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Treatment failure in psychotherapy: The pull of hostility

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Abstract

Client–therapist interactions were studied in 14 positive-change (PC) and 14 negative-change or nonchange (NC) therapies with the same therapists and similar clients. Aggregated structural analysis of social behavior (SASB) scores showed increasingly dissimilar interaction styles between client and therapist in NC therapies. First-lag transition analyses of SASB codings of Sessions 3, 12, and 20 showed the following differences: Stable hostile complementarity characterized NC within and across sessions. Hostile complementarity was nevertheless relatively rare. Therapists met clients' invitations to hostile responses most frequently in nonhostile ways, yet they initiated more belittling and ignoring interactions with NC clients, pointing to the subtly hostile therapeutic climate created. Rejection of therapists' interventions predicted negative outcome most strongly and escalated with time. Clients' skepticism may make therapists vulnerable to feelings of inadequacy and, if not dealt with therapeutically, may easily release the therapists' own hostility.

Keywords: process research; outcome research; therapeutic failure; hostile interaction in psychotherapy

The efficacy of psychotherapy has been convincingly documented for clients with different diagnoses and problems through randomized controlled trials (Roth & Fonagy, 2005). Yet a disturbing 5% to 10% of the treated clients have repeatedly shown deteriorated functioning after psychotherapy (Lambert & Ogles, 2004). Little comparative outcome variance has been explained by different treatment methods (Wampold, 2001). Experimental studies have, however, demonstrated that therapist effects seem to be greater than method effects (e.g., Blatt, Sanislow, Zuroff & Pilkonis, 1996; Svartberg & Stiles, 1992), and different aspects of the therapeutic process have consistently been associated with outcome (Orlinsky, Rønnestad, & Willutzki, 2004). Analyses of process–outcome research, most recently published in the *Handbook of Psychotherapy and Behavior Change* (Lambert, 2004) summarizing 50 years of publications, demonstrate that the most consistent association between process and outcome has been found for the interpersonal aspect of process (Orlinsky et al., 2004).

Close to 100 studies have documented that affirmative therapist communications are related to positive outcome, again most strongly in the client's perspective. Client affirmation versus negation to-

ward the therapist has also been associated with outcome in a number of studies regardless of who assessed the relationship, but most decidedly when assessed by the client or an outside observer.

It is fairly well documented that the therapeutic relationship is formed in the early stages of therapy and that the quality of the working alliance independently predicts later outcome (Gaston, Marmar, Gallagher, & Thompson, 1991; Horvath & Symonds, 1991).

Structural Analysis of Social Behavior

The structural analysis of social behavior (SASB; Benjamin, 1974; Benjamin & Cushing, 2000), a circumplex model for personality and interpersonal functioning, has been exceptionally well suited to study in-session microprocesses in psychotherapy, and a number of process–outcome studies have been completed. The unique feature of this circumplex eight-cluster model is that it has three planes, or surfaces (rather than the usual one), each defining a particular focus of transactions: a transitive surface with interpersonal focus on others, an intransitive surface with focus on reactions to interactions directed at the self by others, and an introject surface with

focus on reactions to interactions directed at the self by others, and an introject surface with focus on how the person treats the self. All three circumplexes are defined by two independent dimensions: affiliation (love vs. attack) and interdependence (emancipation vs. control). The eight resulting clusters on the perimeter of the circumplex describe combinations of the two dimensions. Positions on the low end of affiliation are clusters of hostile control (Cluster 6) and hostile neglect (Cluster 8), whereas positions on the positive end of affiliation are clusters of friendly protection (Cluster 4) and openness and affirmation (Cluster 2). In addition, two clusters are defined only by affiliation (Cluster 7: attack/withdrawal; Cluster 3: love/reactive love) or only by interdependence (Cluster 5: control/submission; Cluster 1: emancipate/separate). The model is presented in Figure I.

In interpersonal theory, the process of internalization is central to explain how interpersonal experiences become mental representations, including organizing principles, scripts, and schemas for later social behavior. The assumption is that individuals tend to behave toward others through the mechanism of identification with the way important others have acted toward them, and this aspect is reflected in the surface measuring individuals' transitive focus on others. Through "recapitulation" (Benjamin's term), individuals have come to expect to be treated by others as important others have treated them and indeed invite such behaviors through their own identifications. This aspect is reflected in the surface measuring individuals' intransitive focus on self. Through introjection, individuals have established

focus of self-relatedness analogous to the way important others have treated them, reflected in the surface called the *introject* (Henry, 1994). The theory further states that individuals tend to act and react in complementary fashions, such that friendliness begets friendliness, hostility invites and is reacted to with hostility, and dominance invites submission and the obverse.

Empirical Studies of Therapy Processes Using SASB

Understanding the role of affiliation and interdependence in social interaction has been a focus of several studies on psychotherapy. In the seminal papers by Henry, Schacht, and Strupp, (1986, 1990), which inspired the present study, it was documented that, in high-change therapies, non-personality-disordered clients entered into more friendly complementary interactions, whereas in low-change therapies, non-personality-disordered clients entered into more hostile complementary interactions with the same therapists in an early therapy session. In a series of early studies, Strupp and collaborators (1980a, 1980b, 1980c) found that therapists were often overtly critical when clients were demanding or critical. Others who have used Benjamin's (1974) SASB interpersonal coding system have found that client and therapist respond to each other in complementary fashion and that hostile complementarity (correspondence of nonaffiliative codes) in treatment is rather common (Tasca & McMullen, 1992; Wiseman, Shefler, Caneti, & Ronnen, 1993).

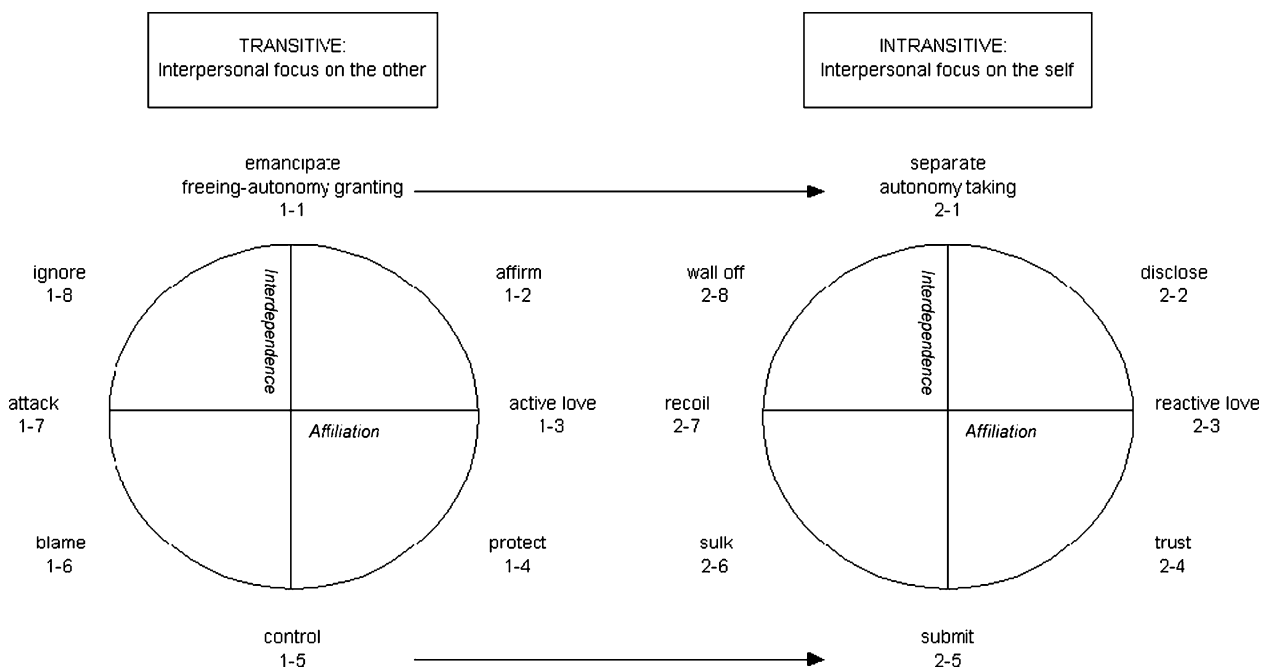


Figure I. The structural analysis of social behavior interpersonal model.

Najavits and Strupp (1994) concluded that effective therapists received fewer hostile SASB codings, and Samstag (1999) also found that negative complementarity was more often found in treatment failures compared with good outcomes with personality-disordered clients. Tasca and McMullen (1992) also found that in unsuccessful therapies hostile complementarity remained high in all phases of therapy. Safran and Muran (1995) found that therapists reacted differently to different forms of hostile expression by clients, but most reactions tended to be counteraggressive. Binder and Strupp, in a 1997 review, also noted that therapists with some regularity responded to client hostility with counteraggression, openly or subtly. Svartberg and Stiles (1992) found positive and negative complementarity to be more predictive of outcome than therapist competence. These results suggest that both therapist and client initiate and respond to interpersonal hostility with hostility in therapy and that high levels are associated with negative outcomes. These findings are clearly a challenge of importance to researchers, psychotherapists, and trainees.

According to interpersonal theory, a person who has repeatedly experienced humiliation and rejection from important others will internalize expectations of rejection and invite it from others through defensive, rejecting behaviors and be quick to respond to hostile humiliation and control with defensive and often passive, rejecting behaviors. This has so far been supported in the literature. It may also be anticipated (e.g., both from interpersonal and psychodynamic theory) that a client who has internalized expectations of being humiliated, rejected, or neglected will also be hypervigilant to such behaviors from others, experience doubt and skepticism about the therapist's helpfulness, and tend to perceive criticism when the therapist tries to be helpful and respectful (Killingmo, 1995).

Hypotheses

Four hypotheses were addressed, all of which were related to the dominant role of hostility in treatment failures. First, we expected that clients and therapists in negative-change therapies would show a lower "match" in their interpersonal communication patterns than clients and therapists in positive-change cases and that this would characterize all three sessions studied. Although Henry et al., (1986) and later studies have examined differences between clients and between therapists in various outcome groups, the focus in this study was on the similarities and differences between therapists and clients within each outcome group.

Second, we anticipated that proportionately less friendly and more hostile complementary interactions would predict negative outcomes regardless of initiator and be predictive of all sessions studied. This expectation is a partial replication and expansion of earlier studies of, for example, Henry et al. (1986) and Svartberg and Stiles (1992).

Third, we hypothesized that client rejection of therapist efforts would characterize negative-change therapies over the course of therapy. Consequently, there should be proportionately more instances of client defensive responses to therapist friendly interventions in the negative-change group (e.g., Killingmo, 1995), and this may help explain why therapists not only respond to but initiate hostile interactions. This expectation was based on the premise that therapists' hostility would be especially aroused by clients' rejection of their professional skills.

Finally, it was expected that the development of the client-therapist interaction within individual sessions would be different in the two groups. Specifically, we anticipated that hostile interactions would be high and not resolved during the in-session in negative-change therapies and client defensiveness against therapist interventions would not abate. In contrast, in therapies with good outcomes, we expected a normal course of client disclosing and therapist affirming in the first part of the session, followed by increasing therapist activity spent on efforts to explain, clarify, or interpret, which the client accepted or became engaged in discussing further. Hostile interaction would be low throughout or at least be resolved at the end of the session.

By choosing a nested within-therapists design with one positively changed and one negatively or not changed client from each, an effort was made to study whether the same therapist gets drawn into different interpersonal behaviors with clients who later have good outcomes than with clients who end up as treatment failures. In the present investigation, interpersonal behaviors were studied in Sessions 3, 12, and 20 of positive- and negative-change therapies with the same therapists to evaluate whether the interactions established early in therapy were stable throughout or whether the trajectories were different in different outcomes. Earlier research (Henry et al., 1990; Nelson, 2004) suggested that therapists with negative self states are more easily drawn into hostile interchange in difficult therapeutic situations, whereas this study focuses on microanalytic interactions that arise in therapeutic dialogues between different clients with the same therapist. A purpose was also to choose clients with different therapy outcomes who, at the outset of therapy, did not differ in diagnosis, level of symptomatic distress or in who

described interpersonal problems to control for the possible moderating effects of severity of psychopathology.

Method

Client Sample

Data from this study came from the Norwegian Multisite Study of Process and Outcome in Psychotherapy (NMSPOP; Havik et al., 1995), which is a naturalistic study with a sample of 373 outpatients from eight sites comprising 15 psychiatric outpatient clinics within the Norwegian public health system. The Regional Committee for Medical Research Ethics for Eastern Norway accepted the protocol for the study. Participation in the study was based on informed and signed consent. Enrollment of clients took place from 1995 to 2000. The inclusion policy was liberal: The only exclusion criteria were age younger than 18 years, psychosis, drug or alcohol abuse as the primary problem, mental impairment, and need for emergency treatment and hospitalization. At each site, a trained coordinator (psychologist or psychiatrist) informed, assessed, and included the clients. An effort was made to ensure that 50% of participants had a diagnosis of personality disorder. Most clients accepted the invitation to participate. In a pretreatment session, the clients completed several questionnaires. Also, the coordinator made diagnostic assessments according to the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition [DSM-IV]; American Psychiatric Association, 1994) criteria based on the Structured Clinical Interview for DSM-IV Axis I Disorders (Spitzer, Gibbon, Skodol, Williams, & First, 1994) and Axis II Disorders (First, Spitzer, Gibbon, Williams, & Benjamin, 1994). Clients were also assessed during and after therapy and at follow-up, and all therapy sessions were audiotaped.¹

From this sample, 28 individuals were selected: 14 negative-change cases (NC) and 14 positive-change (PC) cases. The sample was drawn at a time when fewer than 100 therapies were completed, and the therapies, at the time of selection, were identified as a PC and an NC or no-change case by the same therapist and the participant had completed therapy. All but one individual completed more than 20 hr of therapy.

Fourteen (eight women, six men) mostly highly experienced therapists each contributed one PC and one NC case. They had practiced therapy for 11.9 years (range = 4–26). All but two were psychologists. Only four clients (one PC and three NC) were men. The clients were a mean age of 36 years ($SD = 7.8$; range = 26–52 years) with an average of 12 years of education (range = 7–18 years). Fourteen were mar-

ried or cohabiting and 14 were single or divorced. Twenty had from one to four children, and eight had none. Fourteen therapies were time limited to 40 sessions. The therapies were conducted as usual in the clinics. Eight therapists were psychodynamically oriented, five identified as eclectic, and one was cognitively oriented.

Procedures

After selection of cases, the first, middle, and last 7 minutes of the audiotaped Sessions 3, 12, and 20 were chosen for transcription. The communications were divided into thought units according to the criteria used by Henry et al. (1986). Each unit consisted of a meaningful sentence, called an entry. Using the SASB conceptual model, each entry was coded for speaker, surface, and cluster. Each entry was given a cluster code (eight elements) on the basis of their scores on the two dimensions: affiliation and interdependence. In some cases, however, more than one cluster code was evaluated as appropriate. In such cases, the entry was given more than one code or element. The entries were identified and coded by two graduate students after extensive training in coding rules. The coders were unaware of therapy outcomes. Reliabilities of cluster scoring were tested for Session 3; mean $\kappa = .76$ (range = .69–.83). The reliability for Cluster 8 (ignoring/walling off) was low, and disagreements were most often with Cluster 6 (criticizing/sulking; Høibakk & Hægland, 2000). In the further analyses, Clusters 6 and 8 were combined.

The clusters defining the poles of each SASB dimension were not used by the coders except for Cluster 5 (control/submission). In a therapeutic relationship, which is a helping and neither a fighting nor love relationship, it is not to be expected that the polar extremes of affiliation, Cluster 7 (attack) and Cluster 3 (active/reactive love), are relevant codes. For the interdependence dimension, Cluster 1 (emancipate/separate), which is the extreme negative of interdependence, was not coded, whereas Cluster 5 (control/submission) was. This coding pattern duplicates Henry et al.'s (1986) study, of which the present study is a partial replication. Interpersonal communication in the therapeutic settings seems, therefore, most often to be understood as a real blend of affiliation and interdependence. Clusters 1, 3, and 7 were, therefore, omitted, leaving Clusters 2, 4, 5, and 6/8 for analysis.

Defining Outcome Groups

Differences in change scores on Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1983). The

Global Severity Index (GSI) was used as one of two criteria defining the two outcome groups. The GSI, which combines information about the number of symptoms and the intensity of perceived distress across the 90 symptoms, was used because it is seen as the best single indicator of current level of distress (Hill & Lambert, 2004). A PC outcome was defined as a clinically reliable GSI change (Jacobson, Follotte, & Revenstorf, 1984) from beginning to end of therapy. In the current data, the critical value for reliable PC was .40. Clients with GSI change scores below this level were classified as showing no or negative change. Thirteen of the 14 clients in this group showed deteriorating scores.

Inventory of Interpersonal Problems (IIP-C; Alden, Wiggins, & Pincus, 1990). The IIP-C from the 64-item circumplex version was completed by all participants pre- and posttherapy. The general factor of IIP-C has been shown to be related to symptom severity, negative affectivity, and self-deception (Tracey, Rounds, & Gurtman, 1996). The change scores for the outcome groups are given in Table I, both pre-post therapy change (which constituted the second criterion for group membership) and pre-to follow-up 2 years later.

Additional instruments. All participants completed a version of the introject surface of SASB- Intrex long form A (Benjamin, 1988), which contains 36 items that describe attitudes and feelings toward oneself. Different members of the steering committee of the NMSPOP, all researchers and clinical experts with extensive bilingual competence, did the translation and back translation.

In NMSPOP, the general SASB instruction asking participants to rate themselves "at best" and "at worst" was changed into rating themselves as they "usually are." The reason for changing this reference of judgment was to increase the probability of measuring more stable aspects of self-relatedness.

The attack pattern (ATK) describes the most hostile form of self-relatedness and has been demonstrated empirically (Monsen, Lippe, Havik, Halvorsen, & Eilertson, 2007) to be the pattern most strongly related to psychopathology. Initial scores and change scores are presented in Table I.

DSM-IV Axes I, II, and V assessments (i.e., of, respectively, symptom diagnoses, personality disorders, and global functioning [Global Assessment of Functioning, or GAF; First et al., 1994]) were available pre- and posttherapy. Change index for GAF (T1-T2) was computed. For Axis II, the total sum of personality disorder criteria was used as a

Table I. Characteristics of Clients before Therapy and Change after Therapy.

| Variable | Negative change (<i>n</i> = 14) | | Positive change (<i>n</i> = 14) | | <i>t</i> | ES |
|------------------------------|----------------------------------|-----------|----------------------------------|-----------|----------|-------|
| | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | | |
| Group defining criteria | | | | | | |
| GSI | | | | | | |
| Pretherapy (T1) | 1.45 | 0.74 | 1.53 | 0.56 | -0.33 | -0.12 |
| Posttherapy (T2) | 1.71 | 0.87 | 0.72 | 0.47 | 3.76** | 1.43 |
| Change (T2-T1) | 0.27 | 0.46 | -0.82 | 0.33 | 7.11** | 2.75 |
| Change (T5-T1) | -0.12 | 0.46 | -0.71 | 0.36 | 3.41** | 1.42 |
| IIP | | | | | | |
| Global score pretherapy (T1) | 1.72 | 0.60 | 1.60 | 0.68 | 0.47 | 0.18 |
| Global score (T2-T1) | 0.01 | 0.20 | -0.42 | 0.36 | 3.65** | 1.48 |
| Psychopathology measures | | | | | | |
| Sum SCID-II criteria | 15.29 | 3.00 | 13.57 | 2.24 | 1.71 | 0.65 |
| SASB Attack | 0.28 | 0.64 | 0.14 | 0.68 | 0.57 | 0.30 |
| SCID | | | | | | |
| GAF (T1) | 52.29 | 11.94 | 60.36 | 4.83 | -2.34* | -0.89 |
| GAF change (T2-T1) | 5.38 | 9.06 | 6.79 | 8.44 | -0.42 | -0.16 |
| Therapy | | | | | | |
| Total sessions | 46.93 | 22.47 | 39.00 | 17.76 | 1.07 | 0.39 |
| Duration (months) | 16.30 | 6.61 | 15.01 | 3.94 | 0.75 | 0.24 |
| Demographic | | | | | | |
| Age (years) | 35.29 | 6.93 | 36.50 | 6.93 | -0.42 | -0.17 |

Note. GSI = Global Severity Index; T1 = pretherapy; T2 = posttherapy; T5 = 2-year follow-up; IIP = Inventory of Interpersonal Problems; SCID = Structured Clinical Interview for *DSM-IV* Axis II Disorders; SASB = structural analysis of social behavior; GAF = Global Assessment of Functioning.

p* < .05. *p* < .01.

measure of severity of pathology. Sixty-five percent of the clients had diagnoses of affective disorders, either major depressive episode or dysthymic disorder; 50% had anxiety disorders, 29% of whom also had affective disorders and 14% had somatoform disorders. Thirty-nine percent had a personality disorder (Cluster C: 72%; Cluster B: 9%; Cluster A: 18%).

Coding SASB

The ratings showed that practically all therapist entries were coded for Surface 1 (i.e., focus on other), while practically all client entries were coded for Surface 2 (i.e., focus on self), reflecting the asymmetrical nature of the psychotherapeutic relationship. Surface 3 (i.e., the introject) was coded so rarely that it was dropped from the analyses.² Some entries received more than one code (complex codes) consisting mostly of one friendly code with an additional underhanded hostile code. These are considered negative and occur mostly in treatment failures (Henry et al., 1986). In this study, complex codes were also significantly more frequent in negative outcomes, $\chi^2(1)$, ($N=2,494$) = 130.27, $p < .01$. Because the hostility (or meta-message) is underhanded, we considered this the more important part of the message and entered only the negative code in the analyses. We did not consider the friendly and the hostile codes as independent codes where both could be separately entered into the analyses. In double friendly codes, the most prominent one was chosen.

Transition Analyses

Interactions were coded sequentially, making transition analyses possible. For these analyses, adjacent entries from client and therapist were chosen. Both clients and therapists had uninterrupted sequences of from one to nine entries between entries from the other dialogue partner. (The longest number of uninterrupted entries for any client was nine and for therapists six. The modal numbers of entries between entries from the other were one and two). The last element from one (the initiator) and the first element from the other (the responder) comprised a "transition." Transitions initiated by each were separated in the analyses (i.e., there were separate analyses of therapist-initiated and client-responding transitions and client-initiated and therapist-responding transitions). Only first-lag transitions were analyzed (i.e., adjacent communications). Examples of friendly complementarities would be "Yes, both positive and negative feelings are held back, nothing is coming out, neither desperation, tears, nor joy"

(T4), "No (C4), that's characteristic of me as a person, that I want control. I asked my Dad, he said that 'already as a boy you wanted control'" (C2). Negative complementarity is exemplified by the following statements: "Perhaps? You, who go around fearing that you will go crazy?" (T6) "Do you think that is so strange?" (C6). An example of a helping therapist cluster score followed by a rejective client cluster score is "It has become so painful to remain in the situation without getting the response you need that you would rather avoid taking an initiative?" (T4), "I feel that it doesn't mean anything. Nothing means anything anymore" (C8). The latter is a walling off and avoiding response, ignoring the therapist's invitation to explore through an interpretation.

Given four cluster categories (2, 4, 5, and 6/8) and the two participants as either initiator or responder, 16 (4 × 4) possible transition types and 16 types for the therapist as initiator could be analyzed as transitions. Only seven of these were selected for further analyses, namely those relevant to the communication-related expectations: six complementary transitions and clients' defensive reactions to therapist protective interventions.

Complementarity

Complementarity as an organizing principle in interaction has been demonstrated both generally and in therapy (cf. Henry et al., 1986; Sohlberg, Claesson, & Birgegard, 2003; Svartberg & Stiles, 1992). It is, however, not a concept with unitary meaning or measurement. Henry et al. (1986) defines complementarity as affiliation correspondence and interdependence reciprocity. Complementarity has been operationalized as correlations between aggregated cluster frequencies in interactions (e.g., Sohlberg et al., 2003), but more often it has been measured in transition and sequence analyses. Several researchers use complementarity to mean the adjacent speeches of two speakers in a transition that are given the identical cluster code or nearly the same cluster code (i.e., identical codes on both or only one SASB dimensions). Degree of closeness between clusters in the circumplex has also been used to weight sequences for degree of complementarity in some analyses (cf. Dietzel & Abeles, 1975; Henry et al., 1986; Svartberg & Stiles, 1992). In the present study, it seemed inadvisable to use weighted scores, because three of the eight clusters were never coded. Complementarity was, therefore, defined as adjacent client-therapist speeches given the identical cluster code.

Definitions of positive and negative scores may also differ. Henry et al. (1986) and Svartberg and

Table II. Mean Relative Frequencies (Percentages) and Correlations Between Relative Frequencies of Clients and Therapists by Interaction Types.

| Variable | Session 3 | | | Session 12 | | | Session 20 | | |
|--|----------------|----|----------|----------------|----|----------|----------------|----|----------|
| | Rel. frequency | | <i>r</i> | Rel. frequency | | <i>r</i> | Rel. frequency | | <i>r</i> |
| | C | T | | C | T | | C | T | |
| Positive-change group (<i>n</i> = 14) | | | | | | | | | |
| Positive clusters | 85 | 81 | .77** | 81 | 83 | .64** | 80 | 73 | .70** |
| Negative clusters | 10 | 8 | .64** | 13 | 8 | .79** | 11 | 14 | .72** |
| Interdependence cluster | 5 | 11 | .76** | 6 | 10 | -.07 | 6 | 12 | .18 |
| Negative-change group (<i>n</i> = 14) | | | | | | | | | |
| Positive clusters | 72 | 73 | .70** | 70 | 75 | .74** | 75 | 75 | .42 |
| Negative clusters | 21 | 16 | .77** | 24 | 14 | .73** | 20 | 17 | .43 |
| Interdependence cluster | 7 | 12 | .67** | 5 | 11 | .41 | 4 | 8 | -.48 |

Note. Positive clusters = sum Clusters 2 and 4; negative clusters = sum Clusters 6 and 8; interdependence cluster = Cluster 5. C = client; T = therapist.

p* < .05. *p* < .01.

Stiles (1992) have all included the negative pole of interdependence (i.e., separation) as positive and the positive pole (i.e., enmeshment) as negative. The interpretation of “pure” interdependence (i.e., when not in a blend with affiliation) is as yet unclear (see Monsen et al., 2007, and Tracey et al., 1996, for comments on interdependence in the introject surface), and we chose to keep it as a separate code. Clusters 2 (affirm/disclose) and 4 (help/trust) were combined in a positive index and Clusters 6 (criticize/sulk) and 8 (ignore/wall off) in a negative index in the analysis of aggregated scores presented in Table II. Cluster 1 (emancipate/separate) was never coded, and Cluster 5 (control/submit) was analyzed as a separate interdependence score, leaving three aggregated scores (positive, negative, and interdependent) for analyses of interaction styles and four clusters for transition analyses (Clusters 2, 4, 5, and 6/8).

Base rates of codes (i.e., how frequently a code is used) are likely to influence measures of complementarity and other interaction measures (Gurtman, 2001). To evaluate a possible influence on correlations between client and therapist scores, base rates (mean aggregated frequencies) were included in Table II.

Analyses

The data were examined at two levels. For the transition analyses, the transition (defined as a combination of two adjacent elements) was the observational unit. In those analyses, each element contributed to the total pool of elements, disregarding in which therapy the transition was observed. This strategy may obviously introduce uncontrolled dependency among observations and thereby invalidate statistical tests. Results of these analyses are

presented for descriptive purposes, without tests of statistical significance. Besides unconditional and conditional probabilities, adjusted standardized residuals (ASRs) were applied. ASRs were computed as follows: $(O - E) / \text{SQRT}[nR * nC * (1 - nR/N) * (1 - nC/N) / N]$, where *O* is an observed frequency, *E* is an expected frequency, *nR* is the row total, *nC* is the column total, and *N* is the total number of cases. The expected frequency was calculated as $(nR * nC) / N$, and the residual thereby indicates a deviation from what would be expected from the marginal distributions (base rates). The ASR has a normal distribution and may normally also be interpreted as a statistical test (with values above 1.96 being statistically significant at a .05 level). As pointed out, this application of the ASR may not be warranted in the present context. At any rate, a large ASR will be improbable if data are generated by a random process, and ASR is presented to highlight cells that deviate substantially from what would be expected if data were random.

For analyses of cluster proportions and for transition proportions, data were aggregated to an individual level (*n* = 28), and for these analyses dependency of observations was not a problem. In these analyses, ordinary statistical tests (*t* tests) of mean differences as well as correlations (Pearson's *r*) were applied.

Results

Representativeness of the Groups Studied

Two questions concerning representativeness need attention. One is whether the sample of 28 clients is representative for the larger group of 373 in the therapy project. The other is whether NC clients completing therapy are representative also for early

dropouts from therapy. The NC group consisted of completed therapies. It might be argued that therapies headed for a negative outcome often lead to early dropout, and dropouts may be different from negative outcome completers. Dropouts are rarely followed up in research because of client unwillingness, as was the case also in our larger study. All clients were assessed before therapy, however, and differences on the SCL-90-R and IIP-C before therapy were analyzed by analysis of variance (ANOVA). Four groups were compared: early dropouts (before 20 sessions, $n=28$), NC clients, PC clients, and completers in the remaining sample ($n=319$). Tukey's corrections were applied for all post hoc comparisons. No significant differences between any two groups were found on any SCL-90-R subscales. On IIP-C scores, differences were found only between the remaining sample and dropouts on IIP clusters HI (nonassertive), JK (exploitable), and LM (overly nurturant), with significantly higher scores for the large remaining group of completers. There were no significant differences between any of the four groups on *DSM-IV* Axis V GAF or on *DSM-IV* Axis II personality disorder sum of criteria. The generalizability of findings in the present study does not seem to be limited by unique features in the NC completers. The present sample also seems representative of the larger therapy project sample.

Characteristics of the Sample

As shown in Table I, the PC and NC groups were not different on most diagnostic measures at pretherapy. Their scores did not differ on outcome measures, SCL-90-R, and IIP global scores, and there were no significant differences on SASB introject scores or sum criteria on *DSM-IV* Axis II. The groups did not differ on *DSM-IV* Axis I diagnoses, nor did they differ on sum criteria on Axis II diagnoses of personality disorders. The only measure on which the two outcome groups differed was *DSM-IV* Axis V (GAF), where the NC group scored significantly lower, indicating somewhat lower general level of functioning. NC individuals were more often single and not cohabiting (eight in NC group vs. one in PC group), suggesting fewer intimates in their social network. The two groups did not differ either in number of therapy sessions or in total duration of therapy. Expectations of positive change from therapy were equally optimistic in both groups (from target Complaints, Havik, 1975), $t(26)=0.67$, *ns*.

Whereas T2-T1 and T5-T1 changes on the SCL-90-R were both significantly different across outcome groups, this was not so for IIP at follow-up. For IIP global scores, the T1-T5 change was not

significantly different for the two groups even if the effect size was fair ($d=0.65$).

Client-Therapist Communication Patterns

Table II presents the distributions of mean relative frequencies (percentages) of positive, negative, and interdependent cluster scores for each outcome group and each session as well as correlations between relative frequencies of clients and therapists by interaction types. Aggregated scores were computed as frequencies of certain cluster scores divided by total number of entries for each session within therapies. Worth noting is that the correlations shown do not seem to be affected by the base rates of the cluster scores (i.e., the frequencies of scores underlying the correlations). For example, in the NC group, the correlations between client and therapist scores are comparatively low in Sessions 12 and 20, whereas the relative frequencies of scores are identical to those found in Session 3. In addition, the correlations between clients' and therapists' scores are lower for negative outcomes as anticipated and decrease throughout the sessions. In positive outcomes, correlations are higher throughout and more stable. The latter suggests that in negative outcomes clients and therapists are increasingly "out of tune" in their communication patterns.

Complementary Interactions in the Outcome Groups

The results of the transition analyses of the three sessions are presented in Table III. The table shows conditional probabilities (as percentages) of a certain outcome given the type of client-therapist interaction and ASRs (see Method section). Conditional probabilities as well as ASRs were calculated based on marginal distributions from a Transition \times Outcome cross-tabulation done separately for each session. ASRs are only presented for the NC group, because those for the PC group will, by definition, be identical except for a reversed sign.

As anticipated, hostile complementarity (Clusters 6/8) predicted NC outcome for Session 3 and peaked at Session 12. This tendency was clearly weaker in Session 20. For the first two sessions analyzed, the predictions were the same whether clients or therapists initiated the interaction. Friendly complementarities (Clusters 2 and 4) predicted PC outcome in Sessions 3 and 12, but the tendency for hostile complementarity was weaker in Session 20. Again, this was the case regardless of who initiated the interaction. The anticipated stability in client-therapist interaction could, therefore,

Table III. Conditional Probabilities (Percentage) of Type of Outcome by Session and Type of Client–Therapist Interaction.

| C–T interaction | Session 3 | | | Session 12 | | | Session 20 | | |
|--------------------------|-----------|------|------|------------|------|------|------------|------|------|
| | NC | PC | ASR | NC | PC | ASR | NC | PC | ASR |
| T affirming/C disclosing | 45.9 | 54.1 | –1.4 | 43.1 | 56.9 | –1.1 | 46.5 | 53.5 | –2.4 |
| C disclosing/T affirming | 43.7 | 56.3 | –2.8 | 44.4 | 55.6 | –0.5 | 46.1 | 53.9 | –2.8 |
| T helping/C trusting | 41.7 | 58.3 | –2.6 | 34.3 | 65.7 | –4.7 | 51.6 | 48.4 | 0.3 |
| C trusting/T helping | 42.8 | 57.2 | –1.5 | 31.7 | 68.3 | –3.9 | 49.1 | 50.9 | –0.4 |
| T hostile/C hostile | 70.7 | 29.3 | 5.0 | 70.2 | 29.8 | 5.7 | 60.0 | 40.3 | 2.0 |
| C hostile/T hostile | 66.7 | 33.3 | 3.9 | 72.2 | 27.8 | 5.3 | 57.4 | 42.6 | 1.3 |
| T helping/C hostile | 75.2 | 24.8 | 5.8 | 70.9 | 29.1 | 5.4 | 81.8 | 18.4 | 6.8 |
| Total | 48.2 | 51.8 | | 45.3 | 54.7 | | 54.7 | 45.3 | |

Note. ASR is calculated as $(O-E)/\text{SQRT}[nR*nC*(1-nR/N) * (1-nC/N)/N]$, where O is an observed frequency, E is an expected frequency, nR is the row total, nC is the column total, and N is the total number of cases. C = client; T = therapist; NC = negative change group; PC = positive change group; ASR = adjusted standardized residual.

not be documented beyond Session 12 for the complementarities studied.

Client Defensive Rejection of Therapist Friendly Interventions

The third hypothesis predicted that NC outcome would be predicted by clients' defensiveness and walling off in response to the therapist's friendly interventions. Table III shows that the probability of a NC outcome given this type of interaction (T4/C6/8) was very high in all three sessions.

Transitions (therapist–client dyads) were also aggregated to an individual level ($n=28$). Low frequencies of especially hostile interactions will necessarily lead to unstable estimates on an individual level and hinder detailed analyses. To overcome this problem, the seven types of transitions were collapsed into four main categories (mutually affirming, helping–trusting, mutually hostile, and client rejecting), disregarding who initiated the transition. Two-way ANOVAs, with session as a repeated measures factor and outcome as a between-subjects factor, were performed for all main categories. Because no main effect of session and no Outcome \times Session interactions were found, only the main effects of outcome are presented in Table IV. For mutual hostility and client rejection, the main effects of outcome were statistically significant.

Interaction Development Within Sessions

The number of observations was too low to permit a complete Session \times Period analysis, and observations for all three sessions were merged in these analyses. The anticipated developments were found. As may be seen from Table V, the NC group was characterized by relatively high levels of therapist helping (T4)/client rejecting (C6/8) and hostile

complementarity transitions throughout sessions. An interesting observation was that, in the NC group, hostile complementarity, especially therapist initiated, seemed to slightly increase rather than decrease in the last part of the session. This suggests that the tensions between client and therapist did not abate during the session, and conflicts or alliance ruptures were not resolved. In the PC group, especially the therapist helping (T4)/client trusting (C4) transitions increased toward the end of the session, possibly indicating an increased mutual understanding between therapist and clients.

Discussion

There did not seem to be initial differences on the defining criteria between dropouts in the larger sample and the NC group limiting the generalizability of the findings of low-change cases. Other differences in dropouts not studied here may, of

Table IV. Mean Probabilities of Different Interaction Patterns by Outcome.

| Outcome | <i>M</i> | <i>SD</i> | <i>t</i> (<i>p</i>) |
|--------------------|----------|-----------|-----------------------|
| Mutually affirming | | | |
| NC | .56 | .184 | –1.18 (.25) |
| PC | .63 | .112 | |
| Helping–trusting | | | |
| NC | .20 | .101 | –1.88 (.07) |
| PC | .27 | .091 | |
| Mutually hostile | | | |
| NC | .16 | .139 | 2.11 (.04) |
| PC | .07 | .071 | |
| Client rejecting | | | |
| NC | .08 | .075 | 2.19 (.04) |
| PC | .03 | .033 | |

Note. $n=14$ in both outcome groups. NC = negative change; PC = positive change.

Table V. Conditional Probabilities (Percentage) of Type of Outcome by Session Period and Type of Client–Therapist Interaction.

| C–T interaction | 1st period: beginning | | | 2nd period: middle | | | 3rd period: end | | |
|--------------------------|-----------------------|------|------|--------------------|------|------|-----------------|------|------|
| | Probability | | | Probability | | | Probability | | |
| | NC | PC | ASR | NC | PC | ASR | NC | PC | ASR |
| T affirming/C disclosing | 46.6 | 53.4 | –1.1 | 43.1 | 56.9 | –1.8 | 45.5 | 54.5 | –2.0 |
| C disclosing/T affirming | 45.1 | 54.9 | –2.1 | 42.7 | 57.3 | –2.3 | 46.4 | 53.6 | –1.7 |
| T helping/C trusting | 41.5 | 58.5 | –2.4 | 44.0 | 56.0 | –1.2 | 39.4 | 60.6 | –4.0 |
| C trusting/T helping | 39.5 | 60.5 | –2.0 | 39.9 | 60.1 | –2.0 | 40.0 | 60.0 | –2.5 |
| T hostile/C hostile | 65.5 | 34.5 | 3.8 | 62.0 | 38.0 | 3.7 | 75.5 | 24.5 | 5.4 |
| C hostile/T hostile | 64.0 | 36.0 | 3.0 | 59.8 | 40.2 | 2.9 | 73.6 | 26.4 | 4.7 |
| T helping/C hostile | 77.1 | 22.9 | 6.1 | 69.6 | 30.4 | 5.3 | 83.3 | 16.7 | 6.8 |

Note. ASR is calculated as $(O-E)/\text{SQRT}[nR*nC*(1-nR/N)*(1-nC/N)/N]$, where O is an observed frequency, E is an expected frequency, nR is the row total, nC is the column total, and N is the total number of cases. C = client; T = therapist; NC = negative change group; PC = positive change group; ASR = adjusted standardized residual.

course, be the case because there were some differences between the dropouts and the larger sample of completers in the direction of more experienced difficulties with nonassertiveness and exploitability.

Another limitation is the amount of data necessary for analysis of infrequent interactions. Twenty-two thousand entries were analyzed in this modest study. To obtain stable estimates of infrequent transitions, entries rather than persons were sometimes used as the unit of analysis. Statistics based on aggregated data were, however, also presented, but these analyses were less differentiated because of the relative infrequency of hostile transitions.

The four expectations formulated in the present study were mainly supported. The match in interaction style between therapist and client was reasonably high at the outset of therapy in the two outcome groups but decreased markedly in the NC group as therapy progressed. This suggests that in successful therapy therapist and client follow each other, as in a dance (i.e., the overall balance of positive and negative affiliation can be predicted for one by knowing the other), while this harmony decreases over time in treatment failures.

The match in Dominance \times Submission interaction did not differ between the two outcome groups at the outset and decreased markedly for both across sessions. At least in this study, interdependence did not appear to be related to outcome. Match in interdependence may have been an initial sign of acceptance of the therapist's authority, which lessened over time as clients began to assert themselves, in protest or autonomy.

The transition analyses confirmed that the therapists got entangled in belittlement, rejection, and ignoring of client messages in response to client interpersonal self-defense, and this predicted negative outcomes. The therapist not only responded to clients' invitations to complementary hostility but

also initiated hostility, to which the client reacted by avoidance and defensive complaints. Because the client nearly always had interpersonal focus on the self, active attacks or overt pejorative comments about the therapist were rare. Rather, the reactions were mostly passive, sulking, and defensive as if expecting negativity, seemingly causing irritation in the therapist or making for feelings of defeat. Negative complementarity predicted negative outcome more strongly in Session 12 compared with Session 3 but less than in Session 20. The interactions may have become more complex and individualized and less complementary as the participants got well into therapy. This study can only confirm that at about one third of the way into the average length therapy, hostile interplay between client and therapist predicts negative outcome. Apparently, the damage may have been done in the first 12 sessions, even if the hostility abated some later in the therapy process.

It is not known whether the two groups showed different trajectories in interpersonal interaction in the latter part of therapy. Half of the NC clients, despite lack of improvement in symptoms or in social relationships, nevertheless stated at the end of treatment that they were mostly satisfied (or more) with their treatment (6/14) and that they had changed some (or more; 8/14). None had direct criticisms of the therapist. Previous research (e.g., Johnson, Taylor, D'elia, Tzanetos, Rhodes, & Geller, 1995; Rhodes, Hill, Thompson & Elliot, 1994) has similarly found that clients rarely voice complaints about the therapist.

When the NC group commented on positive changes, they mostly emphasized "increased self-understanding," while PC clients expressed that they were more content. The latter suggests an essential difference in satisfaction not with treatment but with life.

It was difficult in this study to point the finger at the actor who brought with her the seed of failure to the dialogue. The same therapists were represented in the PC and the NC groups, and the clients could not be differentiated on psychodiagnostic measures used at the outset, except for a somewhat lower functioning and capacity for attachment and relatedness (GAF and single status). It seemed to be in the dialogue itself that the constructive or unconstructive therapeutic climate was created. It may well be that by the third hour this climate had already been established and positions had become entrenched. What we observed in Session 3 and onward were signs of distrust, skepticism, and defensiveness toward therapists' effort to help among the clients who did not improve and signs of anger in the therapists. "The human tendency to transfer painful childhood experiences to significant persons in the present and to make the latter co-actors in the clients' conflicts and maladaptive patterns of behaviors" (Strupp, 1998) seems to be especially difficult to avoid and especially counterproductive with distrustful and angry clients.

Looking at developments during the in-sessions studied gave an expected development in the PC therapies. The session started with client disclosure and therapist affirmation and later in the hour efforts to understand and construct meaning. Hostility was steadily low. The NC group's sessions did not follow this pattern of development. Most marked was the high and increasing hostility throughout and the clients' rejection of therapists' efforts to help. The tension and distrust did not seem to subside or be resolved during their dialogue. The NC therapists' lower affirmation of clients' disclosures might also have been a sign of the therapists' discouragement as the smooth flow between therapist and client did not develop.

Despite the prediction of a negative outcome when therapists responded with hostility to client hostility, it is nevertheless noteworthy that therapists in NC therapies did not respond negatively to client hostility more often than therapists in PC therapies (27.7% in NC therapies vs. 31.1% in PC therapies). NC clients just invited them 2.5 times as frequently. This suggests that therapists frequently curbed a potential inclination to respond with hostility. The finding that therapist-initiated hostility nevertheless predicted negative outcome indicates that therapists in NC therapies were more negatively aroused. As Vakoch and Strupp (2000) comment on Klee, Abeles, and Müller's (1990) research on negative outcome therapies, "Therapists may try assiduously to interact positively even with very difficult patients, but they remain prone to negative reactions" (p. 206).

The strongest finding in this study was that NC clients rejected the therapists' efforts to be helpful. This was a pattern that persisted and even intensified through Session 20. It may be that the steady refusal to accept the therapists' competence made the therapists more vulnerable to counterrejection than any other factor in the therapy failures.

Insecure self states is one factor that increases therapists' vulnerability in the face of hostility (Henry et al., 1990) and their ineffectiveness during alliance ruptures in therapy (Nelson, 2004). Client distrust and defensiveness may be another factor that increases therapists' feelings of defeat. When combined, the prospect of a successful outcome seems remote, but these factors may also separately influence the potential for failures.

Therapeutic technique does not only consist of affirmation of the client, but it also includes challenge of maladaptive behavior, misperceptions, and repetitions and, not least, confrontation with both character and dynamic resistance. This will sometimes be perceived as negative criticism and will temporarily or more permanently lead to hostility and ruptures in the alliance unless dealt with. It is in the analysis and handling of such ruptures that therapy hinges (Safran & Muran, 1995). Several writers (e.g., Binder & Strupp, 1997; Teyber & McClure, 2000) have pointed to the necessity to heighten trainees' sensitivity to the complexity, subtlety, and vulnerability of negative interactions in psychotherapy and not least to clients' tendency to hide their misgivings about the therapist and to therapists' tendency to overlook alliance ruptures or misunderstandings. Strupp (1998) recommended intensive studies of single cases selected from well-organized studies. Especially important are case studies of therapies in which defensive, distrustful, and skeptical clients nevertheless reach positive outcomes. It seems advisable that such studies, highlighting positive and negative processes, also should be incorporated in therapist training.

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Notes

¹ All therapy hours were audiotaped, but transcription was limited because of the prohibitive cost.

² Because of the uniformity of focus in clients and therapists, further notation of focus or surface in the text is dropped.

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