

Abstract

The relationship between individual therapist variables, specifically the internal mental processes of the therapist, and therapeutic process and outcome is currently an under-examined area of psychotherapy research. The present study investigated the relationship between therapist reflective functioning and the therapeutic alliance, rupture resolution process, session depth, session smoothness, and outcome. Therapist reflective functioning refers to one's capacity to think explicitly about the mind of self and others (Fonagy, Gergeley, Jurist, & Target, 2002). The results indicated a strong predictive relationship between therapist RF and therapist report of the alliance, as well as patient report of the depth of the session. The results indicated no evidence of a predictive relationship between therapist RF and patient report of the alliance, therapist report of the depth of the session, and patient and therapist report of smoothness of the session. The results also indicated a strong predictive relationship between therapist reflective functioning and the patient and therapist report of *addressing* and *resolving* ruptures in the therapeutic alliance. Last, the present study's results indicated a moderate correlation between therapist RF and patient self-report of the symptoms (SCL-90) at termination ($r = .45, n = 21, p < .05$), and a strong correlation between therapist RF and the residual gains score from termination to 6-month follow-up for both the patient report of interpersonal problems (IIP-32) ($r = -.74, n = 15, p < .01$) and symptoms (SCL-90) ($r = -.69, n = 15, p < .01$). The findings demonstrate that therapist reflective functioning may be an important pre-treatment variable in psychotherapy process and outcome. These findings have implications for training of future therapists.

Keywords: reflective functioning; therapist characteristics; treatment outcome; working alliance.

Investigating the Role of Therapist Reflective Functioning
in Psychotherapy Process and Outcome

by

Romy Alexandra Reading, MA

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Dissertation Committee:
Dr. Jeremy D. Safran
Dr. Chris Muran
Dr. Miriam Steele

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Literature Review:

Introduction

The impact of therapist variables and characteristics on psychotherapy process and outcome has drawn increasing attention in the past several decades from both researchers and clinicians alike. A growing interest in understanding differences in efficacy among therapists has generated an examination of multiple therapist factors, which has moved beyond consideration of merely the therapist's theoretical orientation and demographic background (Asay & Lambert, 2002). Efforts to understand the contributions of specific therapist variables on the therapeutic relationship, psychotherapy process, and outcome have opened important avenues of research. In this article, we review the existing research on the role of therapist facilitative factors in psychotherapy process and change, with a particular emphasis on the their impact on the therapeutic relationship and outcome. In addition, we consider the potential relationship of therapist reflective functioning to the quality of the therapeutic relationship, as well as to treatment outcome. A thorough explanation of the concept of reflective functioning is provided. In order to elucidate the conceptual relationship between therapist reflective functioning and the therapeutic relationship and outcome, we also examine the role of the therapist in the negotiation of the therapeutic alliance.

The Role of the Therapist in the Change Process

Most clinicians would likely endorse the importance of the therapist's role in the change process. This view is harmonious with the growing trend in psychotherapy

research towards a consideration of the therapist, not as a neutral technician, but has an active participant in the change process (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Gelso & Hayes, 1998; Moltu, Binder, & Nielsen, 2010; Skovholt & Jennings, 2005; Wampold & Bolt, 2006). Beginning with the client-centered approach of Carl Rogers and colleagues (Rogers, 1957; Rogers & Dymond, 1954), a strong emphasis has been placed on the importance of therapist interpersonal skills in the change process. In fact, Rogers (1957) went so far as to say that the therapist's relational skills of (a) *empathic understanding*, the ability to communicate an understanding of the client's experience in an attuned manner, (b) *unconditional positive regard*, the extent to which the therapist communicates non-judgmental caring to the client, and (3) *congruence*, the therapist's capacity to be genuine and non-defensive with the client are necessary and sufficient for the change process. Although subsequent research has not supported the "necessary and sufficient" hypothesis (Bergin, 1971; Meltzoff & Kornreich, 1970), a review of 116 controlled outcome studies between 1946 and 1969 demonstrated a positive relationship between outcome and therapist empathy and experience (Luborsky, Chandler, Auerbach, Cohen, and Bachrach, 1971).

Subsequent researchers have examined the relationship of therapist facilitative skills, among several other factors, to treatment outcome. Lafferty, Beutler, and Crago (1991) examined the differences in therapist trainees of varying levels of efficacy. The findings indicated that less effective therapists had lower levels of empathic understanding, and that their clients felt less understood (Lafferty et al., 1991). Najavits and Strupp (1994) demonstrated that more effective therapists were differentiated by higher levels of warmth, understanding, and affirmation, and less ignoring and negating,

belittling and blaming, and attacking and rejecting. In their exhaustive review of over 2000 studies of process and/or outcome since 1950, Orlinsky, Grawe, and Parks (1994) identified several therapist variables that have been consistently related to positive psychotherapy process and outcome. Some of these variables include therapist skill, collaborativeness, empathic understanding, capacity to facilitate a strong therapeutic bond, and direct attention to the patient's affective experience. Studies have also focused on the examination of the impact of therapist self-awareness on the therapeutic process, finding a positive relationship between the two (e.g., Fauth & Williams, 2005, Williams & Fauth, 2005).

Furthermore, demographic characteristics have not been found to be significant predictors of therapeutic outcome, while factors such as therapist emotional adjustment and personality do predict outcome with moderate effects (Beutler et al., 2004). Additionally, Anderson and colleagues (2009) examined a broad range of therapist variables, including therapist demographics and interpersonal skills and found only therapist interpersonal skills as predictive of outcome. Okiishi, Lambert, Nielsen, and Ogles (2003) demonstrated that therapist variables accounted for variance in treatment outcome. Although the specific factors that contributed to this variance were not identified in this study, they did demonstrate that therapist demographics and theoretical orientation did not account for the variance.

An increasing number of studies have fairly consistently demonstrated the importance of therapist factors in treatment process and outcome. However, to a large extent therapist factors remain an under-examined variable in psychotherapy research (Anderson et al., 2009). In addition, the mechanisms by which specific therapist

variables facilitate aspects of the psychotherapy change process that have been empirically and theoretically related to treatment outcome have yet to be examined and understood. One such aspect of the change process that has been both theorized and empirically demonstrated to be of particular importance is that of the therapeutic alliance.

Importance of the Therapeutic Alliance

The quality of the therapeutic alliance has consistently been recognized as an important predictor of psychotherapy outcome across a range of diverse treatment modalities (Castonguay, Constantino & Holtforth 2006; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Preliminary research on the therapeutic alliance has provided empirical evidence establishing that a strong therapeutic alliance is a critical prerequisite for positive change in the psychotherapy process (Hartley & Strupp, 1983; Safran, Muran, Samstag, & Stevens, 2002), and that poor early therapeutic alliance is predictive of unilateral treatment termination by the patient (Martin et al., 2000; Samstag, Batchelder, Muran, Safran, & Winston, 1998). Subsequently, researchers have pioneered efforts to clarify both the specific factors that contribute to the development of the alliance, as well as the processes involved in working through conflicts or ruptures in the alliance as they emerge (Crits-Cristoph, Barber, & Kurvias, 1993; Safran and Muran, 2000; Safran et al., 2002).

The therapeutic alliance has been conceptualized in numerous ways and several instruments have been developed to measure the construct. In recent years, the conceptualization proposed by Bordin (1979) has come to define a widely accepted contemporary notion of therapeutic alliance. Bordin's (1979) trans-theoretical

formulation of the therapeutic alliance is constructed on the premise that *both* the therapist and the patient contribute to the formation and quality of the therapeutic alliance, which is a critical element of effective psychotherapy. He conceptualized the therapeutic alliance as consisting of three interdependent components: *tasks*, *goals*, and *bond*. The tasks of therapy refer to the specific activities that the patient participates in, in order to benefit from treatment. The goals are the patient's objectives in entering in treatment, while the bond relates to the affective connection shared between both partners of the therapeutic dyad. When considered as a whole, Bordin's (1979) conceptualization suggests that the quality of the therapeutic alliance depends on the degree to which the patient and therapist can agree on the tasks and goals of therapy in the context of the mutually generated quality of the bond. His conceptualization highlights the importance of mutuality in the therapeutic relationship and of the contributions of both the therapist and the patient to the quality of the therapeutic alliance.

Importance of the Negotiation of the Therapeutic Alliance

Given the empirical evidence establishing the importance of the therapeutic alliance to positive treatment outcome, subsequent research has examined the factors contributing to the process of negotiation in establishing and maintaining the quality of the alliance (Safran, Muran, & Eubanks-Carter, 2011). Bordin (1994) highlights the importance of the negotiation of the alliance as both necessary for the establishment of the conditions for change to take place and as central to the change process in and of itself. More than mere movement towards consensus or compliance, the process of negotiation involves both patient and therapist engaged in a struggle to resolve the

tension between the needs and perspectives of oneself with those of the other (Safran et al., 2002). This conceptualization of the negotiation process parallels contemporary relational thinking, which emphasizes a dynamic mutuality in the negotiation of two differing subjectivities within the therapeutic dyad on both conscious and unconscious levels (Aron, 2006; Benjamin, 2004; Mitchell, 1993). Thus, each participant strives to understand the perspective of the other while attempting to maintain a sense of clarity in regards to the understanding of their own perspective. Additionally, contemporary relational theory describes a process of mutual recognition in which a third *intersubjective* perspective can emerge from the process of negotiating the differing individual perspectives within the dyad (Benjamin, 1990; 2004). Thus, a clear understanding of both the perspective of the self and the other, as well as of the interaction of the two perspectives in the co-creation of an emergent understanding or subjectivity, can be important to the process of negotiation.

Often the process of negotiation can be fraught with moments of misunderstanding, tension, or misattunement. These moments have been referred to as therapeutic alliance ruptures and can be defined as “a negative shift in the quality of the existing alliance or as difficulty in establishing an alliance” (Samstag, Muran, & Safran, 2004, p.188). Alliance ruptures are considered to be unavoidable events in the course of the therapeutic relationship. They can vary greatly in intensity from minor moments of tension to major breakdowns in communication resulting in difficult therapeutic impasses between therapist and patient. Per Bordin’s (1979) understanding, ruptures may result from disagreements about either the tasks or goals of therapy and/or be due to strains in the bond. Consistent with relational thinking concerning the mutuality of the therapeutic

dyad, a rupture includes contributions from both patient and therapist, and thus resolution of ruptures must acknowledge the dynamic dyadic nature of such events. Furthermore, the process of rupture resolution, in and of itself, can serve as a mechanism of change in the psychotherapy process (Safran & Muran, 2000).

Rupture Resolution and the Therapeutic Alliance

Working through a rupture event in a collaborative manner can facilitate change in a patient's relational schemas (Safran and Muran, 2000). Safran and Muran (2000) note that an emphasis on the therapeutic value of working through rupture events can be traced back to the work of Sandor Ferenczi (1932). Ferenczi's emphasis on the therapeutic relationship as a vital mechanism in the change process has recently been reexamined in fairly recent years by contemporary relational psychoanalysts (Aron & Harris, 1991; Wallerstein, 1995). When the therapist can facilitate a collaborative exploration of a rupture event with the patient several therapeutic benefits become possible. In addition to the potential for change in the patient's relational schema as previously mentioned, there is the possibility for the recovery of dissociated aspects of oneself that have been "split-off" as the result of past traumatic relational experiences (Safran and Muran, 2000). Careful and safe exploration of moments of rupture in the therapeutic relationship may provide new opportunities for expression of these previously disowned aspects of oneself.

Various studies have empirically demonstrated how alliance ruptures provide an opportunity for exploration and modification of a patient's maladaptive interpersonal schemas via the process of rupture resolution (Muran, 2001; Muran & Safran, 2002;

Safran et al., 2002; Safran & Segal, 1990). In this regard, resolution of ruptures function as an important component of the change process in psychotherapy, and accordingly have become an important focus of therapeutic alliance research. Following a decade of research on resolution processes, Safran and Muran (2000) created a rupture resolution model that captures the sequences involved in rebuilding an alliance after a rupture event. The model relies on the categorization of ruptures into two subtypes: confrontation and withdrawal.

A withdrawal rupture is characterized by the patient disengaging from the therapist, an aspect of the therapy process, or from his or her own internal experience. Withdrawal ruptures occur in multiple ways. In some instances it can be quite obvious that the patient is disengaging from the therapist or the therapy process (e.g. extended silence or missed sessions). However, in some instances the withdrawal may manifest in a subtle manner. For example, the patient may become overly compliant and accommodating thereby forming a "pseudo-alliance" in which true engagement in the therapeutic process is avoided.

Aggressive and accusatory statements of resentment, hostility, or dissatisfaction in regard to the therapist or some aspect of the therapy process characterizes a confrontation rupture. These ruptures can also manifest in overt and obvious ways (e.g. the patient directly criticizing the therapist) or in a more subtle and indirect manner (e.g. the patient expressing dissatisfaction about the appointment time). Although certain patients may present with a predominance of one rupture type over another, over the course of treatment both types are likely to emerge. Therefore, therapists must be attuned

to both the existence and the type of rupture that emerges in the relationship, as this will guide the therapist's capacity to intervene effectively.

According to Safran and Muran (2000), the therapist approaches the resolution process from an awareness of their own internal feeling states and motivations in regards to the therapeutic relationship, as well as of those of the patient. The therapist's own internal states may be the best indicator that a rupture event is active in the relationship. Awareness of either intense disturbing emotions (i.e. anger or frustration) elicited by a confrontation rupture or subtle feelings of disconnection and disinterest during a withdrawal rupture can signal the therapist to invite collaborative exploration with the patient. In addition, the therapist works to help the patient differentiate internal states by providing feedback to the patient that invites exploration of their possible internal processes and feelings.

With this rupture resolution model in mind, Safran and colleagues (2000; 2005) developed a manualized treatment, Brief Relational Therapy (BRT) that encourages therapists to focus on the "here-and-now" of the therapeutic relationship. BRT emphasizes the importance of directing awareness to the moment-by-moment processes that occur in the therapeutic relationship. Thus, therapists who successfully employ the skill of *mindfulness*, a non-judgmental awareness of the present moment, will be able to constructively attune to rupture moments in the therapeutic alliance. In the BRT model, therapists are also encouraged to use the technique of *therapeutic metacommunication* in order to successfully facilitate exploration of these rupture moments. Therapeutic metacommunication entails stepping outside of the relational exchange in order to explicitly communicate about the interpersonal transaction or implicit communication

that is taking place between the patient and therapist. In sum, BRT emphasizes the dyadic nature of the therapeutic relationship and encourages collaborative exploration of the contributions to the relational matrix by both the therapist and the patient. Although the dyadic and bi-directional nature of the relationship is recognized and emphasized, the therapist's role is key to the effective implementation of interventions that facilitate such exploration, as well as to the resolution of ruptures as they occur.

According to Safran and Muran's (2000; 2005) conceptualization of the dyadic nature of negotiation in the rupture resolution process, the therapist aims to access an understanding of the patient's perspective and internal states while attuning to her own thoughts and feelings that are often key in signaling the onset of a rupture event. To the extent that the therapist is able to simultaneously hold in mind representations of the patient and oneself, each having their own subjective feelings, thoughts, and desires, the process of negotiation and rupture resolution can proceed in a therapeutically effective manner. Thus, an argument can be made that in order to intervene effectively during a rupture event the therapist's capacity to reflect with clarity on the internal states of self and other, as both separate and interactive, is critical to successful resolution of the rupture.

Given the demonstrated relationship of the therapeutic alliance to the change process and treatment outcome, and the evidence highlighting the importance of the therapist as an agent of change, it follows that the therapist's role in the establishment and negotiation of the alliance is likely to be of considerable importance. Specifically, when examined from the perspective of Safran and Muran's (2000) model of resolution of ruptures in the therapeutic alliance, the importance of the therapist's capacity for

attending to, reflecting on, and making explicit the internal states of self and other (therapist and patient) is evident. Therefore, a therapist variable that we speculate may be of particular importance in facilitating the therapist's capacity for resolution of alliance ruptures, and ultimately the development of a positive therapeutic alliance, is that of mentalization.

Mentalization and Reflective Functioning

Mentalization refers to an individual's capacity to access and reflect upon the mental states underlying behaviors of self and other, including desires, feelings and beliefs. It describes not merely the implicit knowledge of mental states but the activity of "thinking explicitly about states of mind" (Fonagy, Gergeley, Jurist, & Target, 2002, p.2). Mentalization refers not just to self-awareness, but also to the explicit knowledge about the minds of self and others in general. The capacity for mentalization develops from infancy within the relational context of the attachment to a primary caregiver (Fonagy & Target, 1998). Fonagy and Target (1998) maintain that the development of a stable capacity for mentalization is dependent upon a secure attachment relationship, one that fosters a child's representation of his or herself as a separate yet related, thinking and feeling being.

Fonagy and Target (1997) theorize that the ability to mentalize is an essential factor in the development of a child's capacity for "self-organization" in the context of early social relationships. The capacity to understand the mind of the self and the other underlies the capacity to regulate one's own affective experience, to control one's

impulses, to self-monitor, and to experience self-agency. Fonagy and Target (1997) regard these capacities as essential building blocks of self-organization.

Inspired by and rooted in groundbreaking work in the field of attachment theory research, Fonagy, Target, Steele, and Steele (1998) operationalized the construct of mentalization with the creation of the Reflective Functioning Scale. The Reflective Functioning (RF) scale was created to evaluate the strength of an individual's capacity for mentalization. Specifically, four aspects of the capacity for mentalization are assessed using this scale: (a) awareness of the nature of mental states including for example, that our understanding of self and others is invariably limited, (b) explicit efforts to identify mental states underlying behavior – such as, understanding that our interpretations of others may be influenced by our own mental states, (c) recognition of the developmental aspects of mental states, including the understanding that mental states and perspectives can and do change over time, and (d) awareness of mental states in relation to the interviewer (or other) – for example, that the other can not fully know what one knows about their own mental states (See Fonagy et al., 1998 for full description). Mentalization as measured by the RF scale includes both self-awareness and perspective taking.

Reflective Functioning and Attachment

Initial research on reflective functioning examined the role that parental mentalization plays in their child's attachment patterns. Parents with insecure attachment patterns and higher RF were more likely to have securely attached children than insecurely attached parents with lower RF (Fonagy et al., 1995; Fonagy, Steele, Steele,

Moran, & Higgitt, 1991). Thus, RF was demonstrated to serve as a crucial mechanism for the intergenerational transmission of attachment patterns. These findings were further supported by Slade and colleagues (2005). Specifically, their study of 40 mother–infant dyads demonstrated a relationship between higher parental RF and greater security of attachment in *both* the parent and infant. As theorized by Fonagy and colleagues (2002), the development of the child's capacity for understanding mental states develops in the context of their early social world with their caregivers. The parental capacity for understanding the mental world of themselves and others can help to facilitate and organize the establishment of a child's capacity to attach to their caregiver in a secure manner.

Patient Reflective Functioning and Psychotherapy

Recently, researchers have begun to utilize the measure of reflective functioning as an indicator of psychological well-being, demonstrating that impairments in reflective functioning are often associated with various forms of psychopathology. Fonagy, Gergely, Jurist, and Target (2002) hypothesize that a deviation in the development of a stable capacity for mentalization results in severe psychopathology, most notably borderline personality disorder. Bouchard and colleagues (2008) empirically demonstrated that deficits in reflective functioning, as well as high levels of defensiveness, contribute significantly to the presence of personality disorder pathology, over and above the presence of Axis I pathology or attachment status. In a study conducted by Fischer-Kern and colleagues (2010) reflective functioning was not associated with severity of Axis I and II pathology. However, they did demonstrate a

relationship between deficits in reflective functioning and presence of borderline personality disorder. Arnott and Meins (2007) demonstrated that individuals with low RF who reported abuse, versus individuals with higher RF who reported abuse, were more likely to be diagnosed with borderline personality disorder. Thus, higher RF was reported to serve as a buffer to the development of borderline pathology. Research on RF and the presence of other forms of psychopathology is sparse at this time. However, a few initial studies have demonstrated lower RF in patients with anorexia nervosa versus controls (Ward et al., 2001), highly impaired RF in severely depressed patients (Fischer-Kern et al., 2008), and low RF in panic disorder patients, specifically with regard to their understanding of their panic symptoms (Rudden, Milrod, Target, Ackerman, & Graf, 2006).

Additionally, RF has been identified as a mechanism of change in transference-focused psychotherapy with patients diagnosed with borderline personality disorder (Yeomans, Clarkin, Diamond, & Levy, 2005). Anthony Bateman and Peter Fonagy (2004) have further highlighted the importance of reflective functioning as a mechanism of change with the development of Mentalization-Based Treatment, which focuses on enhancing an individual's capacity for mentalization as a primary goal in the treatment of borderline personality disorder (BPD). Bateman and Fonagy (2008; 2010) empirically demonstrated positive outcome on several measures when utilizing Mentalization-Based Treatment (MBT) with patients with BPD.

RF has also been utilized as a measure of outcome in and of itself. In a randomized control trial comparing dialectical behavior therapy, transference-focused therapy (TFP), and supportive psychotherapy, Clarkin, Levy, Lenzenweger, and

Kernberg (2007) demonstrated significant positive changes in RF in patients treated with TFP. In this study, changes in RF were reported as a measure of positive psychotherapy outcome.

Therapist Reflective Functioning and Psychotherapy

While research has begun to demonstrate the importance of the relationship of RF to attachment and psychological well-being, and as an indicator of positive psychotherapy outcome, far less is known about the potential role of therapist reflective functioning in therapist efficacy and skill. However, there is initial evidence that discussions about emotions and motivations for people's actions are linked to relatively early development of reflective function (Brown, Donelan-McCall, and Dunn, 1996; Dunn and Brown, 1993). In an experimental study Appleton and Reddy (1996) demonstrated that conversations concerning mental states appear to improve children's mentalization capacities. Additionally, mother-child interactions associated with development of reflective capacities largely were focused on emotionally charged topics (Dunn, 1996). Although these studies do not examine the therapeutic dyad of patient and therapist specifically, it is possible to speculate about the potential importance of the role of the therapist's capacity to mentalize in both the therapeutic process and in enhancing the patient's reflective functioning.

Diamond, Stovall-McClough, Clarkin, and Levy (2003), in addition to analyzing data on attachment classification and reflective functioning for ten patients treated with TFP, present two cases that illustrate how the quality of mentalization in the dyad is a "bi-directional" process. Specifically, they demonstrated that a patient working with a

therapist with a higher capacity for mentalization was able to move from a rejecting stance toward mentalization, to being able to consider rudimentary mental states after one year of treatment. The patient working with a therapist whose reflective capacity mirrored the patient's low and rudimentary reflective function did not achieve similar change and had poorer outcome. Although this study is limited by its small sample size, initial findings indicate that therapist reflective functioning may play a significant role in both the quality of the therapeutic process and in outcome.

Implications for Future Research

In this article, we review the literature examining the importance of the role of therapist factors in successful psychotherapy process and outcome. In addition, literature highlighting the importance of the therapeutic alliance to psychotherapy process and outcome is also discussed. Subsequent research and theory elaborating on the role of the therapist in establishing and negotiating the therapeutic alliance is also reviewed. The role of the therapist is considered to be of crucial importance in regard to the negotiation of the therapeutic alliance.

Building on these bodies of evidence, as well as the evidence demonstrating the importance of reflective functioning to psychological well-being and as a component of positive psychotherapy outcome, we speculate that the therapist's capacity for mentalization may be instrumental to successful psychotherapy process and outcome. The therapist's capacity for mentalization could facilitate the negotiation of the therapeutic alliance, specifically with regard to the process of rupture resolution. To the extent that the therapist is able to simultaneously hold in mind representations of self and

other, the process of rupture resolution will be able to proceed in a therapeutically effective manner. The therapist's capacity to reflect with clarity on the internal states of self and other, as both separate and interactive, is critical to successful resolution of the rupture event. Furthermore, successful repair of ruptures would likely lead to a more positive therapeutic alliance overall. Given the importance of the alliance to psychotherapy outcome, therapists who can successfully resolve ruptures in the alliance are potentially more likely to facilitate greater positive psychotherapy outcome overall. Empirical studies are necessary in order to substantiate these hypotheses. Unfortunately, currently there is a dearth of studies on therapist reflective functioning and its impact on psychotherapy process, rupture resolution, and outcome. Such studies could potentially contribute greatly to the discussion raised by several psychotherapy researchers regarding which therapist skills and factors contribute to process and outcome.

Training implications

Should such studies be conducted and ultimately demonstrate that therapist reflective functioning is important to the quality of the therapeutic alliance, as well as to overall psychotherapy outcome, there would be significant implications for training. The therapist's ability to achieve a collaborative understanding during a rupture event requires she/he to maintain themselves as a distinct subject with a valid perspective and view, while simultaneously experiencing the other as a subject with equally valid and independent feelings, thoughts, and desires. These skills are facilitated by one's capacity for mentalization. Thus, clinical training focusing on the development of mentalization skills via direct modeling by the supervisor, as well as promoting conversations that

encourage the participants to engage in actively teasing apart the mental states underlying behavior in both the patient *and* the therapist, is essential. Additionally, the limitations of one's efforts to mentalize are necessary to keep in mind so as to avoid the therapist developing an overly confident and all-knowing stance about the mind of their patient. Careful attention should also be paid to the development of a distancing intellectualized stance versus a stance of authentic mentalization, which remains closer to the affective experience of both the patient and the therapist.

Conclusion

It is clear from this review that therapist characteristics are of critical importance to the formation of a positive therapeutic relationship, which in turn is essential to the success of any psychotherapeutic endeavor. Research on the therapeutic alliance has shifted from merely substantiating the importance of its relationship to psychotherapy outcome, to understanding the factors that contribute to its successful establishment and negotiation. Specifically, the role of the therapist in the negotiation of the alliance is of particular importance in order to understand the processes of alliance negotiation. However, given the dyadic nature of the negotiation of the therapeutic alliance the client's contributions are not to be underestimated. Nevertheless, understanding the impact of the therapist on the negotiation process is essential to furthering efforts in the training of therapists and the implementation of successful psychotherapy.

In this article, we speculate as to the role of therapist reflective functioning in the process of alliance negotiation and outcome. Although, we consider therapist reflective functioning to be a potentially important focus of future research, it is not likely that it is

the only therapist characteristic of import. Therapist empathy, warmth, mindfulness, capacity for affective regulation, and non-defensiveness, among others, are also potentially important with regard to their contributions to the process and outcome of psychotherapy. We welcome and encourage future research on these and other therapist variables that may ultimately contribute to successful outcome.

Empirical Study:

Introduction

Mentalization refers to an individual's capacity to access and reflect upon the mental states underlying behaviors of self and other, including desires, feelings and beliefs. It describes not only the implicit knowledge of mental states, but also the activity of "thinking explicitly about states of mind" (Fonagy, Gergeley, Jurist, & Target, 2002, p.2). Mentalization refers not just to self-awareness, but also to the explicit knowledge about the minds of self *and* others. The capacity for mentalization emerges within the relational context of one's attachment to a primary caregiver (Fonagy & Target, 1998). Fonagy and Target (1998) maintain that the development of a stable capacity for mentalization is dependent upon a secure attachment relationship, one that fosters a child's representation of self as a separate yet related thinking and feeling being.

Fonagy, Target, Steele, and Steele (1998) operationalized the construct of mentalization with the reflective functioning (RF) scale. The reflective functioning scale was created to evaluate the strength of an individual's capacity for mentalization. Specifically, four aspects of the capacity for mentalization are assessed using this scale: (1) Awareness of the nature of mental states including, for example, that our understanding of self and others is invariably limited (2) Explicit efforts to identify mental states underlying behavior, as well as understanding that our interpretations of others may be influenced by our own mental states (3) Recognition of the developmental aspects of mental states, including the understanding that mental states and perspectives

can and do change over time (4) Awareness of mental states in relation to the other, for example, that the other can not fully know what one knows about their own mental states (See Fonagy et al., 1998 for full description). Thus, mentalization as measured by the RF scale includes self-awareness, awareness of the other, and perspective taking.

Empirical research on reflective functioning has demonstrated that differences in one's capacity for identifying and differentiating the mental and emotional states of self and others are a vital aspect of psychological well-being. Fonagy, Steele, and Steele (1991) demonstrated that children of high scorers on the RF scale are more likely to be securely attached than children of low scorers on the RF scale. Fonagy and colleagues (1991) elaborate on this finding by stating that parents' capacity to reflect on the mental states underlying their children's behavior enhances the child's capacity for affect regulation and self-control. Additionally, Slade and colleagues (2005) demonstrated that parental reflective functioning plays a crucial role in the intergenerational transmission of attachment. Specifically, the study demonstrates a relationship between higher parental RF and greater security of attachment as assessed in the child.

Recently, researchers have begun to directly utilize the measure of reflective functioning in psychotherapy research as an indicator of psychological well-being, demonstrating that impairments in reflective functioning are often associated with various forms of psychopathology (Bouchard et al., 2008; Fischer-Kern et al., 2010; Yeomans, Clarkin, Diamond, & Levy, 2005). Additionally, RF has been utilized as a psychotherapy process measure (Bateman & Fonagy, 2008; Fonagy & Bateman, 2007; Karlsson & Kermott, 2006; Levy et al., 2006). Specifically, an improvement in a patient's capacity for RF is being conceptualized as a mechanism of change.

While research has begun to demonstrate the importance of the relationship between RF and various components of psychological well-being, less is known about the potential role of reflective functioning in therapist efficacy and skill. Most clinicians would likely endorse the importance of the therapist's role in the change process. This view is harmonious with the growing trend in psychotherapy research towards a consideration of the therapist, not as a neutral technician, but as an active participant in the change process (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Gelso & Hayes, 1998; Moltu, Binder, & Nielsen, 2010; Skovholt & Jennings, 2005; Wampold & Bolt, 2006). In a meta-analysis, Wampold (2001) found significant individual differences between therapists, with some being more consistently able to facilitate positive therapeutic outcome. Estimates of outcome variance attributable to therapist effects are in the range of 5% to 9% (Crits-Christoph & Mintz, 1991; Wolfgang, Leon, Martinovich, Lyons, Leon & Stiles, 2007). Anderson, Ogles, Lambert & Vermeersch (2009) found significant difference in the effectiveness of individual therapists, with more effective therapists showing evidence of a variety of interpersonal skills relevant to dealing constructively with challenging encounters with patients.

One domain in which the role of the therapist is considered to be of crucial importance is in regard to the negotiation of the therapeutic alliance. The quality of the therapeutic alliance has consistently been recognized as an important predictor of psychotherapy outcome across a range of diverse treatment modalities (Castonguay, Constantino & Holtforth 2006; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). The therapeutic alliance has been conceptualized in numerous ways, and several instruments have been developed to measure the construct. In recent years, the

conceptualization proposed by Bordin (1979) has come to define a widely accepted contemporary notion of the therapeutic alliance. Bordin's (1979) trans-theoretical formulation of the therapeutic alliance is constructed on the premise that *both* the therapist and the patient contribute to the formation and quality of the therapeutic alliance, which is a critical element of effective psychotherapy.

Given the empirical evidence establishing the importance of the relationship of the therapeutic alliance to positive treatment outcome, subsequent research has examined the factors contributing to the process of negotiation in establishing and maintaining the quality of the alliance (Safran, Muran, & Eubanks-Carter, 2011). Bordin (1994) highlights the importance of the negotiation of the alliance as both necessary for the establishment of the conditions for change to take place, and as central to the change process in and of itself. More than mere movement towards consensus or compliance, the process of negotiation involves both patient and therapist engaged in a struggle to resolve the tension between the needs and perspectives of oneself with those of the other (Safran et al., 2002). These moments of tension have been referred to as therapeutic alliance ruptures and can be defined as "a negative shift in the quality of the existing alliance or as difficulty in establishing an alliance" (Safran & Muran, 2006). Various studies have identified how alliance ruptures provide an opportunity for exploration and modification of a patient's maladaptive interpersonal schemas via the process of negotiating and resolving ruptures (Muran, 2001; Muran & Safran, 2002; Safran et al., 2002; Safran & Segal, 1990). In this regard, resolution of ruptures can function as an important component of the change process in psychotherapy, and accordingly has

become an important focus of therapeutic alliance research (Safran & Muran, 2000; Safran, Muran, Samstag, & Stevens, 2002; Safran, Muran & Eubanks-Carter, 2011).

Following a decade of research on resolution processes, Safran and Muran (2000) developed a rupture resolution model that captures the sequences involved in rebuilding an alliance after a rupture event. According to Safran and Muran (2000), the therapist approaches the resolution process from an awareness of their own internal feeling states and motivations in regards to the therapeutic relationship, as well as from an awareness of those of the patient. The therapist's own internal states may be the best indicator that a rupture event is active in the therapeutic relationship. Awareness of either intense disturbing emotions (i.e. anger or frustration) elicited by a confrontation rupture or subtle feelings of disconnection and disinterest during a withdrawal rupture can signal the therapist to invite collaborative exploration and negotiation with the patient. In addition, the therapist works to help the patient differentiate internal states by providing feedback to the patient that invites exploration of their own internal processes and feelings. Thus, an argument can be made that in order to intervene effectively during a rupture event the therapist's capacity to reflect with clarity on the internal states of self and other, as both separate and interactive, is critical to successful resolution of the rupture.

According to Safran and Muran's (2000; 2005) conceptualization of the dyadic nature of negotiation in the rupture resolution process, the therapist aims to understand the patient's perspective and internal states while attuning to her own thoughts and feelings that are often key in signaling the onset of a rupture event. To the extent that the therapist is able to simultaneously hold in mind representations of the patient and oneself, each having their own subjective feelings, thoughts, and desires, the process of

negotiation and rupture resolution can proceed in a therapeutically effective manner. Thus, the therapist's reflective functioning capacity can be estimated to be critically important to the process of rupture resolution and ultimately to successful psychotherapy outcome.

In light of the evidence highlighting the importance of the role of parental RF in the transmission of affect regulation, self-control, and mentalization capacities in the child, as well as the growing evidence for the role of therapist factors in the psychotherapy in general, we speculate that the therapist's capacity for reflective functioning could potentially play a vital role in the efficacy of alliance negotiation, rupture resolution, and psychotherapy outcome. Unfortunately, there is a dearth of studies on therapist reflective functioning and psychotherapy. The current study is preliminary in nature and is designed to test several hypotheses regarding the role of therapist reflective functioning in psychotherapy process and outcome. We assessed therapist reflective functioning in the context of an interview with the therapist about their relationship with the patient. We hypothesized that higher therapist reflective functioning as measured in this interview would be predictive of the following dimensions of psychotherapy process :1) higher therapeutic alliance ratings, 2) greater depth of exploration in session, and 3) higher ratings of degree of of alliance rupture resolution. We were agnostic with respect to predicting treatment outcome at termination, but predicted a relationship between therapist RF and change at the 6 month follow-up. Our reasoning for making different predictions with respect to change at termination and outcome is also follows : There are both theoretical and empirical

grounds for predicting multiple pathways towards symptom change at outcome. There is evidence, however, that xyz (decide which studies)

Method

Participants

Patients. Data from 43 patient-therapist dyads were included in the study.

Participants were drawn from an ongoing research project at the Brief Psychotherapy Research Program, which is housed in the psychiatry department of Beth Israel Medical Center in New York City. Patients are drawn from a community sample which is largely recruited through newspaper advertisement and the project website offering low-fee psychotherapy for individuals willing to participate in a research project. Patients are also drawn from affiliated provider or program referrals.

Patients are screened for inclusion criteria by research assistants who are masters level or first year doctoral students in clinical psychology during a brief phone interview, followed by the Structured Clinical Interview for DSM-IV (SCID I and II; First, Spitzer, Gibbon, & Williams, 1995), which was used to determine diagnosis. Training for these students included viewing a training video, role-playing, observation of a live demonstration, and completion of an inter-rater reliability test that consisted of rating various videotaped samples of previous interviews conducted by trained interviewers. These samples included patients presenting with anxiety and mood disorders, as well as personality disorders. The standard for completing training was an intra-class coefficient of $> .90$ on both the Axis I & II sections of a reliability test interview.

Inclusion criteria for the program are that the patient is between the ages of 18 and 65, meets criteria for an Axis II diagnosis of a cluster C Personality Disorder or Personality Disorder Not Otherwise Specified (PD NOS) on Axis II, is willing to be videotaped and complete a series of questionnaires during the course of treatment, and is proficient in the English Language. Patients are excluded if any of the following are present: organic brain syndrome, mental retardation, psychosis, Bipolar Disorder, active suicidal ideation or severe depression, need for psychiatric hospitalization, a significant medical condition that would impair participation, active substance abuse, a history of violent or impulsive behavior, or the use of psychotropic medication at a dose that has not been stabilized for a minimum duration of three months.

Participants consisted of 29 females and 14 males between the ages of 24 and 68 (median age 46). The majority of the sample was Caucasian (73%), followed by Hispanic (12%), Asian (2%), and African-American (1%). Psychiatric diagnoses for the sample were derived from SCID interviews and are presented in Table 1.

Therapists. Therapists consisted of psychology externs and interns, and psychiatry residents at Beth Israel Medical Center. Participants included 35 female and eight male therapists. 34 therapists were advanced clinical psychology trainees and nine were psychiatry residents. The majority of trainees (57.7%) had less than two years clinical experience, with the remaining trainees (22.3%) having two to 5 years of experience. 8 therapists chose not to report their years of experience. A total of 43 therapists provided Brief Relational Therapy (BRT; Safran, 2002; Safran & Muran, 2000). Safran and colleagues (2000; 2005) developed a manualized treatment, Brief Relational Therapy (BRT) that encourages therapists to focus on the “here-and-now” of

the therapeutic relationship. BRT emphasizes the dyadic nature of the therapeutic relationship and encourages collaborative exploration of the contributions to the therapeutic relationship by both the therapist and the patient. Although the dyadic

Table 1. *Diagnostic characteristics of sample*

	n	%
Axis I diagnoses		
Depressive Disorder	22	51.1
Anxiety Disorder	9	20.1
Adjustment Disorder	5	11.6
Other	1	2.3
None	6	14.0
Axis II diagnoses		
Personality Disorder NOS	22	51.2
Avoidant PD	3	7.0
Obsessive Compulsive PD	2	4.7
Dependent PD	2	4.7
Negativistic PD	2	4.7
Depressive PD	3	7.0
None	9	20.9

and bi-directional nature of the relationship is recognized and emphasized, the therapist's role is key to the effective implementation of interventions that facilitate such exploration, as well as to the resolution of ruptures as they occur. Trained members of the research program's staff confirmed adherence to the therapy modality (see Muran, Safran, Samstag, & Winston, 2005, for details). The treatment consisted of 30 sessions of therapy, with sessions occurring approximately once per week. All therapists participated in weekly 90-minute group supervision sessions. A supervisor with extensive training in BRT led the supervision sessions. The supervision format makes

extensive use of videotaped psychotherapy sessions and focuses on the facilitation of the therapists' internal experience through the use of mindfulness exercises, role-playing exercises incorporating BRT interventions, various experiential exercises, and feedback from the supervisor.

Measures

Therapist Reflective Functioning. Therapist capacity for reflective functioning was measured by applying the *Reflective Functioning Scale* (see description below) to interviews with the therapist that were administered by research assistants after session 10 and before session 15. The *Therapist Interview at Mid-phase* (TRI-M; Safran et al., 1999) is a semi-structured interview of the therapist aimed to assess how the therapist thinks about the patient and the therapeutic relationship. The TRI-M is designed to elicit information from participants regarding their feelings, thoughts, and memories about their relationship with their patient. The format and structure of the TRI-M parallels the Parent Development Interview - Revised developed by Slade, Aber, Berger, Bresgi, and Kaplan (PDI-R; 2003), which is a semi-structured interview designed to elicit information from parent's representation of his or her relationship with the child. The TRI-M, like the PDI-R, asks therapists to briefly describe their relationship with their patients, to provide adjectives that illustrate the relationship, and then to elaborate on any of these adjectives with specific memories. Furthermore, the TRI-M also asks therapists several questions about the occurrence of rupture moments in the relationship and how they think the event has impacted the patient, themselves, and the therapeutic relationship.

The Reflective Functioning Scale (RF; Fonagy, Steele, Steele, & Target, 1998) is an observer-based measure designed to describe and measure an individual's capacity for mentalization. The RF scale was originally developed at the London Parent-Child Project for the purpose of coding the Adult Attachment Interview (Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Fonagy, Steele & Steele, 1991). The RF scale assesses the quality of mentalization of an individual when speaking about attachment relationships, and a global score for an interview ranges from negative one (interviews which are devoid of mentalization) to nine (interviews which are exceptionally sophisticated in their reflective stance). Coders rate statements that demonstrate the presence or absence of a reflective stance in relation to self and other. Raters use the frequency, clarity, and quality of a subject's response over the course of the interview to score the subject on the scale. Descriptions of the quality of reflection and narrative examples are given in the RF Manual to demonstrate the designation of points 1, 3, 5, 7, 9 (Fonagy et al., 1998). The RF scale has strong inter-rater reliability ($r = .91$; Fonagy et al., 1996) and has been validated in numerous studies (Fonagy et al., 1998).

Psychotherapy Process.

The *Post Session Questionnaire* (PSQ; Muran, Safran, Samstag, & Winston, 2002) was administered and completed by therapist and patient following each session. The PSQ consists of several self-report scales assessing session impact and the therapeutic relationship, including the 12- item version of the *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989; Tracey & Kotolovic) and the *Session Evaluation Questionnaire* (SEQ; Stiles & Snow, 1984). In addition, the PSQ includes six questions

designed as a global assessment of rupture and resolution within each session (Muran, Safran, Gorman, Samstag, Carter, & Winston, 2009). These questions provide a context for responding to the rupture resolution items and assess the following on a 5-point Likert Scale: (1) whether the rater experienced any “tension, problems, misunderstandings or conflicts” with the other in the dyad (2) the extent to which the problem was addressed, (3) the degree to which the problem was resolved, and (6) a brief description of what contributed to the resolution.

The *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989) is a well-established measure of the strength of the therapeutic alliance between patient and therapist. The current study used the short-form of the original 36-item WAI, which consists of 12 items and has been shown to correspond to scores on the long version (Tracey & Kokotovic, 1989). It was derived from Bordin’s (1979) trans-theoretical conceptualization of the alliance and is comprised of three subscales measuring therapeutic bond, agreement on task, and agreement on goals. The 12 items are rated on a 7-point Likert-type scale where 1 = “never” and 7 = “always.” The WAI has been used extensively as a measure of the therapeutic alliance, and its validity has been established as a predictor of treatment outcome (Horvath & Symonds, 1991). Both therapist and patient WAI scores for each session were used in this study.

The *Session Evaluation Questionnaire* (SEQ; Stiles & Snow, 1984) is a self-report measure assessing the impact of psychotherapy sessions on two sub-scales, Depth and Smoothness. It consists of 12 bipolar adjective scales presented in 7-point semantic differential format that yields the two subscales of Depth and Smoothness of the session.

Both therapist and patient Depth and Smoothness scores for each session were used in this study.

Psychotherapy Outcome.

In addition to measures assessing psychotherapy process, the patients completed demographic questionnaires and both the Symptom Checklist Revised -90 (SCL-90R; Derogatis, 1983); and the Inventory of Interpersonal Problems -32 (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000), at intake, termination and at a 6-month follow-up post termination.

The *Symptom Checklist Revised-90* (SCL-90R; Derogatis, 1983) was employed to assess outcome on the symptom dimension. The SCL-90 consists of 90 Likert scale items with a rating of 0 to 4 indicating the presence and amount of distress associated with each symptom within a week of administration. The Global Severity Index (GSI) represents the mean of all 90 items and can be used a global indicator of overall symptom distress (Derogatis, 1983). The scale is widely used and has been shown to have high internal consistency and reliability (Nguyen, Atkinson, & Stenger, 1983; Rosen et al., 2000).

The *Inventory of Interpersonal Problems-32* (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000) is a 32-item inventory developed to assess patient social adjustment and interpersonal functioning. The IIP-32 yields a total interpersonal functioning score, as well as scores on eight scales. The IIP has been shown to possess high internal consistency, ranging from .82 to .94, (Horowitz et al., 2000), and high test–retest reliability score of .90 (Hansen, & Lambert, 1996).

Procedure

The measures used in this study comprise the assessment packets completed by patients and therapists who participate in the Brief Psychotherapy Research Program. Patients are scheduled for 1 hour meeting, with 45 minutes allotted for the therapy session and 15 minutes allotted for measure completion following the session. Patients and therapists complete the Post Session Questionnaire (PSQ) separately and return them to locked drop-boxes located in the waiting room. Patients completed the outcome measures upon completion of the intake assessment, at termination, and at a 6-month follow-up. Therapists complete outcome measures after the third session and at termination.

Reflective Functioning scale coding. The *Therapist Mid-phase Interviews* (TRI-M) were administered by research assistants at the Brief Psychotherapy Research Program after session 10 and before session 15. TRI-M interviews are videotaped and subsequently transcribed by research assistants. Verbatim transcripts were used for coding verbalizations for reflective functioning in this study. To measure the therapists' RF capacity, coders were first be trained by the primary author until they obtained a minimum 0.70 single measure intra-class coefficient reliability score on 3 practice TRI-M transcripts coded by the primary author and the coding trainee. Once coders were deemed reliable, each transcript was assigned to a pair of coders. Any discrepancies between coders were resolved via consensus. Additionally, periodic reliability checks were conducted to assess for rater drift. Coders obtained single measure intra-class coefficient reliability scores of .82, .89, and .89 for the three reliability checks conducted over the course of the data collection process.

Results

Therapist Reflective Functioning and Psychotherapy Process.

Table 2 presents the means and standard deviations for the psychotherapy process variables investigated in our study, which included the mean of the *Working Alliance Inventory* (WAI), *Depth of Session* score (D), and *Session Smoothness* score (S).

Table 2. Means and standard deviations for therapist RF and process variables

Variable	Mean (M)	Standard Deviation (SD)
RF	5.60	1.18
Patient report of WAI	5.54	.98
Therapist report of WAI	5.21	1.75
Patient report of D	5.35	1.18
Therapist report of D	4.82	.93
Patient report of S	4.66	1.36
Therapist report of S	4.38	1.10

*WAI denotes Working Alliance Inventory; D denotes depth of session; S denotes smoothness of session;

To analyze the predictive relationship between therapist RF and the above listed psychotherapy process variables, we conducted a series of regression analyses of repeated measures using a generalized estimating equations approach developed by Liang and Zeger (1986; Zeger & Liang, 1986). This approach was developed for measurements that are obtained at multiple time points for each participant within a group of participants and, unlike other traditional approaches to longitudinal analysis, accommodates for

dependence among the repeated measures and missing data. Additionally, it does require independence across participants.

The results indicated a strong predictive relationship between therapist RF and therapist report of the WAI (Wald Chi-Square = 6.92, $p = .009$), as well as patient report of the depth of the session (D) (Wald Chi-Square = 4.42, $p = .036$). The results indicated no evidence of a predictive relationship between therapist RF and patient report of the WAI, therapist report of the depth of the session (D), and patient and therapist report of smoothness of the session (S). Table 3 presents the Wald Chi-Square values for the regression analyses using generalized estimating equations (GEE) for therapist RF and psychotherapy process variables.

Table 3. *Wald Chi-Square values for regression analyses using GEE for therapist RF and psychotherapy process variables*

Variable	Wald Chi-Square
Patient report of WAI	2.44
Therapist report of WAI	6.92**
Patient report of D	4.42*
Therapist report of D	.71
Patient report of S	.02
Therapist report of S	.63

* Correlation significant at the .05 level

** Correlation significant at the .01 level

In addition, in order to analyze the relationship between therapist RF and the PSQ items that assess the rupture resolution process, we conducted another series of regression

analyses utilizing the same approach described above. The results indicated a strong predictive relationship between therapist RF and patient and therapist report of the therapist both *addressing* and *resolving* a rupture in the therapeutic alliance within a session. Table 4 presents the Wald Chi-Square values for the regression analyses using generalized estimating equations (GEE) for therapist RF and the rupture resolution items.

Table 4. *Wald Chi-Square values for regression analyses using GEE for therapist RF and rupture resolution items*

Variable	Wald Chi-Square
Patient report of addressing rupture	5.49**
Therapist report of addressing rupture	6.66**
Patient report of rupture resolution	5.41*
Therapist report of rupture resolution	11.81**

* Correlation significant at the .05 level

** Correlation significant at the .01 level

Therapist Reflective Functioning and Treatment Outcome at Termination and Follow-up.

In order to assess treatment outcome, we calculated residualized gain scores from intake to termination for patient report on the *Symptom Checklist Revised-90* (SCL-90), and on the *Inventory of Interpersonal Problems-32* (IIP). To analyze the relationship between therapist RF and treatment outcome, we conducted a two-tailed Pearson product-moment correlation. The results indicated a moderate correlation between therapist RF and patient self-report of the SCL-90 at termination ($r = .45$, $n = 21$, $p < .05$), but no significant relationship between therapist RF and patient. Additionally, the results indicated a strong correlation between therapist RF and the residual gains score from

termination to 6-month follow-up for patient report on the IIP-32 ($r = -.74$, $n = 15$, $p < .01$) and between therapist RF and the residual gains score from termination to 6-month follow-up for patient report on the SCL-90 ($r = -.69$, $n = 15$, $p < .01$). Table 5 presents the Pearson correlation values for the correlation between therapist RF and the treatment outcome residual gains scores.

Table 5. *Pearson correlations for therapist RF and treatment outcome residualized gains scores*

	n	Pearson coefficient
<i><u>Intake to Termination</u></i>		
Patient report of SCL-90	21	.45*
Patient report of IIP-32	21	.35
Therapist report of GAS	25	.20
<i><u>Termination to 6-month Follow-up</u></i>		
Patient report of SCL-90	15	-.69**
Patient report of IIP-32	15	-.74**

* Correlation significant at the .05 level
 ** Correlation significant at the .01 level

Discussion

Per our hypothesis, the current study demonstrated that patients working with therapists with higher reflective functioning reported greater levels of depth of exploration in sessions. This is consistent with our theoretical premise that therapists with higher reflective functioning will be more readily able to identify and attune to the mental and emotional states of their patients, thereby facilitating explicit exploration of these internal mental and emotional states of their patients. However, in contrast to our

expectations, patients working with therapists with higher reflective functioning do not report greater working alliance scores. Given that therapists with higher reflective functioning are more likely to encourage patients to more deeply explore their emotional experiences and mental states, this may result in experiencing therapy as more challenging, and ultimately lead to increased experiences of strain and difficulty in the working alliance by the patient.

In contrast, therapists with higher reflective functioning do report greater working alliance scores. It is likely that therapists working within the brief relational framework maintain a differentiated understanding of the working alliance than their patients do. Specifically, alliance ruptures are likely deemed as therapeutically valuable opportunities for change, instead of as failures in the psychotherapy process. It is possible that therapists with higher RF work more actively to attend to and resolve ruptures, and that they view this process as indicative of a strong working alliance.

With regard to report of rupture resolution process, per our hypotheses, both the therapists with higher reflective functioning, and the patients working with therapists with higher reflective functioning, report greater frequency of therapists *addressing* ruptures in the working alliance and that these therapist have greater success in *resolving* these ruptures. In our view, therapists with higher reflective functioning scores are more readily able to accurately identify when they and their patients maintain differentiated perspectives and stances, and therefore are more attuned to the presence of alliance ruptures. Subsequently, therapists with higher RF can more effectively identify the limitations of their mental states, as well as maintain the separateness of their mental states from those of their patients. Thus therapist with higher RF can confidently manage

the challenging task of explicitly addressing the rupture moment. With regard to successful resolution, the extent to which the therapist can recognize the limitations of their own mental states and understand how mental states can affect perceptions of the other, they are able to non-defensively negotiate ruptures, so as to move the therapeutic relationship from a place of tension and misunderstanding to a place of mutual understanding of the rupture event. The therapist who is able to hold in mind the feelings, thoughts, and desires of both the patient and oneself as separate yet interactive, will have a greater capacity to facilitate the process of rupture resolution in a therapeutically productive manner.

Per our hypotheses, the current study also demonstrated that patients who worked with therapists with higher reflective functioning reported fewer symptoms and fewer interpersonal problems at 6-month follow-up on the SCL-90 and the IIP-32. Interestingly, patients reported an increase in symptoms at termination when working with therapists with higher reflective functioning. It is a possibility that the differences in sample size from termination ($n = 21$) to 6-month follow-up ($n = 15$) may account for the differences in these findings. However, this correlation may also be attributable to an increase in symptomatology as reported by the patients in the context of issues of termination. Additionally, therapists with higher reflective functioning are potentially more likely to place an emphasis on exploration of the challenging affective experiences associated with termination, which may exacerbate the patients' experience of distress. Furthermore, per our hypothesis, a process of consolidation of seems to occur in the time period between termination and 6-month follow-up. The nature of this process of

consolidation merits further exploration in order to understand the change processes underlying symptom change in these patients.

There are several limitations to the current study. First, the sample size utilized in the analyses of outcome was relatively small. Second, a self-report methodology of working alliance is limited. Discrepancies in patient and therapist report of the working alliance may be attributable to this limitation. Future studies may consider an observer-based measure of the working alliance, for example the Working Alliance Inventory-Observer (WAI-O; Titchenor & Hill, 1989) in order to account for this limitation. Last, the current study did not account for the level of therapist experience on the psychotherapy process and outcome. We are therefore unable to determine the extent to which therapist levels of experience influenced treatment process and outcome.

Despite these limitations, our results offer some promising preliminary findings. Therapist reflective functioning was positively associated with greater gains after termination as measured at 6-month follow up (as measured by the SCL-90 and the IIP-32). Furthermore, therapist reflective functioning was positively associated with greater depth of exploration in session as reported by the patient, greater working alliance as reported by the therapist, and with greater success in the negotiation of ruptures in the working alliance as reported by both patient and therapist. These findings are considerable in light of the importance of the negotiation of the therapeutic alliance for positive psychotherapy outcome.

To date research on reflective functioning has focused primarily on enhancing the patient's capacity for mentalization in order to facilitate improved psychological health, while neglecting to address the importance of the contribution of the therapist's reflective

functioning capacities. Given that it is maintained that the capacity for reflective functioning emerges in the context of a relational dyad, it is important to consider how the reflective therapist as an agent of change, not merely a neutral mechanism for delivery of interventions and techniques, facilitates changes in the patient. Subsequent research examining improvement in patient reflective functioning, as facilitated by the therapist, may provide additional understanding of this change process.

The current study provides a preliminary attempt at understanding the relationship between therapists reflective functioning and psychotherapy process and outcome. Additional research is necessary in order to replicate these findings with larger sample sizes and different treatment modalities. Future studies may also begin to explore how training of therapists may be aimed at increasing therapist reflective functioning, especially with regard to understanding the interpersonal complexity of ruptures in the therapeutic alliance. This may move us closer to the goal of improving therapists' rupture resolution skills, thereby leading to improvements in psychotherapy process and treatment outcome overall.

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