ICC; 3,k) for a random third of the material, on the "Self-blame" dimension .77, and on the "Other-blame" dimension .82, after several weeks of training. At this point, raters scored the material without close supervision. Because of continued high interrater reliability during the rating process, no consensus discussions were held. The mean values between the three raters were used in this study.
2.3 Frequency counts and linguistic shifts

All frequency counts, including the presence or absence of specific linguistic characteristics, were performed by the present writer (please refer to the data analysis section for details on the variables).

2.4 Treatment outcome measures

2.4.1 Session outcome

Session effectiveness was measured by two elements of the Post-Session Questionnaire (PSQ). The first item is question 1 on the PSQ, Part A, about how hindering or helping a session was (rated on a 1-9 likert scale). The second element is comprised of a cluster of adjectives describing the “depth” of the session. “Depth” is one of two dimensions (Depth and Smoothness) extracted from the Session Evaluation Questionnaire (SEQ) section of the PSQ (Part C). The items on the SEQ are rated on a 1-7 likert scale. Four items ask about the extent to which a session was (1) valuable-worthless, (2) shallow-deep, (3) full-empty, and (4) special-ordinary and are averaged to obtain the “depth” score. Before computing the average, the direction of the value of the scores on items 1, 3, and 4 is reversed (to reflect the same side of the polarity as item 2) and the value on item 2 remains as it is.

2.4.2 Overall treatment outcome

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Overall treatment outcome was measured as follows: Standardized residual gain scores were derived from the difference between patients' performance at intake and termination on five measures: (1) the Inventory of Interpersonal Problems (IIP); (2) the Global Assessment Scale (GAS); (3) the Patient Target Complaint (PTC); (4) the Therapist Target Complaint (TTC); and (5) the Revised Symptom Checklist-90 (SCL-90-R) suboutcome measures. A composite measure was then computed from the mean of all five residual gain scores (a reversal of the score is required for the GAS). Negative scores on all of these five measures and hence on the composite measure reflect a better outcome and positive scores reflect a worse outcome because a negative score captures reduction in symptomatology or complaints by the end of the treatment thereby indicating improvement. The five measures are presented in detail below:

**Inventory of Interpersonal Problems (IIP):** The IIP (Horowitz, Rosenberg, Beer, Ureno & Villasenor, 1988) is a 127-item patient rated inventory of interpersonal functioning describing common interpersonal problems and the experiences often associated with them. Items are rated on a 5-point Likert type scale. The inventory is divided into two parts, 78 questions relate to behaviors that are difficult for the patient to engage in, and 49 items relate to behaviors the patient might engage in excessively. The overall mean score of the IIP was used to assess general interpersonal functioning. Outcome was indicated by change in this score.
**Target Complaint (TC):** The TC (Battle et al., 1965) is a self-report instrument designed to assess a patient’s presenting problems. It consists of two parts: (1) Patient Target Complaint (PTC) where patients were asked to list and rate the severity of their presenting problems on a likert-type scale ranging from “problem couldn’t be worse” to “not at all bothered by problem,” and (2) Therapist Target Complaint (TTC) which consisted of the therapist’s own rating of the severity of a patient’s problems. Outcome was measured by the change in the average degree of severity for the three target complaints between intake and termination.

**Global Assessment Scale (GAS):** The GAS (Endicott, Spitzer, Fleiss & Cohen, 1976) is a clinician rated scale for evaluating the overall mental health of the patient. It provides a single rating on a range from 1 to 100. The rating is based on clinical descriptions characterizing each 10-point interval in terms of social and occupational functioning and levels of subjective distress. Outcome was measured by the change in GAS score from intake to termination.

**Symptom Checklist 90-Revised (SCL-90-R):** The Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1983) is a 90 item list of psychiatric symptomatology. Patients rate, on 5-point scale, the extent to which they experience distress from each symptom.

3. **Procedure**
The linguistic analyses were based upon 768 brief written statements from 39 patient-therapist dyads in the Brief Relational Therapy modality at the Beth Israel Medical Center Brief Psychotherapy Project. These narratives were provided in response to item 4 of Part B of the PSQ (patient version) and the corresponding item 6 of Part B of the PSQ (therapist version) which asks participants to respond to the open ended question, “briefly describe the problem or tension experienced during the session,” if one was experienced.

The narratives used in this study were collected from the relevant section of the PSQ and transferred into a word processing file. In the first part of the project, each narrative was provided with a number representing whether the author was the patient or the therapist, the therapy case number, and the therapy session (e.g. 1863.01 would be patient’s narrative from case #863, session #01; 2746.30 would be therapist’s narrative from case #746, session #30 etc.). Frequency counts were conducted by the present author on all the predictor variables besides the Referential Activity subscales, and the dimensions of Blame Attribution (see data analysis section below). In the second part of the project, the order of the identification numbers was randomized and the original ID numbers were matched with new ones in order to be presented to the two raters on the Referential Activity subscales, and the three raters on the Blame Attribution Scale. Raters were thereby kept blind to the original sequence of the narratives and to who the author was.
4. **Study design and data analysis**

4.1 **Study design**

Seven hypotheses were examined in this study and are presented next. Two tables summarize the predictor variables and the criterion variables and are meant to be a reference point for the reader. First, the three predictor variables “PSQ,” “Tens,” and “Narr” capture the level of participation of both patients and therapists: Was there a PSQ for the session returned? If so, was tension reported? In that case, was any narrative written to describe it? If there was no tension reported, scoring stopped at the stage “Tens”=0 (no tension). If there was tension reported and a narrative was written, scoring was continued for all other variables. If there was no narrative for that particular session, the count stopped at the stage “Narr”=0 (no narrative).

**Table 1: Summary of predictor variables**

<table>
<thead>
<tr>
<th>Hyp.1</th>
<th>PSQ</th>
<th>Was a Post-Session Questionnaire returned? (0=No, 1=Yes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tens</td>
<td>Was tension reported in the PSQ? (0=No, 1=Yes)</td>
</tr>
<tr>
<td></td>
<td>Narr</td>
<td>Was a narrative written to describe the tension? (0=No, 1=Yes)</td>
</tr>
<tr>
<td>Hyp.2</td>
<td>Con</td>
<td>Level of Concreteness in the narrative (mean score of two raters 0-10)</td>
</tr>
<tr>
<td></td>
<td>Spe</td>
<td>Level of Specificity in the narrative (mean score of two raters 0-10)</td>
</tr>
<tr>
<td>Hyp.3</td>
<td>SB</td>
<td>Level of Self-blame in the narrative (mean score of three raters 1-7)</td>
</tr>
<tr>
<td></td>
<td>OB</td>
<td>Level of Other-blame in the narrative (mean score of three raters 1-7)</td>
</tr>
<tr>
<td></td>
<td>Blame</td>
<td>Ratio of OB to SB</td>
</tr>
</tbody>
</table>
Hyp.4 Name  Shift from the use of “patient,” “therapist” to the use of their name, first name or initials (0=No, 1=Yes)

Hyp.5 Third Use of third person to refer to oneself in the narrative (0=No, 1=Yes)
Shift Shift back to the use of “therapist” and “patient” after having used their name, or initials (0=No, 1=Yes)

Hyp.6 We Use of “we, us, together…” in the narrative (0=No, 1=Yes)

Hyp.7 I Use of I-referents (I, mine, my…) in the narrative (a frequency count)
Other Use of Other-referents in the narrative (a frequency count)
Ratio Ratio of Other to I-referents

The following list summarizes the criterion variables, the first two are the session outcome variables and the composite is the overall treatment outcome variable. All hypotheses had all three outcome measures as criterion variables.

**Table 2: Summary of criterion variables**

<table>
<thead>
<tr>
<th>Helping or Hindering</th>
<th>Rating on 1-9 likert scale how helping or hindering the session was (1 is extremely hindering and 9 is extremely helping)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depth</td>
<td>Level of depth of the session as rated on four items of the Session Evaluation Questionnaire within the PSQ</td>
</tr>
</tbody>
</table>
Composite measure of overall treatment outcome, the mean of the standardized residual gain scores derived from the difference in scores between beginning and end of treatment on the five suboutcome measures IIP, PTC, TTC, SCL-90-R, and GAS (reversed).

4.2 Data analysis

Patients’ and therapists’ records were scored for each session on: (1) the presence or absence of a Post-Session Questionnaire for the session, (2) the presence or absence of a tension report, and (3) the presence or absence of a narrative to describe the tension. Only if a tension was reported and a narrative describing it was present, could the following linguistic characteristics be counted: (1) the presence or absence of shifts to the use of first name, name or initials to describe the other person in the dyad, (2) the use of third person to refer oneself (e.g. use of “patient” instead of “I” or “therapist” instead of “I”), (3) the presence or absence of a shift back to a more impersonal description of the other person, after having used their name, (4) the presence or absence of a shift in the writing to a stance indicative of more inclusiveness as captured by the use of “we, us, together,” and (5) the number of “Other-referents” and “I-referents” leading to a ratio. Each narrative was also rated on the Referential Activity subscales, Concreteness and Specificity, and on the dimensions of the Blame Attribution Scale, “Self-blame” and “Other-blame.”
To provide background information before testing hypothesis #1 on the number of Post-Session Questionnaires returned, the number of tension events reported, and the number of narratives written to describe that tension, descriptive data and paired t-tests were conducted. In order to test the hypotheses in this study, a series of regression analyses of repeated measures were conducted. This procedure is called Generalized Estimating Equations (GEE: Stata, XTGEE 1999), and is used to analyze the predictive relationship of the predictor variables on the session effectiveness ratings of patients and therapists as well as on the composite measure which reflects overall treatment outcome. The GEE approach was first developed by Liang and Zeger (1986; Zeger & Liang, 1986) and is appropriate for use when measurements have been obtained at multiple time points for each participant within a group of participants who are independent from each other. Unlike the traditional approaches to the analysis of longitudinal data, the GEE approach accommodates dependence among the repeated measures, as well as missing data.
CHAPTER V

RESULTS

1. The sample

From the original sample of 39 dyads, two cases among the 28 who completed treatment reported having never experienced any tension throughout the course of treatment. For these cases, there were no narratives to analyze and no basis for comparing patient to therapist on the linguistic variables examined in this study. Nine cases had incomplete termination data, meaning that one or two of the five final outcome measures were not returned after termination of treatment and that the composite score, therefore, might not be a true reflection of treatment outcome for those cases. The missing values nevertheless were adjusted for by the Generalized Estimating Equations analyses. Two cases extended treatment beyond the 30 session protocol for unclear reasons and completed 32 instead of 30 sessions.

The patient-therapist dyad was the main unit of analysis in this study. For the paired t-tests to be conducted to compare patients and therapists within the dyad on
the levels of participation, two elements were important to consider. First, data for
the group of 28 cases who completed treatment were examined separately from the
data for the group of 11 drop-out cases, because there were very little data available
for analysis of the drop-out cases. After paired t-tests were conducted for the
variables summarizing the levels of participation of the participants (PSQ, Tens, and
Narr). Second, as described previously, narratives were provided by patients and
therapists after sessions that both experienced as rupture sessions. Only when both a
patient and a therapist within a dyad provided a narrative for tension in a session
were analyses using these paired t-tests possible, since paired t-tests require that the
two groups to be compared to each other have each a data point. There were 156
instances of such narrative pairings, from a total of 244 narratives from patients’
records and 477 from therapists’ records. The term “corresponding narratives” was
used to refer to these 156 instances where both therapist and patient supplied
narratives about tension in a particular session. These “corresponding narratives”
provided the basis for comparing patients to therapists within the dyad on the
linguistic variables of interest in the present study. Whereas conducting paired t-tests
required the presence of “corresponding narratives,” the GEE analyses, which were
conducted to predict relationships between the predictor variables and the criterion
variables, used all available data points or “observations” for the reduced sample of
28 cases which completed treatment. The number of observations as well as the

44
number of dyads for which data were available are reported below in each of the GEE tables as N1 and N2 respectively.

2. Hypothesis #1

To test Hypothesis #1, which stated that the more reporting of tension and writing of narratives to describe the tension the better the session outcome as well as the overall treatment outcome, the following statistical analyses were conducted: descriptive analyses of the predictor variables (PSQ, Tens and Narr) and a series of paired t-tests to provide a basis of comparison between patients and their therapists within the dyads. In the first t-test, patients and their therapists were compared on the number of PSQs returned (aggregated means were used to reflect the number of PSQs in proportion to the total number of sessions attended). In the second t-test, patients and their therapists were compared on the number of tension reports made (aggregated means were used to reflect the number of tension reports in proportion to the total number of PSQs returned by each of them). In the third t-test, patients and their therapists were compared on the number of narratives they have written (aggregated means were used to reflect the number of narratives in proportion to the

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3 To compare patient and therapist within each dyad in the paired t-tests, values were derived from dividing the number of PSQs by the total number of attended sessions, e.g. if patient #1 provided 22 PSQs out of the possible 30, and the treating therapist #1 provided 27 PSQs out of the possible 30, 22 and 27 were each divided by 30 and the results of the divisions (.73 and .81) were the ones used in the paired t-tests. The means for all such values obtained for patients on the one hand and therapists on the other hand constitute what is called “aggregated means.” This approach was also used to compare therapists and patients on the variables “Tens” and “Narr.”
total number of tension reports made by each of them). GEE analyses were used to examine whether the three predictor variables (PSQ, Tens, and Narr) had a predictive relationship to the three criterion variables (session effectiveness ratings by patients on how helping or hindering the session was and on the depth of the session, session effectiveness ratings by therapists on the same two criterion variables, and the composite measure, the overall treatment outcome measure). The descriptive data of the predictor variables are presented: Table 3 presents the descriptive data for the predictor variables for Group 1, the cases which completed treatment. Descriptive data for Group 2, the cases which dropped out, is shown on Table 4.

**Table 3: Descriptive data of “PSQ,” “Tens,” and “Narr” variables for the cases which completed treatment**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Patient M</th>
<th>SD (5.20)</th>
<th>min 13</th>
<th>max 32</th>
<th>N 28</th>
<th>Therapist M</th>
<th>SD (2.56)</th>
<th>min 20</th>
<th>max 32</th>
<th>N 28</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSQ</td>
<td>25.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27.89</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tens</td>
<td>7.93</td>
<td>(7.00)</td>
<td>0</td>
<td>29</td>
<td>28</td>
<td>14.18</td>
<td>(5.11)</td>
<td>3</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>Narr</td>
<td>8.08</td>
<td>(6.96)</td>
<td>1</td>
<td>29</td>
<td>26</td>
<td>14.18</td>
<td>(5.04)</td>
<td>3</td>
<td>26</td>
<td>28</td>
</tr>
</tbody>
</table>

PSQ = Frequency of return of Post-Session Questionnaires, Tens = Frequency of reporting tension, Narr = Frequency of writing a narrative describing the tension reported.

Table 3 showed that although the majority of patients and therapists returned PSQs after most sessions (Patients’ PSQ Mean = 25.25 and Therapists’ PSQ Mean = 27.89) therapists reported experiencing tension during an average of 14.18 sessions, while patients reported experiencing tension during an average of only 7.93 sessions. If one compares the Mean “Tens” to the Mean “Narr” for both patients and therapists by visual inspection of the descriptive data, (while keeping in mind a change in N, the
sample size), both therapists and patients apparently described in a narrative the tension they reported having experienced during the session. The range of how many tension events were reported by patients was quite wide (see "min" and "max" columns for the variable "Tens" under "Patient" in Table 3). Some patients reported no tension whatsoever during the entire treatment, whereas others reported as many as 29 tension events, meaning that almost every session was tension laden for those cases. Table 4 shows similar trends in the descriptive data for the cases who dropped out.

**Table 4: Descriptive data of the variables “PSQ,” “Tens,” and “Narr” for the sample of drop-outs**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Patient</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>PSQ</td>
<td>6.45</td>
<td>(5.57)</td>
</tr>
<tr>
<td>Tens</td>
<td>3.45</td>
<td>(4.91)</td>
</tr>
<tr>
<td>Narr</td>
<td>4.63</td>
<td>(5.26)</td>
</tr>
</tbody>
</table>

PSQ = Frequency of return of Post-Session Questionnaires, Tens = Frequency of reporting tension
Narr = Frequency of writing a narrative describing the tension reported

The mean number of sessions for which both participants within the dyad experienced tension and wrote a narrative to describe it, instances of the so-called “corresponding narratives,” was computed in addition to the descriptive data presented in Tables 3 and 4, and is presented in Table 5. There were on average 4.75 (SD = 3.57) “corresponding narratives” for the cases which completed treatment, which means that on average, that is the amount of sessions both participants experienced as rupture sessions and wrote a narrative describing the tension in a
particular session. The average number of “corresponding narratives” was 2.55 ($SD = 4.95$) for the sample of drop-out cases.

Table 5: Descriptive data of “corresponding narratives”

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>M</th>
<th>$SD$</th>
<th>min</th>
<th>max</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corres</td>
<td>1</td>
<td>4.75</td>
<td>(3.57)</td>
<td>0</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2.55</td>
<td>(4.95)</td>
<td>0</td>
<td>17</td>
<td>11</td>
</tr>
</tbody>
</table>

Corres = corresponding narratives; Group 1 = cases which completed treatment, Group 2 = drop-out cases

The paired t-tests to compare data of patients and therapists within the dyad which were performed on the aggregated means of the predictor variables “PSQ,” “Tens,” and “Narr” in addition to a paired t-test of aggregated means on the proportion of “corresponding narratives” to the number of total narratives patients and therapists reported are presented next. These paired t-tests were conducted to determine whether the differences in means and standard deviations observed between patients and therapists in the descriptive data presented in Tables 3, 4 and 5 were also statistically significant. A negative statistically significant t-value indicates that therapists exceeded patients significantly on the variable; while a positive t-value indicates that patients exceeded therapists on that variable. Table 6 shows that there was a statistically significant difference between patients and therapists on these variables when the aggregated means were compared. Therapists returned PSQs significantly more regularly after the session ($t=-2.27$), and reported tension in them significantly more often than did patients ($t=-3.57$). The comparison of patients and
therapists on “r Narr” was near significance (t=-1.94), meaning that therapists had the tendency to follow up each report of tension with a narrative describing that tension more regularly than did patients. The significance of the “r Corres” indicated that when patients wrote a narrative about tension in a session, their therapist had almost always a “corresponding narrative” for the same session. This finding is not surprising considering that therapists reported episodes of tension more often than did patients and described such tension by writing about it.

Table 6: Paired t-tests of the aggregated means of the “PSQ,” “Tens,” “Narr,” and “Corres” variables

| Variable | Group | Patient | | Therapist | | | | | | | | | N | |
|----------|-------|---------|---------|-----------|---------|-------|-------|-------|-----------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
|          |       | M       | SD      | M         | SD      | t     | p     | N     |           |       |       |       |       |       |       |       |       |       |       |       |       |
| r PSQ    | 1     | .84     | (.17)   | .92       | (.08)   | -2.27 | <.05  | 28    |           |       |       |       |       |       |       |       |       |       |       |       |       |
|          | 2     | .21     | (.12)   | .32       | (.25)   | -1.45 | ns    | 11    |           |       |       |       |       |       |       |       |       |       |       |       |       |
| r Tens   | 1     | .31     | (.25)   | .51       | (.18)   | -3.57 | .001  | 26    |           |       |       |       |       |       |       |       |       |       |       |       |       |
|          | 2     | .50     | (.43)   | .73       | (.19)   | -1.58 | ns    | 10    |           |       |       |       |       |       |       |       |       |       |       |       |       |
| r Narr   | 1     | .93     | (.14)   | 1.00      | (.11)   | -1.94 | ns*   | 26    |           |       |       |       |       |       |       |       |       |       |       |       |       |
|          | 2     | .96     | (.09)   | 1.00      | (.00)   | -1.00 | ns    | 8     |           |       |       |       |       |       |       |       |       |       |       |       |       |
| r Corres | 1     | .68     | (.23)   | .38       | (.27)   | 3.56  | <.01  | 26    |           |       |       |       |       |       |       |       |       |       |       |       |       |
|          | 2     | .67     | (.39)   | .44       | (.37)   | 1.16  | ns    | 8     |           |       |       |       |       |       |       |       |       |       |       |       |       |

N= Number of dyads; r PSQ= PSQs filed in proportion to the number of total sessions attended by the participant, r Tens= sessions reported as tension sessions in proportion to the total number of PSQs returned by the participant, r Narr= narratives written in proportion to the total number of tension events reported by the participant, r Corres= corresponding narratives in proportion to the total number of narratives written by the participant; Group 1= cases which completed treatment, Group 2= drop-outs, * indicates near significance (between .05 and .1)

After these preliminary analyses and data descriptions were conducted to provide an overview of the data, GEE analyses were conducted to examine the extent to which these predictor variables were associated with session effectiveness as rated by
patients and therapists, and the extent to which they were associated with the
composite measure of overall treatment outcome. These results of the GEE analyses
are presented in Tables 7, 8 and 9 to answer Hypothesis #1.

Table 7: GEE on the relationship between the “PSQ,” “Tens,” and “Narr”
variables and session outcome ratings by patients

<table>
<thead>
<tr>
<th></th>
<th>Patient on Helping or Hindering</th>
<th>Patient on Depth of Session</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>PSQ</td>
<td>Pt</td>
<td>-.07</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>-.01</td>
</tr>
<tr>
<td>Tens</td>
<td>Pt</td>
<td>-.47</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>-.32</td>
</tr>
<tr>
<td>Narr</td>
<td>Pt</td>
<td>-1.10</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.67</td>
</tr>
</tbody>
</table>

Pt = Patient, Th = Therapist; N1 = Number of observations, N2 = Number of dyads; * indicates near significance (between .05 and .1)

Table 7 presents data demonstrating a significant relationship between patients’
tension reporting and patients’ rating of the session as more hindering. There was
also a significant relationship between therapists’ tension reporting and patients’
rating of the session as more hindering as well as less deep. When patients actually
wrote a narrative describing the tension, they seemed to have experienced the session
not only as significantly more hindering but also as significantly less deep. These
partial findings do not support Hypothesis #1 stating that patients’ reporting and
writing about tension may promote better outcome. Rather, for patients, writing
seems to be associated with the presence of rupture and documents a great
dissatisfaction with the session.
Table 8: GEE on the relationship between the “PSQ,” “Tens,” and “Narr” variables and session outcome ratings by therapists

<table>
<thead>
<tr>
<th></th>
<th>Therapist on Helping or Hindering</th>
<th>Therapist on Depth of session</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>PSQ</td>
<td>Pt</td>
<td>-.05</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>-.08</td>
</tr>
<tr>
<td>Tens</td>
<td>Pt</td>
<td>.04</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>-.39</td>
</tr>
<tr>
<td>Narr</td>
<td>Pt</td>
<td>-.34</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.30</td>
</tr>
</tbody>
</table>

Pt = Patient, Th = Therapist; N1 = Number of observations, N2 = Number of dyads; * indicates near significance (between .05 and .1)

Table 8 above showed that the only significant relationship found was between therapists' tension reporting and how hindering the session was perceived to be by them. Therapists who reported tension in a session described that session as hindering. There was a trend toward significance between patients' reporting of tension and therapists' rating of sessions with tension as deeper than the average session. Table 9 below presents the results for the relationship between the predictor variables and overall treatment outcome. A number of values were identified as "estimates diverging" and GEE analyses were consequently not performed. This situation occurs when, after several attempts, the procedure could not estimate the constant and the error terms in the regression analysis, because the values did not converge. The GEE procedure fails in other instances as well: when there is a problem of collinearity in the data set, or when the correlations obtained between
predictor and criterion variables are greater than the number one (which is statistically impossible).

Table 9: GEE on the relationship between the “PSQ,” “Tens,” and “Narr” variables and overall treatment outcome

<table>
<thead>
<tr>
<th></th>
<th>Coef</th>
<th>z</th>
<th>p</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSQ</td>
<td>Pt</td>
<td>e.d.</td>
<td>e.d.</td>
<td>e.d.</td>
<td>e.d.</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>e.d</td>
<td>e.d</td>
<td>e.d</td>
<td>e.d</td>
</tr>
<tr>
<td>Tens</td>
<td>Pt</td>
<td>e.d</td>
<td>e.d</td>
<td>e.d</td>
<td>e.d</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.00</td>
<td>.21</td>
<td>ns</td>
<td>697</td>
</tr>
<tr>
<td>Narr</td>
<td>Pt</td>
<td>-.004</td>
<td>-.27</td>
<td>ns</td>
<td>198</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.003</td>
<td>2.52</td>
<td>.01</td>
<td>396</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads; e.d.= estimates diverging

Table 9 however did indicate that therapists’ writing of narratives was related to a higher composite score, which means poorer overall treatment outcome.

3. Hypothesis #2

Hypothesis #2 stated that the narratives about tension as reported by patients and therapists will be relatively higher on dimensions of Concreteness and Specificity in sessions rated as more effective by the participants. The GEE analyses are presented next to answer Hypothesis #2. As a reminder, the GEE used all available observations from the 28 dyads which completed treatment. Table 10 indicates that neither dimension of “Concreteness” nor “Specificity” in the narratives
of either therapists or patients bear a relationship to patients’ perceptions of session
effectiveness.

Table 10: GEE of the relationship between “Concreteness” and “Specificity,”
and session outcome ratings by patients

<table>
<thead>
<tr>
<th></th>
<th>Patient on Helping or Hindering</th>
<th>Patient on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>Con</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>-.10</td>
<td>-1.47</td>
</tr>
<tr>
<td>Th</td>
<td>-.06</td>
<td>-1.08</td>
</tr>
<tr>
<td>Spe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.09</td>
<td>.89</td>
</tr>
<tr>
<td>Th</td>
<td>-.09</td>
<td>-1.42</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads

Table 11: GEE of the relationship between “Concreteness” and “Specificity,”
and session outcome ratings by therapists

<table>
<thead>
<tr>
<th></th>
<th>Therapist on Helping or Hindering</th>
<th>Therapist on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>Con</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>-.05</td>
<td>-.80</td>
</tr>
<tr>
<td>Th</td>
<td>.12</td>
<td>2.17</td>
</tr>
<tr>
<td>Spe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.08</td>
<td>.92</td>
</tr>
<tr>
<td>Th</td>
<td>.10</td>
<td>1.77</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads; * indicates near significance (between .05 and .1)

Table 11 on the other hand showed that the levels of “Concreteness” in therapists’
narratives bear a significant relationship to their own ratings of the sessions as more
helping. “Specificity” levels in their narratives showed a similar trend, not only on
their rating of the session as more helping but also on their impression of the session
as a deeper one, yet fell short of statistical significance. Hypothesis #2 was partially
supported for the “Concreteness” dimension in therapists’ narratives. Because of the
significant finding on “Concreteness” in therapists’ narratives on the session outcome level (as reported previously in Table 11), it was interesting to examine the relationship of this dimension to overall treatment outcome, although it was not originally part of Hypothesis #2.

Table 12: GEE of the relationship between “Concreteness” and “Specificity,” and overall treatment outcome

<table>
<thead>
<tr>
<th>Composite measure</th>
<th>Coef</th>
<th>z</th>
<th>p</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Con</td>
<td>Pt</td>
<td>-.009</td>
<td>-1.59</td>
<td>ns</td>
<td>183</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.00</td>
<td>-.75</td>
<td>ns</td>
<td>372</td>
</tr>
<tr>
<td>Spe</td>
<td>Pt</td>
<td>-.009</td>
<td>-1.29</td>
<td>ns</td>
<td>183</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.00</td>
<td>.08</td>
<td>ns</td>
<td>371</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads

The GEE analyses testing for a relationship between the two dimensions and overall treatment outcome indicated that neither “Concreteness” nor “Specificity” in the narratives of either therapist or patient were associated with overall treatment outcome (as shown in Table 12 above). The significance of “Concreteness” to the session outcome level did not generalize to the level of overall outcome.

4. **Hypothesis #3**

Hypothesis #3 stated that the more evenly distributed the blame for the tension between self and other, the better the session as well as overall outcome.
Table 13 presents the GEE analyses on the relationship of these predictor variables to session outcome ratings of patients, and Table 14 presents their relationship to session outcome ratings of therapists.

Table 13: GEE of the relationship between “Self-blame,” “Other-blame,” and “Blame ratio,” and session outcome ratings by patients

<table>
<thead>
<tr>
<th></th>
<th>Patient on Helping or Hindering</th>
<th>Patient on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>SB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>-1.87</td>
<td>-1.55</td>
</tr>
<tr>
<td>Th</td>
<td>-.05</td>
<td>-.90</td>
</tr>
<tr>
<td>OB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.048</td>
<td>.40</td>
</tr>
<tr>
<td>Th</td>
<td>-.19</td>
<td>-2.11</td>
</tr>
<tr>
<td>Blame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.11</td>
<td>1.06</td>
</tr>
<tr>
<td>Th</td>
<td>.008</td>
<td>.16</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; SB= Self-blame, OB= Other-blame, Blame= Blame ratio of Other-blame to Self-blame; N1= Number of observations, N2= Number of dyads

Table 14: GEE of the relationship between “Self-blame,” “Other-blame,” and “Blame ratio,” and session outcome ratings by therapists

<table>
<thead>
<tr>
<th></th>
<th>Therapist on Helping or Hindering</th>
<th>Therapist on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>SB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>-.03</td>
<td>-.61</td>
</tr>
<tr>
<td>Th</td>
<td>-.18</td>
<td>-2.96</td>
</tr>
<tr>
<td>OB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>-.02</td>
<td>-.35</td>
</tr>
<tr>
<td>Th</td>
<td>.02</td>
<td>.44</td>
</tr>
<tr>
<td>Blame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.06</td>
<td>.90</td>
</tr>
<tr>
<td>Th</td>
<td>.07</td>
<td>1.32</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; SB= Self-blame, OB= Other-blame, Blame= Blame ratio of Other-blame to Self-blame; N1= Number of observations, N2= Number of dyads; * indicates near significance (between .05 and .1)
Table 13 showed that therapists’ level of attribution of blame to the other (the patient) was related to patients experiencing the session as significantly more hindering and less deep. Table 14 showed that therapists assuming more “Self-blame” for the tension in the session was significantly related to them experiencing the session as more hindering as well as less deep. In contrast, therapists blaming the other (the patient) for the tension was significantly associated with therapists experiencing the session as deeper. The “Blame ratio” of “Other-blame” to “Self-blame” did not reveal any significant impact of this variable on session outcome.

Table 15: GEE of the relationship between “Self-blame,” “Other-blame,” and “Blame ratio,” and overall treatment outcome

<table>
<thead>
<tr>
<th></th>
<th>Composite measure</th>
<th>Coef</th>
<th>z</th>
<th>p</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>SB</td>
<td></td>
<td>Pt</td>
<td>-.01</td>
<td>-1.59</td>
<td>ns*</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Th</td>
<td>.00</td>
<td>.37</td>
<td>ns</td>
<td>372</td>
</tr>
<tr>
<td>OB</td>
<td></td>
<td>Pt</td>
<td>.008</td>
<td>1.54</td>
<td>ns*</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Th</td>
<td>.00</td>
<td>.81</td>
<td>ns</td>
<td>372</td>
</tr>
<tr>
<td>Blame</td>
<td></td>
<td>Pt</td>
<td>.016</td>
<td>2.20</td>
<td>&lt;.05</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Th</td>
<td>.00</td>
<td>.05</td>
<td>ns</td>
<td>372</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; SB= Self-blame, OB= Other-blame, Blame Blame ratio of Other-blame to Self-blame; N1= Number of observations, N2= Number of dyads; * indicates near significance

Table 15 indicated that the higher the patients’ “Blame ratio” was (the more blame patients placed on their therapists for the tension experienced in the session), the higher the composite measure score, indicating worse overall treatment outcome.
5. **Hypothesis #4**

Hypothesis #4 stated that the presence of shifts in patients’ narratives from an impersonal to a personal stance as measured by the presence in the narrative of the first name, name or initials of the other person in the dyad will predict greater levels of relatedness between the participants and better session as well as overall treatment outcome. This hypothesis was expected to apply primarily for patients. GEE analyses were conducted to examine the relationship of this variable to all three criterion variables.

**Table 16: GEE of the relationship between “Name” and session outcome ratings by patients**

<table>
<thead>
<tr>
<th></th>
<th>Patient on Helping or Hindering</th>
<th>Patient on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.62</td>
<td>2.03</td>
</tr>
<tr>
<td>Th</td>
<td>-.19</td>
<td>.28</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads, * indicates near significance (between .05 and .1)

Table 16 indicated that patients’ use of first name, name or initials of their therapists in their narratives was associated with the patients perceiving the session as significantly more helping (but not deeper).

**Table 17: GEE of the relationship between “Name” and session outcome ratings by therapists**

<table>
<thead>
<tr>
<th></th>
<th>Therapist on Helping or Hindering</th>
<th>Therapist on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.14</td>
<td>.79</td>
</tr>
<tr>
<td>Th</td>
<td>-.22</td>
<td>-1.19</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads
Table 17 indicated that there was a significant relationship between use of patients' name by therapists and therapists' perceptions of the session as less deep. This is an interesting unexpected result. Hypothesis #4 was initially conceptualized to examine patient’s use of therapist’s names as an indicator of increased relatedness on the part of the patients and findings reported in Table 17 supported that on the session outcome level.

**Table 18: GEE of the relationship between “Name” and overall treatment outcome**

<table>
<thead>
<tr>
<th>Composite measure</th>
<th>Coef</th>
<th>z</th>
<th>p</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name Pt</td>
<td>-.03</td>
<td>-1.36</td>
<td>ns</td>
<td>187</td>
<td>23</td>
</tr>
<tr>
<td>Th</td>
<td>-.00</td>
<td>.03</td>
<td>ns</td>
<td>373</td>
<td>25</td>
</tr>
</tbody>
</table>

*Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads*

Table 18 indicated that there was no association between name use and overall treatment outcome, thereby failing to support Hypothesis #4 on this factor.

6. **Hypothesis#5**

Hypothesis #5 stated that the presence of shifts over time from a personal to an impersonal stance to refer to oneself or to the other person in the dyad will indicate a decrease in the relatedness level and will predict poorer session outcome as well as overall treatment outcome. GEE analyses were conducted to examine the relationship between these predictor variables and the outcome variables. Table 19 presents the GEE analyses of the relationship between the predictor variables “Third,” the use of
third person to refer to oneself, and "Shift," the shift to an impersonal stance after having used the name of the other in the dyad, and session outcome as perceived by the patient.

**Table 19: GEE of the relationship between "Third" and "Shift," and session outcome ratings by patients**

<table>
<thead>
<tr>
<th></th>
<th>Patient on Helping or Hindering</th>
<th>Patient on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>Third</td>
<td>Pt</td>
<td>2.28</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.21</td>
</tr>
<tr>
<td>Shift</td>
<td>Pt</td>
<td>-.69</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>-.02</td>
</tr>
</tbody>
</table>

*Pt = Patient, Th = Therapist; N1 = Number of observations, N2 = Number of dyads*

**Table 20: GEE of the relationship between "Third" and "Shift" and session outcome ratings by therapists**

<table>
<thead>
<tr>
<th></th>
<th>Therapist on Helping or Hindering</th>
<th>Therapist on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>Third</td>
<td>Pt</td>
<td>.40</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>-.47</td>
</tr>
<tr>
<td>Shift</td>
<td>Pt</td>
<td>1.80</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.18</td>
</tr>
</tbody>
</table>

*Pt = Patient, Th = Therapist; N1 = Number of observations, N2 = Number of dyads; * indicates near significance level (between .05 and .1)*

Table 20 presented the relationship between the predictor variables to session outcome as perceived by the therapist. A word of caution regarding those two variables: The observations of patients using those forms of speech were negligible, this was noticed as the present author was conducting the count on the raw data at the beginning of the project. Results in the following tables have been affected by what
is called "outliers" in statistics, which were here the rare cases which used "Third" and "Shift," thereby skewing results in a certain direction and influencing the outcome of the analyses. In other words, the rare instances (one or two) when those two variables were used in patients' narratives led to the obtained the statistical significance. Only the sections regarding therapists' narratives were therefore considered. In Tables 19 and 20, findings demonstrated that none of the two variables, "Third" or "Shift," were related to patients' ratings of session effectiveness. In Table 20, therapists' use of third person to refer to the self was related to therapists rating the session as significantly more hindering.

**Table 21: GEE analyses of the relationship between "Third" and "Shift," and overall treatment outcome**

<table>
<thead>
<tr>
<th></th>
<th>Composite measure</th>
<th>Coef</th>
<th>z</th>
<th>p</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third</td>
<td>Pt</td>
<td>.16</td>
<td>10.98</td>
<td>&lt;.001</td>
<td>188</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.001</td>
<td>1.34</td>
<td>ns*</td>
<td>372</td>
<td>25</td>
</tr>
<tr>
<td>Shift</td>
<td>Pt</td>
<td>1.08</td>
<td>1.08</td>
<td>ns</td>
<td>187</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.00</td>
<td>.87</td>
<td>ns</td>
<td>373</td>
<td>25</td>
</tr>
</tbody>
</table>

N1 = Number of observations, N2 = Number of dyads
* indicates near significance level (between .05 and .1)

Table 21 above showed the trend that therapists' use of the third person to refer to themselves was related to poorer overall treatment outcome, with the finding being in the direction of the prediction of Hypothesis #5.

7. Hypothesis #6
Hypothesis #6 stated that the presence of shifts over time from a first person stance to a “We, us, together…” stance will indicate a greater level of inclusiveness in the negotiation process and predict better session as well as overall treatment outcome. This hypothesis was predicted to be mainly true for therapists. GEE analyses were conducted to examine the relationship between the predictor variable and the three criterion variables.

**Table 22: GEE on the relationship between “We” and ratings of session outcome by patients**

<table>
<thead>
<tr>
<th></th>
<th>Patient on Helping or Hindering</th>
<th>Patient on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td>We Pt</td>
<td>Coef .35 z 1.55 p ns* N1 209 N2 26</td>
<td>Coef .11 z .60 p ns* N1 209 N2 26</td>
</tr>
<tr>
<td>Th</td>
<td>.14 z .89 p ns N1 316 N2 28</td>
<td>.21 z 1.32 p ns* N1 317 N2 28</td>
</tr>
</tbody>
</table>

Pt = Patient, Th = Therapist; N1 = Number of observations, N2 = Number of dyads; * indicates near significance level (between .05 and .1)

Table 22 showed that the use of the more inclusive “We” did not reach significance in relation to patients’ assessment of the session’s effectiveness. On the other hand,

**Table 23: GEE of the relationship between “We” and ratings of session outcome by therapists**

<table>
<thead>
<tr>
<th>Therapist on Helping or Hindering</th>
<th>Therapist on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td>We Pt</td>
<td>Coef .25 z -1.63 p ns* N1 185 N2 26</td>
</tr>
<tr>
<td>Th</td>
<td>.19 z 1.78 p ns* N1 395 N2 28</td>
</tr>
</tbody>
</table>

Pt = Patient, Th = Therapist; N1 = Number of observations, N2 = Number of dyads; * indicates near significance level (between .05 and .1)

Table 23 showed a significant relationship between therapists’ use of “We” and their own perception of the session as deeper, but it missed significance on the session being perceived as more helping. Hypothesis #6 was supported only on the session
outcome level. Table 24 below shows no significant relationship between the use of “We” and overall treatment outcome.

**Table 26: GEE of the relationship between “We” and overall treatment outcome**

<table>
<thead>
<tr>
<th>Composite measure</th>
<th>Coef</th>
<th>z</th>
<th>p</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>We Pt</td>
<td>.006</td>
<td>.43</td>
<td>ns</td>
<td>187</td>
<td>23</td>
</tr>
<tr>
<td>Th</td>
<td>.00</td>
<td>.22</td>
<td>ns</td>
<td>373</td>
<td>25</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads

8. **Hypothesis #7**

Hypothesis #7 stated that the more evenly distributed the “Self” to “Other-referents” (Objectivity to Subjectivity), the better the session as well as overall treatment outcome. GEE analyses were conducted to answer Hypothesis #7 on the relationship between the predictor and the criterion variables. Table 25 and 26 present findings on the relationship between the predictor variables “I-referents,” “Other-referents” and the ratio of the two, and session outcome as rated by patients and therapists respectively. Table 27 summarizes findings regarding the relationship of these predictor variables to overall treatment outcome. Table 25 indicates a statistically significant relationship between greater use of “Other-referents” by therapists and the session being perceived as more hindering and less deep by patients. Furthermore, the ratio of “Other” to “I-referents” was significantly positively related to patients’ perception of the session as more helping.
Table 25: GEE of the relationship between “I-referents,” “Other-referents” and the “Ratio” of Other/I-referents and session outcome rating by patients

<table>
<thead>
<tr>
<th></th>
<th>Patient on Helping or Hindering</th>
<th>Patient on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>-.005</td>
<td>-.16</td>
</tr>
<tr>
<td>Th</td>
<td>-.06</td>
<td>-1.54</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.14</td>
<td>1.71</td>
</tr>
<tr>
<td>Th</td>
<td>-.06</td>
<td>-2.44</td>
</tr>
<tr>
<td>Ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.56</td>
<td>1.90</td>
</tr>
<tr>
<td>Th</td>
<td>-.01</td>
<td>-.22</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads; * indicates near significance level (between .05 and .1)

Table 26 indicates that therapists’ use of “Other-referents” was related to their own perception of the session as deeper, a finding that is in the opposite direction to patients’ perceptions of the session (see Table 25) who instead felt that a greater use of “Other-referents” in therapists’ narratives, the more patients perceived that session to be hindering and less deep.

Table 26: GEE of the relationship between “I-referents,” “Other-referents” and the “Ratio” of Other/I-referents and session outcome ratings by therapists

<table>
<thead>
<tr>
<th></th>
<th>Therapist on Helping or Hindering</th>
<th>Therapist on Depth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef</td>
<td>z</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.01</td>
<td>.47</td>
</tr>
<tr>
<td>Th</td>
<td>.00</td>
<td>.01</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.06</td>
<td>.96</td>
</tr>
<tr>
<td>Th</td>
<td>.00</td>
<td>.41</td>
</tr>
<tr>
<td>Ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.08</td>
<td>.48</td>
</tr>
<tr>
<td>Th</td>
<td>-.00</td>
<td>-.02</td>
</tr>
</tbody>
</table>

Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads; * indicates near significance (between .05 and .1)
Table 26 also indicated that a higher ratio of “Other” to “I-referents” in therapists’ narratives was associated with therapists’ impression of the session as deeper.

**Table 29: GEE of the relationship of “I-referents,” “Other-referents,” and the “Ratio,” and overall outcome**

<table>
<thead>
<tr>
<th></th>
<th>Coef</th>
<th>z</th>
<th>p</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Pt</td>
<td>-.003</td>
<td>-.63</td>
<td>ns</td>
<td>188</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.00</td>
<td>1.31</td>
<td>ns*</td>
<td>372</td>
</tr>
<tr>
<td>Other</td>
<td>Pt</td>
<td>.002</td>
<td>.34</td>
<td>ns</td>
<td>188</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>.00</td>
<td>.33</td>
<td>ns</td>
<td>372</td>
</tr>
<tr>
<td>Ratio</td>
<td>Pt</td>
<td>.03</td>
<td>.88</td>
<td>ns</td>
<td>146</td>
</tr>
<tr>
<td></td>
<td>Th</td>
<td>-.00</td>
<td>-1.50</td>
<td>ns</td>
<td>257</td>
</tr>
</tbody>
</table>

*Pt= Patient, Th= Therapist; N1= Number of observations, N2= Number of dyads

Table 27 showed that none of these variables reached significance in relation to overall treatment outcome, thereby failing to support Hypothesis #7. Only therapists’ use of “I-referents” showed a trend toward being related to a higher composite measure, indicating poorer overall treatment outcome.

9. **Summary of findings**

The summary of the results as they pertain to answering the seven hypotheses is presented next:

**Hypothesis #1**: was neither supported on the session outcome level nor on the overall treatment outcome level: Reporting tension and writing narratives about tension were associated with lower session effectiveness ratings by both patients and
therapists. Therapists’ frequency of writing narratives was also associated with poorer overall treatment outcome.

**Hypothesis #2** was partially supported on the session outcome level only, for the dimension Concreteness, but not Specificity: Therapists’ level of Concreteness was predictive of a higher effectiveness rating of the session (more helping) by the therapists themselves only.

**Hypothesis #3** was partially supported on the overall outcome level. Only patients’ Blame ratio (ratio of Other-blame to Self-blame), reflecting the lack of shared blame, was associated with poorer overall treatment outcome.

**Hypothesis #4** was partially supported on the session outcome level. Patients’ use of the name of their therapists (the main focus of this hypothesis) was associated with the patients rating the sessions as more helpful (but did not reach significance on their ratings of the sessions as deeper).

**Hypothesis #5** had to be examined only for therapists’ narratives because patients hardly used the predictor variables “Third” and “Shift” in their narratives. Findings did not reach significance but indicated a trend towards the prediction of this hypothesis but only for therapists’ use of “therapist” instead of first person pronouns to refer to themselves.

**Hypothesis #6** was partially supported on the session outcome level only. The main focus was on how therapists’ use of “We” might affect outcome. Therapists’ use of “We” was associated with therapists’ perception of the session as deeper. Near
significance values were found for patients’ ratings of these sessions as deeper as well.

**Hypothesis #7** was not supported. Therapists’ use of more “Other-referents” than “I-referents” (the ratio) was associated with them rating the session as deeper, whereas patients’ use of more “Other-referents” than “I-referents” was associated with patients’ rating of the session as more helping. There was no evidence of a more even use between “Other-referents” and “I-referents” as being associated with better outcome. The only overall treatment outcome finding (near significance) was that the more therapists used “I-referents” in their narratives, the poorer the overall treatment outcome.
CHAPTER V

DISCUSSION

This study extends prior knowledge about the psychotherapeutic process, specifically the negotiation of tension within session, through the microanalysis of short written narratives by patient and therapist dyads. Narratives, describing tension between therapists and patients, were obtained as part of the data collected for the Brief Relational Therapy at Beth Israel Medical Center, New York, and were analyzed in this study. The aims of the study were: first, to determine how the process of reporting tension and writing about tension might reflect the extent of participants’ engagement in the process of therapy; and second, how changes in the usage of language in this type of written communication were possible markers of changes or shifts in the therapy process itself and perhaps also were an indication that some of the Brief Relational Therapy metacommunication principles have been “assimilated” in better outcome cases (Stiles and Elliott, 1990: refer to the quote on p.6 for a discussion on the process of assimilation).
The hypotheses examined in this study were based upon several principles of metacommunication used in Brief Relational Therapy. These hypotheses explored the relationships between several factors: the presence of linguistic characteristics (Concreteness, Specificity), shifts indicative of changes in the levels of relatedness (increase and decrease of relatedness), inclusion of the other person in the negotiation process about tension in the session, and the sharing of blame for the tension as presented in the narratives, and session as well as overall treatment outcome. A discussion of the findings will be presented next: It will take into account an appraisal of the predictor and criterion variables and how the findings relate to each of the BRT metacommunication principles borrowed for this project. An evaluation of the instruments used, theoretical and clinical implications of the study’s findings, the study’s methodological limitations, as well as directions for future studies will be considered in this chapter.

1. Discussion of the findings

1.1 Participants’ engagement in the therapy process

The study revealed that it was therapists who cooperated in returning the Post-Session Questionnaires more regularly than did patients. Therapists also reported more tension within session and more often wrote narratives about it on the questionnaires than did patients, perhaps suggesting that therapists were aware of tension within the
session and were willing to acknowledge its presence. The reasons why so many more sessions were perceived by therapists as “rupture” sessions might include: (1) that because treatment was provided in the context of this research program, therapists had an “insider” view on the purpose of the project and were sensitized to the identification of ruptures, or (2) that therapists were conscientious about their participation in the research project, specifically in the accurate completion of forms. Therapists might also have been conscientious about reporting tension within a session, because sessions were videotaped and reviewed by colleagues which serves as a means of supervision. Patients’ tension reporting was more rare but also revealing in many ways. Patients might have been more guarded about reporting difficulties in the treatment, as some literature has previously documented, in that it may be sometimes more challenging for patients, and for therapists too, to give feedback about “hindering” events rather than “helping” ones (Litaer, 1992). One may speculate about why it might be challenging for patients in particular to give feedback on self-report questionnaires when the event is perceived as hindering: it could be fear of confrontation, defensiveness about the treatment, or reluctance to put extra effort into writing a narrative, while responding to items on a likert scale may not require such effort etc. Litaer (1992) has wondered whether patients dared to write about the negative, although they were reassured that their comments would not be read by their therapists. Rennie (1990) stated that patients’ reluctance to criticize their therapist may be due to intrapsychic barriers. In any case, when patients did report tension in the
present study and wrote about it, their narratives were clear expressions of their dissatisfaction with the session. The only significant result regarding the association between the writing of narratives describing tension and overall treatment outcome indicated that the more frequently therapists reported tension in a narrative, the poorer the treatment outcome of the particular case. This can mean several things, for example, that therapists’ perceptions were correct, that in fact there were significant problems in the alliance with a particular patient, which remained unresolved by the end of treatment. Perhaps therapists’ elaboration of narratives were a reflection of the extent of the tension between therapist and patient and their concerns about it. Another explanation might be that the perception of the therapist differed from that of the patient with the therapist identifying problems and tensions inaccurately and writing about them. It remains unclear whether therapists over-reported or whether patients under-reported tension.

1.2 Language usage as marker of shifts in the process

From patients’ perspectives, what was associated with more helpful sessions were narratives in which patients mentioned the name of their therapist, and narratives including more reference to others (the therapist) than to themselves. What seems to have been associated with more hindering sessions according to patients was blame for the tension in the session being attributed primarily to them by the therapist.
From therapists’ perspectives, the element associated with the perception of a session as more helpful was the level of “Concreteness” with which they expressed themselves about the tension in their narratives, their use of “We” in the narrative, and surprisingly, blaming of the patient for the tension. What was associated with a worse rating of the session (either less helpful, or less deep) was therapists referring to themselves as “therapist” instead of “I”, the level of “Self-blame” in the narratives, as well as their use of the patient’s name, quite surprisingly.

On the overall treatment outcome level, one characteristic found in the narratives had a relationship to poorer outcome: When patients attributed more blame for the tension to the therapist than to themselves. Some speculation about the reasons for these findings is presented next.

1.2.1 “Concreteness” and “Specificity”

The finding on “Concreteness” was embedded in 15 non significant findings, therefore it needs to be considered with caution as it may be due to chance. “Concreteness” is defined as the more “visceral” dimension among the four within the Referential Activity scale (Bucci, 1985). The definition of “Concreteness,” as a reminder, is that “it reflects perceptual or sensory quality, the extent to which verbal expressions refer to sensate properties of actual things or events or to anything that is experienced as sensation or feeling. This may include reference to imagery in any sense modality; somatic or visceral experience; or representations of motoric activity,
e.g. any components of the nonverbal representation and processing systems” (Bucci & Mc Ray, 1992, pp.45). If we refer to a few of the narratives written by therapists and examine several which obtained higher scores than others on the dimension of “Concreteness,” then perhaps some light might be shed on why narratives high on this dimension were related to better session effectiveness ratings by the therapists in the present study. In one narrative that was rated a level 6, one of the highest scores in the study, a therapist described the tension experienced in the session as follows: “Patient always appears tense and guarded during the sessions. Appeared less annoyed than last session, calmer, but was still not relaxed, with some hostility.” Another narrative which had been scored a level 5 was as follows: “Patient looked at me very intensely. It felt strange and intense so I addressed it.” Perhaps during such sessions, therapists were themselves more intensely reacting to the patient. Generally, the narratives bearing more “Concreteness” were also scored high on “Specificity.” “Specificity” levels in therapists’ narratives nevertheless missed statistical significance in relation to session outcome ratings on effectiveness, and neither dimension was significant in relation to overall treatment outcome. It may be that therapists use more concrete and specific language in their narratives in accordance with their professional training, and manualized training in BRT: One principle of metacommunication explored in this study calls on therapists to use specific and concrete language to negotiate rupture in the session in order to reduce abstractions and intellectual speculation in the dialogue. It may also simply be that therapists are in general trained to write clinical progress
notes in a specific and concrete manner and that might have influenced their writing style in the narratives under study.

1.2.2 Blame attribution

When therapists assumed blame for the tension in the session, it was associated with a less helpful, more shallow session according to them. This contradicted the principle of metacommunication calling on therapists to accept their own contribution to the interaction, which had been examined in this study in the levels of blame attribution. The main finding on the dimension of blame attribution was the relationship between patients assuming less blame for the tension compared to the extent to which they blamed their therapists for it, and poorer overall treatment outcome. One could speculate about the reasons for these findings: First, lack of acknowledgment on the part of the patients of their contribution to the problems and tensions which arise between them and their therapist might be indicative of a passive, dependent, hostile or defensive position on their part. This in turn would make the treatment a greater challenge for the treating clinician than the treatment of patients who have a perspective on what they might have done wrong in the interaction and are willing to negotiate difficulties in the ongoing process between them and their therapist. Second, patients may be taking such position of defensiveness in reaction to how they are being treated by their therapist. If feeling blamed by their therapist for what goes wrong in the session, they are more likely to “sulk,” and be defensive, a
reactive attitude described in the Structural Analysis of Social Behavior (SASB; Benjamin, 1974).

1.2.3 **Shifts in relatedness levels**

BRT metacommmunication principles discussed previously call on therapists to monitor subtle shifts in relatedness. Several findings in this study supported that notion. One was the finding on the use of first name of the therapist by the patient, as a sign of having experienced the session as more helpful, as was hypothesized. Patients’ names being mentioned in the therapists’ narratives however was related to sessions that were perceived by therapists as lacking depth. Mentioning patients’ names in the narratives seem to have been an exception to the rule. Therapists usually write more formally about their patients in progress notes, and rarely mention names for confidentiality reasons.

A second finding in this study seemed to support the BRT metacommmunication principle regarding “establishing a sense of “we-ness” which calls on inviting the patient to join the therapist in an attempt to understand any shared dilemma. When used by therapists in their narratives, the words “we, us, together…” were associated with deeper sessions according to the therapists but not to patients. This showed that therapists might well be using the principle of “we-ness” to engage the patient on a more equal basis but it is unclear whether that is what matters to the patients themselves.
1.2.4 Subjectivity/objectivity

The principle of emphasizing one’s subjectivity when making comments to the patient by using statements like “What occurs to me…” was difficult to trace in the narratives. A near significance finding indicated that the more therapists used first person referents in their narratives, the poorer the overall outcome of the case. It is unclear whether this was because “I” statements in the narratives were typically an expression of the therapists being focused on themselves rather than on their patients, in that case, such “I” statements did not indicate an effort to be using strategies like the quote used above, but a self-absorption on the part of the therapist that might have been hindering to the process.

2. Methodological limitations

This study had several methodological limitations that will be considered in this section.

2.1 Few overall treatment outcome findings

There were many more findings on the session outcome level than the overall outcome level. This has been noted by several psychotherapy researchers who faced the same limitations when conducting their studies. Several authors have warned against the meaningfulness of conducting psychotherapy research in examining correlations between certain variables and final outcome (Stiles, Shapiro & Harper, 1994; Greenberg, 1994). They emphasized that the problem of frequency versus
intensity of a particular phenomenon under study presents itself in psychotherapy research. This has been called the correlation-criterion problem, also referred to as the “drug metaphor.” More precisely, “it has been assumed that if a particular process component is therapeutically active, then lower incidence leads to poorer outcome and higher to better, therefore the process and outcome should be correlated across clients. Conversely, if its incidence is uncorrelated with outcome then that component was taken to be therapeutically inert” (Stiles, Shapiro, & Harper, 1994, pp.42). As mentioned above in the discussion of Litaer’s work, sometimes the dosage and the timing of the same kind of intervention is what could make that same intervention be perceived as “helping” or as “hinder ing.”

Many findings in the present study were not statistically significant. Stiles and his colleagues have also emphasized that improvement per se during treatment may enable some clients to tolerate more interpretation, more exploration of difficult issues, or confrontational interventions, and help them engage in deeper self-exploration. Therefore, a null correlation between predictor and criterion variables may be misleading because it does not suggest necessarily lack of efficacy. It overlooks wide variations in client requirements for particular process components, and therapists’ responsiveness to those requirements. Process-outcome will be attenuated, to the degree that therapists are responsive to client requirements and the levels of their interactions change with time (Stiles, Shapiro & Harper, 1994).
The present study had begun with suggestions of more recent psychotherapy research specifically meant to help avoid some of the pitfalls of psychotherapy research. Although the focus of this study has been on smaller in-session units of change, it seems to have faced similar limitations as many other psychotherapy process studies when it based its analyses on correlating predictor variables with criterion variables, particularly final outcome measures. The composite measure used in this study as a treatment outcome measure summarizes change between beginning and termination of treatment but does not give information about phenomena occurring in between. Such feedback exists and is to be found in the suboutcome data on the three thirds of the treatment duration. The reason such suboutcome data was not used in this study was the lack of consistency in the availability of tension narratives for each of the dyads for each of the thirds of the treatment duration.

2.2 Study instruments

It was particularly challenging to find existing instruments to rate the narratives on linguistic dimensions. Wilma Bucci’s Referential Activity Scale was felt to be one of the best choices at the time when the study was designed, to capture links between words and other levels of processing. The shortness of the narratives however was a challenge for raters who were used to more elaborate texts or transcripts. The RA scale had to be taken out of its theoretical context. This put a limit not only on the scope of the interpretation of the findings, but also on the possibilities to draw any parallels to
existing literature which have used that instrument more successfully. As an alternative, one could attempt rating the narratives by using Mc Carthy’s (1986) instrument. Perhaps it would be more adequate for rating such short narratives like the ones that were studied here. Mc Carthy’s instrument has been used in studies by Martin and colleagues (1988, 1990) for example, and includes classifications of Deep-Shallow, Elaborative-Nonelaborative, Personal-Impersonal, Clear-Vague and Conclusion Oriented-Descriptive Oriented, and such categories may have lent themselves to the exploration of this study’s hypotheses.

The Blame Attribution Scale seems to have been more robust and methodologically more sound. Interrater reliability was stable and high throughout the coding. Findings also seemed more meaningful in the context of theoretical and methodological considerations. Although the SASB as a rating instrument would have provided an even richer theoretical framework, the BAS seems to have been helpful and interesting to use for the purpose for which it was designed.

2.3 Limitations of some predictor and criterion variables

A pattern throughout the study became evident indicating that perhaps certain variables could or should not be studied in both participants’ narratives in the same way. The greatest difference seemed to occur on the use of third person instead of first person to refer to oneself in the narratives. Only therapists used it to express themselves. There were only one or two observations on this variable in the entire
sample of patients. It is frequently encountered that therapists refer to themselves as “therapist” or “present writer” instead of “I” in clinical progress notes for example. That seems to have been the case as well in the narratives examined in this study. It was not meaningful to test the presence of name use as a sign of increased relatedness in therapists’ narratives as much as it was in patients’ narratives.

Limitations regarding the predictor variables included that findings at times diverged between the ratings of the session on the “helping or hindering” dimension and the ratings on “depth.” This created some fragmentation in the reporting of the findings and complicated the interpretation of the results. The Session Evaluation Questionnaire (SEQ) used in its entirety (the two dimensions: depth and smoothness) might have been a better criterion variable, without the first item of the PSQ on helpfulness. Other research has proven that the SEQ is an appropriate and good instrument to capture session effectiveness (e.g. Stiles et al. 1990; Cummings et al. 1992a & 1992b).

2.4 Other methodological limitations

Other study limitations to be considered are the reduction of the original study sample from 39 dyads to the 28 dyads which completed treatment. Too little data were available for the 11 drop-out cases to allow for meaningful inferences about the reasons for dropping out, or for the analysis of shifts and changes in their narratives. Low statistical power made analyses of such scarce data uninformative. The only way
one could examine the drop-out cases was to examine whether their symptomatology or DSM-III-R or DSM-IV diagnoses at the beginning of treatment were indicative of a higher severity of problems that might have hastened dropping out of treatment. After visual inspection of the data, this was clearly not the case: Although, for example, three cases among the drop-outs had diagnoses such as Avoidant Personality Disorder, Phobias, or Paranoid Personality Disorder, three or more patients among the cases that remained in treatment had similar diagnoses. In general, in any kind of therapy, it is very difficult to attribute premature termination of treatment to any particular set of reasons. Each case may be different. One should not forget that some patients need shorter periods of treatment than others. Some of the drop-out cases in this study gave clear indication, by rating session effectiveness above average, that they were very satisfied with the few sessions they attended, and that they perhaps felt they did not need to continue treatment despite their involvement in a research protocol. Some researchers have commented on the fact that many patients report much improvement after the first four or five sessions (see extensive reviews in Messer & Warren, 1995).

3. Clinical implications of the study

The significant findings in this study showed that the observation of certain subtle shifts in the use of language during tense moments in a session is meaningful and reflects session outcome as examined in the narratives. Therapists are already sensitized to several levels of communication in the therapy, e.g. body language, tone.
of voice etc. This study also has indicated that subtle linguistic changes might also add to the therapists’ impression of the ongoing process. Therapists can be made aware of their presence and encouraged to monitor them, as signs of shifts in relatedness between them and the patient. The findings have some implications for Brief Relational Therapy as well as for the other modalities at the Brief Psychotherapy Project. First, it was particularly interesting to find that therapists and patients in BRT in particular have been responding to the self-report measures in such a different way, when they reported tension. If resolving rupture is at the heart of the BRT method, it would be important that therapists as well as patients know exactly what is meant by “rupture.” It seems that either therapists over-report or patients under-report such instances. Perhaps this is due to a lack of understanding of the concept itself, particularly on the part of therapists who are beginners in practicing BRT. Patients at least in the first phase of treatment, may be in the dark as to the meaning of “rupture” or what is really meant by “tension” on the Post-Session Questionnaire. Perhaps an early orientation of the patient to the BRT modality might be helpful, to reduce possible patients’ defensiveness for example, in their return of Post-Session Questionnaires, and their description of how they felt about the sessions. Another implication for BRT is the extent to which this study showed that although some principles of metacommunication might be used by the therapists who are implementing the BRT manual, it is important to keep the dialogue alive with the
patient who might be perceiving what is helping or hindering the process quite differently from the therapist.

4. Conclusion and suggestions for future studies

This dissertation has attempted to feel the “pulse” of the therapy process in the Brief Relational Therapy modality by using short written narratives of the participants and analyzing them linguistically. What could be the next step to the present study are studies which use the presence of a predictor variable in a narrative as a starting point for the exploration of the wider context of the session. For example patients’ narratives including the name of the therapist could be used to examine the corresponding session more thoroughly. This would provide additional information about the particularities of the case in such moments and examine whether the narrative was truly representative of a moment of increased relatedness between patient and therapist.

Future studies could also focus on longer narratives which could be possibly obtained if participants were provided with more space than is currently the case on the Post-Session Questionnaires to answer the open-ended questions. In another study, the 28 cases could be ranked along the dimension of best to worst outcome, and graphs of some of the best and worst outcome cases could be drawn to display the variations throughout the treatment on the predictor and criterion variables under
study. This seems particularly interesting for the predictor variables “Self-blame” and “Other-blame.”

It appeared that in the language used in the narratives by therapists and patients, the same linguistic variable could have different relevance depending on whether it was in a narrative written by a therapist or one written by a patient. The linguistic variables studied here, although inspired by several principles of metacommunication guiding the Brief Relational Therapy approach, were exploratory. Others could be examined with the therapists’ and the patients’ roles in mind. The BRT principles are after all addressed towards the therapists being trained in this particular modality, and are not meant to be practiced by the patients, but rather be helpful to the patients and to the patient-therapist dyads in untangling rupture moments in the therapy. Other principles could be studied in how they might be influencing therapists’ interventions in particular.

Language is contextually based, and to be able to tap more fully into that context and test whether the relationships found in this study between certain linguistic variables and outcome were a reflection of the ongoing process between the participants, it would be necessary to refer back to the actual narratives and to the corresponding sessions. A qualitative analysis of the narratives by reading and rereading the narrative series of a particular dyad and examining them for patterns, as advocated by Polkinghorne (1990), might be interesting and perhaps more revealing.
than a correlational study between the presence or absence of certain ingredients and outcome.

It would be interesting to compare the presence or absence of certain predictor variables in a sample of resolution sessions in contrast to a sample of nonresolution sessions (e.g. Safran, et al., 1994). Such sampling has been previously used by Safran and his colleagues on the basis of converging therapist and patient responses on the Post-Session Questionnaires.

Taking into account shorter segments of the treatment period would shed more light on the various phases of treatment, the beginning, middle, and end, because certain phenomena and interventions might be more likely to take place in each of these phases.

In summary, future research endeavors might include longer narratives, other types of shifts and changes to be analyzed, a comparison between findings regarding short statements and longer segments of sessions, a qualitative instead of a quantitative analysis of the narratives, a comparison between narratives extracted from resolution and nonresolution sessions, and a case by case study after ranking the cases on the overall outcome dimension.

I conclude this dissertation hoping that this study will encourage others to carry on the search for ways to measure the “pulse” of the therapy process, thereby helping patients and professionals understand the bidirectional process better and improve their work together.
REFERENCES


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APPENDIX I

Blame Attribution Scale Reference List

Self-blame

1  My future work and being productive again

2  After many productive weeks, pt came unwilling to work. She felt foggy and unable to focus, seemed to be questioning the value of therapy. I was aware that this had to do with termination, but still felt somewhat uneasy.

3  I am on a different wavelength and don’t know how to come through.

4  I was a little nervous. For no real reason other than I had a general sense of nervousness.

5  Why was I asking about patient’s feelings regarding termination?

6  Constant questions about the interactions between us that I can’t deal with.

7  I was distracted/not paying attention to him at all.

Other-blame

1  I was tense during the session. I do not always want to volunteer information. Also part of myself does not want to actually find out what is wrong with the way I handle personal issues.

2  My concern that pt felt criticized by interventions in previous session.

3  Briefly discussed pt’s reluctance to discuss her experience with me.
Pt felt that us needing to go back to talking about what this therapeutic process was a step backward.

Pt directly asking for more guidance and direction- some hedging re: expressing dissatisfaction with therapy.

I feel pt is sending me mixed messages. She is asking for help but at the same time seems to feel that I will not help her or I cannot help her. I feel rejected by her and feel confused about what to way or do in session.

Therapist was probing down a dead-end street.