

**CYCLICAL DYNAMICS IN THE THERAPY ROOM:  
THE INTERACTIVE ROLE OF THE THERAPEUTIC  
ALLIANCE IN PSYCHOTHERAPY PROCESS**



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# *Abstract*

The last decades have seen an exponential trend toward a relational reconsideration of psychoanalysis (Greenberg & Mitchell, 1983) that has drastically influenced aspects of both psychotherapy theory and research. On the theoretical side, indeed, the therapeutic process has been reformulated under an intersubjective perspective, and it is now conceived as a “specific psychological field” created by the interplay between the patient’s and therapist’s subjectivities (Stolorow, Brandchaft & Atwood, 2014). On the research side, the construct of therapeutic alliance as a relational dimension has become very important. Accordingly, recent conceptualizations define the therapeutic alliance as an “intersubjective negotiation process” (Safran & Muran, 2000) that interacts with the other variables of the therapeutic process (Roth & Fonagy, 2013), although little is still known about the precise dynamic involving these key dimensions. On these grounds, the present doctoral thesis aims to explore the role of the therapeutic alliance in the therapeutic process, by means of an intersubjective perspective in both group and single-case studies.

The first part of the thesis investigates the interaction between therapeutic alliance, technical interventions and metacognitive functioning in groups of patients, by focusing in a first study on the earliest stage of the treatment and, in a second one, on the more advanced stages. Results of both studies show that technical interventions and therapeutic alliance are associated in specific interactive patterns that can be differentiated in three different levels of therapeutic alliance: a positive, a neutral and a negative level. Furthermore, in these interactive patterns, metacognitive functioning plays a specific role of mediator depending on the level of alliance.

The second part of the thesis includes two single-case studies, involving a patient with an anxiety disorder diagnosis and with a deferential behavior toward the

therapist. The first study specifically focuses on the patient's collaborative alliance and its association with defense mechanisms, therapeutic relationship and therapist's technical interventions. On the contrary, the second study focuses on the investigation of alliance ruptures and their interaction with transference patterns and defense mechanism. Results show that the intersubjective approach applied on the deferential behavior, on the one hand challenges the real authenticity of patient's collaborative process, and on the other hand suggests that ruptures may provide a better understanding of the patient's transference and defense mechanisms.

Overall, this doctoral thesis indicates that the therapeutic process can be conceived as an interpersonal cyclical dynamic that involves both technical and relational factors. In this sense, the therapeutic alliance may be considered as a medium, by means of which other variables operate during the therapy.

# *Abstract*

Negli ultimi decenni, con l'affermarsi del modello relazionale (Greenberg & Mitchell, 1983), la concezione del lavoro terapeutico ha subito profonde trasformazioni, sia in ambito teorico che empirico. Nell'ambito della teoria psicoanalitica il process terapeutico è stato riletto secondo una prospettiva intersoggettiva, considerandolo "campo psicologico specifico" costituito dall'intersezione delle soggettività di paziente e terapeuta (Stolorow, Brandchaft & Atwood, 2014). Nel campo della ricerca empirica, ha acquisito particolare rilevanza lo studio del costrutto di alleanza terapeutica, la cui definizione ha assunto sempre più valenza relazionale. Recenti concettualizzazioni definiscono, infatti, l'alleanza terapeutica come un processo di "negoziiazione intersoggettiva" continuo (Safran & Muran, 2000) che si ipotizza interagire con altre variabili del processo terapeutico (Roth & Fonagy, 2013). Il presente elaborato ha dunque l'obiettivo di esplorare il ruolo dell'alleanza nel processo terapeutico attraverso una prospettiva intersoggettiva, sia in disegni di ricerca su gruppi di pazienti che in studi di caso singolo.

La prima parte della tesi indaga l'interazione tra alleanza terapeutica, interventi tecnici e funzionamento metacognitivo in gruppi di pazienti, focalizzandosi in un primo studio sulla fase di inizio della terapia ed in un secondo sulle fasi successive. Entrambi gli studi rivelano che gli interventi terapeutici e l'alleanza terapeutica si associano in pattern interattivi specifici, distinti in tre diversi livelli di alleanza terapeutica: positiva, neutrale e negativa. All'interno di questi pattern, il funzionamento metacognitivo gioca un ruolo di mediatore, differenziandosi a seconda del circuito preso in considerazione.

Nella seconda parte della tesi vengono, invece, presentati due studi di caso singolo che riguardano una paziente affetta da disturbo ansioso generalizzato e, nello

specifico, con modalità relazionale di qualità deferente nei confronti del terapeuta. Il primo studio si focalizza sull'indagine dell'alleanza collaborativa della paziente in associazione con gli interventi tecnici del terapeuta, i meccanismi di difesa e la relazione terapeutica. Il secondo studio si focalizza, invece, sull'indagine delle rotture dell'alleanza in interazione con i pattern transferali e i meccanismi di difesa. I risultati rivelano che l'approccio intersoggettivo declinato nello studio del funzionamento deferente, da un lato mette in dubbio l'autentica qualità dei processi collaborativi, dall'altro, la rottura fornisce una più chiara esemplificazione della qualità difensiva e transferale della paziente.

In conclusione, questo elaborato indica come il processo terapeutico possa essere inteso come una dinamica ciclica interpersonale che coinvolge fattori tecnici e relazionali. L'alleanza, in questo senso, viene considerata come un mezzo terapeutico, attraverso il quale altre variabili del processo operano nel corso della terapia.

*a Luca*

*1+1=1*

*"Nostalgia" di A. Tarkovskij*





# 1

*From A One-Person  
To A Two-Person Approach  
Of The Therapy Room*

*"Never did my heart beat for a lover as it did the day I walked up the Berggasse. Was that Vienna street really a steep climb? Or did it only appear so to me because I was at last going to see my God (at that time), who by some miracle had become accessible?"*

Maryse Choisy (1955) "Memories of my visit with Freud"

## 1 | THE RELATIONAL TURN IN PSYCHOANALYSIS

### 1.1 One-Person Psychoanalysis

The classical view of psychopathology mainly concerns the inner mind world of the patient (Breuer & Freud, 1883). At the beginning of Freud's theorization, symptoms were conceived consequences of traumatic experience coming from childhood and were often associated to sexual behavior (Freud, 1900, 1901, 1905a, 1905b). Hereafter, Freud started to consider psychopathology as an expression of inner conflicts about sexuality. In his structural model, the etiology of psychopathology was conceived as developmental immaturity, resulting from fixation, regression or retardation (Freud, 1923). This perspective embraced an intra-psychic and mono-personal perception that drastically impacted on the technique of analytic work with the patient. In fact, the therapist was considered both as an observer and as an interpreter: transference dynamics would originate from the patient, whereas countertransference dynamics would reveal an emotional interference in analyst's understanding of the patient (Freud, 1910).

The Freud's classical approach was then resumed by Melanie Klein. Indeed, on one hand, Klein underlined for the first time the importance of the relationship with the external ambient and the internal object in childhood for the development of Ego (Klein, 1931), introducing the "projective identification" concept (Klein, 1946). On the other hand, Klein continued to focus only on an intra-psychic interpretation of motivation, aggression and fantasy in the early childhood, following the mono-personal way.

Between 1940 and 1970, many authors, especially belonging to British Psychoanalytical Society, promoted different theorizations about the etiology of psychopathology in developmental age, linked to difficulties in the family environment. First, Balint (1968) moved the core focus from an intra-psychic conflict to a deficit configuration in familiar environment. Caregivers, that are not

able to give physical and psychological care to the child, would produce the “basic fault”, a psychological deficit that can be responsible for the child’s personality disorders (Balint, 1968). Second, Fairbairn (1952) underlined that libido is not primarily a pleasure seeking, but rather an object seeking. Therefore, the etiology of psychic diseases in Fairbairn’s conceptualization was based on the absence of the object in the caregiving. Similarly, Winnicott (1965) indicated the cause of psychopathology in a “not good enough mother” that is not able to properly satisfy infant’s needs. Finally, Sullivan (1954) focused on the needs to re-define the therapist’s role, who was no longer seen as a neutral therapist, but rather as a “participant observer” that may continuously influence the patient.

Far apart from this viewpoint, Anna Freud (1974) recognized two category of developmental psychopathology: a conflicted one, following the classical way, and a distorted growing, originated by a deficit in caregiving.

Despite the different perspectives of these authors, all of them developed new theories based on the structural model, encompassing to a certain extent also a relational framework (see for a discussion, Fonagy, 2010). Indeed, all these authors focused on the exploration of risk and protective factors of family environment for child development. Hence, these conceptualizations radically changed developmental psychopathology models (Fonagy & Target, 2003), stressing the importance of the mother’s real contribution.

In line with this, Kohut underlined the importance of the relationship between caregiver and child, focusing on the emphatic aspects of the caregiving bond (1977). Furthermore, Bowlby (1969) theorized that attachment is the fundamental motivational system in human being. Indeed, the quality of the attachment relationship between caregiver and infant may increase risk factors for the child’s development, and may even predict the formation of different psychopathological configurations. Together, Kohut and Bowlby’s contributions had a decisive impact to orient psychoanalysis from a mono-personal to a two-personal perspective (Carr & Cortina, 2011).

## 1.2 Two-Person Psychoanalysis

The new psychoanalytic trend toward a relational perspective was set forth by Greenberg and Mitchell's work (1983). These authors contrasted the British object relation approach (Fairbairn, 1952; Balint, 1968; Winnicott, 1965) and the American interpersonal psychiatry of Sullivan (1953) to the classical pulsional approach. In 1988, Mitchell and colleagues established a new study group in the Postdoctoral Program in Psychotherapy and Psychoanalysis in the New York University, named as "Relational Oriented" (Aron, 1990). Subsequently, in 2000, the International Association Psychoanalysis and Psychotherapy (IARPP) further established the Relational Movement. The Relational Movement was born as an "integrative movement" (Greenberg & Mitchell, 1983), in which different perspectives, even far from the psychoanalytic theory such as the infant research (Sander, 1977; Stern, 1985), the intersubjective perspective (Benjamin, 1990; Stern et al., 1998), the systemic-dyadic model (Beebe & Lachmann, 2002), could flow into.

First, the Boston Psychotherapy Research Group (Stern et al., 1998), focused on the intersubjectivity (Stern, 1985), defined as an innate motivational system. Stern explained that during the childhood, infants create implicit Schemas of Self, Schemas of Other and Schemas on Self with Other, that guide the interpersonal interactions. In this dynamic, the "affective syntonization" moments between caregiver and infant, where the emotions are expressed and shared with the caregiver, are extremely important. The therapist would, therefore, generate transformations in the patient, through the "present moment", in which the therapist may share new affective states in a subjective experience (Stern et al., 1998). In this approach, the therapeutic relationship would become itself the therapeutic instrument of change (Stern, 2004). Furthermore, Tronick (2003) sustained that the therapeutic relationship would act through the affective syntonization between therapist and patient, transforming the implicit memory system associated to the preverbal experience and to the regulation skills of the patient.

Second, Jessica Benjamin (1999) also drew attention to the reciprocal recognition

between self and others. Influenced by Stolorow, Brandschaft e Atwood (1987), Benjamin emphasized, the interaction between two subjectivity, the therapist and the patient, in the clinical setting, with the therapist who would have an active role in the therapeutic process.

Third, infant research gave scientific evidence about the relational importance in the early infancy, linked with the therapist-patient dynamic in the therapeutic process. More specifically, infant research underlined the regulatory principles that organize the relational experience with the other, that always exist, at an implicit level, in every interpersonal relation, and thus even between therapist and patient (Beebe & Lachmann, 2002). Influenced by Sandler's (1977) and Tronick's theory (Tronick & Cohn, 1989), authors in this framework pointed out the importance of balance of self-regulation and interactive-regulation processes in the interaction between caregiver and infant: a non-balanced regulation can evoke a relational inhibition or an hypervigilance. Ruptures and reparations moments in the interactive process between mother and infant may characterize also the interactive process between therapist and patient. These moments are conceived as very important for the therapeutic process, because they allow to reorganize the affective regulation skills of the patient.

Overall, in these perspectives, "intersubjectivity" has become a core concept in the understanding of theoretical changes from the one-person to the two-person psychoanalysis. Intersubjectivity was, indeed, defined as "the dynamic interplay between the analyst's and the patient's subjective experience in the clinical situation" (Dunn 1995, p. 723). Following Person, Cooper and Gabbard viewpoint (2005), in the last decades, intersubjectivity has assumed a focal point position in psychoanalysis theories and practice. In particular, intersubjectivity has emerged as one of the major foundations of several new schools in psychoanalysis, such as: the broad category of intersubjectivist schools (Aron, 1991; Atwood & Stolorow, 1984; Beebe & Lachman, 2002; Benjamin, 1990, 1995; Greenberg, 1988; Modell, 1993; Ogden, 1994; Renik, 1993; Spezzano, 1995; Stolorow et al., 1987), the interactional school (Boesky, 1990; Chused, 1991; Chused & Raphling, 1992), the relational schools (Bollas, 1987; Greenberg & Mitchell, 1983; Mitchell, 1988, 1993, 1997, 2001),

and schools based on aspects of self psychology (Goldberg, 1988, 1994; Kohut, 1959, 1977; Wolf, 1988). All of these schools, indeed, have highlighted some of the basic intersubjectivist assumptions that set these approaches apart from classical Freudian psychoanalysis, at least theoretically (Aron, 1991; Dunn, 1995; Mitchell, 2001). From here on out, in this doctoral thesis, the term “intersubjective perspective” harks back to this common meaning.

### **1.3 A Comparison Between One-Person And Two-Person Psychoanalysis**

The differences between the intersubjective and the classical conceptions of the nature and process of psychoanalysis can be summarized along three major lines.

First, the classical approach assumes that the analyst can be objective and that he or she can observe the patient from a “third person perspective”. The patient’s subjective reality is determined intrapsychically by the interaction of psychobiological tendencies (e.g., drives, original phantasies, psychosexual stages) with earlier experience, i.e., earlier than walking into the analyst’s office that day. In contradistinction, the intersubjective approach suggests that neither the analyst nor the patient can ever take a “third person perspective” because the material that emerges in a session is inevitably co-created by the mingling of both the patient’s and the analyst’s subjectivities. From an extreme point of view, there is no objective reality that stands outside the intersubjective matrix of a session. In this view, the patient’s subjective reality, as it emerges in a session, is not independent from the intersubjective matrix with the analyst. The patient’s psychic reality is not discovered or brought forward in time; rather, it is determined by interactive and relational phenomena prevailing at the moment. The intrapsychic origins assumed by the classical position have been replaced, therefore, by social origins (Person, Cooper & Gabbard, 2005).

Second, there is a divergence in what is conceived of as the main tendency of the psyche. In the classical view, it is to discharge energy and achieve pleasure. With this as a central goal, the immediate context becomes relatively nonspecific. This view leads toward a one-person psychology, in which the subjectivity of the analyst can be relegated to a secondary position. In the intersubjective view, the main

tendency of mind is to establish object relationships. To do this, the subjectivity of the object, as well as that of the subject, becomes crucial, and a two-person psychology emerges (Person, Cooper & Gabbard, 2005).

Third, the thinking behind the classical approach is causal and positivistic in that one searches for presumably findable causal links already existing in someone's mind. This is the classical model for proceeding in any natural science. Even in the more hermeneutic tradition, one searches for the pieces of subjectivity that make the most coherent narrative. In the intersubjective approach, the classical model of science has been partially replaced by a more nonlinear mode of conceptualizing that is inspired by dynamic systems theory (Prigogine, 1997; Prigogine & Stengers, 1984), complexity theory (Waldrop, 1992), or chaos theory (Gleick, 1987). This switch in models is necessary if the primary data in a session arise by virtue of the unpredictable interplay of two subjectivities.

## 2 | THERAPEUTIC ALLIANCE

### 2.1 Therapeutic Alliance Concept: From A One-Person To A Two-Person Approach

The therapeutic alliance is one of the most popular topics of psychotherapy research, especially because there is compelling evidence showing that the quality of the therapeutic alliance predicts treatment outcome (Horvath & Symonds, 1991; Martin et al., 2000). Critically, the evolution of therapeutic alliance concepts was strongly influenced by the psychoanalytic relation turn.

Therapeutic alliance concept originated from Freud's theorization about transference. Freud (1912) divided transference dynamics into "positive transference" and "negative transference" or translation. Positive transference means the positive, affective feeling between therapist and patient. Negative transference is composed by negative and sexual feelings; notably, this kind of affectivity was considered as an obstacle to the treatment. Positive transference, on

the contrary, reflects an “alliance” with the therapist, creating a collaborative mood, which is necessary to work with the patient. Indeed, in one of his last publications, influenced by Sterba, Freud (1937) specified that the analytic situation is based on an alliance between the analyst and a more rational and mature part of the patient Ego.

Subsequently, Ferenczi (1932) was the first author who considered the importance of the role of therapist personality and therapist experience, as an element that may influence the transference and countertransference. Authors from the Psychology of Ego (Anna Freud, 1936; Hartmann, 1958) focused on the real aspects of therapeutic relationship that lead them to develop the Therapeutic Alliance concept (Zeitzel, 1956). In fact, inefficacy of therapeutic process in some patients was conditioned by the failing of interpretative interventions because they were not accepted from the patient. This finding has allowed to change the approach of many therapists, for instance supporting the use of interpretative interventions only with other kind of technics (Safran & Muran, 2000).

Later on, Sterba (1934) differentiated the patient ability to work together with the therapist and the transference relationship between them. In particular, Sterba sustained that the Ego during the analysis is dissociated in two parts: one part able to cooperate with the therapist and the other one strictly related to the Es and the Super-Ego. Only when the first part is connected with the therapist, it would create the “Ego alliance” through a positive identification of patient with therapist, allowing to reach therapeutic goals.

Importantly, Zeitzel in 1956, conceived the term “Therapeutic Alliance” as a fundamental core of therapeutic work that is not possible to establish to some kind of personality diseases. Hence, Zeitzel was the first author to introduce a relational essence of therapeutic alliance (1958) describing that a good alliance with the therapist depends on the patient ability to create a positive and a trusted relationship with the others, which is in turn dependent on the patient’s quality of caregiving in his/her early childhood. In fact, only after the establishment of a good alliance, the patient may accept to work on the neurotic conflict, previously defended.



Finally, Greenson (1965) proposed a tripartite definition of therapeutic alliance, divided in working alliance, transference and real relationship, respectively. In particular, the working alliance is the therapist and patient ability to work together; the transference is the repetition of past irresolute conflicts in the present; the real relationship is the human correspondence between therapist and patient feelings, trust and respect between them. These three dimensions would be strictly interconnected to each other and reciprocally influenced (Greenson, 1967).

## 2.2 Trans-Theoretical Models Of Therapeutic Alliance

In the 70's, the interest on the therapeutic alliance construct shifted from psychoanalysis to empirical research. Therapeutic alliance, in fact, was empirically recognized as a relevant construct across different therapeutic approaches, with its reformulation that reflected this trans-theoretical perspective. In particular, the therapeutic alliance transition from a theoretical concept to an empirical construct was mainly sustained by Bordin's contribution.

Bordin's new definition of alliance (1979) re-interpreted the trans-theoretical role of the therapeutic alliance in a pantheoretical conceptualization. Bordin's therapeutic alliance is, indeed, composed by three interdependent components, that are: *tasks*, *goals* and *bond*. *Tasks* are the implicit and explicit activities that patients have to face during the psychotherapeutic process; *goals* are the objectives of the therapy; *bond* is the affective quality of the relationship between therapist and patient. These three dimensions would reciprocally influence each other. Critically, the value of Bordin's theorization can be fully understood only by the importance given to the interdependence between the three components, and thus to the view of alliance as a complex, dynamic and multidimensional construct (Safran, & Muran, 2003). Furthermore, it is worth noticing that each kind of task, goal or different quality of bond can be experienced in a dissimilar way by different patients (Bordin, 1979): a single task, for example, can be experienced as more or less useful, depending on the ability and/or the psychological functioning of the patient.

The most distinguishing feature of the modern pan-theoretical

reconceptualization of the alliance is its importance on collaboration and consensus (Bordin, 1980; Hatcher, Barends, Hansel, & Gutfreund, 1995; Luborsky, 1976). In contrast to previous formulations that emphasized either the therapist's contributions to the relationship (Rogers & Wood, 1974) or the unconscious distortions of the relation between therapist and patient (Freud, 1912), the "new" alliance concept emphasized the conscious aspects of the relationship (as opposed to unconscious processes) and the achievement of collaborative, "work together" aspects of the relationship. It is only with Bordin's definition of therapeutic alliance (1979), therefore, that the relational connotation of this dimension is introduced. Compared to previous conceptualizations, Bordin considered alliance itself as a curative aspect of therapeutic process (Lingiardi & Colli, 2015). From this point of view, Bordin's contribution has given a pantheoretical facet of the psychotherapy process (Lingiardi & Colli, 2015).

### **2.3 Empirical Research On Therapeutic Alliance And Outcome**

From the 50's to the 70's, psychotherapy research focused on outcome research, aiming to demonstrate the effectiveness of psychotherapy, in order to answer to Eysenck's provocation (1952) about the absence of empirically evidence on therapeutic changes. Meta-analysis studies demonstrated the effectiveness of psychotherapy compared to placebo and to control samples (Smith, Glass & Miller, 1980; Shapiro & Shapiro, 1982) and, critically, that all psychotherapy models have an equal level of efficiency, proclaiming the so called "Dodo Bird Verdict" (Luborsky, Singer & Luborsky, 1975).

Subsequently the "Dodo Bird Verdict", the therapeutic alliance became the nonspecific factor most investigated in psychotherapy research, also because it was identify as the nonspecific factor able to mainly explain variance in the outcome (Horvath & Luborsky, 1993). In this phase, many researchers investigated the relationship between therapeutic alliance and therapy outcome, taking into consideration several variables such as the perspective of evaluation (patient, therapist, or observer), the time of evaluation (early, middle, late, averaged), and

the kind of therapy (psychodynamic, cognitive-behavioural therapy, interpersonal psychotherapy, etc.) The results of this research were summarized in several meta-analysis studies.

The first meta-analysis of Horvath (Horvath & Symonds, 1991), including 24 studies, confirmed a moderate, but consistent association between alliance and outcome. Authors' review suggested that outcome was better predicted by patient-based ratings than by therapist or observer ratings, and that rating of alliance early on in therapy are more powerful predictors of outcome. The second meta-analysis of the author (Horvath & Bedi, 2001) confirmed that therapeutic alliance is the only variable that remains a stable predictor of the treatment outcome across treatment methods, leading to the necessity of focusing on the effects of personal and interpersonal interaction variables on outcome.

From the 70's a huge number of measures were created *ad hoc* to assess therapeutic alliance (Elvins & Green, 2008). Some of them conceptualized the alliance as a patient dimension, such as Luborsky's "Helping Alliance Counting Sign" (1976), others recognized also the therapist contribution to alliance formation, such as the "Working Alliance Inventory" (Horvath & Greenberg, 1989), other measures also evaluated negative therapist contributions, such as the "Vanderbilt Therapeutic Alliance Scale" (Harley & Strupp, 1983), and others recognized his/her emotional involvement, such as the "California Psychotherapy Alliance Scale" (Marmar & Gaston, 1988).

Until the 90's, most researches focused on the relationship between therapeutic alliance and outcome. These studies allowed to recognize the importance of nonspecific factors for therapy outcome. More specifically, growing interest was focused on the exploration of factors common to every psychotherapy orientation, such as, therapeutic alliance. Consequently, empirical research has tried to demonstrate the presence of therapeutic alliance in therapeutic process and its relevance in determine treatment outcome (Lingiardi, 2002). At the same time, because these researches ignored the processes implicated in the establishment and development of the therapeutic alliance, the results were not completely relevant for clinical practice (Lingiardi & Colli, 2015).

## 2.4 From Therapeutic Alliance To Intersubjective Negotiation

Starting from the 90's, there was a growing interest on the role of therapeutic alliance and on techniques that may disturb its development in therapist-patient relationship. In this exploration, alliance was no longer considered as a static phenomenon and as a prerequisite of the treatment, but rather as an ongoing co-construction between patient and therapist. Therefore, the phenomenon of therapeutic alliance ruptures became very interesting in empirical exploration. This interest reached both empirical research but also the theoretical conceptualization of therapeutic alliance itself.

Safran and Muran (2003) refined the concept of alliance by drifting from the construct of "agreement" to "negotiation". More specifically, they proposed that alliance is a negotiation between therapist and patient: under this view, alliance is not a static variable necessary to establish an effective intervention, but rather a constantly shifting, emergent property of the therapeutic relationship (Safran & Muran, 2003, 2006). Therefore, Safran and Muran (2000) defined the therapeutic alliance a constant intersubjective negotiation process between therapist and patient, underlining that the negotiation process represents itself the therapeutic changing process. The co-participation in this process would originate continuous sequence of ruptures and repairing phenomenon. The authors describe therefore the development process of ruptures of alliance, as a discordance about task or goal of the therapy or problems about bond quality (Safran & Muran, 2000). In this formulation rupture moments can be defined as "a breakdown in the collaborative process between therapist and patient, a poor quality of therapist-patient relatedness, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset" (Safran & Muran, 2006, p. 288). As a consequence, ruptures became an essential element as a "window on the relational schemas of the patient", or rather as the opportunity to investigate and better understand patient' functioning. In this direction, repairing alliance ruptures means to intervene and to reorganize the relational schemas of the patient (Safran &

Muran, 2000). Alliance ruptures were divided in two main categories: withdrawn ruptures and confrontation ruptures. Withdrawn ruptures are characterized by a patient avoidance from the therapist or an isolation of his/her affectivity; confrontation ruptures are characterized by a direct opposition to the therapist that may generate in the therapist feeling of anger, impotence or desperation. The type of ruptures mostly shown by the patient reflects his/her coping strategy or feature of the psychic functioning: consequently, correctly identifying ruptures can guide the therapist interventions to repair it. Therapists, in fact, should be able to recognize the relational cycles that patient produces, exploring with the patient the "*hic et nunc*" of the therapeutic relationship in an emphatic attitude (Safran & Muran, 2000).

In line with Safran and Muran perspective, literature pointed out the importance to treat alliance ruptures, as a fundamental aspect of change process. In fact, a better outcome has been reported in patients who passed across a phase characterized by an increase of negative behaviour than in patients who have only showed a positive collaboration (Golden & Robbins, 1990). Accordingly, in Patton and colleagues' research (1997), a quadratic alliance trend "U" correlated with a positive outcome, compared to a linear alliance trend. Moreover, Kivlighan and Shaughnessy (2000) explored the alliance trend in a sample of 79 dyads of therapists and patients in the first 4 sessions of therapy. Results showed the existence of three different patterns: a stable one, a linear one and a quadratic one. In line with the previous study, a positive correlation between the quadratic trend and a positive outcome emerged. On the contrary, Stiles and colleagues (2004), found a "V" trend as a sequence of ruptures and reparation associated to a better outcome.

To conclude, Safran and Muran's contribution seems to bridge the gap between psychoanalytic theory and empirical research. Previously, while empirical research has deserved a growing interest in therapeutic alliance, psychoanalysis theory started to lose interest in the exploration of such concept (Levy, 2000; Safran & Muran, 2000). This huge paradox is explained, on the one hand, by the psychoanalytic culture's inclination to neglect the empirically evidence of his

theoretical consideration (Ponsi, 2000), and, on the other hand, by the overlapping between “relationship” and “therapeutic alliance” concepts. In psychoanalytic theory, indeed, the therapeutic alliance was considered as a part of the therapeutic relationship, i.e., the reason why it lost importance. In line with this, in the two-person model, the therapeutic relationship and its regulation became the core concepts of theory and technique, whereas therapeutic alliance was essential in previous formulations, such as the classical psychoanalysis and Ego Psychology, in which relational aspects were undervalued (Safran & Muran, 2000). Yet, alliance concept did not disappear from relational theories: on one hand, it was absorbed by the more comprehensive therapeutic relationship conceptualization (Lingiardi & De Bei, 2011), losing interest and usefulness; on the other hand, some “alliance” concepts are necessary to identify problems of relationship, such as rupture or impasse. In this framework, Safran’s intersubjective negotiation theory seems to integrate the specificity of therapeutic alliance conceptualization with a relational perspective: ruptures and reparation of therapeutic alliance are co-constructed by therapist and patients.

## 2

### *The mystery of the therapy room*

*“Psychoanalysis was my last and most deeply experienced revolution; and Freud, who was rightly considered a conservative on social and political issues, became for me the greatest revolutionary of the century. Looking back, I see three distinct upheavals in my life: liberation from the tyranny of my mother; the revelation of socialism; and my release from the chains of the unconscious through psychoanalysis.”*

Helene Deutsch (1973) “Confrontations with Myself, an epilogue”

## 1| THERAPEUTIC ALLIANCE AS A COMMON GROUND FOR THEORY AND RESEARCH

Theoretical conceptualizations from psychoanalytic clinical theory and psychotherapy research tend generally to interpret therapeutic process and therapeutic change as the result of interactive dynamics between therapist and patient.

In particular, since the 80's, psychoanalytical theory has adopted a relational perspective, in which the relationship between therapist and patient represents the theoretical and clinical core (Greenberg & Mitchell, 1983). In this sense, the relationship with the therapist may likely become a corrective emotional experience (Alexander & French, 1946; Alexander, 1961), able to change patient's inner dysfunctional experience.

On these grounds, authors from different theoretical perspectives, ranging from the interpersonal motivation system (Liotti, 1994) to Ogden "intersubjective psychoanalytic third" (Ogden, 1991, 1994), focused on the "*hic et nunc*" of the therapist-patient relationship. More specifically, Jessica Benjamin (1990), within the intersubjective perspective, hypothesized that the core element driving therapeutic changes is the negotiation process between two different subjectivities, i.e., the therapist and the patient. In this way, the therapeutic process is re-interpreted with an intersubjective perspective, in which two subjectivities, with their own histories and specificities, may continuously influence each other (Benjamin, 1990). Similarly, Mitchell (1993), within the relational movement, underlined that the negotiation between patient's and therapist's desire is a fundamental therapeutic mechanism of change. More generally, the Boston Group identified the main aim of the treatment as the achievement of an affective syntonized "present moment" (Stern et al., 1998), grounded on an empathic and technical support of the therapist.

Technically, focusing on the "*hic et nunc*" of the therapeutic relationship requires the therapist to move from a neutral to an active position, becoming a participant



observer who acts in a bidirectional influence with the patient, as anticipated by Sullivan in 1953. More recently, in a modern attachment perspective, the personal involvement, the emotive responsiveness and therapist subjectivity became fundamental aspects for the effectiveness of the therapy (Wallin, 2007). In a systemic-dyadic perspective (Beebe & Lachmann, 2002) the intersubjective negotiation of Therapeutic Alliance can be re-interpreted as a reciprocal regulation in therapist and patient interaction. In this way, it is indeed possible to explore patient functioning and disconfirm his/her interpersonal expectations (Beebe & Lachmann, 2002).

This therapeutic goal can be reached through the resolution of the therapeutic impasse: patient resistance is no more considered as an obstacle to the therapy, but rather as an useful dimension to discuss patient's inner feelings in an intersubjective negotiation process. In this direction, the innovative aspect of Safran and Muran's theory (2000) is the positive role attributed to this relational moment in the psychotherapy context, because it can be considered as an opportunity offered to the clinician to improve the understanding of the patient's world and, eventually, of the way to encourage changes. This means that working on this clinical ground can help both clinician and patient in getting into the interpersonal dynamic, focusing on its causes and motivations. In this context, the therapist needs to maintain an open mind to grasp any rupture markers and, possibly, to repair them by exploiting the meta-communication as the middle point between the relational *hic et nunc* and the transference dynamics. From this point of view, each rupture or disagreement on the tasks, goals or bond are not considered drawbacks anymore, but they become starting point that promote a new awareness of the patient (Lingiardi, 2002). Consequently, relational dimensions and technical factors are conceived as inextricably interconnected. At both theoretical and empirical levels, therapist-patient interaction is characterized by a complex association between interactive variables.

## 2 | THE “RELATIONAL” PSYCHOTHERAPY RESEARCH ON THERAPEUTIC ALLIANCE

### 2.1 Interdependency Between Technical And Relational Factors

Harking back to Bordin (1979), Safran and Muran (2000) underlined the importance of the interdependency of technical and relational factors. Safran and Muran (2000), indeed, sustained that therapeutic alliance is a common factor that develops depending on the relational context that therapist and patients create and on the technical characteristics of the therapist’s orientation model. In particular, therapeutic alliance is conceived as the “quintessential integrative variable” (Wolfe & Goldfried, 1988), by means of which the meaning of technical factors can be understood depending on the relation context, and that can determine a positive or a negative impact on the dyad’s bond quality.

This importance has been resumed by the American Psychological Association, which created the 29 Division, a task force aimed to study technical interventions and relational factors of therapeutic alliance. Previous research on therapist interventions focused on the efficacy of treatment - specific techniques in Empirically Supported Treatments studies (Nathan & Gorman, 1998). In particular, Menninger Psychotherapy Research Project (Wallerstein, 1986) aimed to provide empirical evidence for the efficacy of psychoanalysis and psychodynamic therapy. The research on technical interventions showed that empathic-supportive interventions are transversal to any approach, even for the psychoanalytic ones. Indeed, this kind of interventions was even able to produce therapeutics changes. This finding led, therefore, the authors to underline the importance of empathy that seems to be as effective as classical interpretative intervention. Moreover, since research focused mainly on patients with severe personality disorders, often characterized by ruptures of alliance, findings showed that a therapist’s empathic disposition may create a solid alliance and, through this, could give effectiveness to supportive interventions (Gaston, Marmar, Thompson & Gallagher, 1988).

After the “Dodo Bird Verdict” (Luborsky, Singer & Luborsky, 1975), literature moved interest from the technical factor to nonspecific and relational factors (Horvath & Symonds, 1991; Martin et al., 2000; Horvath & Bedi, 2002). Technical factors were studied in association with therapeutic relationship: “good” interventions are reciprocally interconnected with “good” relationship (De Bei, Colli & Lingiard, 2007). Recent researches, however, have considered technical interventions as a dimension associated with others important dimensions of the therapeutic process, such as therapeutic alliance or repairing-ruptures process (Dazzi, Lingiard & Colli, 2006). Alliance quality, in fact, may influence the quantity and the quality of interventions, and, at the same time, effectiveness of interventions is able to support the development of a positive alliance (Gabbard et al., 1994; Horwitz, Gabbard & Allen, 1996). For example, interpretative interventions in a good relational context may increase patient’s collaboration and elaborations (Silberschatz, Fretter & Curtis, 1986; Crits-Christoph & Connolly, 2001). The relationship between interventions and therapeutic alliance seems characterized by a bidirectional association that can be investigated by a microanalysis of the interactions between therapist and patients (Dazzi, Lingiard & Colli, 2006). Accordingly, recent literature underlines the importance to integrate the technical and relational dimensions, in order to understand the their reciprocal interconnection (Horvath, 2005).

On these grounds, the 29 Division pointed out that psychotherapy is an interpersonal process, whereas the therapeutic relationship is a crucial factor, vehicle of the therapeutic technics. After Norcross’s work (2002; Empirically Supported Relationship), the core of the psychotherapy research moved into the investigation of the therapeutic relationship and of the therapist’ and patient’ personality characteristics. Consequently, in the last decade, many researches focused on the therapeutic alliance, as a key feature of therapeutic relationship. Therapeutic alliance was defined as a common factor, able to mainly explain the effectiveness of psychotherapy outcome (Horvarth & Symonds, 1991; Horvarth & Bedi, 2002; Martin et al., 2000; Lingiard, 2002).

## 2.2 Patient's Role On Therapeutic Alliance: An Empirical Review

### Severity of Psychopathology

There are many investigations concerning the impact of the severity of the patient's disorder on the development of the alliance in therapy. The findings, nevertheless, are abundantly contrasting: some researches indicated that more severely disturbed patients are associated to poorer alliances (Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Yeomans et al, 1994; Zuroff et al., 2000), while others studies found little or no difference between more or less severely injured patients (Gaston, Marmar, Gallagher, & Thompson, 1991; Joyce & Piper, 1998; Liebermann, von Rehn, Dickie, Elliott, & Egerter, 1992; Orlinsky, Grawe, & Parks, 1994; Paivio & Bahr, 1998). The critical difference found between these studies seems to be linked to four factors. First, the literature is dominated by reports based on mildly disturbed patients. Second, when reports are available on more severely disturbed patients, such as hospital inpatients, the data often do not include contrasting groups of less severely impaired patients, making the range of severity highly restricted. Third, there are four studies in the literature indicating that there is an interaction among the therapist's level of experience, severity of impairment, and quality of alliance (Hayes, 1995; Kivlighan, Patton, & Foote, 1998; Mallinckrodt & Nelson, 1991; Paivio & Bahr, 1998; Rounsaville et al., 1987). Last, there is evidence that patients with poor alliance are more likely to drop out early in therapy (Mohl, Martinez, Ticknor, Huang, & Cordell, 1991; Plotnicov, 1990; Tryon & Kane, 1990, 1993; Yeomans et al., 1994). Therefore it is possible that the relatively weak overall relationship between severity and strength of the alliance reported in the literature may be due, at least in part, to the early loss of the more severe cases.

### Type of Disorder

There are some reports linking specific psychological problems with difficulties in developing the therapeutic alliance. Patients with borderline and other personality disorders, either as the main diagnosis or as a comorbid feature, present

a particularly challenging task in this sense (Andreoli et al., 1993; Hersoug, Monsen, Havik, & Hoglend, 2001b; Muran et al., 1995). Zuroff and colleagues (2000) reported that patient alliance might have a moderating effect, regardless of other aspects of the relationship, between perfectionism and premature termination. Difficulty in developing alliances has also been reported with delinquents, homeless individuals, and some drug-dependent populations (Barber et al., 1999; Florsheim, Shotorbani, Guest-Warnick, Barratt & Hwang, 2000; Gunderson, Najavits, Leonhard, Sullivan, & Sabo, 1997; Hersoug, Monsen, Havik, & Hoglend, 2000). However, the challenge of developing an alliance with this group of patients may be confounded by health, legal, economic, and social problems.

### Object Relations and Attachment Style

The impact of a patient's prior relational experiences, especially those in formative years, has been supposed to play a crucial role in therapeutic alliance (Hersoug, Monsen, Havik, & Hoglend, 2000; Hilliard, Henry, & Strupp, 2000; Kivlighan, Patton & Foote, 1998; Mallinckrodt, 1992, 1996, 2000; Paivio & Bahr, 1998). One of the most frequently studied variable has been the quality of the patient's object relations (e.g., Piper, Azim, Joyce & McCallum, 1991; Piper, Boroto, Joyce, McCallum & Azim, 1995) and introject (Henry & Strupp, 1994; Hersoug, Monsen, Havik, & Hoglend, 2000). Also in this case, however, there is conflicting evidence on the magnitude of impact of patients' early relational experiences (Hersoug, Monsen, Havik, & Hoglend, 2002; Mallinckrodt, 1992), despite there is growing data suggesting that the quality of the alliance is influenced by the quality of patients' attachment style (Eames & Roth, 2000; Hilliard, Henry, & Strupp, 2000; Joyce & Piper, 1998; Mallinckrodt & Leong, 1992; Ogrodniczuk, Piper, Joyce, & McCallum, 2000; Rubino, Baker, Roth, & Fearon, 2000; Tyrrel, Dozier, Teague & Fallot, 1999). In particular, poor initial alliances are often associated with fearful, anxious, dismissive, and preoccupied styles (Eames & Roth, 2000; Ogrodniczuk, Piper, Joyce, & McCallum, 2000; Rubino, Barker, Roth & Fearon, 2000; Tyrrel, Dozier, Teague & Fallot, 1999).

## Alliance Across Phases of Therapy

The establishment of a strong alliance may have a different impact on outcome, depending on the specific phase of the therapy. For instance, there is evidence showing that it may be crucial to establish a proper alliance in the early phases of the therapy. Accordingly, alliance measured between the third and fifth session is a good predictor of final therapy outcome (Barber et al., 1999; Castonguay, Goldfried, Wisner, Raue, & Hayes, 1996; Gaston, Thompson, Gallagher, Cournoyer & Gagnon, 1998; Hersoug, Monsen, Havik, & Hoglend, 2000; Horvath & Symonds, 1991; Krupnick et al., 1996; Sexton, 1996). Similarly, studies that compared early and mid-phase alliance assessment as predictor of outcome found a better outcome based on early rather than later alliance (Barber et al., 1999; Castonguay et al., 1996; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Hersoug, Monsen, Havik, & Hoglend, 2002; Joyce & Piper, 1998; Krupnick et al., 1996; Sexton, 1996; Florsheim, Shotorbani, Guest-Warnick, Barratt & Hwang, 2000). Once again, contrasting results are not missing: Crits-Christoph and colleagues and Gaston and colleagues found no correlation between alliance measurements at different phases of the therapy (Crits-Christoph, Cooper, & Luborsky, 1988; Gaston, Piper, Debbane, Bienvenu, & Garant, 1994).

Interestingly, there is also evidence suggesting that the strength of the alliance at intake or after the first session is a good predictor of premature termination (Barber et al., 1999; Mohl, Martinez, Ticknor, Huang, & Cordell, 1991; Plotnicov, 1990; Tryon & Kane, 1993). However, it is worth noting that the flip side of high levels of alliance at the beginning of the therapy might be represented by unrealistically high initial expectation, and hence associated to poor outcome and premature termination. In this sense, more realistic expectations can be associated to a more positive outcome (Florsheim, Shotorbani, Guest-Warnick, Barratt & Hwang, 2000; Joyce & Piper, 1998).

Following this line, Gelso and Carter (1994) hypothesized that successful treatment would typically have a U-shaped (high-low-high) alliance curve. This begins with the establishment of a strong opening relationship, followed by deterioration this phase due to the therapist's increasing focus on the patient's

dysfunctional relational schemas and ending when, later in therapy, a positive relationship is re-established. Though fascinating, such hypothesis was examined by Kivlighan and Shaughnessy (1995, 2000), with mixed results. Indeed, the U-shaped alliance pattern for successful short-term therapies was not supported, but an increasing alliance pattern was a good predictor of positive outcome in brief dynamic therapy. However, the "shape" of a productive alliance over time is far from being settled. Some researchers found "flat" as opposed to "sloping" alliance pattern (Bachelor & Salame, 2000; Krupnick et al., 1996), whereas others observed a good fit between a quadratic pattern of alliance and positive outcome in time-limited therapy (Horvath & Marx, 1991).

Gaston and Marmar (1994) proposed that the alliance is a malleable phenomenon, which is influenced by patient variables but not exclusively driven by them. Although such variables are crucial, they do not guarantee or preclude the development progression, or maintenance of a quality therapeutic alliance. In fact, as some authors have argued (e.g. Henry & Strupp, 1994) that it is through the process of the alliance, its establishment, ruptures and resolution, that changes can come about via the alteration of cyclical maladaptive patterns of personal functioning. Indeed, the maladaptive patient variables are an integral part of the alliance construct, conceived as the on-going interpersonal process, taking place between patient and therapist. Additionally it is important to consider the contribution of therapist's in-session and pre-treatment characteristics, since these may play an independent role that impacts on the alliance or may interact with certain patient's characteristics, at least having a qualitative effect on the therapeutic relationship (Constantino, Castonguay & Schut, 2002).

### **2.3 Therapist Role On Therapeutic Alliance: An Empirical Review**

#### Therapist Interpersonal and Communicative skills

Clinician personal attributes or characteristics have a significantly and positively influence on the therapeutic alliance during the course of the treatment. Significant relationships are reported between alliance and therapist's attributes. These

comprise conveying a sense of being trustworthy (Horvath & Greenber, 1989; Evans-Jones, Peters & Barker, 2009), supporting (Najavits & Strupp, 1994; Moyers, Miller & Hendrickson, 2005), flexible (Kivlighan, Clements, Blake, Arnzen & Brady, 1993) equal (Moyers, Miller & Hendrickson, 2005), involved, observant, relaxed, confident (Hersoug, Monsen, Havik, & Hoglend, 2001; Saunders, Howard & Orlinsky, 1989), warm (Mohl, Martinez, Ticknor, Huang, & Cordell, 1991; Moyers, Miller & Hendrickson, 2005), empathic (Peters & Barker, 2009), more experienced (Peters & Barker, 2009; Hersoug, Monsen, Havik, & Hoglend, 2001), capable and respectful (Bachelor, 1995).

On the contrary, there are other therapist characteristics that may have a significantly negative impact on the alliance. Lower alliance ratings were reported when therapists were more inflexible, self-focused, critical, repressive (Eaton, Abeles & Gutfreund, 1993), unclear, stressed (Sexton, Hembre & Kvarme, 1996), belittling, accusing, inspecting, detached, and distant (Price & Jones, 1998), disconnected or indifferent (Hersoug, Høglend, Havik, von der Lippe & Monsen, 2009), and less involved in the psychotherapy process (Marmar, Horovitz, Weiss & Marziali, 1986).

### Therapist's technique

Therapist techniques, such as Supportive, Exploratory, Experiential-Affect Focused, and Engaged-Active Relationship, usually contribute in a positive way to the alliance (Ackerman & Hilsenroth, 2003). Similarly, many recent studies indicated an association between positive alliance and therapist techniques that specifically convey support, understanding, affirmation (Moyers, Miller & Hendrickson, 2005; Boardman, Catley, Grobe, Little & Ahluwalia, 2006), or techniques that increase a patient's understanding of the problems (Mohl, Martinez, Ticknor, Huang, & Cordell, 1991; Crits-Christoph et al. 1998; Gaston & Ring, 1992; Allen et al., 1996). Furthermore, a similar association is reported for techniques that carry patients through greater exploration (Price & Jones, 1998; Svenson & Hansson, 1999) as well as accurate and specific interpretations. Techniques that maintained focus on the patient's in-session subjective experience



and affect are also important in a positive therapeutic relationship (Saunders, Howard & Orlinsky, 1989; Crits-Christoph et al. 1998; Price & Jones, 1998; Coady & Marziali, 1994; Joyce & Piper, 1998).

Notably, therapists may also make mistakes in their application of technique that may, in turn, negatively influence alliance levels. These include therapist's rigidity in treatment planning, inappropriate use of silence (Eaton, Abeles & Gutfreund, 1993), emphasized patient resistance (Marmar, Horovitz, Weiss & Marziali, 1986), self-disclosure of therapist's own emotional conflicts (Price & Jones, 1998; Coady & Marziali, 1994), and inflexible use of transference interpretation (Marmar, Horovitz, Weiss & Marziali, 1986; Piper, Azim, Joyce & McMallum, 1991; Piper et al, 1999).

In other researches, a significant association between the ruptures and the presence of dysfunctional relational schemas involving the therapist, identified by using the CCRT method (Sommerfeld, Orbach, Zim & Mikulincer, 2008, Luborsky & Crits-Christoph, 1998) was found. Moreover, an occurrence of therapist rupture interventions in 31 % of the sessions and a significant correlation between therapist negative intervention and the occurrence of more disruptive patient alliance rupture markers was reported (Colli & Lingardi, 2009). These results seem to confirm alliance ruptures as a patient's way for the expression of core relational problems and to suggest that alliance is mainly a patient and therapist co-construction (Lingardi & Colli, 2015).

### Therapist's experience and training

Evidence on the influence of the level of the therapists training and experience in relation to alliance is also controversial. Dunkle and Friedlander (1996) found that therapist's experience was not related to the quality of the alliance, while others have reported partial support for such relationship (Bein et al., 2000; Kivlighan, Patton & Foote, 1998; Mallinckrodt & Nelson, 1991). Hersoug (2000, 2001b, 2002) reported negative correlation between alliance and training, but a positive correlation with a measure of therapist's skill. Perhaps the answer to the seemingly conflicting findings lies in a recent study which found that patients with difficulty

in forming intimate relationships have stronger alliances with more experienced counsellors, while patients with no such relational difficulty did not respond differentially to levels of experience (Kivlighan, Patton & Foote, 1998). Another paramount piece of the puzzle may be the finding that experienced therapists are typically better at identifying deteriorating or poor alliances (Mallinckrodt & Nelson, 1991). The ability to better detect the patients' relational problems in therapy enables these therapists to build and repair their alliances with these patients more efficiently; however, this increased efficacy does not show up in research involving only the less relationally impaired patients.

Although this section focuses on the therapist's contributions to alliance, it is critical for research to examine the interpersonal exchanges between the patient and therapist that impact alliance development. Investigating these in-session interactions may deepen our understanding of the nature of alliance development and the specific variables impacting it (Ackerman & Hilsenroth, 2003).

## **2.4 Therapist-Patient's Relationship Role On Therapeutic Alliance: An Empirical Review**

### Therapist-Patient Matching and Complementarity

Complementarity has been mainly explored through two perspectives: competing versus complementing interpersonal behaviors, and complementing versus similar personality structures of therapists and patients. The hypothesis that greater complementarity in terms of dominance and control would result in more harmonious verbal transactions has received some empirical support (Kiesler & Watkins, 1989; Tracy & Ray, 1984). More clinically meaningful relationship was found between the quality of the alliance and harmonious (i.e., friendly and autonomy-enhancing) as opposed to competitive (i.e., hostile or controlling) interaction. Harmonious, positive moment-to-moment interactions were found to be closely related to good alliance, whereas the opposite was true for any form of negative interaction (either participant expressing hostile or negative affect) (Henry & Strupp, 1994; Svartberg & Stiles, 1994). Together, it seems that what is most

important is that the therapist-patient transactions are not hostile, negative, or competing.

### Rater's Perspective

The majority of early investigators obtained better predictions of outcome based on patients' than therapists' reports and noted significant differences between patients' and therapists' ratings. However, it is worth noting that therapists' assessment of the alliance may become a better predictor of outcome later in therapy (Hersoug, Monsen, Havik, & Hoglend, 2000; Kivlighan & Shaughnessy, 1995; Yeomans et al., 1994). Moreover, while earlier studies suggested that the patient's alliance was better outcome predictor than the therapist's one, and that therapists' ratings showed poor correlation with patients' (Horvath & Symonds, 1991), more recent researches monitoring the patients' and therapists' assessment at different phases of therapy found that as therapy progresses, patients' and therapists' assessments become more similar. Critically, the degree of similarity between therapist and patient alliance rating in middle and late phases of therapy was positively related to outcome (Gunderson, Najavits, Leonhard, Sullivan, & Sabo, 1997; Hersoug, Monsen, Havik, & Hoglend, 2000).

Overall, these findings suggest that when therapy begins, patients respond globally to the therapy experience driven by their own need for safety and desire to actively engage with the therapeutic opportunities the therapist offers. The sense of "being listened to" and "understood," the feeling of a shared purpose (goal), and active collaboration by positive engagement with the therapeutic activities in the session are critical for the patient (Diamond, Liddle, Houge & Dakof, 1999; Jennings & Skovholt, 1999; Lichtenberg et al., 1998; Strupp, 1998; Tryon & Kane, 1993). Without these needs being adequately satisfied, there is a risk of early disengagement or the dominance of conflicting feelings about the therapy. The therapist, on the other hand, mainly perceives the quality of the emerging alliance in light of the theoretical premises of his/her particular orientation. These premises translate to expectations of the kinds of ways a "good" patient ought to respond to therapy (Hersoug, Monsen, Havik, & Hoglend, 2000). Supporting these hypotheses

are the reports indicating that therapists' alliance scores show greater variability than patients' (Hersoug, Monsen, Havik, & Hoglend, 2000; Kivlighan & Shaughnessy, 1995). Under these circumstances we would expect initial differences between the patient's and the therapist's assessment of the quality of the alliance. Furthermore, it seems likely that, if the patient fails to perceive the relationship as adequate, premature termination or poor outcome would be highly possible.

### Collaboration

As underlined above, collaboration is a central aspect of the alliance concept. Most alliance measures strongly focus on the degree of felt collaboration among the dyad. In terms of in-therapy behaviors, it is common to observe that patient and therapist exchanges build upon each other's verbal contributions. A validation of the sequential and mutual impact of the participants in therapy, nevertheless, requires sophisticated research design and complex analyses; the results of these kinds of research are just beginning to appear in the literature. Brossart and colleagues (1998) conducted a time series analysis of short-term dynamically informed therapy and proposed a model that demonstrated significant therapist influence on the working alliance, at both short and medium term, whereas no patient influence was reported (Brossart, Willson, Patton, Kivlighan & Multon, 1998). At the same time, Chen and Bernstein (2000) found evidence that complementary interaction between supervisor and trainee resulted in better alliance and better outcome. In another study, the alleged impact of collaborative activity was demonstrated by means of time series analysis of therapist-patient interaction (Kowalik et al., 1997). Together, these studies provide preliminary evidence linking collaboration and cooperation to better alliance and positive outcome.

### Ruptures and Resolution Research

In quantitative process research the central focus is the study of the occurrence of ruptures and resolution in psychotherapy and, in some cases, the link between these processes and therapy outcome. Across several studies, the occurrence of

alliance ruptures has been found to vary from 19% of the sessions (Eames & Roth, 2000) to 100% (Colli & Lingardi, 2009; Eubanks-Carter, Muran & Safran, 2010). Whereas confrontation ruptures are usually rare, withdrawal markers can be found in each session.

In other research, the authors found a significant association between the occurrence of ruptures and the presence of dysfunctional relational schemas involving the therapist, by means of CCRT method (Sommerfeld, Orbach, Zim & Mikulincer, 2008; Luborsky & Crits-Christoph, 1998). Conversely, in other studies a significant correlation between therapist negative intervention and the occurrence of more disruptive patient alliance rupture markers was reported (Colli & Lingardi, 2009). These results seem to support two important “relational” ideas. First, an alliance rupture may be conceived as a patient’s vehicle to express core relational problems. Second, under this view alliance can be seen as a patient and therapist co-construction.

Critically, in qualitative process studies, a privileged attention has been devoted to negative experiences, impasse, and misunderstanding events (Hill, 2010), with an emphasis on the perceptions of the events by patient and therapist captured by the use of interviews with open-ended questions. Some researchers found that patients had negative feelings about their therapies (Rennie, 1994; Regan & Hill, 1992) and that experiences of anger toward the therapist occur quite often (Dalenberg, 2004), though the patient often try to hid them.

### **3 | A NEW PROPOSAL: AN INTERACTIVE STUDY OF THE THERAPEUTIC PROCESS**

In psychotherapy research, as aforementioned, the intersubjective perspective focused major attention to the interactions between patient and therapist, across time. Blatt and Beherends (1987) revealed the need to study the therapeutic dyad, rather than assuming that therapy involves a therapist “doing something” to patients. In this sense, Ablon and Jones (2005) used the concept of “positive and

negative interactive structures”, in which the measure unit is the therapeutic dyad. This perspective, however, opened a window onto a new, wide and complex perspective of the therapy process. The investigation on the therapeutic dyad, in fact, has showed that psychotherapeutic change is probably not a linear process, but rather a process characterized by sudden gains and regressions. From this perspective, some changes are progressive, but others can be extemporize, hiding regression phenomenon (Vermote et al., 2010) or latent effect (Grant & Sandell, 2004). In particular, regression phenomenon in long-term psychotherapy can show a very important changing point in patients, where there is a decline of reflective functions before an improvement of them (Vermote et al., 2010).

These findings indicate the huge complexity in understanding the therapy outcome and therapy changing point and they underline the necessity of a more comprehensive perspective in understanding the psychotherapy process. From a psychotherapy process research point of view, the interactive processes involve a wider meaning, and are expected to lead to two types of related changes: internal changes, such as an improved ability to make sense of one’s own and other’s mind, and external changes, such as changes in person–environment contacts. On these grounds, the solely study of the correlation between technical and relational factors seems to represent a restricted exploration of the psychotherapy process. Conventional psychotherapy research appears to have largely settled for the view that treatment effects are only in part due to the use of specific techniques. Research has pointed out that other factors account for a large portion of the variance in treatment outcome, with estimates ranging from 15% of the variance in outcome predicted by specific techniques (Lambert & Barley, 2002), 30% by common factors (providing support and empathic understanding), 15% by expectancy and placebo effects, and 35–40% by extra-therapeutic effects (spontaneous remission, positive events or changes). Although mainstream approaches assume that these factors interact, they essentially consider these factors as independent and additive. However this approach is wrongly based on assumptions from pharmaceutical trials, where the assumption that psychotherapy consists of supplying interventions by the therapist to patients that are essentially passive (Stiles &

Shapiro, 1989). Similarly, the conclusions of Empirically Supported Treatment project (Nathan & Gorman, 1998) promote unidirectional and linear therapeutic algorithms.

From a new relational and dynamic interactionism perspective, by contrast, all these factors are seen as interconnected factors that interact often nonlinearly and mutually (Levy, Ablon & Kachele, 2012). This perspective, well grounded in social psychology, seems to well fit the new needs in the study of the psychotherapy process. The aim, here, is to integrate quantitative and qualitative analyses of the interactions between patients and therapists, in order to gather a clinically meaningful picture of the data (Ackerman & Hilsenroth, 2003).

### **3.1 An “Interactive Methodology”**

The complexity of process-outcome research, as well as the complex interaction of many therapeutic variables, underlines the necessity to develop new methodological strategies to better understand the interrelation between psychotherapy factors. A dynamic interactionism or action-theory approach, however, may be much better suited to study the process of treatment, arguing that the therapeutic process can be conceived as a series of interactions, both at conscious and unconscious levels, between two individuals, with moments of experienced compatibilities and incompatibilities, moments of meeting, understanding, and mutuality versus moments of separation and misunderstanding (Blatt & Benrends, 1987).

From intersubjective perspective, in fact, treatment can be defined in terms of the activation of prototypical representations of self and others, and ways of thinking about the self and others, in the context of the therapeutic relationship. This relationship is a especial one, with a significant other that provides both care and support while exploring and interpreting: it is only through this exploration in the therapeutic relationship that changes in representations of self and others can be achieved. This increasing ability to make sense of one’s own mind and that of others may then be increasingly moved outside the treatment setting (Levy, Ablon

& Kachele, 2012). Therefore, this leads to the view that the goals of treatment are changes in person–environment transactions. These findings are of key relevance for psychoanalytic psychotherapy researchers because they are congruent with the concept of transference, and with interpersonal models that argue that specific interpersonal behaviors pull for specific behaviors in relationships, including the therapeutic relationship (Luyten, Mayes, Fonagy, Target & Blatt, 2015).

The aforementioned considerations had led to develop new methodologies that can grasp this complexity. First, in the last years, an increase in the application of qualitative methods in psychotherapy research, which represents the best approach in converting the focus from mechanistic causal models to holistic ones, has been observed; indeed, qualitative research focuses to the intentional and narrative structure of meaning through the description of multidimensional, circular, and reciprocal interactions and relationships between dimensions of the human experience (Elliott, 2010).

Second, there has been a trend toward the revision of existing quantitative methods and the development of new ones. A privileged example is the microanalytic sequential process design, which consists of the quantitative within session investigation of the turn-to-turn exchanges between patient and therapist. In this analysis, the interactions are coded on rating scales and/or category systems, in order to test micro-theories of clinical processes. Notably, these methods adopt modern statistical procedures able to take into account the time-dependent nature of the investigated variables (sequential analysis, time-series analysis, growth curve analysis).

Third, there has been a development of complex mixed-method designs, integrating both qualitative and quantitative approaches. This approach typically requires the researcher to join qualitative model of in-session exploration and to quantitatively connect these within-session processes with post-session and eventually post-treatment outcomes (Gelo, Pritz & Reiken, 2015).

Taken together, mixed-method approaches have the potential to unify the strengths of both quantitative and qualitative and should as well be fostered future research (Braakman, 2015). A desirable goal could be, indeed, to strengthen the



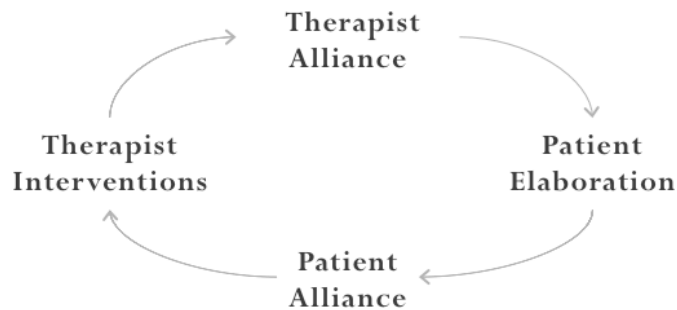
three methods in an independent way, but also to endeavour for an interaction between the three approaches (Braakman, 2015).

### **3.2 Therapeutic Alliance's interactive role**

In approaching the study of the interrelation between psychotherapy factors, the construct of therapeutic alliance became particularly fundamental. Therapeutic alliance, indeed, is considered as a single and non-specific factor (Horvath & Symonds, 1991; Horvath & Bedi, 2002; Martin et al., 2000; Lingardi, 2002), and, across a range of therapies, appears to make a small but consistent contribution to outcome. More specifically, alliance acts as a moderating variable, a catalytic way of action that makes therapy more effective. Another interpretation of therapeutic alliance role in the therapy process is that it acts as an effector variable: it works in a complex relationship with technique and other processes, with these variables acting and reacting in a temporal sequence (Roth & Fonagy, 2013). In fact, therapeutic alliance is central in every theory approach; it's influenced by different variables, in a complex and interdependent matrix created by therapist and patient, and it is specific for the therapy orientation (Safran & Muran, 2000). In addition, the therapeutic process is considered as the construction (i.e., therapeutic alliance) of a sure relationship (i.e., attachment), through a process (i.e., ruptures and reparations), characterized by dimensions (i.e., transference, countertransference) of participants' subjectivity (Lingardi & De Bei, 2007). In this direction, therapeutic alliance can have different meanings depending on the specific therapist-patient dyad, that reveals the importance to: "Matching patients to therapies" (Roth & Fonagy, 2004), "Tailoring psychotherapies and therapists to patients" (Horwitz et al., 1996) and "What works, for whom...and how?" (Roth & Fonagy, 1996).

On these grounds, Lingardi, Tanzilli and Colli (2008) pointed out that it is necessary to leave the dichotomist perspective between specific and nonspecific factors or technical and relational models, in order to orient toward an integrative perspective. Lingardi et al. (2008) further proposed to study psychotherapy

dimensions, as variables interrelated between each other, to better understand the process and outcome of the treatments. This can be summarized in a circular interactive model of therapist-patient interaction:



In particular, in this formulation therapeutic alliance represent a key variable that modulates the level of patient's elaboration, which promotes an effect on therapist alliance and influences the quality of therapist interventions. In this way, therapeutic alliance can be considered as a platform that can promote the good balancing of technical techniques and that move the relational dimension (Mitchell, 1997): a sort of "relational motor" or a "therapeutic agent" (Lingiardi, Tanzilli & Colli, 2008).

Influenced by validation construct method, the hallmark of therapeutic process is a "nomological network" (Cronbach & Meehl, 1955; Messick, 1981; Westen & Rosenthal, 2003). Therapeutic process can be represented as a network of logically and theoretically justified constructs and construct relations with specifications as to how these translate into observable operational definitions. The therapeutic relationship involves the validation of the multiple operation-level relations that are derived. The network or theory surrounding the constructs informs and guides the researcher as to the operational definitions that should and should not be related as well as to the direction and magnitude of those relations.

In this sense, current literature points out the importance of therapist-patient relationship and all the different dimensions underneath the relationship, along with their connections with participants' characteristics. The relevant associations

can be displayed in a multidimension-multimethod matrix (Campbell & Fiske, 1959). This is a table that sets out the correlations between several ways of measuring several different constructs. The multidimension-multimethod matrix displays the correlations among all of these variables. The complex dynamic of therapeutic process needs to analyse the micro-process interaction between therapist and patient (Dazzi, Lingardi & Colli, 2006), but this detailed analysis should be supplemented by macro-analysis, to better understand the clinical meaning of the interaction. In this way, it becomes necessary to work on a multi-instrumental view across the measure of different dimensions involved in therapeutic process and evaluation between them and participant's characteristics (De Bei, Colli & Lingardi, 2007).



## PART 1

### *Cyclical Dynamics Of Different Patients In The Therapy Rooms*

*"I always find the rug carefully folded at the foot of the couch when I came in. Did the little maid Paula come in from the hall and fold the rug or did the preceding analysand fold it, as I always carefully did before leaving? I was preceded by the Flying Dutchman; he probably left the rug just anyhow-a man would. Should I ask the Professor if everybody folded the rug on leaving, or if only I did this? The Professor had said in the beginning that he classed me in the same category as the Flying Dutchman-we were students. I was a student, working under the direction of the greatest mind of this and of perhaps many succeeding generations. But the professor was not always right."*

Hilda Doolittle (1970) from "Tribute to Freud".



# 3

## *Cyclical Dynamics Of Different Patients In The Therapy Rooms: An Introduction*

### 1 | INTERACTIVE DYNAMICS IN PSYCHOTHERAPY PROCESS

The relational aspects in psychotherapy have been recognized both in clinical practice and in formal research as significant elements of the therapeutic process. This is particularly the case for the therapeutic alliance concept, which alleged importance has been drastically reconsidered in the recent years. As discussed in the previous chapters, indeed, literature has demonstrated that the alliance is the most important common factor that predicts empirically successful outcomes (Horvath, 2006; Lambert, 2004; Wampold, 2001). Nevertheless, despite research on therapeutic alliance is apparently abundant, there are still many open questions that cry out for clarification. In particular, the shift of interest from “variables” to “responsive behaviors” (Stiles, Honos-Webb & Surko, 1998) opens up a new range of potential methods for a novel investigation of the therapeutic process, which seems to be facilitated through the alliance between therapist and client. In fact, the term “responsiveness” describes those behaviors affected by the specific therapeutic context, including the perceptions of contingent characteristics and features of the others. In this sense, as therapist and patient cyclically respond to

each other's verbalization, responsiveness implies a dynamic relationship between key dimensions of the therapeutic process, that can be operationalized as variables involving bi-directional causation and feedback loops.

"Responsive behaviors" can be conceived as micro events, observable at the level of turn-by-turn interaction, which structure the overall sense-making activity of the therapeutic dyad. They comprise non-verbal as well as verbal actions and communications and, hence, can be better grasped in the more general domain of "pragmatics", i.e., the study of human communication in its immediate context. Historically, pragmatics encompassed different empirical disciplines, such as sociology, psychology, and linguistics. Relevantly to the present thesis, its central proposition is that knowledge and meaning are grounded in human interaction. It follows that the detailed study of human interaction, at the level of the talk, can reveal the processes by which a meaningful, intersubjectively shared world is co-produced (Enfield & Levinson, 2006). This is achieved often through an observational approach to human communicative interaction placing turn taking, involving both patterns at the prelinguistic, at the heart of human communicative interaction (Lepper, 2015), and linguistic levels.

The methodological approach adopted in the two studies involved in the first part of the thesis is based on the above principles and assumptions, which consider "responsive behaviors" as observable patterns at the level of turn-by-turn interaction between therapist and client. We, therefore, aim to apply a quantitative observational perspective on the psychotherapy process, and to establish what kinds of therapeutic interactions are linked to good outcomes, providing critical evidence with direct relevance to clinical practice. Such an approach may also contain the potential to bridge the gap between the research and the clinical practice in the therapy room.

## 2 | QUANTITATIVE OBSERVATIONAL METHOD

The origin of the psychotherapy process research can be brought back to the work of Carl Rogers and the client-centered group in the 1940s and 1950s. These



were the first researchers who explored recordings of actual therapeutic interactions, and who quantified aspects of the therapeutic relationship, such as therapist empathy (Kirschenbaum, 1979). Subsequently, researchers have investigated a vast number of different process variables, ranging from global constructs, such as the quality of the therapeutic alliance, to specific types of responses used by the therapist and client (Greenberg & Pinsof, 1986).

Importantly, the therapeutic process research is characterized by a non-experimental approach. In opposition to the experimental approach and quasi-experimental approach, the non-experimental approach does not analyze the relationship between two (or more) variables in terms of cause-effect relationship, but rather in terms of association or covariance of the relationship. In this sense, the hypothetical independent variable (such as a specific aspect of the therapeutic process) cannot be manipulated, but only observed. Despite some limits of this approach, non-experimental research is nevertheless characterized by high ecological validity and the targeted behaviors often reflect those observable in everyday life.

The first step in quantitative observation is to operationally define the behavior to be observed. The goal is to specify the behavior sufficiently well, so that it can be observed with high inter-rater reliability. Often this means that the behavior should be defined without the raters having to make large inferences, although for many variables this may not be possible. Many different dimensions of behavior can be examined with this approach such as perspective of observation, person/focus, aspect of behavior, unit level, sequential phase (Elliott, 1991). Having specified the dimensions of the behavior to be observed, the next step is to choose an appropriate observational method (Cone, 1999; Hayes, Strosahl & Wilson, 1999; Haynes & O'Brien, 2000). It is worth noting that the mechanics of recording the observations need to be as simple as possible, so that the recording does not interfere with making the observations themselves. With this respect, possible aids may include coding sheets, stopwatches, counters, and electromechanical devices. The observations may be conducted in real time, or the interactions may be recorded on audio or videotape for subsequent observation and analysis. A consistent

advantage of quantitative observation methods is that they facilitate the calculation of reliability that can be maximized by design or the selection of measures with clear, well-defined variables and good examples of categories (Cone, 1999; Moras & Hill, 1991).

In the first part of the present thesis, we assessed the process variable (considered here as an independent variable) and one in-session “impact” variable (considered as a dependent variable) over the course of the sessions and/or treatment. In particular, following a micro-analytic sequential process design (Elliott 2010), the treatment process and the change process variables were investigated at a turn-to-turn, in-session, level with the aim of assessing the extent to which the treatment process variable effectively triggers the in-session impact variable. Moreover, following a macro-analytic process design, the treatment process and the change process variables were investigated at a more general level, indicative about the overall interactions between variables in the whole therapy session.

### 3 | MICRO-ANALYTIC AND MACRO-ANALYTIC LEVELS

In the first part of the thesis, both micro-analytic analytic and macro-analytic process design were integrated to gain a better insight of the therapeutic process.

In micro-analytic sequential process design (Elliott 2010), a turn-to-turn view is applied on the categorical data, obtained by codifying of sessions verbatim transcript. In our specific case, we adopted sequential analysis (Bakeman & Gottman, 1997), a statistical method used to find sequences, usually probabilistic sequences, by collapsing the occurrence of sequences over time to provide an overall picture of what occurs in a session. Because of its aggregation of data, this approach does not provide an opportunity for isolating the unique pattern; however, it is a useful method for moving beyond frequency counts of variables in isolation toward identification of sequential dependencies among a number of variables. Sequential analysis utilizes conditional probabilities, i.e., the probability

of  $x$  occurring, given that  $y$  has occurred, to describe the effects of antecedents on consequents. This strategy seems important to catch, the truer representation of process as patterns of change or trajectories across sequential time points (Orlinsky, Ronnestad & Willutzki, 2004). Hence, such an approach might be well suited for the study of sequential dependencies among the therapist and the patient during the therapy.

At a macro-analytic level, within cross-sectional designs, rank and Pearson's correlations may be used to investigate the overall relationship between the variables of interest (e.g., Lingardi et al., 2011); however, more complex data-analytic strategies may be employed as well, in order allow researchers to make inferences of a more causal nature. Examples of these methods include the hierarchical linear modeling (Raudenbush & Bryk, 2002), which is able to take into account the nested structure of the data (e.g., Owen et al. 2012) and the multiple regression analysis (Petrocelli, 2003; Kolden, 1996). In the studies reported in the first part of this thesis, we used simple mediation analysis (Hayes, 2013) and path analysis (Kline, 1998; Quintana & Maxwell, 1999; Kolden et al., 2006) to infer the macro-analytic level relationship between the involved variables.



# 4

## *Interactive Dynamics In The Early Stages Of The Psychotherapy Process<sup>1</sup>*

### 1 | INTRODUCTION

The past decades have seen a clear shift of psychotherapy theory and practice toward the interpersonal perspective. Accordingly, psychoanalytic theories have moved from the one-person approach to the more comprehensive two-person approach, i.e., the core concept of the psychoanalytic relational school (Greenberg & Mitchell, 1983; Aron, 1996; Benjamin, 1988, 1998, 1999; Mitchell, 2001).

The relational perspective, indeed, recasts the internal experience and dynamics of patient and therapist, traditionally regarded as the primary focus of clinical work, as secondary and as determined in the context of their relationship. In line with this, the parallel developments in psychotherapy research and psychoanalytic thinking point to the potential value of understanding the therapeutic process in terms of relational phenomena (Rozmarin, Muran, Safran, Gorman, Nagy & Winston, 2008). Several authors suggest, therefore, the need of considering the integration of specific and non-specific factors in an interdependent way in order to explore the therapeutic process with an intersubjective approach (e.g., Beutler, Moleiro & Malik, 2000).

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<sup>1</sup> Chapter adapted from: Francesca Locati, Germano Rossi & Laura Parolin (*Under Review*). *Interactive Dynamics In The Early Stage of the Psychotherapy Process*.

Together with the evolution of psychodynamic theory, therapeutic alliance theory and research has also drawn new attention from the study of individual factors to the therapeutic relationship. In particular, the conceptualization of therapeutic alliance moved from a single and non-specific factor to a relational construct. Since Bordin's (1979) formulation, alliance concept was extended beyond patient's beliefs and feeling to embrace the mutual relationship between patient and therapist. Bordin (1979) moved therefore along an interpersonal perspective, including the agreement on goals and agreement on tasks. This concept gave heavy emphasis to the process by which the tasks and goals of therapy develop and change in the course of therapeutic endeavour (Rozmarin, Muran, Safran, Gorman, Nagy & Winston 2008). Accordingly, in considering the emerging relational perspective in psychoanalytic thinking (Aron, 1996; Benjamin, 1990; Mitchell, 1993), Safran and Muran (2000) refined the concept of alliance by replacing the notion of "agreement" with that of "intersubjective negotiation".

Notably, an interpersonal context might be extremely useful not only in the understanding of therapeutic alliance, but also of other dimensions of the psychotherapy process, such as metacognition (Davis, Eicher, & Lysaker, 2011). Metacognition is defined as a set of skills necessary to identify mental states, to reflect on and to reason about mental states and, finally, to exploit this information in order to solve problems or psychological and interpersonal conflicts, and to master subjective suffering (Dimaggio & Lysaker, 2010; Macbeth, Gumley, Schwannauer, Carcione, McLeod & Dimaggio 2015). Interestingly, some authors have suggested an influence of metacognition on therapeutic alliance (Davis, Eicher & Lysaker, 2011). In fact, it has been shown that patient's low level of metacognitive skills can negatively affect the quality of the relationship with the clinician; on the contrary, high metacognitive skills seem to facilitate the emergence of a positive therapeutic alliance (Lysaker, Bob, Pec, Hamm, Kukla & Vohs, 2013; Semerari, Carcione & Nicolò, 2000; Conti & Semerari, 2003, Carcione & Semerari, 2006; Popolo et al., 2010; Semerari, 1999, 2010). Critically, the relationship between therapeutic alliance and metacognitive functioning seems to be bidirectional, rather than being unidirectional. Indeed, the presence of a strong therapeutic alliance is

supported by the occurrence of patient's highest metacognitive functions, whereas alliance ruptures are associated with falls in such skills (Dimaggio et al., 2010; Liotti, Cortina & Dazzi, 2008; Semerari, 1999, 2010). In particular, Dimaggio et al. (2010) suggested that metacognitive deficits are an obstacle to the therapeutic alliance development, whereas Fonagy (2002) proposed that therapeutic alliance can be a vehicle for developing metacognitive abilities in individuals with personality disorders.

To overcome reasoning problems (Costantino et al., 2008), increase awareness of affects (Bateman & Fonagy, 2004), interrupt malfunctioning patterns (Clarkin, Yeomans & Kernberg, 1999) and, more generally, to work on the patient alliance and on the patient metacognitive functioning, the therapist makes use of specific technical interventions (Safran & Segal, 1990). Insofar, there are contrasting views about the relationship between patient's metacognition functioning and therapist interventions. On the one hand, supportive interventions, rather than interpretative ones, can be more useful in promoting metacognition functions. In this way, supportive interventions focused on mental states that arise in the here and now of the therapeutic relationship, and that convey understanding, validation and support to the patient, would promote the development of metacognitive skills (Bateman & Fonagy, 2004; Liotti, 2011; Semerari, 1999; 2010), whereas interpretative interventions wouldn't be helpful in the metacognition functions, inasmuch as they would even confuse the patient (Wallin, 2007). On the other hand, other authors (Kernberg, Diamond, Yeomans, Clarkin & Levy, 2008; Levy, Clarkin, Yeomans, Scott, Wasserman & Kernberg, 2006) ascribe a key role to transference or defence interpretations techniques in enhancing metacognitive abilities of patients, considering them more useful than supportive interventions.

To give more effectiveness to therapist technical intervention a good therapeutic alliance is also essential (Gaston, Thompson, Gallagher, Cournoyer & Gagnon, 1998). Indeed, supportive interventions may establish a positive therapeutic alliance (Horwitz, Gabbard & Allen, 1996), even in the first phase of the therapy (Cartwright, 2004). Nevertheless, also the association between therapeutic alliance and technical intervention is characterized by a bidirectional and complex

relationship. For instance, supportive interventions are supposed to be used with low level of therapeutic alliance, but, at the same time, interpretations techniques are useful to increase the collaboration and the elaboration of the patient (Crits-Christph & Connolly, 2002), with this complex dynamic that may be understood only by a micro-analytic analysis of therapist and patient interaction (Milbrath, Bond, Cooper, Znoj, Horowitz & Perry, 1999).

On these grounds, in the present study we aimed to investigate, by means of an intersubjective perspective, the relationship between three crucial dimensions involved in psychotherapy: therapeutic alliance, metacognition functioning and therapeutic interventions. To better investigate this relationship, we specifically focus on the earliest phase of the therapy, in which the main goal of the therapist-patient dyad is the building up of the therapeutic alliance.

## 2 | THE PRESENT STUDY

The aim of the present study was to investigate the first phase of the psychotherapy, focusing on the process of building a therapeutic alliance between therapist and patient. In particular, we aimed to identify the interaction between three key dimensions of the therapy process: the therapist interventions, the patient's therapeutic alliance and the patient's metacognition functioning. This was done in two different steps, exploring the micro-analytic and the macro-analytic levels of the therapy session, respectively. An analysis at the micro-analytic level, indeed, allowed us to study the turn-to-turn verbal exchange between the therapist and the patient. On the contrary, an analysis at the macro-analytic level allowed us to study the overall dynamics of a whole therapy session.

*Micro-analytic level: investigating the interaction between technical interventions and therapeutic alliance.* We first aimed to identify specific therapist-patient interactive patterns between interventions and alliance. We differentiated the patient's alliance variables in three different levels, which we named as "cycles": a "Positive cycle" characterized by high levels of collaboration, a "Neutral cycle" characterized by



neutral levels of collaboration and a “Negative cycle” characterized by ruptures markers. We next hypothesized to find specific therapeutic interventions that can elicit a specific patients’ alliance and, in particular, to find definite therapeutic interventions linked the each of the three cycles aforementioned. In order to understand the association between therapeutic interventions and therapeutic alliance we used co-occurrence analysis. The co-occurrence analysis allows, indeed, to identify contingent relationships among a large number of behavior categories. By means of this technique, therefore, we could recognize interactive patterns that qualified the therapy process.

*Macro-analytic level: exploring the interaction between technical interventions, therapeutic alliance and metacognition function.* The second step of the research aimed to understand the role of metacognition in each cycle (i.e., Positive, Neutral and Negative). We hypothesized that metacognition may act as a mediator of the relationship between therapist intervention (independent variable) and therapeutic alliance (dependent variable). More specifically, we hypothesized an active mediation role of metacognition in the *Positive cycle* and in the *Neutral cycle*. On the contrary, we do not expect metacognition to mediate between therapist intervention and therapeutic alliance in the *Negative cycle*, characterized by ruptures. This was tested by means of three different simple mediation analyses (Hayes, 2013).

### 3 | METHODS

#### 1.1 Participants

*Patients.* The sample was composed by 24 patients, 17 females and 7 males, aged between 20 and 29 years old ( $M=24.06$  years,  $SD=2.5$ ). Patients were selected from the Counseling Centre of the University of Padua. Participants were all Italian citizens, with Italian as their mother language, and most of them were university students. The sample was homogeneous in terms of diagnosis and composed by

high-functioning neurotic patients. Before starting treatment, all patients gave the consent to audio-record the clinical sessions and to use these materials for research purposes.

*Therapists.* The clinicians involved in the research were 12 therapists (8 females and 4 males) aged between 28 and 35 years old ( $M=31.5$  years,  $SD=1.75$ ). Clinicians were young psychodynamic oriented therapist-in-training.

### 3.3 Measures

To investigate the early stages of the psychotherapy process, we considered the first three sessions of each patient therapy (verbatim transcripts of 72 sessions).

In particular, three transcript-based instruments were applied on each session: a) the Collaborative Interactions Scale (CIS) developed by Colli and Lingiardi (2009) to measure the therapeutic alliance; b) the Psychodynamic Intervention Rating Scale (PIRS) developed by Cooper and Bond (1992) to code the technical interventions of the therapist; c) the Metacognition Assessment Scale-Revised version (The MAS-R) developed by Carcione et al. (2010) to assess the patients' metacognitive functioning.

*The Collaborative Interaction Scale (CIS)* is based on Safran and Muran's (2003) conceptualization of therapeutic alliance. CIS is structured into two main scales: one for the evaluation of therapist alliance (CIS-T) and one of patient alliance (CIS-P), each comprising different sub-scales. In particular, two subscales compose the CIS-T scale: the Positive Interventions and the Negative Interventions scales. Similarly, the CIS-P scale is composed of three subscales evaluating patients' positive and negative alliance markers: the Collaborative Processes, the Direct Rupture Markers, and the Indirect Rupture Markers scales. In the present research we specifically focused on the CIS-P.

*The Psychodynamic Intervention Rating Scale (PIRS)* was developed by Cooper and Bond (1992). PIRS is a transcript-based tool, used to identify therapist technical

intervention. Interventions are coded in two different scales: the Interpretative Interventions and the Supportive Interventions scales. Interventions are coded in 9 categories: Interpretive Interventions (defense interpretation, transference interpretation), Supportive Interventions (question, clarification, association, reflection, supportive strategy) or Interventions about the therapeutic frame (work-enhancing statement, contractual arrangement).

*The Metacognition Assessment Scale-Revised version* (MAS-R) is a rating scale that assesses metacognitive abilities (Carcione et al., 2010). The rater has to identify the level of success of patients' metacognitive function during the clinical session. MAS-R items are divided into three distinct scales: "understanding of one's own mind" or the comprehension of one's own mental states; "understanding of other's minds", or the comprehension of other individuals' mental states and "mastery" or the ability to work through one's representations and mental states, with a view to implementing effective action strategies. In the present research we focused on the "understanding of one's own mind" ability scale<sup>2</sup>.

### 3.3 Statistical Analysis

Two experienced judges blindly rated the transcripts of all therapy sessions with PIRS and CIS. The scores showed a good inter rater reliability (mean Cohen's K for PIRS = .82 and for CIS = .91). Two other judges rated all the sessions with MAS-R and found a good agreement (mean Cohen's K = .79).

To test the first hypothesis (i.e., micro-analytic level), we used a multievent sequential analysis performed with the Generalized Sequential Querier program (GSEQ 5.1; Bakeman & Quera, 2001). Sequential analysis determines the probability of occurrence of a given behavior together with the occurrence of a target behavior: hence, no causality effect is implied. CIS-P (Colli & Lingardi, 2009) coding was used to differentiate therapeutic alliance in the different levels: the "*Positive alliance*" composed by high level of Collaborative Process (i.e., levels 2 and 3 of the

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<sup>2</sup> "Understanding of other's minds" and "mastery" scales of MAS-R were characterized by several missing data, likely due to the specific stage of the therapy and to the therapist orientation model.

CIS-P); the “*Neutral alliance*” composed by low level of Collaborative Process (i.e., levels 1 and 0 of the CIS-P); the “*Negative alliance*” composed by Direct and Indirect Ruptures Markers. This allowed us to test the co-occurrence of collaborative process (*Positive alliance* and *Neutral alliance*) and of ruptures markers (*Negative alliance*) with specific therapist’s interventions. More specifically, this allowed us to explore the existence of three possible interactive patterns (named as cycles): the *Positive cycle*, the *Neutral cycle* and the *Negative cycle*. The non-inclusion of any lag analysis was motivated by the CIS coding instructions, which force coders to consider therapeutic interventions as an antecedent of patient’s conversational turn. In this way, each discourse unit (and lag 0 of sequential analysis) is made by a therapist’s intervention connected to subsequent patient’s speech.

Then, in order to test the second hypothesis (i.e., macro-analytic level), we introduced the metacognition variable “understanding of one's own mind”, rated in each session as a global index of the level of patient’s metacognition functioning of self-reflection. We performed three mediation analyses (i.e., one for each cycle), using the metacognition variable “understanding of one's own mind” as a mediator and therapist intervention and therapeutic alliance (i.e., resulted significantly associated to each other from the first step of analyses) as independent and dependent variables, respectively.

## 4 | RESULTS

Regarding the first hypothesis (i.e., micro-analytic level), co-occurrence analyses showed a significant transitional probability between therapeutic interventions and therapeutic alliance. Critically, this significant co-occurrence differed depending on the level of alliance considered (for all results of the sequential analyses, please see Table 1).

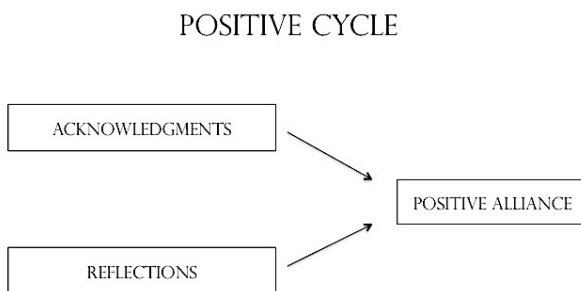
**Table 1.** Co-occurrence Analysis for Therapist’s Intervention and Therapeutic Alliance

Therapist Intervention	Patient Alliance	N	Adjusted Residual	p-value
Defense Interpretations		13	.32	.75
Transference Interpretations		0	-1.26	~.21
<b>Reflections</b>		<b>131</b>	<b>6.16</b>	<b>&lt;.01</b>
Questions		467	-3.1	<.01
Contractual Arrangements	<b>Positive</b>	6	-5.63	<.01
Clarifications	<b>Alliance</b>	155	-.46	.65
Support Strategies		28	.86	.39
Work-enhancing strategies		30	-.18	.86
<b>Acknowledgments</b>		<b>161</b>	<b>6.92</b>	<b>&lt;.01</b>
Associations		166	-2.47	.01
Defense Interpretations		45	-3.25	<.01
Transference Interpretations		1	-4.4	~<.01
Reflections		331	-6.09	<.01
Questions		2454	1.57	.12
<b>Contractual Arrangements</b>	<b>Neutral</b>	<b>207</b>	<b>5.58</b>	<b>&lt;.01</b>
Clarifications	<b>Alliance</b>	777	1.93	.05
Support Strategies		111	-.57	.57
Work-enhancing strategies		129	-2.94	<.01
Acknowledgments		425	-4.89	<.01
<b>Associations</b>		<b>972</b>	<b>4.13</b>	<b>&lt;.01</b>
<b>Defense Interpretations</b>		<b>15</b>	<b>5.18</b>	<b>&lt;.01</b>
<b>Transference Interpretations</b>		<b>7</b>	<b>9.62</b>	<b>&lt;.01</b>
Reflections		36	1.08	~.28
Questions		212	2.06	~.04
Contractual Arrangements	<b>Negative</b>	10	-1.03	~.30
Clarifications	<b>Alliance</b>	41	-2.66	~.01
Support Strategies		8	-.34	~.73
<b>Work-enhancing strategies</b>		<b>29</b>	<b>5.41</b>	<b>&lt;.01</b>
Acknowledgments		25	-2.18	~.03
Associations		47	-3.38	~<.01

~< : p-value does not meet the condition of normality assumption

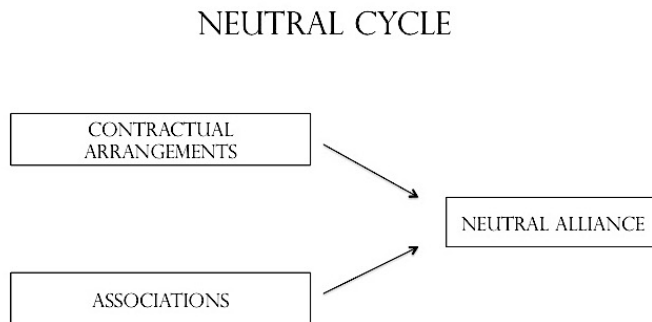
In particular, the *Positive alliance* showed significant positive co-occurrences with Acknowledgments ( $p < .01$ ) and Reflections ( $p < .01$ ), whereas a significant negative co-occurrence with Questions ( $p < .01$ ) and Contractual Arrangements ( $p < .01$ ). The

significant association between *Positive alliance* and both Acknowledgments and Reflections thus determined the *Positive cycle* (Figure 1).



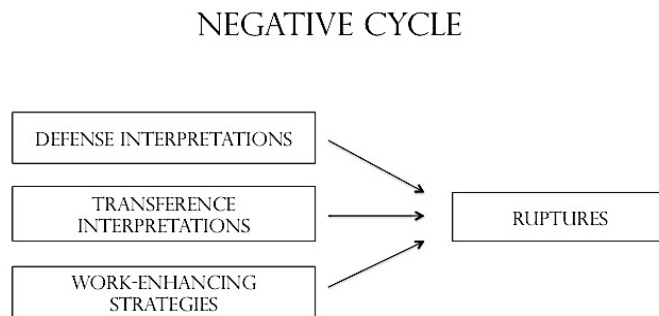
**Figure 1.** Co-occurrence analysis: the *Positive cycle* was determined by the significant association between *Positive alliance* and both Acknowledgments and Reflections.

The *Neutral alliance* was positively associated with Contractual Arrangements ( $p < .01$ ) and Associations ( $p < .01$ ), whereas it was negatively associated with Defense Interpretations ( $p < .01$ ), Transference Interpretations ( $p < .01$ ), Reflections ( $p < .01$ ), Work-enhancing strategies ( $p < .01$ ) and Acknowledgments ( $p < .01$ ). The significant association between *Neutral alliance* and both Contractual Arrangements and Associations thus determined the *Neutral cycle* (Figure 2).



**Figure 2.** Co-occurrence analysis: the *Neutral cycle*, was determined by the significant association between *Neutral alliance* and both Contractual Arrangements and Associations.

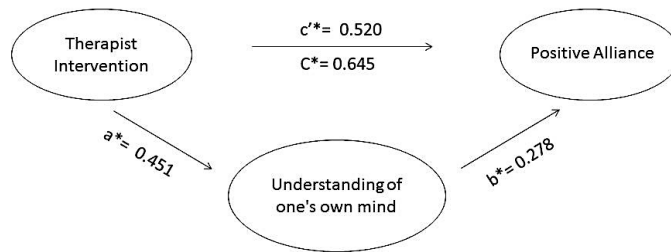
Finally, the *Negative Alliance* was positively associated with Defense Interpretations ( $p < .01$ ), Transference Interpretations ( $p < .01$ ) and Work-enhancing strategies ( $p < .01$ ), whereas a negative relationship was found with Associations ( $p < .01$ ). The significant association between *Negative alliance* and with Defense Interpretations, Transference Interpretations and Work-enhancing strategies thus determined the *Negative cycle* (Figure 3).



**Figure 3.** Co-occurrence analysis: the *Negative cycle* was determined by the significant association between *Negative alliance* and Defense Interpretations, Transference Interpretations, and Work-enhancing.

Regarding the second hypothesis (i.e., macro-analytic level), different mediation analyses were performed verify whether the effect of therapist intervention on the patient's alliance was mediated by patient's metacognition, i.e., "understanding of one's own mind". In particular, a mediation analysis was performed for each cycle. In the *Positive cycle* (Figure 4) a significant mediation effect of the "understanding of one's own mind", with 95% Bootstrap CI [0.020; 0.194], was found.

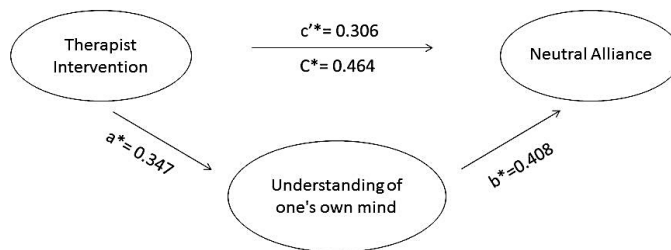
### POSITIVE CYCLE



**Figure 4.** Mediation analysis applied on the *Positive cycle*. A significant mediation effect of “understanding of one's own mind” variable was found.

Similarly, in the *Neutral cycle* (Figure 5) a significant mediation effect of the metacognition variable “understanding of one's own mind”, with 95% Bootstrap CI [0.043; 0.284], was found.

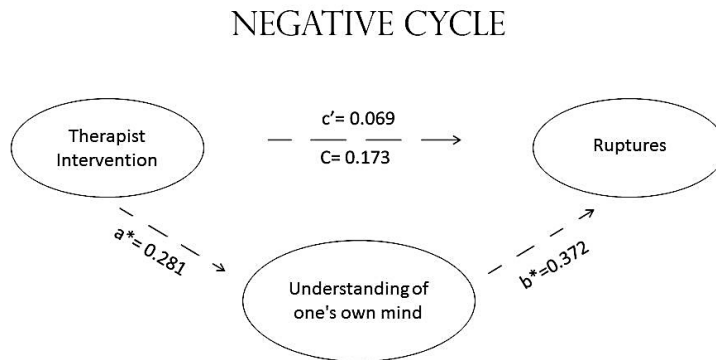
### NEUTRAL CYCLE



**Figure 5.** Mediation analysis applied on the *Neutral cycle*. A significant mediation effect of the metacognition variable “understanding of one's own mind was found.



On the contrary, and critically, the meditational model did not fit the *Negative cycle* (Figure 6). In fact, there was no significant mediation effect of the metacognition variable, with 95% Bootstrap CI [0.002; 0,309].



**Figure 6.** Mediation analysis applied on the *Negative cycle*. No significant mediation effect of the metacognition variable was found.

## 5 | DISCUSSION

This study explored the possible interactive patterns between therapist interventions, patients' therapeutic alliance and patients' metacognitive functioning in the early phase of a therapeutic work. To do so, we first aimed to identify the association between specific therapist interventions and different levels of therapeutic alliance. Results of co-occurrence analysis showed that therapist interventions were differently associated with the three levels of alliance. In particular, therapist acknowledgment and reflection interventions elicited a positive collaboration, giving rise to what we referred to as the Positive cycle. On the other hand, therapist contractual arrangements and association interventions elicited a superficial collaborative response in the patient, which we referred to as the *Neutral cycle*. Finally, interpretative interventions (e.g., defence and transference

interpretations) and work-enhancing strategies elicited ruptures of alliance, i.e., referred to as the *Negative cycle*. These findings, therefore, clearly demonstrate that in the first sessions of the therapy there are mutual interactions between the therapist and the patient. Critically, these interactions should not be simply conceived as non-specific patterns, but rather they seem to be grounded on the specific level of therapeutic alliance. In fact, specific interventions were related to specific levels of the therapeutic alliance.

In the early phases of the therapy, clinicians typically use supportive techniques (i.e., exhibiting nonthreatening behaviors and a nonanxious presence, and conveying respect and lack of judgment) to put the client at ease and engage them in the process (Tryon, 2002). In this sense, both positive and neutral alliance may be better built up by interventions associated to an emotive and concrete exploration, respectively, of the patient's world, which is an important aspect in the early stages of the therapy (Hill, 2005). The therapist, indeed, often begins the therapy process by inviting the client to tell his or her story, state problems, articulate goals, and/or explore feelings. The key for the therapist is to be receptive, responsive to the client's needs, and willing to listen without passing judgment. The therapist typically does this through not interrupting; by encouraging the client to talk via the use of gentle open-ended questions, restatements, reflections of feelings, and silence; and by listening with a "third ear" (Reik, 1948). Furthermore, although therapists begin conceptualizing cases immediately upon the first contact and continue to refine their thinking throughout the entire therapy, conceptualization seems to occur mostly during this stage. The initial conceptualization comes from listening to the client's presenting problems and history, observing client mannerisms, and paying attention to one's feelings in the immediate interaction with the client. This conceptualization deepens as the therapist gains additional information about the client, develops a closer relationship with him or her, and as new situations arise in the therapy process. Therapists also often provide initial structuring and information (e.g., informing clients about confidentiality and procedures) in this stage to educate clients about the process and structure the process. It is, therefore, likely that the neutral alliance may be a conceived as a

necessary precondition that orients the patient-therapist dyad toward an interactive “platform” and may be taken as the ground for establishing a more positive alliance (Liotti, Cortina & Dazzi, 2008). The present study, and the relative distinction between the *Neutral cycle* and the *Positive cycle* in the early stages of the therapy, offers initial empirical support to this view. On contrary, the lower level of alliance was found to be mostly associated with interpretative interventions. This finding is also in line with previous empirical evidence suggesting a negative relationship between a high frequency of transference interpretations and both therapeutic relationship and outcome (Marmar, Horovitz, Weiss & Marziali, 1986; Piper, Azim, Joyce & McMallum, 1991; Piper et al, 1999). Critically, such a negative relationship is found in both brief and long-term psychoanalytic treatment, and even in patients with high levels of personality organization (Piper et al., 1991; Hoglend et al., 2006; Hoglend et al., 2008), indicating that, in the early stages of the therapy, interpretative interventions may be conceived as premature, since they can often intimidate patients (Bateman & Fonagy, 2004).

Critically, the present study also tested the possible role of the metacognition function in the relationship between therapist interventions and patients alliance, in the three cycles described above. The literature, indeed, suggests that a “good alliance” can be associated with a development of metacognitive ability of the patient (Liotti & Monticelli, 2008). Our results go beyond this suggestion, by further showing that in the *Positive cycle* and in the *Neutral cycle*, metacognitive function played a mediator role between therapist intervention and patient’s alliance. On the contrary, in the *Negative cycle*, the metacognitive function did not mediate between therapist interventions and patients ruptures. Nevertheless, it is worth noting that, in this cycle, therapist interventions had a positive influence on the metacognition variable. Therefore, although metacognition seems to be always enhanced by any therapist interventions, when therapist used interpretation or work-enhancing interventions, such as in the *Negative cycle*, the metacognitive functions did not influence the patients’ alliance answers.

In conclusion, the present study attempted to explore the nature of the dynamic relationship between the patient and the therapist in the early phases of the

therapy, both at conscious and unconscious levels (Blatt & Benrends, 1987). We show that the combination of an interactionist approach, which conceives process factors as interrelated dimensions interacting in non-additive and often nonlinear ways (Luyten, Blatt & Mayes, 2012), and analyses at both micro- and macro-analytic levels, may lead to a more complete understanding of the process trajectory and of dynamics underneath interaction structures. The interactive cycles reported here (i.e., neutral, positive and negative), indeed, indicate that therapeutic alliance work in a complex relationship with other variables, acting and reacting in a temporal sequence (Roth & Fonagy, 2013). These intersubjective “cycles” seem to reflect more generally the concept of “interpersonal cycles” (Safran & Muran, 2000) or “interpersonal schema” (Dimaggio et al., 2015), activated in the relationship between therapist and patient during the treatment.

# 5

## *In-Session Interactive Dynamics Of The Psychotherapy Process<sup>3</sup>*

### 1 | INTRODUCTION

Recent literature has emphasized the necessity of a more comprehensive perspective in understanding the dynamics underlying the therapy process and outcome (Levy, Ablon & Kachele, 2012). Conventional psychotherapy research appears to have largely settled for the view that treatment effects are only in part due to the use of specific techniques. In fact, empirical research has pointed out that other factors may account for a large portion of the variance in treatment outcome, with estimates ranging from 15% of the variance in outcome predicted by specific techniques (Lambert & Barley, 2002), 30% by common factors (providing support and empathic understanding), 15% by expectancy and placebo effects, and 35-40% by extra-therapeutic effects (spontaneous remission, positive events or changes). Nevertheless, although the most accepted approaches assume that these factors

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<sup>3</sup> Chapter adapted from: Francesca Locati, Germano Rossi, Margherita Lang & Laura Parolin (*in preparation*). *In-Session Interactive Dynamics Of The Psychotherapy Process*.

may interact, at least at some levels, they essentially consider these factors as independent and additive (Stiles & Shapiro, 1989). From a new relational and dynamic interactionism perspective, by contrast, all these factors are seen as interconnected, interacting often in a nonlinear way and mutually reinforcing or declining the role of each other (Luyten, Blatt, Van Houdenhove & Corveleyn, 2006). Accordingly, in this study we aimed to focus on the exploration of five key dimensions of the therapy process (i.e., therapeutic alliance, technical interventions, therapist expertise, patient metacognition and patient functioning level) and on their relative impact on each other.

Scattered evidence speaks in favour of a relationship between technical interventions and the quality of therapeutic alliance. In particular, the efficacy of expressive interventions is mostly determined by the quality of the alliance in the therapeutic dyad: a solid relationship seems to be a necessary condition for the positive outcome of an interpretation. Nevertheless, it is worth noting that the influence between these two dimensions may be bidirectional. In fact, expressive interventions can support the establishment of a strong and solid therapeutic alliance (Gabbard et al., 1994; Horowitz et al., 1996). Notably, therapeutic alliance as been traditionally considered as a dependent variable influenced by therapist's interventions, though this causal direction seems to be totally mirrored assuming therapist's point of view: the therapist's quality of alliance, indeed, influences radically the categories of intervention, in terms of both their frequency and quality. On these grounds, Milbrath and his colleagues (Milbrath et al., 1999) sustained the necessity to study the relationship between alliance and therapeutic interventions from the therapist's point of view, referring to his/her counter-transference needs (Kantrowitz, 1995), attachment style (Rubino, Barker, Roth & Fearon, 2000) and relational functioning. For what concerns the role of the therapist training and experience in relation to alliance, literature has produced rather contrasting results. For instance, Dunkle and Friedlander (1996) found that therapist experience was not related to the quality of the alliance, whereas on the contrary other studies have reported partial support for such relationship (Bein et al., 2000; Kivlighan, Patton & Foote, 1998; Mallinckrodt & Nelson, 1991). Moreover,

Hersoug (2000, 2001, 2002) reported negative correlation between alliance and training but positive correlation with a measure of therapist skill. Perhaps the answer to these seemingly conflicting findings lies in patient's skills linked to forming and maintaining intimate relationships: patients with such lower skills typically engage in stronger alliance with more experienced counsellors, whereas no difference is found in patients with higher skills (Kivlighan, Patton & Foote, 1998).

Interestingly, the dynamic of the psychotherapy process and the development of therapeutic alliance are further influenced by patient's variables, such as the metacognition functioning and the global level of psychopathological functioning. Metacognition is the ability to think about relational experiences in terms of mental states. It also concerns the ability to interpret other persons' behaviors as products of their wishes, impulses, beliefs and attitudes (Carcione, Falcone, Magnolfi & Manaresi, 1997). These abilities have an important adaptive role in everyday life, allowing individuals to predict other persons' behaviors and elaborate strategies to face internal and external stressors (Carcione & Falcone, 1999). Consequently, some authors proposed that a high level of metacognition functioning facilitates cohesion and alliance in the therapeutic dyad, whereas a low level determines an obstacle to the establishment of the therapeutic alliance, as well as to the resolution of rupture episodes (Carcione & Semerari, 2006; Popolo et al., 2010; Semerari, 1999; 2010). The bidirectional influence is reinforced by the observation that a solid alliance supports the expression of a high level metacognitive functioning, while frequent ruptures in the relationship inhibit it (Liotti, Cortina & Dazzi, 2008; Semerari, 1999; 2010).

With respect to the global level of patient's psychopathological functioning, Semerari and colleagues (Semerari et al., 2014) showed that the severity of psychopathological disease, assessed by the Global Severity Index of Structural Clinical Interview for DSM axis I disorder (SCID; Spitzer, Gibbon & Williams, 1998), was associated to lower global metacognitive scores. This finding is corroborated also by research coming from different theoretical frameworks. For instance, Bouchard and colleagues (Bouchard et al., 2008) found that patient's

reflective function predicted the number of disease in DSM axis I and II, in a heterogeneous clinical sample.

On these grounds, the aim of the present study was to investigate the in-session psychotherapy process dynamics. In particular, we aimed to systematically explore the interaction between the five key dimensions of the therapy process, introduced above: the therapist interventions, the patient's therapeutic alliance, the therapist expertise, the patient's metacognition and the patient's high-functioning level.

## 2 | METHODS

### 2.1 Participants

*Patients.* The sample was composed by 45 patients, 35 females and 10 males, aged between 18 and 66 years old ( $M=38,14$  ys,  $SD=11,56$ ). 23 patients were selected from the Counseling Centre of the University of Padua and 22 patients were selected from the Associazione per la Ricerca in Psicologia Clinica (ARP) in Milano. Participants were all Italian citizens, with Italian as their mother language.

The sample was heterogeneous in terms of diagnosis. Before starting treatment, all patients involved in the research gave the consent to audio-record the clinical sessions and to use these materials for research purposes.

*Therapists.* Clinicians were 14 therapists (10 females and 4 males) aged between 28 and 65 years old ( $M=46.5$  ys,  $SD=14.75$ ). All clinician were psychodynamic oriented therapist. The sample was composed by 12 therapist-in-training from Padua Clinical Centre and 2 expert psychotherapists from Milano Clinical Centre.



## 2.2 Measures

To investigate the psychotherapy process, we considered four randomized sessions of 43 patients and three randomized sessions of 2 patients (verbatim transcripts of 178 sessions).

In particular, four transcript-based instruments were applied on each session: *a*) Collaborative Interactions Scale (CIS) developed by Colli and Lingardi (2009) to measure the therapeutic alliance, *b*) the Psychodynamic Intervention Rating Scale (PIRS) developed by Cooper e Bond (1992) to code the technical interventions of the therapist, *c*) the Metacognition Assessment Scale - Revised version (The MAS-R) developed by Carcione et al. (2010) to assess the patients' metacognitive functioning, and *d*) the SWAP-200 developed by Westen & Shedler (1999a) to assess patients' personality disorder score.

The *Collaborative Interaction Scale (CIS)* is based on Safran and Muran conceptualization of therapeutic alliance (Safran & Muran, 2003). CIS is structured into two main scales: one for the evaluation for therapist alliance (CIS-T) and one of patient alliance (CIS-P), each comprising different sub-scales. In particular, two subscales compose the CIS-T scale: the Positive Interventions and the Negative Interventions. Similarly, the CIS-P scale is composed of three subscales evaluating patients' positive and negative alliance markers: the Collaborative Processes, the Direct Rupture Markers, and the Indirect Rupture Markers. In the present research we specifically focused on the CIS-P.

The *Psychodynamic Intervention Rating Scale (PIRS)* was developed by Cooper e Bond (1992). PIRS is a transcript-based tool, used to identify therapist technical intervention. Interventions are coded in two different scales: the Interpretative Interventions and the Supportive Interventions scales. Interventions are coded in 9 categories: Interpretive Interventions (defense interpretation, transference interpretation), Supportive Interventions (question, clarification, association, reflection, supportive strategy) or Interventions about the therapeutic frame (work-enhancing statement, contractual arrangement).

The *Metacognition Assessment Scale-Revised version (MAS-R)* is a rating scale that assesses metacognitive abilities (Carcione et al., 2010). The rater has to identify the level of success of patients' metacognitive function during the clinical session. MAS-R items are divided into three distinct scales: "understanding of one's own mind" or the comprehension of one's own mental states; "understanding of other's minds", or "the comprehension of other individuals' mental states" and "mastery" or the ability to work through one's representations and mental states, with a view to implementing effective action strategies. In the present study we focused on the "understanding of one's own mind" ability scale. The metacognitive measure of each session was computed as the average of the "understanding of other's minds" and "the comprehension of other individuals' mental states" scores.

*The SWAP-200* (Westen & Shedler, 1999) is a Q-sort instrument designed to quantify clinical judgment of personality pathology. The set of 200 personality-descriptive statements is ranked into eight categories, following a fixed distribution, by a clinician with a good knowledge of the patient. The resulting ordering of the items is then compared with diagnostic prototypes representing each DSM Axis II personality disorders to ascertain the degree of match. The resulting SWAP descriptions were averaged to arrive at a single, aggregate prototype representing the core clinical consensus on the features of each personality disorder (Westen & Shedler, 1999). Overall, these diagnostic prototypes were found to be different from DSM criteria. In the present study we used the "high functioning score" as a global score that reflects patient's level of psychological health.

### **3.3 Hypothesis and Procedures**

The aim of the present study was to investigate the in-session psychotherapy process dynamics. In particular, we aimed to identify the interaction between the therapist interventions, the patient's therapeutic alliance, the therapist expertise, the patient's metacognition and the patient's high-functioning level. This was done in two different steps.

*First step: investigating the interaction between technical intervention and therapeutic alliance.* We first aimed to identify specific therapist-patient interactive patterns between interventions and alliance. We differentiated the patient's alliance variables in three different levels, that we named as "cycles": a "Positive cycle" characterized by high collaboration, a "Neutral cycle" characterized by neutral collaboration, and a "Negative cycle" characterized by ruptures markers. We next hypothesized to find specific therapeutic interventions that can elicit a specific patients' alliance and, in particular, to find specific therapeutic interventions linked each of the three aforementioned cycles. Co-occurrence analysis was used to understand the association between therapeutic interventions and therapeutic alliance we used. In fact, the co-occurrence analysis allows to identify contingent relationships among a large number of behavior categories. By means of this technique, therefore, we could recognize interactive patterns that qualified the therapy process.

*Second step: exploring the interaction between technical intervention, therapeutic alliance, metacognition function, therapist expertise and the patient's high functioning level.* The second step of the research aimed to understand the role of metacognition, therapist expertise and the patient's high functioning level in each cycle (i.e., *Positive, Neutral, Negative*). We hypothesized that: *a)* the previous interactive patterns resulted from the co-occurrence analysis should be confirmed as a latent variable; *b)* metacognition and the high functioning level should positively influence the neutral and the positive cycles, whereas they should negatively influence the negative cycle; *c)* therapist expertise should influence the positive cycle; *d)* the high functioning level should affect the metacognition level. In order to consider the huge complexity of the therapy process, we adopted, instead of a confirmative approach, an explorative approach. In particular, we explored some possible interaction between the variables by means of structural equation models (Loehlin, 1992; Beaujean, 2014).

### 3.4 Statistical Analysis

Two experienced judges blindly rated the transcripts of all therapy sessions with PIRS and CIS. The scores showed a good inter rater reliability (mean Cohen's K for PIRS = .82 and for CIS = .91). Two other judges rated all the sessions with MAS-R and SWAP-200 and found a good agreement (mean Cohen's K for MAS-R = .79 and for SWAP-200=.65).

To test the first hypothesis, we used a multievent sequential analysis performed with the Generalized Sequential Querier program (GSEQ 5.1; Bakeman & Quera, 1995, 2001). Sequential analysis determines the probability of occurrence of a given behavior together with the occurrence of a target behavior: hence, no causality effect is implied. CIS-P (Colli & Linguardi, 2009) coding was used to differentiate therapeutic alliance in the different levels: the "*Positive alliance*" composed by high level of Collaborative Process (i.e., levels 2 and 3 of the CIS-P); the "*Neutral alliance*" composed by low level of Collaborative Process (i.e., levels 1 and 0 of the CIS-P); the "*Negative alliance*" composed by Direct and Indirect Ruptures Markers. This allowed us to test the co-occurrence of collaborative process (*Positive* and *Neutral alliance*) and of ruptures markers (*Negative alliance*) with specific therapist's interventions. More specifically, this allowed us to explore the existence of three possible interactive patterns (named as cycles): the *Positive cycle*, the *Neutral cycle* and the *Negative cycle*. The non-inclusion of any lag analysis was motivated by the CIS coding instructions, which force coders to consider therapeutic interventions as an antecedent of patient's conversational turn. In this way, each discourse unit (and lag 0 of sequential analysis) is made by a therapist's intervention connected to subsequent patient's speech.

In order to test the second hypothesis, we introduced the *Positive cycle*, the *Neutral cycle* and the *Negative cycle* as latent variables. These latent variables were measured with the values of adjusted residuals resulting from the aforementioned co-occurrence analysis, by means of confirmatory factor analysis.

Then, we explored the relationship between latent variables and metacognition, therapist expertise and the high functioning level variables, rated in each of the treatment session ( $N=178$ ). To do so, we performed a structural equation model.

**Table 1.** Co-occurrence Analysis for Therapist’s Intervention and Therapeutic Alliance

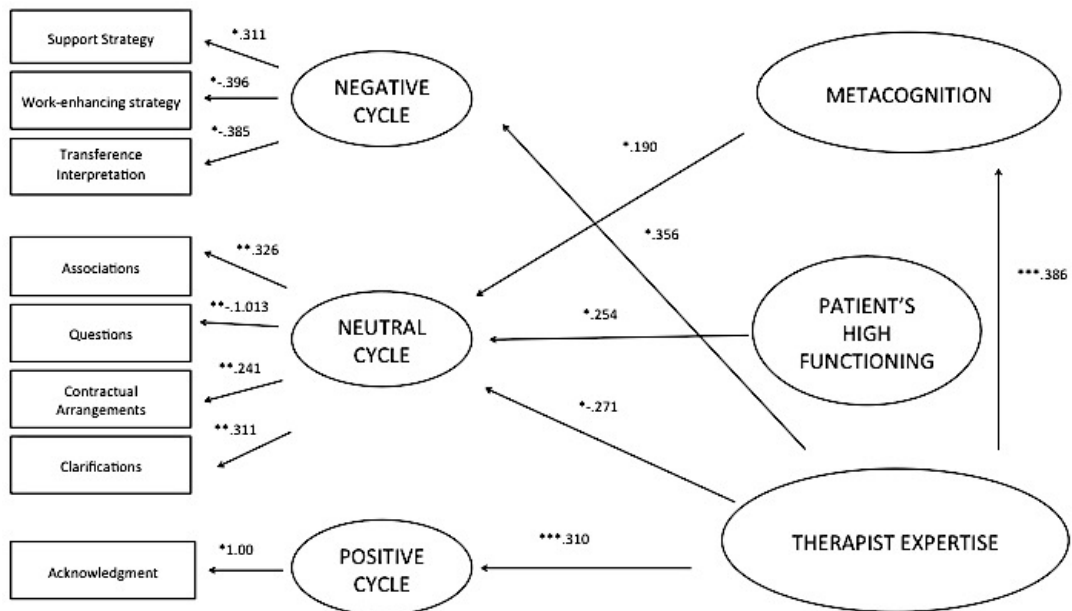
Therapist Intervention	Patient Alliance	N	Adjusted Residual	p-value
Defense Interpretations		96	-.93	.35
Transference Interpretations		3	-1.64	.10
<b>Reflections</b>		<b>211</b>	<b>6.07</b>	<b>&lt;.01</b>
Questions		959	-2.09	.04
Contractual Arrangements	<b>Positive</b>	24	-7.76	<.01
Clarifications	<b>Alliance</b>	270	-.05	.96
Support Strategies		544	-2,24	.03
Work-enhancing strategies		146	-1.10	.27
<b>Acknowledgments</b>		<b>754</b>	<b>14.81</b>	<b>&lt;.01</b>
Associations		360	-8.04	<.01
Defense Interpretations		403	.42	.67
Transference Interpretations		15	-3.95	<.01
Reflections		524	-2.58	.01
<b>Questions</b>		<b>4043</b>	<b>6.69</b>	<b>&lt;.01</b>
<b>Contractual Arrangements</b>	<b>Neutral</b>	<b>207</b>	<b>9.48</b>	<b>&lt;.01</b>
<b>Clarifications</b>	<b>Alliance</b>	<b>1135</b>	<b>5.96</b>	<b>&lt;.01</b>
Support Strategies		1991	-10.61	<.01
Work-enhancing strategies		501	-7.68	<.01
Acknowledgments		1601	-10.70	<.01
<b>Associations</b>		<b>2192</b>	<b>10.64</b>	<b>&lt;.01</b>
Defense Interpretations		78	.48	.63
<b>Transference Interpretations</b>		<b>20</b>	<b>7.33</b>	<b>&lt;.01</b>
Reflections		72	-3.42	<.01
Questions		574	-6.84	<.01
Contractual Arrangements	<b>Negative</b>	33	-4.17	<.01
Clarifications	<b>Alliance</b>	91	-8.16	<.01
<b>Support Strategies</b>		<b>717</b>	<b>17.23</b>	<b>&lt;.01</b>
<b>Work-enhancing strategies</b>		<b>227</b>	<b>11.86</b>	<b>&lt;.01</b>
Acknowledgments		306	-2.26	.02
Associations		274	-5.45	<.01

### 3 | RESULTS

Regarding the first hypothesis, co-occurrence analyses showed a significant transitional probability between therapeutic interventions and therapeutic alliance. Critically, this significant co-occurrence differed depending on the level of alliance considered (for all results of the sequential analyses, please see Table 1). In particular, the *Positive alliance* showed significant positive co-occurrences with Acknowledgments ( $p < .01$ ) and Reflections ( $p < .01$ ), whereas a significant negative co-occurrence with Contractual Arrangements ( $p < .01$ ) and Associations ( $p < .01$ ). The significant association between *Positive alliance* and both Acknowledgments and Reflections thus determined the *Positive cycle*. The *Neutral alliance* was positively associated with Contractual Arrangements ( $p < .01$ ), Associations ( $p < .01$ ), Clarification ( $p < .01$ ) and Questions ( $p < .01$ ), whereas it was negatively associated with Support Strategies ( $p < .01$ ), Transference Interpretations ( $p < .01$ ), Work-enhancing strategies ( $p < .01$ ) and Acknowledgments ( $p < .01$ ). The significant association between *Neutral alliance* and Contractual Arrangements, Clarification, Questions and Associations thus determined the *Neutral cycle*. Finally, the *Negative Alliance* was positively associated with Transference Interpretations ( $p < .01$ ), Work-enhancing strategies ( $p < .01$ ) and Support Strategies ( $p < .01$ ), whereas a negative relationship was found with Questions ( $p < .01$ ), Contractual Arrangements ( $p < .01$ ), Reflections ( $p < .01$ ), Clarifications ( $p < .01$ ) and Associations ( $p < .01$ ). The significant association between *Negative alliance* and Transference Interpretations, Support Strategies and Work-enhancing strategies thus determined the *Negative cycle*.

Regarding the second hypothesis, first a confirmatory factor analysis (CFA) was performed to confirm the relationship between therapist intervention and the patient's alliance, and, successively, a structural equation model (SEM) was performed to explore the relationship between the cycles and the others key variables (i.e., metacognition, therapist expertise and high level functioning).

Results from CFA (significant loadings at  $p < .05$ ) indicated that the *Positive cycle* was composed by the association between Acknowledgment and positive alliance. The *Neutral cycle* was composed by the association between Contractual, Arrangements, Clarification, Questions and Associations and neutral alliance. The *Negative cycle* was composed by the association between Transference Interpretations, Support Strategies, Work-enhancing strategies with negative alliance.



**Figure 1.** Structural Equation Model of the in-session psychotherapy process (all standardized parameters)

Resulting from SEM, the *Positive cycle* a significant effect of the “therapist expertise” was found (Standardized parameter = .310;  $p < .01$ ). Similarly, in the *Neutral cycle* a significant effect of the metacognition variable (Standardized parameter = .190;  $p < .05$ ) and patient’s high functioning (Standardized parameter = .254;  $p < .05$ ) were found. Moreover, results also showed a significant negative effect of therapist expertise variable (Standardized parameter = -.271;  $p < .05$ ). Finally, in the *Negative cycle*, a significant effect of the therapist expertise was found

(Standardized parameter = .356;  $p < .05$ ). A significant effect of the therapist expertise to metacognition variable was found (Standardized parameter = .386;  $p < .01$ ) (Figure 1).

**Table 2.** Structural Equation Model

<b>CONFIRMATORY FACTOR ANALYSIS</b>							
<b>Latent Variable</b>	<b>ADJR Interventions-Alliance</b>	<b>Estimate</b>	<b>Std. error</b>	<b>Z-value</b>	<b>P(&gt; z )</b>	<b>Std.lv</b>	<b>Std.all</b>
<i>Negative cycle</i>	Support Strategy-Negative Alliance	1.000				.286	.311
	Work-enhancing strategy-Negative Alliance	-1.521	.659	-2.306	.021	-.435	-.396
	Transference Interpretation-Negative Alliance	-0.679	.297	-2.284	.022	-.194	-.385
<i>Neutral Cycle</i>	Association-Neutral Alliance	1.000				.369	.326
	Clarification-Neutral Alliance	.865	.269	3.210	.001	.320	.311
	Contractual Arrangement-Neutral Alliance	.648	.238	2.726	.006	.240	.241
	Question-Neutral Alliance	-3.709	1.221	-3.039	.002	-1.370	-1.013
<i>Positive Cycle</i>	Acknowledgment-Positive Alliance	1.000				1.336	1.000

<b>REGRESSIONS</b>							
<b>Dependent V.</b>	<b>Independent V.</b>	<b>Estimate</b>	<b>Std. error</b>	<b>Z-value</b>	<b>P(&gt; z )</b>	<b>Std.lv</b>	<b>Std.all</b>
<b>Metacognition</b>	Therapist Expertise	.485	.087	5580	.001	.485	.386
<i>Negative cycle</i>	High-Functioning	.012	.007	1900	.057	.043	.295
	Therapist Expertise	.203	.095	2133	.033	.712	.356
<i>Neutral Cycle</i>	Metacognition	.112	.056	1984	.047	.303	.190
	High-Functioning	.014	.006	2345	.019	.037	.254
	Therapist Expertise	-.200	.086	-2326	.020	-.542	-.271
<i>Positive Cycle</i>	Therapist Expertise	.830	.190	4356	.001	.621	.310

<b>COVARIANCES</b>							
<b>Dependent V.</b>	<b>Independent V.</b>	<b>Estimate</b>	<b>Std. error</b>	<b>Z-value</b>	<b>P(&gt; z )</b>	<b>Std.lv</b>	<b>Std.all</b>
<b>Negative cycle</b>	Neutral Cycle	.034	.020	1718	.086	.391	.391
	Positive Cycle	.049	.049	1.005	.315	.153	.153
<i>Neutral Cycle</i>	Positive Cycle	-.047	.036	-1.310	.190	-.108	-.108

<b>STRUCTURAL EQUATION MODEL</b>					
	<b>chi-square</b>	<b>df</b>	<b>p-value</b>	<b>cfi</b>	<b>rmsea</b>
	91.88	38	.001	.72	.089



The model show an acceptable fit to the data (RMSEA=.089 (0.066-0.113); CFI=0.718) (Tabel 2).

## 6 | DISCUSSION

This study explored the possible interactive patterns between therapist interventions, patients' therapeutic alliance, patients' metacognitive functioning, therapists' expertise and patients' functioning during psychotherapy. To do so, we first aimed to identify the association between specific therapist interventions and different levels of therapeutic alliance. Co-occurrence analysis showed that therapist interventions were differently associated with the three level of alliance. In particular, therapist acknowledgment and reflection interventions elicited a positive collaboration, giving arise to what we referred to as the *Positive cycle*. On the other hand, therapist questions, clarifications, contractual arrangements and association interventions elicited a superficial collaborative response in the patient (i.e., *Neutral cycle*). Finally, transference interpretations, support strategies and work-enhancing strategies elicited ruptures of alliance (i.e., *Negative cycle*). These findings, therefore, clearly demonstrate that during the psychotherapy there are mutual interactions between the therapist and the patient. Critically, these are not nonspecific interactions, but rather they are grounded on the level of therapeutic alliance. In fact, specific interventions relate to specific levels of the therapeutic alliance.

Clinicians typically reach a collaborative atmosphere with the patients by exploiting supportive interventions that convey warmth (Principe, Marci, Glick & Ablon, 2006; Sexton, Littauer, Sexton & Tommeran, 2005) and understanding (Shick Tyron, 1990). The present results are in line with such evidence. Indeed, the patient reaches a more intensive and depth therapeutic alliance by means of interventions that communicate empathetic attitude and comprehension, as well as through an emotional attitude toward the patient's unique experience (Jungbluth & Shirk, 2009; Karver et al., 2008). Furthermore, the emotional sharing and monitoring of tasks

and goals in therapeutic dyad permits a deeper understanding of the relational impact of therapist's technical interventions (Safran & Muran, 2000). In this way, the therapist can explore in-session process with a non-judgmental approach (Principe, Marci, Glick & Ablon, 2006). Therapist empathic attitude allows the construction of an intense and positive relationship that may represent a "secure base" for the patient, by which he/she can deal with problematic characteristics and negative features of the therapy (Rogers, 1957; Bordin, 1975; Bowlby, 1988; Frank, 1991). As a consequence, the present results confirm that emotional depth and smoothness interventions are the best way to increase the alliance of the patients (Mallinckrodt & Nelson, 1991).

On the contrary, neutral alliance was built up from interventions associated to a concrete exploration. Accordingly, it is likely that interventions focused uniquely on the exploration of cognitive content may encourage the collaboration only at a superficial level. For instance, Wallin (2007) claimed that explorative interventions could be ineffective or even useless in the establishment of a stable alliance. Explorative techniques like questions and clarifications, indeed, have the potentiality to focus patient's attention on his/her mental contents, rather than on the emotional dimension. Contrary to empathic or interpretative interventions, these techniques induce a more neutral emotional representation of the therapist. In line with this, in the present study, the neutral cycle of the alliance seems to be influenced by the lack of relational and emotional dimension. Finally, the lower level of alliance was found to be mostly associated with interpretative interventions. This finding is also in line with previous empirical evidence suggesting a negative relationship between a high frequency of transference interpretations and both the therapeutic relationship and outcome (Silberchatz, Fretter & Curtis, 1986; Marmar, Horovitz, Weiss & Marziali, 1986; Piper, Azim, Joyce & McMallum, 1991; Piper et al, 1999). Critically, such a negative relationship is found in both brief and long-term psychoanalytic treatment, not only in borderline and psychotic structured patients (Fonagy, 1991; Kohut, 1971), but even in patients with high levels of personality organization (Piper, Azim, Joyce & McMallum, 1991; Høglend et al., 2006; Høglend et al., 2008). The present results, therefore, partially

disconfirm the psychoanalytic traditional certainty that interpretation represents the best factor in therapeutic principles hierarchy (Bibring, 1954). It is likely that alliance ruptures after interpretative interventions are influenced by the return to consciousness of removed ideas. In fact, interpretative interventions link important dynamic elements as drives, defenses, transference needs and conflicts, that have a huge impact on the relational dimensions of the patient (Piper, Debbane, de Carufel & Bienvenu, 1987; Hill, 1978). Furthermore, following these interventions, it usually take a longer process of elaboration for the patient to re-arrange the transference feelings about the relationship with the therapist (Etchegoyen, 2005). Such a temporary shock in the relationship may determine the decrease in the quality of the alliance reported here immediately after a transference interpretation. More generally, this finding confirms the *high risk-high gain* role of the transference-based interventions (Gabbard et al., 1994).

As a second step, the present study also tested the possible role of therapist expertise, patient's metacognition and patient's high-functioning, along with their relationship with therapist interventions and patients alliance, in the three cycles described above. First, confirmatory factor analysis overall identified *Positive cycle*, *Neutral cycle* and *Negative cycle* as the latent variables and thus corroborated results of previous analysis. Second, results from SEM indicated a positive effect of therapist expertise on both the *Positive cycle* and the *Negative cycle*. On the contrary, therapist expertise exerted a negative effect on the *Neutral cycle*, whereas the metacognitive function and patient's high-functioning exerted a positive influence on it. Moreover, therapist expertise had a positive effect on metacognitive function. Hence, these findings suggest that therapist expertise may be a crucial variable that can influence the in-session interactive dynamics of the therapy. In particular, the expert therapist seems to be able to move the dialogue on a ruptures or positive alliance, disinvesting consequently from a neutral alliance. This finding is in line with a better capacity of experienced therapists in identifying alliances ruptures (Mallinckrodt & Nelson, 1991). Crucially, the ability to better detect the patient's relational problems during the therapy would allow these therapists to build up and repair their alliances more efficiently. In fact, expert therapists manage the

therapeutic process in a dialectical way moving from negative to positive cycles: the resolution of ruptures in the alliance allows them to explore the relational and emotional meaning of negative feelings about the therapy (Safran & Muran, 2000). Contrarily, it is likely that the explorative interventions of the neutral cycle may be influenced by the inability of non-experienced therapists to identify and resolve ruptures episodes in the alliance. Specifically, inexpert therapists frequently use questions as a defense mechanism to avoid embarrassing moments emerging from episodes of rupture (Jones, 2000). In this sense, patients in treatment with therapists who frequently use this kind of interventions may have a more passive representation of therapeutic process, as it seems to be strongly led by therapist's questions. Differently from expert therapists, who are able to identify and face the negativity of ruptures, provoking and stimulating patient's change, inexpert therapists seem to establish and maintain a more passive and neutral collaborative relationship.

With respect to the significant effect of metacognition and high functioning level on the neutral cycle, it is likely to hypothesize that both of them may determine a sort of accommodation in the establishment of the therapeutic alliance. Furthermore, findings showed a positive effect of therapist expertise on metacognitive functioning. Nevertheless, considering the huge effect of therapeutic expertise on the three cycles, it is worth noting that patient's metacognition and high functioning effects may be partially hidden by the influence of therapist. In fact, these variables are in relation with the neutral cycle, which negatively correlate with therapist expertise.

In conclusion, the present study attempted to investigate the in-session interactions of the therapy, interpreting the therapy process as a dynamic interaction, both at conscious and unconscious levels, between the patient and the therapist (Blatt & Benrends, 1987). By means of an interactive approach, process factors were found to be interrelated dimensions, which interacted in non-additive and often nonlinear way (Luyten, Blatt & Mayes, 2012). These results highlight the central role of therapeutic alliance in the dynamics of several constructs in treatment. As a cornerstone of the entire therapy, alliance is determined by the

emotional and relational structure emergent from the intersubjective matrix of patient and therapist. Alliance provides, during the session, the rhythm onto which the other dimensions of the therapy move in interaction. Critically, the rhythmic cadence of alliance during the session would be strictly dependent on therapist's expertise. Like an orchestra leader, the therapist level of expertise, can draw different kinds of therapy atmosphere and modalities of work.



# 6

## *Cyclical dynamics of different patients*

### *In the therapy rooms: A Discussion*

#### 1 | **GROUP-LEVEL STUDIES**

The aim on the first part of the thesis is to approach the huge complexity of the therapy process adopting a comprehensive perspective in order to understand the interaction between its key dimensions. From a new relational and dynamic interactionism perspective, in fact, the interconnection between factors is often conceived as nonlinear, as mutually reinforcing or as mutually declining (Levy, Ablon & Kachele, 2012).

Accordingly, the two studies presented in the first part of this thesis were focused on exploring the interactive dynamics that characterized the psychotherapeutic process. This was done, in the first study, by investigating the interaction between three crucial variables (i.e., therapist technical interventions, patient's therapeutic alliance, and patient's metacognitive functioning) in the early

stage of the therapy. Furthermore, in a second study, we explored the interaction between the three above variables, along with therapist expertise and patient functioning level, in a group of randomized sessions.

### **1.1 Interventions And Therapeutic Alliance**

In both studies we found that specific therapist interventions related to different levels of therapeutic alliance (i.e., positive, neutral and negative). In particular, the *Positive alliance* was always elicited by therapist acknowledgment and reflection interventions, giving rise to what we referred to as the *Positive cycle*. On the contrary, in both studies the *Neutral alliance* was elicited by therapist contractual arrangements and associations, and, in addition, by questions and clarifications interventions in the second study. This pattern of interaction was referred to as the *Neutral cycle*. Finally, *Negative alliance* was elicited by work-enhancing strategies and interpretative (i.e., defensive and transference) interventions in the first study, and by work-enhancing strategies, support strategies and transference interpretations, in the second one. This pattern of interaction was referred to as the *Negative cycle*.

With respect to the *Positive cycle*, findings from both studies indicated that clinicians typically reach a collaborative atmosphere with the patients, by exploiting supportive interventions that convey warmth (Principe, Marci, Glick & Ablon, 2006; Sexton, Littauer, Sexton & Tommeran, 2005) and understanding (Shick Tyron, 1990). Indeed, patients reached a more intensive and depth therapeutic alliance by means of interventions that communicate empathetic attitude and comprehension, and thus with an emotional approach toward the patient's unique experience (Jungbluth & Shirk, 2009; Karver et al., 2008). This is also paramount to let the therapist explore the in-session process with a non-judgmental approach (Principe, Marci, Glick & Ablon, 2006). These findings confirm that emotional depth and smoothness interventions are optimal tools to increase the alliance of the patients (Mallinckrodt & Nelson, 1991).

On the contrary, the *Neutral cycle* was built up from interventions associated to



a more concrete exploration of the patient's inner world. Accordingly, it is likely that interventions focused uniquely on the exploration of cognitive content encourage the collaboration only at a superficial level.

Finally, the *Negative cycle* was found to be mostly associated with interpretative interventions. This finding is also in line with previous empirical evidence suggesting a negative relationship between a high frequency of transference interpretations and both the therapeutic relationship and outcome (Marmar, Horowitz, Weiss & Marziali, 1986; Piper, Azim, Joyce & McMallum, 1991; Piper et al, 1999). Critically, such a negative relationship has been reported in both brief and long-term psychoanalytic treatment, and even in patients with high levels of personality organization (Piper, Azim, Joyce & McMallum, 1991; Høglend et al., 2006; Høglend et al., 2008).

## 1.2 Patient's Variables

The role of the metacognitive functioning in the relationship between therapist interventions and patients alliance was also deeply explored with respect to the three cycles described above.

In the first study, results unveiled that in the *Positive cycle* and in the *Neutral cycle*, metacognitive functioning played a mediator role between therapist intervention and patient's alliance. On the contrary, in the *Negative cycle*, the metacognitive functioning did not mediate between therapist interventions and patients ruptures. Nevertheless, it is worth noting that therapist intervention had a positive influence on the metacognition variable. These findings suggest that a "good alliance" (*Positive alliance* and *Neutral alliance*) can be associated with a development of metacognitive abilities of the patient (Liotti & Monticelli, 2008). Therefore, in the early phases of the psychotherapy process, metacognition seems to be a crucial variable activated by any therapist intervention. Nevertheless, when therapist used interpretation or work-enhancing interventions (i.e., in the *Negative cycle*), the metacognitive functioning did not influence the patients' alliance answer.

In the second study, we found that metacognition and patient high-functioning

level had a positive influence on the *Neutral cycle*, which was also in turn affected by therapist expertise. It is likely, therefore, that these variables contributed to determine a sort of accommodation in the establishment of the therapeutic alliance. At the same time, however, the massive effect of therapist expertise on the whole model suggests caution in interpreting these findings.

Together, both studies point to patient metacognition and high-functioning level as critical in having a positive impact on the collaborative process. Critically, therapist interventions and expertise can have, in turn, a direct influence on metacognition.

### **1.3 Therapist Patterns**

Both the *Positive cycle* and the *Negative cycle* were positively influenced by therapist expertise, whereas a negative influence was found in the *Neutral cycle*. In this sense, the expert therapist seems to be able to move the dialogue from ruptures to a positive alliance or in the other way round, disinvesting from a neutral alliance. This finding is in line with previous reports, which have linked experienced therapists to a better ability in identifying deterioration or poor alliances during therapy (Mallinckrodt & Nelson, 1991). The ability to better detect the patients' relational problems in therapy, indeed, enables these therapists to build up and repair alliance with difficult patients, in a more efficient way. Expert therapists manage the therapeutic process in a dialectical way moving from negative to positive cycles: the resolution of ruptures in the alliance allows them to explore the relational and emotional meaning of negative feelings about the therapy (Safran & Muran, 2000). It is likely, therefore, that the explorative interventions of the neutral cycle are influenced by the inability of non-experienced therapists to identify and resolve ruptures episodes in the alliance. In particular, non-expert therapists frequently use questions as a defense mechanism to avoid embarrassing moments emerging from episodes of rupture (Jones, 2000). Hence, patients of such therapist may have a more passive representation of the therapeutic process, since this would be mainly oriented by therapist's questions. Contrary to expert therapists,

who are able to identify and face the negativity of ruptures provoking and stimulating patient's change, non-expert therapists seem to establish and maintain a more passive and neutral collaborative relationship.

## 2 | EARLY STAGES OF THE THERAPY

The initial relationship is centered in feeling the possibility of a connection, though this relationship is necessarily superficial and not founded on deep interpersonal trust or shared experiences. Some evidence for this stage comes from the social psychology literature, which is replete with instances of the influence of initial impressions. For example, Kenny (1994) found that person perception takes place very quickly and that initial impressions remain quite stable across time. Furthermore, Snyder and Stukas (1999) found that one's initial beliefs or expectations of another person shape their subsequent interactions and behaviors. At this stage, the client has to decide that the therapist is credible and that it is safe to proceed. The therapist, in turn, has to decide that he or she wants to work with the client and that change is possible.

As a consequence, therapist techniques may be very crucial in this brief stage. In fact, therapists have to convince clients that they are credible (i.e., expert, attractive, and trustworthy; Strong, 1968) by using appropriate techniques. To put the client at ease and engage them in the process therapists typically use supportive (exhibiting nonthreatening behaviors and a nonanxious presence, conveying respect and lack of judgment) techniques (Tryon, 2002). Therapists also often provide initial structuring and information (e.g., informing clients about confidentiality and procedures) in this stage to educate clients about the process and structure the process.

In this sense, facilitating the client exploration is an important component in this stage of the therapy. The therapist begins the process by inviting the client to tell his or her story, state problems, articulate goals, and/or explore feelings. The key is for the therapist to be receptive, responsive to the client's needs, and willing

to listen without passing judgment. The therapist typically does this through not interrupting; by encouraging the client to talk via the use of gentle open-ended questions, restatements, reflections of feelings, and silence; and by listening with a “third ear” (Reik, 1948).

Although therapists begin conceptualizing cases immediately upon the first contact and continue to refine their thinking throughout the entire therapy, conceptualization seems to occur mostly during this stage. The initial conceptualization comes from listening to the client’s presenting problems and history, observing client mannerisms, and paying attention to one’s feelings in the immediate interaction with the client. This conceptualization deepens as the therapist gains additional information about the client, develops a closer relationship with him or her, and as new situations arise in the therapy process.

Of course, other variables can also influence this process: like demographic variables, patient’ expectation about the therapy, transference and countertransference dynamics (Hill, 2005).

### **3 | CYCLICAL INTERACTIVE DYNAMICS OF THE THERAPY PROCESS**

The first part of the thesis aimed at identifying the in-session interactions of the therapy, interpreting the therapy process as a dynamic interaction, at both conscious and unconscious levels, between the patient and the therapist (Blatt & Benrends, 1987). Results from two studies show that the combination of an interactionism approach, which conceives process factors as interrelated dimensions interacting in non-additive and often nonlinear ways (Luyten, Blatt & Mayes, 2012), and analyses at both micro- and macro-analytic levels, may lead to a more complete understanding of the process trajectory and of dynamics underneath interaction structures.

The interactive cycles reported here (i.e., neutral, positive and negative), indeed, indicate that therapeutic alliance work in a complex relationship with other variables, acting and reacting in a temporal sequence (Roth & Fonagy, 2013). These

findings indicated that therapeutic alliance could be conceived as a continuous variable that moves during the therapy session, from low levels of ruptures to high levels of collaboration. In this sense, we were able to go beyond the dichotomic view of alliance as a collaboration or a rupture, by showing the presence of different level of collaboration (neutral vs positive). Notably, each level of this continuum seems to have specific characteristics, in interaction with others variables of the process.

Importantly, the patterns of interaction were found in both studies and, hence, regardless of the fact that different therapists were involved. In fact, the relationship between the kind of interventions and the patient's alliance was not changed by the level of expertise of the therapist. Nevertheless, the expertise of the therapist influenced the dynamics and the rhythm of the process, since it was related to a different use of technical and relational strategies.

These results highlight the central role of therapeutic alliance in the dynamics of several constructs in the treatment. As a cornerstone of the entire therapy, alliance is determined by the emotional and relational structure emergent from the intersubjective matrix of patient and therapist. Alliance moves, during the session, as a rhythm in which the other dimensions of the therapy move in each other's interactions. Furthermore, the studies reported unveil the importance of others dimensions of the therapeutic process, which act in an interactive way. In the first studies, indeed, although the metacognition variable was involved in each cycle, it played a mediation role in increasing the alliance only in the two collaborative cycles. In the second study, the importance of therapist's expertise in increasing and polarizing the rhythmic cadence of alliance during the session was stressed. In this sense, and like an orchestra leader, the therapist level of experience can draw different kinds of therapy atmosphere and modalities of work.



## PART 2

### *Cyclical Dynamics Of A Single Patient In The Therapy Room*

*“There was always a feeling of sacred peace and quiet here. The rooms themselves must have been a surprise to any patient, for they in no way reminded one of a doctor’s office, but rather of an archaeologist’s study. Here were all kinds of statuettes and other unusual objects, which even the layman recognized as archaeological finds from ancient Egypt. Here and there on the walls were stone plaques representing various scenes of long-vanished epochs. A few potted plants added life to the rooms and the warm carpet and curtains gave them a homelike note. Everything here contributed to one’s feeling of leaving the haste of modern life behind, of being sheltered from one’s daily care.”*

The Wolf-man (1972) from “The Wolf-man and Sigmund Freud”





## *Cyclical Dynamics Of A Single Patient In The Therapy Room: An Introduction*

### 1 | SINGLE CASE STUDY

Nomothetic approaches have long been criticized because individual variation can be underestimated by averaging individualities across a larger group (Bergin & Strupp, 1972; Dukes, 1965). In psychotherapy research, in fact, Kiesler (1966) has drawn attention to the existence of what has been referred as “uniformity myths”: the implicit assumption by researchers that clients are all similar or that different therapists can deliver an identical intervention. On the contrary, idiographic methods allow a greater understanding of that person’s unique personality or psychological responses. In this sense, single case designs can therefore go beyond some of the drawbacks of nomothetic designs.

One of the traditional idiographic methods is the narrative case study, i.e., a description of a client or treatment, based on the clinician’s case notes and memory. Classic examples of this kind of approach are Freud’s case histories, e.g., “Little Hans” (Freud, 1909/1955) or “Dora” (Freud, 1905/1953). These and other singles case studies have been paramount in the development of the psychological

theories. These include observing and documenting the existence of a certain clinical phenomenon (in many cases a rare one), disproving a universal proposition by demonstrating a counter-example, demonstrating a new intervention, and generating hypotheses about causes. Obviously, inferences should always take into account the limitation, especially in terms of generalizability, of this approach. In fact, such cases can inform about what is possible, but not about what is common. In a similar way, they can suggest a possible connection or cause, but cannot provide strong confirmatory evidence for it.

### **1.1 A Natural Laboratory**

The clinical setting can be conceived as the natural laboratory imagined by Westen and Bradley (2005) and Peterson (2004). Peterson (2004), in particular, suggested that the databases created in the actual clinical setting may offer a descriptive basis for a science that suits the nature that we try to comprehend. Accordingly, many of the early discoveries of psychological science were inferred from single-case methodologies (Ebbinghaus, 1913; Fechner, 1889; Kohler, 1925; Pavlov, 1927; Skinner, 1938; Watson, 1925; Morgan & Morgan, 2001). As a privileged example, Skinner was a strong supporter of single-organism time-series designs. In his view, the dominant paradigm with large samples in psychology, along with its focus on group, may obscure the individual change in time.

Although, the tradition of case-based time-series design with baseline measurement still persists in literature (Jones, Vaught & Weinrott, 1978; Morgan & Morgan, 2001), this has drastically declined in contrast to group methodologies in the last decades. Anyway, the call for empirically robust single case studies survives and is now increasing. In fact, many researchers have questioned whether laboratory-validated interventions may extend to practice settings (Jacobson & Christensen, 1996; Westen & Bradley, 2005; Westen, Novotny & Thompson-Brenner, 2004). The American Psychological Association's (APA's) Division 12 Task Force on Promotion and Dissemination of Psychological Procedures has explicitly recognized time-series designs as important methodological approaches that can fairly test treatment efficacy and/or effectiveness (Chambless & Ollendick, 2001).

Moreover, the APA Task Force on Evidence-Based Practice (2005) has endorsed systematic single-case studies as contributing to effective psychological practice. The field seems to be recognizing that assaying aggregate effect is not the only empirical window researchers have on the nature of therapeutic change and that systematic observation of one or a few patients can be scientifically sound and instructive (Westen & Bradley, 2005).

## **1.2 Interactive Method In Single Case Studies**

Given the problems with narrative case studies (reliance on memory, anecdotal data collection, narrative smoothing), methodologists such as Kazdin (1981, 1992) and Hayes et al. (1999) have considered more systematic approaches to single case research. They proposed the following features for improving their credibility: systematic, quantitative (versus anecdotal) data; multiple assessments of change over time; multiple cases; change in previously chronic or stable problems; and immediate or marked effects following the intervention. The combination of these features, indeed, substantially improves the researcher's ability to infer that a treatment caused an effect (i.e., it increases the internal validity of the study).

The final example of naturalistic case study designs is the time-series design. The aim of this approach is to evaluate causal processes by mainly adopting correlational methods. Two or more variables are monitored over time and their interrelationship is examined statistically. A large number of observations is, thus, needed in order to meet the statistical assumptions behind the analysis. Gottman and his co-workers have promoted these methods within clinical psychology in general and in the study of psychological therapies in particular (e.g., Gottman, 1981; Gottman & Roy, 1990). Nevertheless, complex statistical methods are needed to assess the evolving relationships within and between variables in time (Gottman, 1981; Skinner, 1991).

In the studies reported in the second part of this thesis, we opted for adopting the interactive approach, already described for the first part of the thesis, in two single case studies. In particular, various measures of different psychotherapy

variables will be considered in order to capture the complex interactions of relational and technical factors. Furthermore, the psychotherapy work will be examined in association with both the psychotherapy process and outcome. More specifically, time series analysis approach will be integrated with sequential analyses, to gain a micro-analytic and a macro-analytic view of the therapy process. This mixed-method integrates a quantitative and a qualitative approach, sustained by clinical interpretations of transcripts.

# 8

## *The Flip Side Of Collaborative Alliance: A Single Case Study<sup>4</sup>*

### 1 | INTRODUCTION

During the last decades, compelling literature focused on the study of the interpersonal perspective (Henry & Strupp, 1994), as a more complete approach able to define the broad construct of therapeutic alliance. On these grounds, therapeutic alliance has been defined as an interactive process between the patient and the clinician, based on their ability to create a respectful and cooperative bond (Bordin, 1994). This formulation harks back to the modern pantheoretical reconceptualization of the therapeutic alliance (Bordin, 1980; Hatcher, Barends, Hansel & Gutfreund, 1995; Luborsky, 1976). Indeed, in contrast to classic formulations that emphasized either therapist's contributions to the relationship (Rogers & Wood, 1974) or the unconscious distortions of the relation between the therapist and the client (Freud, 1912), the "new" alliance construct emphasizes the conscious aspects of the relationship and the attainment of concerted "work

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<sup>4</sup> Chapter adapted from: Francesca Locati, Pietro De Carli, Margherita Lang & Laura Parolin (*Under Review*). *The Flip Side of Collaborative Alliance: a Single Case Study*.

together” aspects of the relationship (Horvath, Del Re, Fluckiger & Symonds, 2011). This recent definition, thus, identifies therapeutic alliance as a relationship, with an active cooperation between the clinician and the patient, who would both work on tasks that are strictly interconnected with a shared goal.

Such approach reflects more generally the vigorous development of relational perspective in psychoanalytic theory (Aron, 1996; Benjamin, 1990; Mitchell, 1993). In line with this, Safran and Muran (2003) refined the concept of alliance by drifting from the construct of “agreement” to “negotiation”. More specifically, they proposed that alliance is a negotiation between therapist and patient: under this view, alliance is not a static variable necessary to establish an effective intervention, but rather a constantly shifting, emergent property of the therapeutic relationship (Safran & Muran, 2003, 2006). In other words, therapeutic alliance is regarded as an intersubjective negotiation, rather than a mere collaboration. Notably, alliance would develop in a continuum of ruptures and resolutions, which would shape and delineate patient-therapist interactions (Safran & Muran, 2006).

Within this theoretical framework, ruptures are conceived as patient’s behaviors or communications that represent critical points during the therapy; in fact, ruptures often emerge when the therapist unconsciously participates in a maladaptive interpersonal cycle that resembles the patient’s dysfunctional interpersonal schemas (Safran, 1990a; 1990b). More specifically, an alliance rupture can be defined as “a breakdown in the collaborative process between therapist and patient, a poor quality of therapist-patient relatedness, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset” (Safran & Muran, 2006, p. 288). One of the innovative aspect of this conceptualization is the positive role of this relational moment in the psychotherapy context, because it can be conceived as an opportunity offered to the clinician to improve her/his understanding of client’s world and, eventually, to promote therapeutic change. From this point of view, each rupture or disagreement on the shared task, goal or bond is not considered as a drawback anymore, rather as a starting point that might promote a new awareness of the client (Lingiardi, 2002). In such a dynamic, the active role of the therapist would not be sufficient to achieve

the resolution process (Safran & Muran, 2003). Indeed, an active role of the patient would be also paramount. Thereof, understanding this maladaptive dynamic would allow a better comprehension of the patient's representations of self-other interactions.

However, although ruptures can be identified as a key aspect in the understanding of the therapeutic process, collaborations might be informative as well. In fact, patient's collaboration has been defined as the extent to which the patient is bringing in significant issues and making good use of the therapist's efforts (Allen, Newsom, Gabbard & Coyne, 1984) or as "the patient's capacity to self-disclose intimate and salient information, to self-observe one's reactions, to explore contributions to problems, to experience emotions in a modulated fashion, to work actively with the therapist's comments, to deepen the exploration of salient themes" (Gaston & Marmar, 1994, p. 89). Similarly, Hatcher (1999) conceptualized collaboration as a joint achievement of the therapeutic dyad, an emergent feature that relies on both patient and therapist contributions. This formulation has been taken up in a recent review on therapeutic collaboration by Lepper and Mergenthaler (2007), who suggested that the processes of coordination (Westerman, 1998) or complementarity (Tracey, 1993) are characterized by a specific quality of communicative action, particularly valuable at the clinical level. Overall, these studies point to collaboration as another fundamental relational aspect in the understanding of the therapeutic process, along with ruptures. Whereas ruptures have been conceived as maladaptive interpersonal cycles, collaborations have been often conceived as adaptive cycles that would represent crucial opportunities for positive interactions.

Yet, in some specific cases, conceiving collaborations as uniquely positive may prevent a comprehensive insight on the therapeutic relationship, with this positive characterization that might represent only one side of the coin. Indeed, it is reasonable to hypothesize the existence of a flip side of collaboration that conceals some of the patient's dysfunctional interpersonal schemas. On these grounds, in the present single case we explored whether positive collaboration may even turn out to be negative. More specifically, we systematically addressed the relational

meaning of collaborative alliance, and whether this specific type of alliance might be characterized by negative aspects, thus reflecting a “false” collaboration.

To better explore the quality of therapeutic collaboration, we used an intersubjective approach, by considering the integration of specific and non-specific factors in an interdependent way. In particular, we assessed different constructs of the therapeutic process and combined them through statistical methods able to investigate the micro and macro analytic processes that define each interaction.

## 2 | METHOD

To explore the clinical and relational meaning of collaboration, we chose as a clinical case a patient that is typically defined as a “good patient” (Shapiro, 1965). In particular, these patients are characterized by high levels of compliance with therapists (Weiner & Bornstein, 2009), and avoid any real connection with their own feelings, by mostly adopting obsessive and neurotic defenses that keep away emotions from awareness. In this scenario, thus, mature defenses can be conceived as an obstacle to a real insight (McWilliams, 2011).

We conducted a mixed qualitative/quantitative study focused on the psychotherapy process in the first two years of treatment.

*Patient.* Sara is a 33 years old lawyer. She came to therapy complaining about anxiety symptoms, insomnia and “fear of losing control”. The psychological assessment, composed of WAIS-R (Wechsler, 1981) and Rorschach Test (Exner, 1993) revealed that Sara has an high cognitive functioning level and a rigid thinking. This functioning is characterized by hypervigilance and emotional constriction. The clinician believed that Sara’s emotions are often replaced by anxiety states. Sara was diagnosed with an Anxiety Disorder NOS (American Psychiatric Association, 2000), and a neurotic personality organization with a rumination attitude. Before starting treatment, Sara gave her consent to audio-record the clinical sessions and to use them to research purposes. The patient was informed about the scientific publication on the treatment process, prior to de-



identification of all sensitive information.

*Therapist.* Sara is actually undergoing a weekly psychodynamic therapy with an expert clinician. Dr. L. is a female 65 years old clinical psychotherapist, with 35 years of clinical experience. She identifies herself as a psychodynamic oriented therapist.

## 2.1 Measures

### *Process Measure*

In the present study we used different instruments that were applied on 63 transcripts of the therapeutic sessions (24 months of treatment).

First, we applied the *Collaborative Interactions Scale (CIS; Colli & Lingiardi, 2009)* to measure therapeutic alliance. This is a transcript-based method, built on Safran and Muran (Safran & Muran, 2006) conceptualization of therapeutic alliance, structured into two main scales: a first one for the evaluation of patient's contributions to the process (CIS-P) and a second one for the therapist's contributions (CIS-T). The CIS-P is composed by three subscales evaluating patient positive and negative contributions: the Collaborative Processes scale (CP), the Direct Rupture Markers scale (DRM), and the Indirect Rupture Markers scale (IRM). Similarly, the CIS-T is composed of two subscales evaluating therapists' contributions to the psychotherapeutic process: the Positive Interventions scale (PI) and the Negative Interventions scale (NI).

Second, in order to identify the interactive pattern, we introduced two different instruments to assess therapist interventions and defense mechanisms. *The Psychodynamic Intervention Rating Scale (PIRS)* developed by Cooper e Bond (1992) is a transcript-based tool aimed to categorize the technical interventions of the therapist. Interventions are divided into two scales: Interpretative Interventions Scale (defense interpretations, transference interpretations) and Noninterpretative Interventions Scale (questions, clarifications, associations, reflections, support strategies, work-enhancing statement, contractual arrangement, acknowledgments).

Third, *The Defense Mechanism Rating Scales (DMRS, Perry, 1990; Perry et al., 2004)* was used to assess defense mechanisms. The DMRS defenses are comparable to those listed by the DSM-IV (American Psychiatric Association, 1994). The instrument describes 30 defense mechanisms assigned to seven hierarchical levels of defensive functioning: high adaptive (mature), obsessional, other neurotic, minor image-distorting, disavowal, major image-distorting, and action defenses. We adopted the DMRS quantitative scoring to compute the Overall Defensive Functioning scores (ODF), used as an outcome measure of the therapy.

The therapeutic alliance was then compared with the *Psychotherapy Process Q-set (PQS; Jones, 2000)*, in order to identify the specific interaction structure between patient and therapist. PQS is a Q-sort method made of 100 items. PQS statements cover a wide range of several dimensions of the psychotherapy process, including both relational and technical aspects. Moreover, PQS contains items that separately describe patient's contributions to the psychotherapy process (e.g., Q97 Patient is introspective, readily explores inner thoughts and feelings), therapist's contributions (e.g., Q50 Therapist draws attention to feelings regarded by the patient as unacceptable, such as anger, envy, or excitement), and patient/therapist interactions (e.g., Q39 There is a competitive quality to the relationship).

#### *Outcome Measure*

The *SWAP-200 (Westen & Shedler, 1999)* is a Q-sort instrument designed to assess personality pathology. It is composed of 200 personality-descriptive items. A rater arranges the items into eight categories, following a fixed distribution. Thus, the procedure yields a numeric score from 0 (not descriptive) to 7 (most descriptive) for each of the 200 personality-descriptive items. The resulting ordering of the items is then compared with 12 personality prototypes representing each DSM Axis II personality disorders, to establish the degree of match. The resulting SWAP descriptions were averaged to define a single prototype, representing the core clinical agreement on the features of each personality disorder (Westen & Shedler, 1999).

## 2.2 Aims And Hypotheses

Three main aims guided the present study:

In order to explore the positive and negative quality of collaborative alliance, our first aim was to identify different patterns of defense mechanisms and technical interventions that characterize the presence of high collaborative levels of alliance during the therapy. Given the maladaptive meaning of the collaborative alliance in this kind of patient, we expect different kind of defense mechanisms to be activated, from mature to primitive defense levels. This was achieved by two main steps:

- a. In a first step, we used the sequential analysis (data analysis was done using the program GSeq5.1; Bakeman & Quera, 1995) to identify defense' and interventions' variables co-occurring with collaborative alliance.
- b. Subsequently, we explored the trend over time of collaborative alliance, by means of time series analysis.

We next aimed to verify whether the patients' relational functioning, even if characterized by collaborative alliance, has a negative meaning. To address this possibility, we compared the measure of collaborative alliance with an external criterion, that is informative about the quality of the relationship between the therapist and the patient (PQS). We hypothesized to find a correspondence between collaborative alliance and negative interaction structures. This second aim was achieved by two further steps:

- a. We built PQS factors, by means of Principal Component Analysis.
- b. We then explored the time trend of PQS and CIS variables, comparing positive alliance with PSQ factor, by means of time series analysis.

Finally, we hypothesized to find significant changes during the therapy. This was achieved by two additional steps:

- a. We compared the SWAP-200 profile in the initial phase of the therapy with the one in the last phase.
- b. We analyzed defense mechanism (ODF) trend during the therapy, by means of the ARIMA model.

### 3.2 Procedure And Statistical Analysis

Two experienced judges blindly rated the transcripts of all therapy sessions with DMRS and PQS. The scores showed a good inter rater reliability (mean Cohen's K for DMRS = .79 and for PQS = .87). Two other judges rated all the sessions with PIRS and found a good agreement (mean Cohen's K = .85). After coding, the judges discussed the case and the scores to reach a complete agreement. Each of two other independent raters evaluated the swap profiles of the patient at the beginning pre and post treatment. The first evaluation was based on the transcripts of the first five sessions, while the second one on the last five sessions.

To test the first hypothesis, we built an empirically derived operationalization of the "*Positive Alliance*", through a Sequential Analysis performed with the Generalized Sequential Querier program (GSeq5.1; Bakeman & Quera, 1995). This allowed us to test the co-occurrence of collaborative markers with specific therapist's interventions and patient's defensive processes. The non-inclusion of any lag analysis was motivated by the CIS coding instructions, which force coders to consider therapeutic interventions as an antecedent of patient's conversational turn. In this way, each discourse unit (and lag 0 of sequential analysis) is made by a therapist's intervention connected to subsequent patient's speech. All categories with less than 5 occurrences were eliminated prior to the analysis. The positive cycle collaboration measure (sum of highly collaborative categories) was tested to investigate its tendency during treatment with an ARIMA model.

Then, in order to test the second group of hypotheses, we followed the procedure explained by Jones and colleagues (Jones, Ghannam, Nigg & Dyer, 1993): we performed a Principal Component Analysis (PCA) on the PQS ratings of each of the treatment hours (N=63) to identify some dimensions of the therapy process. In

this way, we could test the effect of different interpersonal structures (PQS factors) on our measure of collaboration (representing the positive cycle) using five different ARIMA models.

We used the SWAP assessment as outcome measure: we reported pre-post personality scores and tested the Reliable Change Index (Jacobson & Truax, 1991) for each of them. Finally, we tested the ARIMA model to analyze defense mechanism trend during the first 24 months of the therapy.

### 3 | RESULTS

#### *Process Measures*

Sequential analysis determines the probability of occurrence of a given behavior together with the occurrence of a target behavior; hence no causality effects are implied. Defenses Mechanisms and Therapeutic Alliance showed a significant association ( $\chi^2 (28) = 1611.58, p < .01$ ) and the significant co-occurrences are presented in Table 1. Positive collaborations is characterized by a more likely presence of Self-Observation, Suppression, Isolation of Affect, Intellectualization, Undoing, Repression, Displacement, Devaluation, Projection, Rationalization, Passive Aggression, and by less likely absence of defensive mechanisms.

Table 2 shows the significant co-occurrences between Therapeutic Interventions and Therapeutic Alliance ( $\chi^2 (16) = 978.24, p < .01$ ). Positive collaboration is likely to be positively associated with Acknowledgments and negatively with Defensive Interpretation, Contractual Arrangements, Support Strategies and Associations.

**Table 1.** Sequential Analysis for Defensive Mechanism and Therapeutic Alliance.

<b>Defense Mechanism</b>	<b>Alliance</b>	<b>N</b>	<b>Adjusted Residual</b>	<b>p value</b>	<b>Yule's Q</b>	<b>Odds Ratio</b>
Self-Observation		65	-20.84	<.01	-0.84	0.09
Suppression		5	-2.94	~<.01	-0.64	0.22
Isolation of Affect		210	-19.64	<.01	-0.68	0.19
Intellectualization		47	-8.19	<.01	-0.62	0.24
Undoing		91	-6.85	<.01	-0.47	0.37
Repression		122	-6.8	<.01	-0.42	0.41
Reaction		55	-4.09	<.01	-0.39	0.44
Formation	<b>Neutral</b>					
Displacement	<b>Collaboration</b>	16	-4.51	<.01	-0.6	0.25
Devaluation		51	-9.03	<.01	-0.64	0.22
Projection		10	-7.8	<.01	-0.82	0.1
Rationalization		29	-3.63	<.01	-0.44	0.39
Passive		3	-3.55	~<.01	-0.77	0.13
Aggression						
No Defenses		573	35.5	<.01	0.74	6.63
Self-Observation		229	21.53	<.01	0.84	11.69
Suppression		8	3.11	~<.01	0.66	4.95
Isolation of Affect		328	19.97	<.01	0.68	5.3
Intellectualization		68	8.7	<.01	0.64	4.58
Undoing		84	7.24	<.01	0.49	2.89
Repression	<b>High</b>	101	7.27	<.01	0.45	2.61
Displacement	<b>Collaboration</b>	22	4.8	<.01	0.62	4.27
Devaluation		76	9.16	<.01	0.64	4.55
Projection		34	8.16	<.01	0.83	10.64
Rationalization		25	3.63	<.01	0.44	2.59
Passive		7	3.02	~<.01	0.69	5.41
Aggression						
No Defenses		112	-35.79	<.01	-0.74	0.15
Reaction		14	10.88	~<.01	0.86	13.04
Formation						
Passive	<b>Ruptures</b>	1	2.16	~.03	0.75	7.05
Aggression						

NB. Only the significant effects are presented. Target column represents CIS variables: Neut. Collaboration = neutral processes (CP1). High Collaboration = high collaboration processes (CP2 and CP3). Ruptures = negative processes (IRMs).

**Table 2.** Sequential Analysis for Therapist's Intervention and Therapeutic Alliance

Intervention	Alliance	N	Adjusted Residual	p value	Yule's Q	Odds Ratio
Defense	<b>Neutral Collaboration</b>	1018	6.46	<.01	0.24	1.64
Interpretation						
Support Strategies		337	7.03	<.01	0.51	3.1
Acknowledgments		1345	-26.84	<.01	-0.59	0.26
Associations		2545	16.48	<.01	0.44	2.54
Defense	<b>High Collaboration</b>	182	-9.07	<.01	-0.36	0.47
Interpretation						
Contractual arrangements		2	-2.02	~.04	-0.6	0.25
Support Strategies		37	-6.87	<.01	-0.52	0.32
Acknowledgments		1143	28.73	<.01	0.62	4.29
Associations	426	-16.64	<.01	-0.45	0.38	
Defense	<b>Ruptures</b>	53	9.07	~<.01	0.64	4.58
Interpretation						
Contractual arrangements		2	2.7	~.01	0.71	5.86
Acknowledgments		10	-5.1	~<.01	-0.64	0.22

NB. Only the significant effects are presented. Target column represents CIS variables: Neut. Collaboration = neutral processes (CP1). High Collaboration = high collaboration processes (CP2 and CP3). Ruptures = negative processes (IRMs).

The trend of positive collaboration, measured by CIS was tested with an ARIMA (2,0,0) model that showed no significant change during therapy,  $b = 0.25$ ,  $SE = 0.22$ ,  $t(62) = 1.13$ ,  $p = .26$ . Visual inspection of data suggested the presence of two different moments of positive collaboration, with an abrupt change between the 37 and the 38 sessions. An ARIMA (1,0,0) model with a dummy variable (coded as 1 until session 37, and as 1 from session 38) confirmed this significant change,  $b = 15.15$ ,  $SE = 5.04$ ,  $t(62) = 3.00$ ,  $p = .004$ . In particular, results indicated that whereas the positive collaboration was higher until session 37, it turned out to be lower from session 38.

The PCA yielded five factors after varimax rotation, able to account for 37% of variance. The most descriptive items for each factor are listed in Table 3.

**Table 3.** Patient Sara: PCA Factors

<b>Item n.</b>	<b>Item</b>	<b>Loading</b>
<b>Factor 1</b>		
3T	Therapist's remarks are aimed at facilitating patient speech.	.58
6T	Therapist is sensitive to the patient's feelings, attuned to the patient; empathic.	.86
9T	Therapist is distant, aloof (vs. responsive and affectively involved).	-.74
13P	Patient is animated or excited.	.53
18T	Therapist conveys a sense of nonjudgmental acceptance. (N.B. Placement toward uncharacteristic end indicates disapproval, lack of acceptance).	.79
31T	Therapist asks for more information or elaboration.	.60
37T	Therapist behaves in a teacher-like (didactic) manner.	-.53
39I	There is a competitive quality to the relationship.	-.82
51T	Therapist condescends to or patronizes the patient.	-.76
65T	Therapist restates or rephrases the patient's communication in order to clarify its meaning.	.59
66T	Therapist is directly reassuring (N.B. Place in uncharacteristic direction if therapist tends to refrain from providing direct reassurance).	-.53
72P	Patient understands the nature of therapy and what is expected.	-.74
77T	Therapist is tactless.	-.58
78P	Patient seeks therapist's approval, affection, or sympathy.	-.66
89T	Therapist intervenes to help patient avoid or suppress disturbing ideas or feelings.	.59
93T	Therapist refrains from stating opinions or views of topics the patient discusses.	.51
<b>Factor 2</b>		
15P	Patient does not initiate or elaborate topics.	.55
20P	Patient is provocative, tests limits of the therapy relationship. (N.B. Placement toward uncharacteristic end implies patient behaves in a compliant manner).	.51
27T	Therapist gives explicit advice or guidance (vs. defers even when pressed to do so).	-.56
45T	Therapist adopts supportive stance.	-.57
47T	When the interaction with the patient is difficult, the therapist accommodates in an effort to improve relations.	.70
52P	Patient relies upon therapist to solve his/or her problems.	-.63



56P	Patient discusses experiences as if distant from his or her feelings.	-53
60P	Patient has cathartic experience (N.B. rate as uncharacteristic if emotional expression is not followed by a sense of relief).	-68

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**Factor 3**

5P	Patient has difficulty understanding the therapist's comments.	-51
8P	Patient is concerned or conflicted about his or her dependence on the therapist (vs. comfortable with dependency, or wanting dependency).	.66
17T	Therapist actively exerts control over the interaction (e.g., structuring, introducing new topics).	.60
32P	Patient achieves a new understanding or insight.	.59
48T	The therapist encourages independence of action or opinion in the patient.	-51
58P	Patient does not examine thoughts, reactions or motivations related to his or her role in creating or perpetuating problems.	-53
70P	Patient struggles to control feelings or impulses.	.52
97P	Patient is introspective, readily explores inner thoughts and feelings.	.59

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**Factor 4**

12	Silences occur during the hour.	-53
28T	Therapist accurately perceives the therapeutic process.	.63
54P	Patient expresses himself or herself in a clear and organized fashion.	.50
55P	Patient conveys positive expectations about therapy.	.74
73P	The patient is committed to the work of therapy.	.62
96	There is discussion of scheduling of hours, or fees.	.59

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**Factor 5**

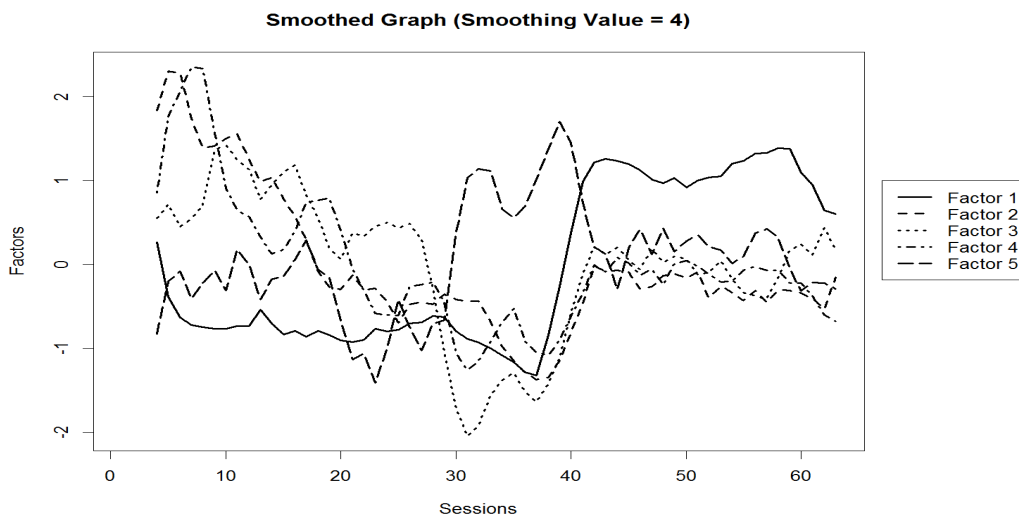
26P	Patient experiences discomforting or troublesome (painful) affect during the session.	-52
38	There is discussion of specific activities or tasks for the patient to attempt outside of session.	.61
40T	Therapist makes interpretations referring to actual people in the patient's life (N.B. Placement toward uncharacteristic end indicates therapist makes general or impersonal interpretations).	.52
59P	Patient feels inadequate and inferior (vs. effective and superior).	-52
71P	Patient is self-accusatory; expresses shame or guilt.	-56

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T = Therapist, P = Patient

Factor 1, which was labeled "Empathic and Authentic Relationship", describes the empathic effort of the therapist in understanding the emotional states of the patient, encouraging her description of emotions and conveying a sense of

nonjudgmental acceptance. The patient is animated and looks for therapist affection. Factor 2, labeled “Asynchronous Relationship”, represents a dimension of distance between patient and therapist, where the two of them seem to go in different directions. The patient tests the limits of therapy and the therapist moves toward the patient, although without any real empathic comprehension or supportive role. Factor 3, labeled “Toward the insight”, shows a patient struggling with feelings but able to explore her own emotions, helped by the active role of the therapist who actively exerts control over the interaction. Factor 4, labeled “The good therapy”, describes a dimension of high collaborative stance, where both patient and therapist are successfully focused on the task. Factor 5, labeled “Life outside the room”, describes the collusion of patient and therapist in avoiding the painful feeling of the patient focusing on specific activities and individuals outside the therapeutic session. The smoothed raw scores of the factors are presented in Figure 1.



**Figure 1.** The smoothed raw scores of the five PQS factors in the 63 sessions of therapy. In particular, Factor 1 was labeled as “Empathic and Authentic Relationship”, Factor 2 as “Asynchronous Relationship”, Factor 3 as “Toward the insight”, Factor 4 as “The good therapy”, and Factor 5 as “Life outside the room”.

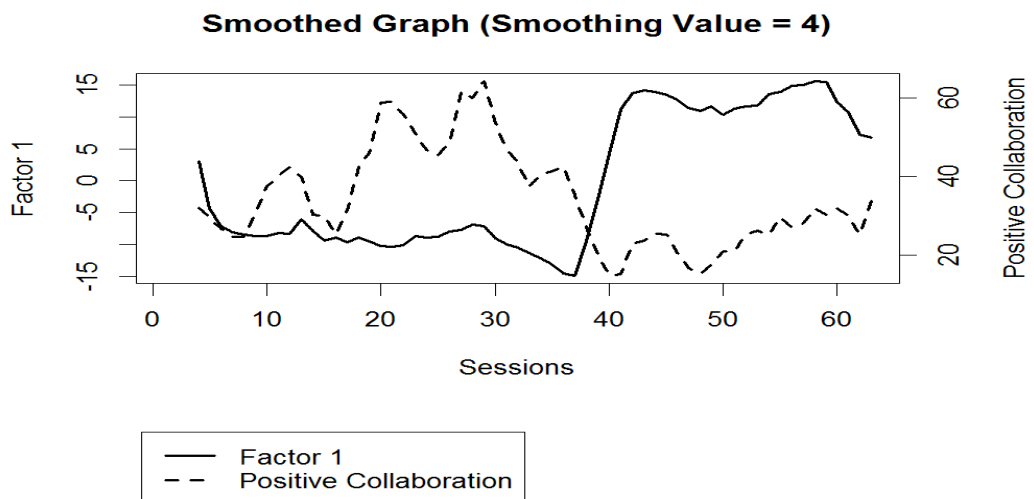
The effects of the PQS factors on the positive collaboration measure was tested

using five different ARIMA models, reported in Table 4.

**Table 4.** ARIMA Models: independent effects of PQS Factors on CIS Positive Collaboration

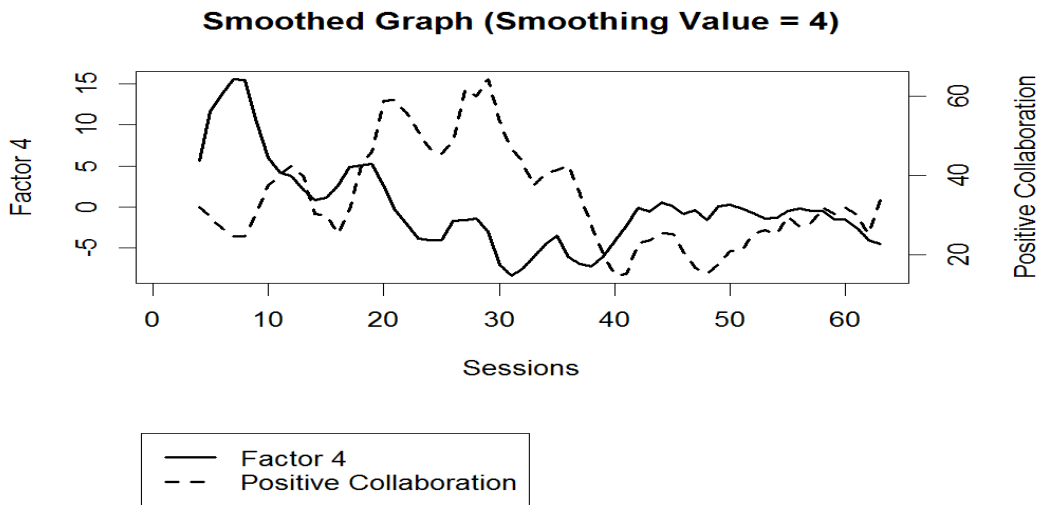
ARIMA Model	Predictor Variable	ARIMA Model Parameters			
		<i>b</i>	<i>SE</i>	<i>t</i> (62)	<i>p</i>
(1,0,0)	Factor 1: Empathic and Authentic Relationship	-.53	.23	<b>-2.32</b>	.02
(2,0,0)	Factor 2: Asynchronous Relationship	.20	.32	.64	.53
(2,0,0)	Factor 3: Toward the insight	.05	.36	.14	.89
(1,1,0)	Factor 4: The good therapy	.43	.20	<b>2.26</b>	.03
(1,0,0)	Factor 5: Life outside the room	-.99	.33	<b>-3.03</b>	<.01

A significant negative association was found for Factor 1 and 5, while a positive association was found for Factor 4.

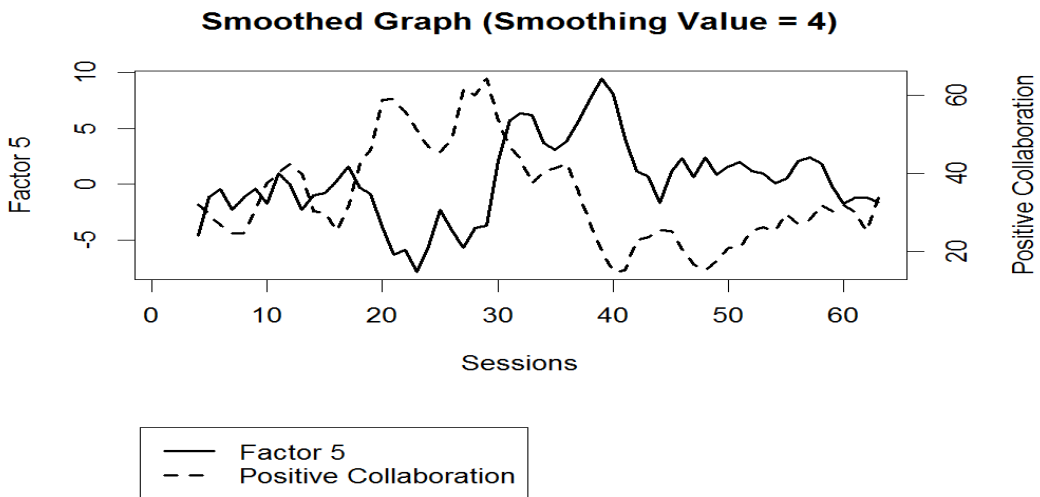


**Figure 2.** The negative association between the PQS Factor 1 (Empathic and Authentic Relationship) and the positive collaboration (CIS Positive Collaboration), tested by the ARIMA model, in the 63 sessions of therapy.

The smoothed raw scores of positive collaboration and Factor 1, Factor 4 and Factor 5 are presented in Figure 2, Figure 3 and Figure 4, respectively.



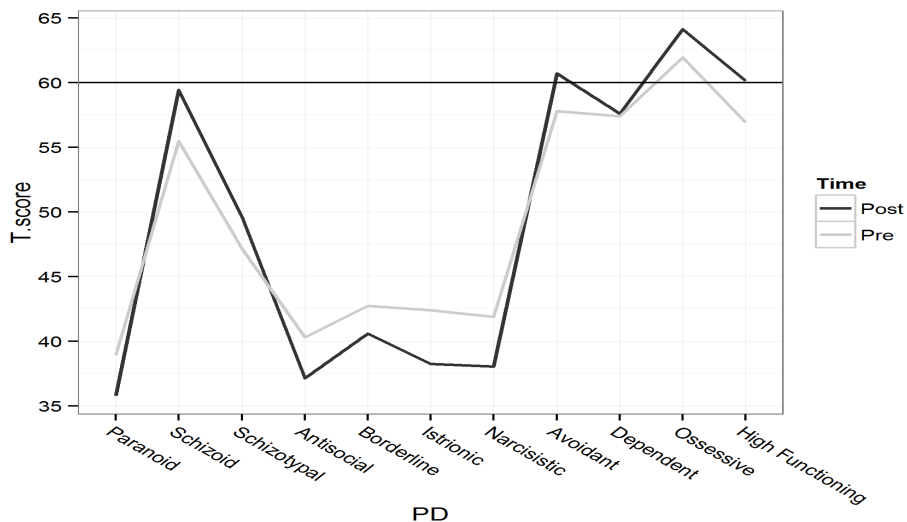
**Figure 3.** The positive association between the PQS Factor 4 (The good therapy) and the positive collaboration (CIS Positive Collaboration), tested by the ARIMA model, in the 63 sessions of therapy.



**Figure 4.** The negative association between the PQS Factor 5 (Life outside the room) and the positive collaboration (CIS Positive Collaboration), tested by the ARIMA model, in the 63 sessions of therapy.

### Outcome measure

Results of the pre/post SWAP assessment are shown in Figure 5. There was no change of personality scores, as revealed by the Reliable Change Index (Jacobson & Truax, 1991).



**Figure 5.** SWAP-200' T-scores did not show any significant change between the first and last phases of the therapy.

A process variable that can be useful in understanding patient's change during therapy is the Overall Defense Functioning (ODF) calculated on the DMRS scores. We computed an ARIMA (0,0,0) model on the ODF to assess linear change, and we found a significant positive effect across time,  $b = 0.005$  SE = 0.002,  $t = 2.30$ ,  $p = .02$ .

## 4 | DISCUSSION

The present study aimed to explore the therapeutic process under an intersubjective perspective, by considering multiple "points of observation". Such approach, in fact, may allow a better understanding of patients' psychological functioning, along with a deeper comprehension of the clinical reality of the therapeutic process. This, in turn, may unveil the flip side of collaborative alliance, that has been for long considered only with its positive connotation. Results of a single case study indicated that the critical features of therapeutic alliance can be better understood by focusing on the interactions between patient alliance, defenses and relationship dynamics. Notably, within such complex scenario, the present findings pointed out that collaborative alliance does not always correspond to a positive relationship.

According to clinical literature descriptions (Lorenzini & Sassaroli, 2000; McWilliams, 2011), indeed, Sara can be conceived as a compliant and collaborative patient. As hypothesized, however, this represents just one side of the coin. Indeed, this functioning holds back many critical aspects that hardly conciliate with the classic positive definition of collaboration.

First, sequential analysis described the interactive characteristics of the collaborative functioning during the therapy. On the one hand, high levels of collaboration are uniquely elicited by one specific therapist intervention: the Acknowledgments. This finding suggests that the collaborative alliance is reinforced by soft interventions, which encourage Sara's elaboration and allow her to enhance the intimacy of the conversation. On the other hand, this level of alliance is also associated with the activation of several defensive mechanisms, such as Self-Observation, Suppression, Isolation of Affect, Intellectualization, Undoing, Repression, Displacement, Devaluation, Projection, Rationalization, Passive Aggression. This pattern indicates that the increasing of the quality of alliance is accompanied by the activation of different types of defense mechanisms, located at

both mature and primitive levels. Such an “uncommon” dynamic, not only led us to be suspicious about Sara’s authentic and positive collaborative alliance, but also moved us to suggest that this cooperative interaction holds back some negative meanings (Table 5).

**Table 5.** Illustrative clinical exchanges

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**Interactive pattern: High level of collaboration and defences activation**

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*P: This week has been more complicated than the last one...I brooded over things a bit, but ... I found myself in my usual dynamics, but I bypassed them more quickly than usual...*

*T: Well, this is important*

*P: Also because I can't overcome them, there's no magic formula against them, but...like, especially in the morning, I had many thoughts, but at the same time I bypassed them more quickly, like... without troubling myself.*

*T: Tell me about it!*

*P: (She smiles) Especially I... I don't know ... one thing that we had already noticed. For example, one of the thoughts I had and that often came to mind in the morning, is about my colleague, older than me, she is ten years older than me, working on an arbitral award although she had never done it before, whereas I did.*

*So she asked me for some advices, but, as always...when a fellow asks me about something, I feel like charged with it and then I go “Is she aware about this?” or “Has she noticed this?”*

*Apart from the fact that I don't trust people... like, I mean, because they're always... I mean, I don't underestimate the others, I mean, but the end of the thought is: if I had told her, instead of removing this thought, “did you check it?” I'd have avoided the forthcoming catastrophe. In the end it always falls on me... I mean, I can't say “I'm good at this” but I always say to me “the others are not good at this”. I'm always thinking that I should have helped somebody on this and that even though no one asked me. Then, I mean, I'm always caring about it “Will she be able to do this?” “Will she do right?” “...Or Wrong?” but I'm not responsible for this... like...it's just not fair, nor I'm responsible for her, whom I'll ask “so, did you get it?”... But, I mean, that's a macroscopic thing, that's it. And, in the end, I trouble myself every time. If all of these things that do not belong to me can weigh me down... when I'm not even asked to... But, I mean, I had to repeat it to myself many times. Then, when I go into these dynamics I lose trust in other people. Like... nothing can convince me, I don't know how to say it...except for a few things, but thinking what she's doing, has she learnt it... it's her life, not mine. I feel like I have to solve everything out, by myself.*

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**Factor 1: Authentic and emphatic relationship**

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*P: Yes, it's true. Moreover, another thing that pleased me ... that I've learnt, so to speak, from the arrangement of the house...I mean, I see that it's not true that if people don't dedicated to me for their vocation, so I don't... it means they are not with me. Like.. that's to say, Tom that doesn't conceive a future life with me or my colleague Laura, just to mention two people from my studio that... I mean, of course she doesn't want to leave her family to come and live with me... (She smiles). But, as it were, they...I've involved them and they were happy to get involved in many things! I mean, for instance, I can choose among these 3 things: what do I do in your opinion? Let's see, take pictures, let's think about it, they went to Ikea with me....*

*T: Eh sure.*

*P: Like... they've helped me in a project that is mine, that was making me feel like “I'm alone, I have to manage it alone”*

T: Mmh. Feeling alone sounds like feeling abandoned

P: Yes...

T: Someone can say: it's true that "the house is your project"; it's true also that "I'm your friend and it's a pleasure for me to participate..."

P: Exactly, we had fun, in fact.

T: It was not like: oh my god, it's terrible!

P: Eheheh yes.

T: It's like: let's do something that otherwise I wouldn't have been able to do, it's funny...

P: No no, I agree. This is a think that I have never considered, that I really faced this time. My friend Jenny has two little girls and in my imagination she doesn't have time for me. Two days ago she called me and she said "Tell me when you go shopping, I can leave my girls to someone, I really would like to go with you"... I mean, that pleased me, I like it... it's something that I can share with others even if the house is totally mine.

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#### **Factor 4: the "good" therapy**

P: Yes, yes! I don't think so ... I don't think so, I don't know ... I have the impression that... like...as I should intervene, as I...

T: Eh, wait ... why should you intervene?

P: Sure, because...yes...

T: If anyone asks me "please, can I borrow your red pen?" I will borrow the red pen. But if I have that feeling... I can stay, watching him while using the pen a bit like "but what else should I do?" ...

P: Sure, sure ...

T: ... It means that I'm perceiving something ... and somehow I'm trying to handle it. I interpret "I should tell you", "I should tell you", "I should tell you", "Telling you", as a sort of concern arose in you. I interpret it in this way, rather than : "this situation doesn't work, we should do something".

P: Yes...

T: Turning a thing over your mind has nothing to do with the concrete things you have to do, I mean, it has nothing to do with the act itself, but with handling of the situation.

P: Mmh ... yes, it's true.

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#### **Factor 5: Life outside the room**

P: ... Yes, exactly, that's how my house is managed, there's nobody... But I'm tired indeed! (silence). A stupid thing for instance, yesterday night I went to my workplace because I had a deadline this morning, so I went back home at around 10 pm, and I wanted to wash my stuff like and my brother and mother's either as lots of stuff comes back from the hospital too. I wanted to wash it then, so that this morning the cleaning woman would have come, the stuff'd have already dried off and she 'd have ironed (very dogged tone). So I did two laundries, waited until the second one had finished but really was feeling like going to bed, I didn't know how to stay awake, and they are stupid things really, because they're in everyone's life, but I realize that I... (very dogged tone)

T: ... Those are the things, you know, which weigh heavily on everybody, that's why I'll tell you, let's see if... because a person who goes back home at 10 pm ... (whispers) is basically over!

P: Well, yes...

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Second, the time series analysis described the trend of therapeutic alliance over the course of therapy. Results showed that collaborative alliance did not statistically decrease over time. At a closer look, however, qualitative data indicated that whereas collaborative alliance increased during the first phase of the therapy, it



decreased in a subsequent second phase. This points to the time-trend of collaborative alliance as informative about the therapy evolution, and suggests that collaborations should be considered as well, together with ruptures, for a more complete understanding of the therapeutic process. In fact, if we consider collaborative alliance in its maladaptive meanings, the decrease across time can be interpreted as a positive sign in the therapy.

Finally, the comparison between collaborative levels of alliance and an external measure, focused on the relational interaction, confirms the negative quality of patients' collaboration. Indeed, PQS's analysis revealed the different types of the interaction structure that characterizes the therapist and patient dyad. More specifically, whereas a first factor, named as "The good therapy" (i.e., Factor 4), was positively associated with collaborative alliance, two factors were found to be negatively associated with it. These factors were respectively the "Authentic and emphatic relationship" (i.e., Factor 1) and the "Life outside the room" (i.e., Factor 5). The reported scenario, therefore, confirms results of the previous analyses, and suggests that such collaboration more likely reflects an acquiescent and "forced" style of interaction with the other (Table 5).

It is also worth noticing that outcome measures revealed an improvement in defense mechanisms functioning, as indicated by the ODF analysis. In fact, Sara showed a global progress of defense structure during the first 24 months of therapy. Nonetheless, these changes did not imply a significant variation in terms of personality structure, as indicated by the comparison of the SWAP profiles in the first and in the last phases of the therapy. This suggests that the therapy mainly affected the rigid resistant and detached defense structure, although it did not influence the personality structure at this stage. Hence, modifications of the defense structure may represent a first aim of the therapy: in fact, Sara's therapy is still ongoing.

Overall, these findings indicate that Sara's collaborative alliance works as a "pseudo-alliance". Pseudo-alliance can be defined as a specific psychopathological functioning characterized by hidden aggressive feelings and narcissistic tendencies oriented to attack the relationship, as well as the therapist and the therapeutic work

(Etchegoyen, 2005). Pseudo-alliance or “pseudo-collaboration” characterizes specific pathological configurations, giving prominence to the influence of the personality structure in the understanding of the alliance dynamics (Lingiardi, Filippucci & Baiocco, 2005; Taft, Murphy, Musser & Remington, 2004; Zuroff et al., 2000). The present study provides further evidence about an influence of personality structure to the development of alliance, and, in this case, of pseudo-Alliance. Accordingly, only a pre-treatment assessment would allow a more comprehensive understanding of the specific type of therapeutic alliance and of the real patient’s motivations to the therapy.

These results can be also well interpreted in terms of therapeutic misalliance, defined as a relational interaction aimed to undermine therapeutic goals or symptom modifications (Langs, 1975). This concept, indeed, has been developed in an intersubjective perspective and overlaps with different constructs, such as transference and countertransference gratification, resistance, mutual acting out and acting in. In particular, under a relational conceptualization, the resistance becomes an obstacle to the therapeutic process that can be understood as an interactive function between patient and therapist (Safran & Muran, 2003). However, in Sara’s case, the “acquiescent” alliance cannot be identified simply as a resistance. Rather, it identifies a relational way of interacting with the therapist that goes beyond a mere obstacle to the therapy. In other words, pseudo-alliance would better resemble a transference – countertransference dynamic.

To conclude, whereas collaborative alliance has been for long considered under a positive meaning, here we showed that this conceptualization represents just one side of the coin. The flip side of collaboration, indeed, can have a dysfunctional role in the therapeutic alliance. This finding therefore challenges the classic view of collaborative alliance, and provides new horizons in the study of therapeutic alliance. Future studies, possibly involving group of patients, are in any case needed to better explore this issue.

# 9

## *Beyond The Mask Of Deference: Exploring The Relationship Between Ruptures And Transference In A Single-Case Study<sup>5</sup>*

### 1 | INTRODUCTION

Since the first theorization, one of the most prolific issues about therapeutic alliance has concerned its relationship with transference. After Freud's work "*The Dynamics of Transference*" (1912), psychoanalytic theorists have been describing the alliance as independent from the transference, although they also conceived some degrees of overlap, at least at the empirical level. For instance, Sterba (1934) and Bibring (1937), referred to the alliance as a "scission of the Ego", while others, like Nunberg (1928) described it as a relationship based on the same libido roots of the transference and motivated by narcissistic drives (Nunberg, 1928). Critically, until the work by Zetzel and the other Ego-Psychology authors, psychoanalytic models of therapy rejected the alliance as the cornerstone of the treatment (Freud,

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<sup>5</sup> Chapter adapted from: Francesca Locati, Pietro De Carli, Emanuele Tarasconi, Margherita Lang & Laura Parolin (*Under Review*). *Beyond the Mask of Deference: Exploring the Relationship between Ruptures and Transference in A single Case study*

1912; Brenner, 1979; Curtis, 1979; Lacan, 1955; Greenacre, 1968). In contrast with them, Zetzel (1956) described the psychoanalytic process as completely based on the cure and the maintenance of a stable and strong therapeutic alliance. Similarly, Greenson (1967) focused on the most practical characteristic of therapeutic alliance, referred to as the “working alliance”. For all the ego psychologists, indeed, a necessary condition for the establishment of an enduring alliance was a high level of Ego maturity, essential also for the beginning of a “rational and desexualized” relationship (Greenson, 1967).

Thanks to the advent of empirical research in psychotherapy, clinicians and researchers created new theoretical models of alliance and transference based on empirical and clinical evidence (Luborsky & Crits-Cristoph, 1998). The scientific and statistic operationalization, nevertheless, did not favoured the controversy between the two constructs. Meissner, in 1996, warned against the difficulty of studying these two constructs, because once they are operationalized, they become partially overlapping. The “Relational Turn” in psychodynamic theory and the new “pantheoretical” view of some cornerstones (Bordin, 1975) produced new measure tools aimed at describing and evaluating alliance and transference and a more specific reconceptualization of these two constructs. Freud (1905) described transference as the repetition of an old objectual relationship, in which feelings and impulses of an old significant object are transferred on the analyst. This theory is not based on the real relationship in therapeutic dyad, but rather on unconscious and regressive distortion. The new reconceptualization made by recent relational theories in psychoanalysis describes transference as an “interactive communication” (Lingiardi, 2002), in which the symmetry between patient and therapist represents the real engine of treatment.

Following these intuitions, Safran and Muran (1996) deduced that there are stable associations between several transference dimensions and rupture and resolution processes (Safran & Muran, 1995). For instance, depending on the nature of transference, patient can show aggressiveness or sad feelings, denying his anger or vulnerability and using neurotic defense mechanism, such as rationalization or denial (Safran & Greenberg, 1987; Safran, Muran & Wallner Samstag, 1994; Safran

& Muran, 1996). Notably, under a relational approach, ruptures of the alliance between patient and therapist can be used as a key to understand patient's transference dynamics and relational behaviour patterns. Accordingly, conflicts in therapeutic dyad are conceived as central to the exploration of patient's unconscious life. Similarly, repairing ruptures is often related to positive outcome in treatment (Safran, Muran & Eubanks-Carter, 2011). Oppositely, if the rupture remains unresolved, this may lead to patient's dropout or to an impasse in treatment (Henry, Schacht & Strupp, 1996). In order to clarify the relationship between ruptures in the alliance and patient's transference, Safran and Muran found an empirical association between episodes of rupture in the alliance codified on verbatim transcriptions, by means of their *Rupture Resolution Rating Scale* (3RS) and transference material, inferred from patient's Core Conflictual Relationship Theme (CCRT, Luborsky & Crits-Cristoph, 1998). In their model, patient's transference can clarify the unconscious relational meaning of specific episodes of rupture. If therapeutic alliance is the necessary condition for a good outcome, resolution of its ruptures may play an important role in treatment, facilitating the expression of negative feelings about treatment or therapist. Because therapeutic alliance is influenced by transference, patient's relational behavior represents a critical juncture for theoretical, clinical and research attention.

The aim of the present study, therefore, is to examine a particular form of patient's behavior, i.e., the patient's deference and acquiescent behavior, and its connection with therapeutic alliance and transference in treatment's dynamics. Deference describes a significant submission to assertions, skills, judgments and point of views of another person. This behavior plays a very important role in the dynamics of psychotherapy, because the asymmetry of power and competence between therapist and patient can potentiate patient's deference. Nevertheless, this particular form of relationship has not received enough attention in psychotherapy literature (Rennie, 1994). Until the end of the eighties, the only theoretical source about the deference were the philosophical and sociological works of Goffmann (1961) and Foucault (1963) about people's submission to the authoritarian and despotic schemas in treatment centres, and the works of symbolic interactionists

(Mead, 1934). On the contrary, researcher's attention was mainly drawn to constructs commonly related to improvements in psychotherapy, like collaboration, resistance, transference and therapeutic alliance. Therefore, the first studies about the deferential behavior had analysed only the relationship between this construct and other clinical phenomenon. Inherently related to the withdrawal model of rupture in the Safran and Muran theory, the deferential behavior has been explored by Rennie (1994) in a quantitative study using factor analysis. Rennie (1994) extracted five latent factors behind the patient's deferential behavior: fear of hurting the therapist, need to support his hypothesis, implicit acceptance of his limits, fear to excessively criticise him and the fear to appear ungrateful, respectively. Results showed that this particular behavior may be very dangerous for the stability of therapeutic alliance because an overlap with the patient's habitual relational patterns leads the patient to an inability in expressing her/his discomfort and her/his awkwardness during the sessions (Rennie, 1994). In such case, this feeling may therefore induce the patient to interrupt the therapy without any verbalization of the rupture or to a non-verbalized passivity, which can obstruct the therapy process. Furthermore, from their point of view, therapists seemed to be blind to the nonverbal signals of a deferential behavior supported by withdrawal ruptures (Rennie, 1994). This is also in line with Hill and colleagues' study (Hill, Nutt-Williams, Heaton, Thompson & Rhodes, 1996) on the analysis of the therapist's memories of the ruptures, which leded the patient to interrupt the treatment. Taken together, these results support the idea that the deferential behavior of the patient, the non-observance of the withdrawal ruptures' markers and the theoretical rigidity of the therapists can all lead to an illusory type of alliance that is not followed by a significant improvement of the patient and that can be, therefore, very dangerous for the therapy process. Deference is, indeed, a very insidious problem for researchers and clinicians because it negatively influences the intersubjective dynamic of the therapy (Colli & Lingardi, 2009).

On these grounds, the present study aims to explore the dynamics of deferential alliance with other clinically significant constructs (e.g. transference, relational patterns, defense mechanisms and ruptures). This was done in a single-case study

of a patient who, during the treatment, showed a very strong and inflexible deferential approach to the therapist.

## 2 | METHODS

### 2.1 Case description

*Patient.* Sara is a 33 years old lawyer. She came to therapy complaining about anxiety symptoms, insomnia and “fear of losing control”. The psychological assessment, composed of WAIS-R (Wechsler, 1981) and Rorschach Test (Exner, 1993) revealed that Sara has a high cognitive functioning level and a rigid way of thinking. This functioning is characterized by hypervigilance and emotional constriction. The clinician believed that Sara’s emotions are often replaced by an anxiety status. Sara’s father suddenly died when she was five years old: the clinician supposed that this traumatic event could play an important role in her symptomatic structure. Sara was diagnosed with an Anxiety Disorder NOS (American Psychiatric Association, 2000) and a neurotic personality organization with a rumination attitude. Before beginning of the treatment, Sara gave her consent to audio-record the sessions and to use them for research purposes. The patient was informed about the scientific publication on the treatment process, prior to de-identification of all sensitive information.

*Therapist.* Sara is currently undergoing a weekly psychodynamic therapy with an expert clinician. Dr. L. is a female 65 years old clinical psychotherapist with 35 years of clinical experience. She identifies herself as psychodynamic-oriented therapist.

### 2.2 Measures

#### *Process Measure*

In the present study we used different instruments that were applied on 63 transcripts of the sessions (24 months of treatment).

*The Rupture Resolution Rating Scale (3RS, Eubanks, Muran & Safran, 2015)* is used to evaluate and to quantify, from an external point of view, the ruptures or the moments of impasse in therapeutic alliance. The evaluation is made by external observers on video-recorded sessions or verbatim transcriptions. Contents of the discourse, head's and body's non-verbal language, emotion's intensity are important parameters in rupture's evaluation. This instrument identifies two types of rupture, the Withdrawal (W) and the Confrontation one (C). The withdrawal ruptures are more implicit and covert, while the confrontation ruptures are explicit, overt and aggressive.

*The Core Conflictual Relational Theme (CCRT; Luborsky, 1998)* is used to find the conflictual core of the relational functioning of the patient from his verbally expressed narratives. It is based on the identification of specific narrative unities in sessions' verbatim transcripts. These unities include the explicit description of relational episodes (RE) in which patient expresses his Wishes (W), the Response of Others (RO) and his reactions to them (Responses of Self, RS). The CCRT is a very flexible instrument, adaptable to different clinical contexts.

*The Defense Mechanism Rating Scales (DMRS, Perry, 1990; Perry et al., 2004)* is used to assess defense mechanisms. The DMRS defenses are comparable to those listed in the DSM-IV (American Psychiatric Association, 1994). The instrument describes 30 defense mechanisms assigned to seven hierarchical levels of defensive functioning: high adaptive (mature), obsessional, other neurotic, minor image-distorting, disavowal, major image- distorting, and action defenses. Each of this level includes 3-to-8 individual defenses.

### *Outcome Measure*

The *SWAP-200* (Westen & Shedler, 1999a) is a Q-sort instrument designed to quantify clinical judgment of personality pathology. The set of 200 personality-descriptive statements is ranked into eight categories, following a fixed distribution, by a clinician with a good knowledge of the patient. The resulting ordering of the items is then compared with diagnostic prototypes representing each DSM Axis II personality disorders to ascertain the degree of match. The



resulting SWAP descriptions were averaged to arrive at a single, aggregate prototype representing the core clinical consensus on the features of each personality disorder (Westen & Shedler, 1999a). Overall, these diagnostic prototypes were found to be different from DSM criteria.

### **2.3 Hypothesis and procedure**

In order to acquire the most detailed, useful and clinically valuable data following an idiographic approach, we decided to design a single case study. The aim of this single case study was to explore and understand the meaning of alliance ruptures and their relationship with transference in a patient with deference functioning.

First, we hypothesize to observe a deferential behavior in Sara's functioning profile, by exploring, with descriptive analysis, the more frequent patterns of components of the Core Conflictual Relationship Theme, alliance ruptures and of defense mechanisms markers during the therapy.

Second, we hypothesize to find an association between Sara's transference pattern, alliance rupture markers and defense mechanism. More specifically:

a. We expect to find a relationship between alliance ruptures and relational episodes, by exploring the relational meaning of specific kind of ruptures through the co-occurrence (i.e., sequential analyses) between 3RS markers and CCRT components.

b. We hypothesize that the patient's tendency to isolate affects should be linked to avoidance in investing in the relationship with the therapist. More specifically, we hypothesize that either ruptures in the alliance or relational episodes should be associated to a defensive structure based on intellectualization, isolation, denial and rationalization. In order to investigate the relationship between alliance ruptures and patient's defensive functioning, we analysed the co-occurrences (i.e., sequential analyses) of specific 3RS and DMRS markers, whereas in order to investigate the relationship between defensive structure and relational episodes, we analysed the co-occurrence of DMRS markers and CCRT components.

The above hypotheses were tested by means of a multievent sequential analysis performed with the Generalized Sequential Querier program (GSEQ 5.1; Bakeman & Quera, 2001). Sequential analysis determines the probability of occurrence of a given behavior together with the occurrence of a target behavior: hence, no causality effect is implied.

Third, and finally, we hypothesize that the deferential behaviour would lead to an impasse in the treatment. This was investigated by comparing patient's SWAP profiles evaluations in the first and in the last five sessions of therapy, to better capture any possible change during the therapy. We performed a time series analysis on the two SWAP profiles and we evaluated patient's global change (*Reliable Change Index* - RCI, Jacobson & Truax, 1991), and the *Personality Health Index* in both of the groups of sessions (i.e., first and last ones).

### 3 | RESULTS

Verbatim transcriptions of 36 randomly selected sessions in Sara's treatment were analyzed. All available transcripts were coded with 3RS, CCRT and DMRS, by two experienced judges who blindly rated all transcripts. The scores showed a good inter-rated reliability between them (mean Cohen's K for 3RS=.75, for CCRT=.84 and for DMRS=.78). Similarly, SWAP-200, which was applied only on the first and last five sessions of the therapy, reached a good inter-rated reliability (SWAP-200=.72).

According to the first hypothesis, in order to obtain a general profile of patient's functioning, we analysed qualitatively the more frequent items emerging from descriptive analysis of CCRT, 3RS and DMRS measures. The descriptive analysis of CCRT, expressed in standard categories, showed a high frequency of the Wish (W) component, of the Response of the Others (RO) component and of the Response of Self (RS) component. For the W component, the most frequent categories that emerged were: the wish to be close to others (W11; N=25), the need to achieve

(W22; N=24) and the need to feel comfortable (W31; N=21). For the RO component, the most frequent categories that emerged were: the distance from the others (RO12; N=18), acceptance of the others (RO3; N=18), rejection of others (RO4; N=17) and unhelpfulness of others (RO14; N=17). Finally, for the RS component, the most frequent categories that emerged were: expression of anxiety states (RS27; N=42), feelings of uncertainty (RS19; N=39) and reaction of guilt trip (RS25; N=32). The aforementioned standard categories determined the Wish, the Response of the Others and the Response of Self components of Sara's Core Conflictual Relationship Theme.

**Table 1.** Co-occurrence Analysis for 3RS and CCRT.

CCRT component	3RS marker	N	Adjusted Residual	p-value
Wishes	<b>Minimal Response</b>	13	-0.32	~.75
Response Of Others		6	0.45	~.65
Response Of Self		9	-0.03	~.98
Wishes	<b>Abstract Communication</b>	6	-0.76	~.45
Response Of Others		1	-1.29	~.20
Response Of Self		8	1.88	~.06
<b>Wishes</b>	<b>Avoidance Storytelling/ Shifting Topic</b>	<b>13</b>	<b>2.17</b>	<b>~.03</b>
Response Of Others		3	-0.24	~.81
<b>Response Of Self</b>		<b>2</b>	<b>-2.12</b>	<b>~.03</b>
Wishes	<b>Affect Split</b>	4	-0.60	~.55
Response Of Others		2	0.12	~.91
Response Of Self		4	0.54	~.59
Wishes	<b>Denial</b>	0	0.00	~1.00
Response Of Others		0	0.00	~1.00
Response Of Self		0	0.00	~1.00
Wishes	<b>Self-Criticism/ Hopelessness</b>	0	-0.99	~.32
Response Of Others		0	-0.48	~.63
Response Of Self		1	1.45	~.15
Wishes	<b>Deferential And Appeasing</b>	14	-0.31	.76
Response Of Others		7	0.79	.43
Response Of Self		9	-0.33	.74

~< : p-value does not meet the condition of normality assumption

The descriptive analysis of 3RS showed a large stereotypical and inflexible use of the minimal response rupture (N=451) and of the deferential and acquiescent

ruptures (N=425). Regarding other rupture markers, only the affect split rupture (AS) exceeded 50 verbal unities (N=55). Finally, the descriptive analysis of DMRS showed a large use of obsessive defenses, such as isolation (N=113) and reaction formation (N=60), and neurotic defenses, such as repression (N=109) and displacement (N=84). With respect to the narcissistic defenses, devaluation (N=100) was the most activated defense mechanism. Mature defenses of auto-observation (N=78) and humour (N=41) were also frequently activated during the therapy. According to the second hypothesis, we analysed by means of sequential analysis the co-occurrence of 3RS items and CCRT components. Results showed a significant co-occurrence between avoidant storytelling/shifting topic rupture marker (AS/ST) from 3RS and W from CCRT. AS/ST also showed a negative co-occurrence with the RO categories ( $p < .05$ ) (Table 1).

**Table 2.** Co-occurrence Analysis for 3RS and DMRS

DMRS level	3RS marker	N	Adjusted Residual	p-value
Mature defenses		8	1.29	.20
<b>Obsessive defenses</b>		<b>6</b>	<b>-2.30</b>	<b>.02</b>
Neurotic defenses	<b>Minimal Response</b>	10	1.06	.29
Narcissistic defenses		3	0.00	~1.00
Denial defenses		2	-0.13	~.90
Borderline defenses		0	0.00	~1.00
Acting defenses		2	1.11	~.27
Mature defenses			6	-1.45
<b>Obsessive defenses</b>		<b>30</b>	<b>3.37</b>	<b>&lt;.01</b>
Neurotic defenses	<b>Abstract Communication</b>	11	-0.79	.43
Narcissistic defenses		3	-1.17	~.24
Denial defenses		3	-0.45	~.65
Borderline defenses		0	0.00	~1.00
Acting defenses		0	-1.57	~.12
Mature defenses			9	1.47
Obsessive defenses	<b>Avoidance Storytelling/Shifting Topic</b>	11	-0.70	.48
Neurotic defenses		11	1.14	.25
Narcissistic defenses		2	-0.83	~.41
Denial defenses		1	-1.02	~.31
Borderline defenses		0	0.00	~1.00
Acting defenses		0	-1.18	~.24
Mature defenses	<b>Affect Split</b>	4	0.66	~.51

Obsessive defenses		4	-1.26	~.21
Neurotic defenses		4	-0.12	~.90
Narcissistic defenses		3	1.17	~.24
Denial defenses		1	-0.19	~.85
Borderline defenses		0	0.00	~1.00
Acting defenses		1	0.65	~.52
<hr/>				
Mature defenses		0	-0.94	~.35
Obsessive defenses		1	-0.53	~.60
Neurotic defenses		0	-1.16	~.25
Narcissistic defenses	<b>Denial</b>	0	-0.66	~.51
<b>Denial defenses</b>		<b>3</b>	<b>5.39</b>	<b>~&lt;.01</b>
Borderline defenses		0	0.00	~1.00
Acting defenses		0	-0.37	~.71
<hr/>				
Mature defenses		0	-1.43	~.15
Obsessive defenses		4	0.43	~.67
Neurotic defenses	<b>Self Criticism</b>	0	-1.76	~.08
<b>Narcissistic defenses</b>	<b>/</b>	<b>5</b>	<b>4.77</b>	<b>~&lt;.01</b>
Denial defenses	<b>Hopelessness</b>	0	-0.84	~.40
Borderline defenses		0	0.00	~1.00
Acting defenses		0	-0.56	~.57
<hr/>				
Mature defenses		6	-0.35	.72
Obsessive defenses		14	-0.11	.91
Neurotic defenses	<b>Deferential</b>	10	0.25	.80
Narcissistic defenses	<b>and</b>	2	-1.03	.30
Denial defenses	<b>Appeasing</b>	3	0.25	.81
Borderline defenses		0	0.00	~1.00
Acting defenses		3	1.83	~.07

~< : p-value does not meet the condition of normality assumption

Critically, the co-occurrence analysis of DMRS and 3RS items showed that the most frequent rupture marker, i.e., the minimal response rupture, co-occurred negatively only with obsessive defenses ( $p < .05$ ). Furthermore, the abstract communication rupture marker co-occurred significantly with obsessive defenses ( $p < .01$ ), whereas the auto-criticism rupture co-occurred significantly with narcissistic defenses ( $p < .01$ ). Finally, analyses showed a significant co-occurrence between denial rupture marker and denial defenses ( $p < .01$ ) (Table 2).

The co-occurrence analysis between CCRT items and DMRS components revealed a significant co-occurrence between the narration of Responses from the

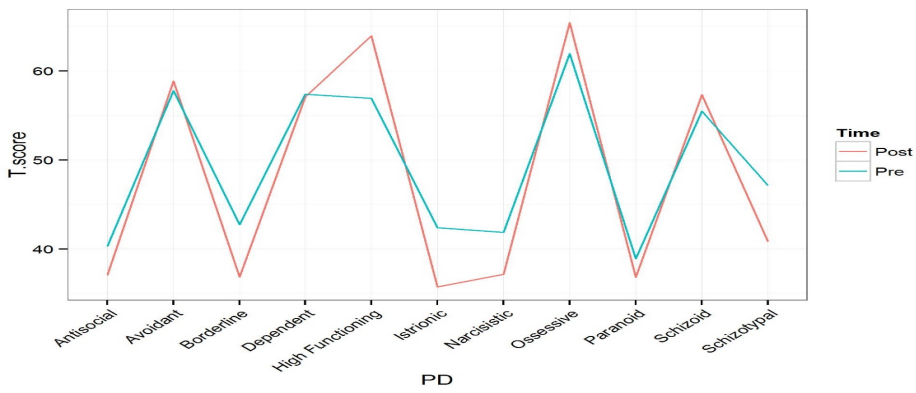
Others and acting defenses ( $p < .01$ ). This type of narratives also showed a negative co-occurrence with mature and high defenses ( $p < .05$ ) (Table 3).

**Table 3.** Co-occurrence Analysis for CCRT and DMRS

DMRS marker	CCRT component	N	Adjusted Residual	p-value
Mature defenses	<b>Wishes</b>	38	1.79	.07
Obsessive defenses		28	0.08	.94
Neurotic defenses		23	0.16	.88
Narcissistic defenses		12	-1.95	.05
Denial defenses		11	1.26	~.21
Borderline defenses		1	-1.74	~.08
Acting defenses		1	-1.74	~.08
Mature defenses	<b>Response of the Others</b>	10	0.26	.79
Obsessive defenses		5	-1.35	.18
Neurotic defenses		8	0.70	.48
Narcissistic defenses		7	1.15	.25
Denial defenses		1	-1.09	~.28
Borderline defenses		2	1.41	~.16
Acting defenses		0	-1.02	~.31
<b>Mature defenses</b>	<b>Responses of Self</b>	<b>8</b>	<b>-2.26</b>	<b>.02</b>
Obsessive defenses		15	1.07	.28
Neurotic defenses		8	-0.78	.44
Narcissistic defenses		10	1.22	.22
Denial defenses		3	-0.50	~.62
Borderline defenses		2	0.76	~.45
<b>Acting defenses</b>		<b>4</b>	<b>2.84</b>	<b>~&lt;.01</b>

~< : p-value does not meet the condition of normality assumption

Finally, in order to identify and investigate how patient's deferential approach influenced the progression of the treatment, we used the Shedler-Westen Assessment Procedure (SWAP-200). Results showed a non-significant influence of the time variable on the *Reliable Change Index* (Figure 2).



**Figure 2.** Swap's Trend

On the contrary, the analysis of the *Personality Health Index* indicated a slow and gradual improvement, especially for the reality exam index (+25%) and the identity integration index (+23%) (Table 4).

**Table 4.** Personality health Index

PHI scores by RADIO domains	Early	Late	Change in Percentile Rank
Overall PHI	19	39	+20%
Reality orientation	20	45	+25%
Affect regulation	13	33	+20%
Defenses	23	32	+9%
Identity integration	36	59	+23%
Object relations	24	42	+18%

#### 4 | DISCUSSION

The present study used a single-case research to explore the association between therapeutic alliance and transference in a patient with deference and acquiescent behavior. Overall, results showed that beyond an acquiescence facet, the patient concealed a resistance to the therapy. In particular, there was a systematic association between alliance ruptures and patient's avoidant functioning, which emerged both in transference relationship and in the quality of the defense structure.

First, frequency analyses on the CCRT components, along with a clinical interpretation of the verbatim transcripts (see Table 5), showed a stable and rigid pattern in the expression of relational episodes. In fact, in Sara's narratives, the Self dimension is frequently devaluated and felt as undeserving and shameful, while the representations of others are grave, severe and austere. Furthermore, her coworkers are often idealized and felt like right-life models, while her relatives are represented as boring, annoying or tedious.

Second, frequency analyses on the 3RS items, again along with a clinical interpretation of the verbatim transcripts (see Table 5), helped us to precisely identify Sara's typical way to interrupt the collaboration with the therapists. The modality of alliance ruptures was found to always be the withdrawal one. In fact alliance ruptures are always unexpressed, implicit and non-verbalized: Sara never puts herself directly in conflict with the therapist, and she never expresses her bad feelings about treatment's activities. This rupture model is strongly characterized by the minimal response rupture, i.e., the patient responds with short and clipped answers to open and exploratory questions, and by the deferential and appeasing rupture, i.e., the patient appears overly compliant and submits to the therapist in an excessively deferential manner. Notably, this stereotypical model of functioning during therapy is coherent with the literature on deferential behavior (Rennie, 1992) and on pathological rumination (Borkovec, Ray & Stöber, 1998; Eysenck & Derakshan, 1992; Ruggiero & Sassaroli, 2003).

Finally, frequency analyses on the DMRS items showed a more frequent use of neurotic, obsessive and mature defense mechanisms. These results, along with a clinical interpretation of the verbatim transcripts (see Table 5), uncover a stereotypical and dysfunctional defensive structure. This defensive and relational model seems to reflect a grave narcissistic wound, which influences significantly the symptomatic dimension of pathological rumination. Moreover, this functioning may be responsible for patient's emotional detachment and may even activate her hypervigilant and intellectual behavior. Hence, it is likely that this relational structure leads the patient to avoid a real and rational alliance with the therapist and determines the construction of a pseudo-alliance.



**Table 5:** Clinical material

<b><i>Defensive Structure</i></b>
<p><i>P: Ahah. Yes! It's been a great summer!</i></p> <p><i>T: Uh</i></p> <p><i>P: yes, indeed...</i></p> <p><i>T (ironically): Ha ha, how dared you?</i></p> <p><i>P: Yes, sure!</i></p> <p><i>T (laughing): you know you can't do that!</i></p> <p><i>P: It has started in the worst way, not feeling bad but with a huge sense of sadness, in the ten days I've been at sea with my mother... instead one..doing.. we were in Finale Ligure, with my mother, mmm... home, breakfast, beach, newspaper, "what do you want for lunch?"... I have done nothing at all, it's been sad! But I felt ok, I was not like "I am a loser because I'm here with you", what I th.. weel, what I wished going away... like "thing I will do. They will be done for me!"</i></p> <p><i>T: Sure!</i></p> <p><i>P: not suffered passively. And we have been ok, so she..mm.. we've been ok, never nervous, there were not bad moments.. I didn't forced myself being good...having patience..</i></p> <p><i>T: Yes</i></p> <p><i>P: Because I was so relaxed, without living anything exciting but we were ok, doing things that we usually like to do.</i></p>
<b><i>Deferential And Appeasing Rupture</i></b>
<p><i>T: There are accidents that happen during life...like that car crash happened to my brother, and in life accidents happen. No one can prevent and beat all those bad</i></p> <p><i>P sighed and start laughing Yes, you are right!</i></p> <p><i>T: but there are also lucky things" (laughing) "otherwise a person can lose it, you know?, someone says &lt;oh, what a terrible thing happened to me!&gt; and then he forget the other side: what a terrible thing but also what a lucky strike, because ahead he had no one, the other driver saw him in his review mirror, he was sort of prepared, had straight wheels...</i></p> <p><i>P: laughing "yes, yes, it's true!"</i></p> <p><i>T: If you have a selective attention considering all data, you may lose a part of the entire sequence!</i></p> <p><i>P: Yes, you are right!</i></p> <p><i>T: Same thing happened to you with, I think, Bob. In case you forget to consider the part in which you two were good together and having a good relationship which kept on working. You were not able to consider the lucky strike of ending your love story without anger or regrets before you could begin living together. It could go very worse...</i></p> <p><i>P: Exactly, sure!</i></p> <p><i>T: Do you understand? Instead, again, you had lost a part of the sequence, saying "what a terrible thing" and not considering that it could go very, very worse...</i></p> <p><i>P: you are definitely right!</i></p> <p><i>T: and you could not say "at least I have got a friend more</i></p> <p><i>P laughing: It is true (pause) yes, I keep on losing parts...</i></p> <p><i>T: Yes, yes. Because you have this idea of unluckiness, you know, which is very worse than it can appear (Patient laughs). You have the idea that you suffer for an unlucky faith which keeps on persecuting you and you can't do nothing to control it.</i></p> <p><i>P: Yes... yes, you are terribly right.</i></p>
<b><i>Minimal Response rupture</i></b>
<p><i>P: Yes, yes! No, It not seem...I do not think so, I don't know, I've got thins idea of...like I have to intervene in first person...</i></p> <p><i>T: wait... why you have to intervene?</i></p> <p><i>P: because yes...</i></p> <p><i>T: You know...If someone asks me for a red pen, I will give to him. Then I do not remain there watching him using my pen and asking myself "what can I do now for him?"</i></p>

P: Mh...

T: ...it means that I am perceiving something and I am trying to control, to manage it... I feel you continuing "I should say something to you", "I should say something to you", "I should say something to you", like you have a sort of terrible agitation, instead of saying "this situation does not work, we have to work it out".

P: yep, mh...

T: Do you understand? Worrying is that kind of rubbish, it has nothing in common with real preoccupation about the things...about the act himself, but with a sort of illusion of management of the bad situation.

P: mmh...

**Patient's typical Relational Episode (1)**

P: You always think "oh, God, what a terrible thing will happen!", but thinking it before analyzing all the data!

T: Mmm

P: Yesterday morning, I had to write a letter together with another colleague: I was worrying, anxious, even before we began...with another colleague in the study. Then it came an e-mail of this colleague: he already wrote the letter and asked me to correct it. He neither asked something about it...but

T: Mmm

P: Well, I'm frightened of everything happens to me...this morning a client called me carrying out a problem, which we all know it would be emerged sooner or later...like it was my fault!

T: Eehh

P: I was more frightened than him! Laughs I do not know...

T: It's like you always have something to repair...to resolve...Mmm

P: Like I always have to fix everything I...I can not say it...I have to repair someone else's problem: If I can help you ok, it's fine...but If not I think myself as a loser, my situation becomes unrepairable.

**Patient's typical Relational Episode (2)**

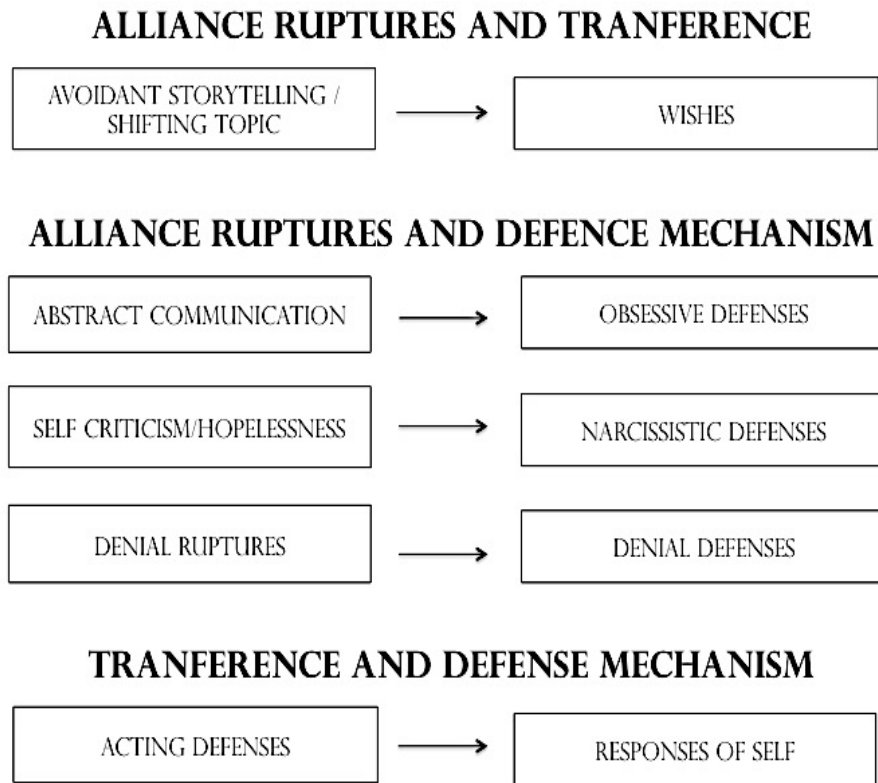
P: Well my mother, thinking about it, she caught me in all my moments of sadness and anxiety. Me, by myself, I try not to tell her what I suffer from. I always try to...

C: to protect her...

P: Yes... because if I tell her something it's like she destabilizes me... She says "Fra, let me think how it might have gone..." and this annoys me because when I told her about, for example, the end of the story with my boyfriend, she was sad like everybody: she knew him, felt good together, we all hoped in another possible future... She never tried to push me doing something concrete. Even in the most uncertain moments... she told me "try to realize what you want and do that" but at the same time "why would you let all this time pass by? Why you never tell him what was going wrong?". I hate when she carried out negative data, even when they are true. So I say "if I'm not ok, well, you should...you can stay here with me but, for fuck sake, mind your fucking own business. Laughs

These results, therefore, support our first hypothesis of a deferential behavior in Sara's functioning profile. In particular, these findings suggest that Sara always tries to avoid the conflict with the therapist. On the one hand, mature level defenses, like humor or auto-observation, are expressed to compensate the patient's resistant behaviors; on the other hand, immature, neurotic and obsessive defenses are expressed with the aim to avoid and isolate patient's negative feelings (Perry, 1990). Moreover, the narcissistic dimension of the patient seems to fluctuate

persistently from the devaluation to the idealization pole depending on the episodes narrated in the treatment.



**Figure 2** Results from the three co-occurrence analysis

Notably, the relationship between the CCRT and the 3RS items was more comprehensively described by the sequential analysis. Indeed, results showed that wish components of Sara’s Core Conflictual Relationship Theme co-occurred significantly with a rupture marker characterized by avoidance and shifting of session’s topic. In other words, patient’s narrations do not express her real desires and needs, but her will to escape from the contact with the therapist. In particular, Sara’s relational episodes are extremely schematic, unclear and incomplete: these narrative patters are frequently expressed with the aim to avoid therapist’s

questions and to hide her emotive dimension. Therefore, passive avoidance and emotional closure seem to define the basis of Sara's transference.

The sequential analyses of DMRS and 3RS items are also coherent with the initial hypothesis that a deeper exploration of the defensive dimension may better clarify the functioning of episodes of rupture. One of Sara's most frequent rupture models, i.e., the Abstract Communication marker, co-occurred positively and significantly with obsessive defense mechanisms. This finding indicates that such frequent rupture episode was expressed when the patient was activating a particular pattern of defense mechanisms, composed by intellectualization, isolation and retroactive annulment. Another significant positive relationship was found between the denial rupture marker and the denial defenses. Indeed, when Sara rejected passively therapist's interventions, she activated a specific pattern of defenses mechanisms composed by rationalization, neurotic denial and projection. Furthermore, results showed a positive co-occurrence between self criticism-hopelessness rupture marker and narcissistic defenses, especially with the devaluation of Self, suggesting that Sara's ruptures were characterized by a worrying sense of impotence and powerlessness.

Notably, the co-occurrence pattern of CCRT and DMRS items indicated that relational episodes narrated by the patient were negatively associated with high-level defenses, likely reflecting a patient's non-sincere exploration of her feelings. Conversely, Response of Self components were positively associated with acting defenses, in particular with the passive-aggression defense. These results suggest that vague narrations of her inner feelings may convey negative emotions by means of passive-aggressive defenses.

Finally, the results of the time series analysis on outcome evaluation corroborated the hypothesis that deferential behavior and acquiescent approach to therapist could determine a strong impasse in the treatment. In fact, Sara's emotional avoidance did not allow her to express any bad feeling about therapist. This functioning seemed to influence also the outcome of the therapy, obstructing a real change in her personality structure and a significant improvement in her symptomatic dimension.

## 5 | CONCLUSION

In this single-case study we investigated the influence of patient's deferential behavior on psychotherapy process and outcome. We found that deferential behavior modulated the dimension of therapeutic alliance, leading the patient to build a sort of pseudo-alliance with the therapist. This pseudo-alliance was characterized by an impossibility to express any bad emotion against treatment's activities, which in turn also likely determined an impasse in the progression of the therapy. In the described dynamic, Sara adopted withdrawal ruptures and, hence, an implicit, unexpressed and non-verbalized alliance modality. In such moments, specific patterns of both mature and immature defenses were activated to avoid therapist's explorative questions. Furthermore, relational episodes narrated during the treatment were extremely vague and schematic and often co-occurred with avoidant defense mechanisms. This reflects the patient's core conflictual relationship theme that was vague and ambiguous. Together, these factors contributed to the creation of an extremely rigid therapeutic context, in which the treatment was disrupted by implicit and unexpressed bad feelings. Indeed, Sara's avoidance played a double role in the treatment: on the one hand it was the main characteristic of her transference structure, based on extreme intellectualization and emotional closure. On the other hand, it contributed to create the impasse in the treatment, based on a withdrawal ruptures model and on obsessive level defenses. Therefore, Sara's alliance ruptures seem to have both a transference and a defensive meaning, responsible for her relational detachment and emotional constriction. Beyond unveiling the impact of deferential behavior on psychotherapy process and outcome, the present study draws new attention to the need of a proper assessment of this elusive behavioral functioning for both clinical and research purposes (Colli & Lingiardi, 2009). Future studies should explore the role of deferential behavior, by possibly assessing its influence on therapeutic techniques and countertransference.



## *Cyclical Dynamics Of A Single Patient In The Therapy Room: A Discussion*

### 1 | SUMMARY OF THE RESULTS

The present studies aimed to reach a better understanding of deference patients' psychological functioning, along with a deeper comprehension of the clinical reality of the therapeutic process. Deference behavior describes a significant submission to assertions, skills, judgments and point of views of another person (Rennie, 1994). This behavior may play a very important role in the dynamics of psychotherapy, because the asymmetry of power and competence between therapist and patient can potentiate patient's deference. Despite a proper study of deference may enrich our understanding of the psychotherapy process, however, this particular form of relationship has not received enough attention in psychotherapy literature.

On these grounds, the present studies aimed to analyze the dynamics of patient therapeutic alliance with other clinically significant constructs, in a deferential

patient. More specifically, the first study specifically focused on the positive alliance, by exploring the possible relationship between a high level of collaborative alliance and relational patterns, defense mechanisms and therapist interventions. On the contrary, in the second study, we investigated ruptures in association with transference and defense mechanism. Critically, both the studies included process and outcome measures.

Results of the first study indicated that the critical features of positive alliance can be better understood by focusing on the interactions between patient alliance, defenses and relationship dynamics. Notably, within such complex scenario, the present findings pointed out that collaborative alliance does not always correspond to a positive relationship, but rather in many cases it may even conceal dysfunctional aspects.

Interestingly, results of the second study showed that beyond an acquiescence facet, the patient concealed a resistance to the therapy. In particular, there was a systematic association between alliance ruptures and patient's avoidant functioning, which emerged both in transference relationship and in the quality of the defense structure.

### **1.1 Aspects Related To Collaboration**

In the first research we focused on the collaboration process of the deferential patient and the interaction between variables at that level of exchanges.

The collaborative functioning of patients was elicited by one specific therapist intervention: the Acknowledgment, a soft intervention, which encourages to enhance the intimacy of the conversation. At the same time, however, collaborative alliance was also associated with the activation of several defensive mechanisms, such as Self-Observation, Suppression, Isolation of Affect, Intellectualization, Undoing, Repression, Displacement, Devaluation, Projection, Rationalization, Passive-Aggression. This pattern of results may indicate that the increasing of the quality of alliance was accompanied by the activation of different types of defense mechanisms, located at both mature and primitive levels.



Furthermore, the comparison between collaborative levels of alliance and an external measures, focused on the relational interaction, showed that there was a positive association with the acquiescent and “forced” style of interaction with the therapist. On the contrary, there was a negative association with the authentic and empathic relationship. The reported scenario, therefore, suggests that such collaboration more likely reflects a superficial rather than an authentic way of interacting with the other.

Such an “uncommon” dynamic, not only led us to be suspicious about Sara’s authentic and positive collaborative alliance, but also moved us to suggest that this cooperative interaction holds back some negative meanings, not graspable with alliance measures, but that can only be inferred from the inner association between crucial variables of the therapy.

## **1.2 Aspects Related To Ruptures**

In the second research we focused on the rupture markers of the deferential patient and on the interaction between variables at that level of exchanges.

We found that in correspondence of rupture marker, characterized by avoidance and shifting of session’s topic, patient’s narrations did not express her real desires and needs, but rather her will to escape from the contact with the therapist. In particular, Sara’s relational episodes were extremely schematic, unclear and incomplete: these narrative patters were frequently expressed with the aim to avoid therapist’s questions and to hide her emotive dimension. Furthermore, transference relational episodes narrated by the patient were negatively associated with high-level defenses, likely reflecting a patient’s non-sincere exploration of her feelings. Conversely, transference relational episodes were positively associated with acting defenses, especially with the passive-aggression defense.

Moreover, one of Sara’s most frequent rupture models, i.e., the Abstract Communication marker, co-occurred positively with obsessive defense mechanisms. This indicates that this frequent rupture episode was expressed when the patient was activating a particular pattern of defense mechanisms, such as

intellectualization, isolation and retroactive annulment. Another significant positive relationship was found between the denial rupture marker and the denial defenses. Indeed, when Sara rejected passively therapist's interventions, she activated a specific pattern of defenses mechanisms, such as rationalization, neurotic denial and projection. Finally, results showed a positive co-occurrence between self criticism-hopelessness rupture marker and narcissistic defenses, especially with the devaluation of Self. This further suggests that Sara's ruptures were characterized by a worrying sense of impotence and powerlessness.

### **1.3 Aspects Related To Outcome**

Outcome measures in the first and in the second study were in line with each other.

In fact, Sara's global progress of defense structure revealed an improvement in defense mechanisms functioning. Nonetheless, these changes did not imply a significant variation in terms of personality structure, as indicated by the comparison of the SWAP profiles in the first and in the last phases of the therapy. This may indicate that the therapy mainly affected the rigid resistant and detached defense structure, although it did not influence the personality structure at this stage. Hence, modifications of the defense structure may represent a first positive signal of Sara's therapy that is still ongoing.

## **2 | DEFERENTIAL BEHAVIOR IN PSYCHOTHERAPY**

Overall, these two studies suggest that in this deferential patients collaborative alliance works as a "pseudo-alliance". Pseudo-alliance can be defined as a specific psychopathological functioning characterized by hidden aggressive feelings and narcissistic tendencies oriented to attack the relationship, as well as the therapist and the therapeutic work (Etchegoyen, 2005). Pseudo-alliance or "pseudo-collaboration" characterizes specific pathological configurations, giving

prominence to the influence of the personality structure in the understanding of the alliance dynamics (Lingiardi, Filippucci, & Baiocco, 2005; Taft, Murphy, Musser, & Remington, 2004; Zuroff et al., 2000). The present study provides further evidence about an influence of personality structure to the development of alliance, and, in this case, of pseudo-alliance. Accordingly, only a pre-treatment assessment would allow a more comprehensive understanding of the specific type of therapeutic alliance and of the real patient's motivations to the therapy.

These results can be also well interpreted in terms of "therapeutic misalliance", defined as a relational interaction aimed to undermine therapeutic goals or symptom modifications (Langs, 1975). This concept, indeed, has been developed in an intersubjective perspective and it overlaps with different constructs, such as transference and countertransference gratification, resistance, mutual acting out and acting in. In particular, under a relational conceptualization, the resistance becomes an obstacle to the therapeutic process, which can be understood as an interactive function between patient and therapist (Safran & Muran, 2003). However, in Sara's case, the "acquiescent" alliance cannot be identified simply as a resistance. Rather, it identifies a relational way of interacting with the therapist that goes beyond a mere obstacle to the therapy. In other words, pseudo-alliance would better resemble a transference - countertransference dynamic.

Critically, findings relative to ruptures pattern have led us to understand the real relational meaning of this alliance (Safran & Muran, 1994). In the described dynamic, Sara adopted withdrawal ruptures and, hence, an implicit, unexpressed and non-verbalized alliance modality. Indeed, Sara's avoidance played a double role in the treatment: on the one hand it was the main characteristic of her transference structure, based on extreme intellectualization and emotional closure. On the other hand, it contributed to create an impasse in the treatment, founded on a withdrawal ruptures model and on obsessive level defenses.

To conclude, whereas collaborative alliance has been for long considered under a positive meaning, here we showed that this conceptualization represents just one side of the coin. The flip side of collaboration, indeed, can have a dysfunctional role in the therapeutic alliance. These findings, therefore, challenges the classic view of

collaborative alliance and provides new facets in the study of therapeutic alliance. Beyond unveiling the impact of deferential behavior on psychotherapy process and outcome, the present study draws new attention to the need of a proper assessment of this elusive behavioral functioning for both clinical and research purposes (Colli & Lingardi, 2009). Future studies should consequently explore the role of deferential behavior, by possibly assessing its influence on therapeutic techniques and countertransference.

# 11

## Conclusions:

### *Looking Outside The Therapy Room*

*“Jofi was father’s favourite and never left him, not even when he treated a patient. Then he would lie motionless near his desk, that desk adorned with its Greek and Egyptian antique statuettes, while he concentrated on the treatment of patients. [...] he never had to look at his watch to decide when the hour’s treatment should end. When Jofi got up and yawned he knew the hour was up: she was never late in announcing the end of a session, although father did admit that she was capable of an error of perhaps a minute, at the expense of the patient”*

Martin Freud (1957) from “Glory reflected: Sigmund Freud man and father”

## 1 | CIRCULARITY AND NONLINEARITY OF THE THERAPEUTIC PROCESS

A mainstream in psychotherapy research is to deal with the variables involved in the psychotherapy room under a reductionist approach. This is largely testified by the prescription that quantitative methodology research should be ideally used to study therapeutic process and outcome. Nevertheless, such approaches have developed coherently with an oversimplified model of the world borrowed from the physical sciences of the nineteenth century (see Danziger, 1985, 1990 for a general discussion; see also Gelo, 2012, Slife, 1998), being therefore based on simplistic assumptions and related models of inquiry (Elliott & Anderson, 1994). In other words, mainstream psychotherapy researchers often end up with a series of simplifying assumptions on psychotherapy in order to be able to investigate its underlying processes, with the negative consequence of increasing the gap between research and practice (see Kazdin, 2008).

In the last two decades, there have been increasingly attempts to borrow a methodological sophistication in psychotherapy research, able to take into account the complex wholeness of clinical practice (e.g., Elliott & Anderson, 1994; Greenberg, 1986; Laurenceau, Hayes & Feldman, 2007). Traditional quantitative psychotherapy research is in fact considered to be simplistic by assuming a direct and linear causality between the phenomena under investigation and by “concentrating on the isolation of effects and on deriving universal laws, while the practice of psychotherapy is characterized by complex and highly individual interrelations between phenomena” (Smith & Grawe, 2003, p. 275). The processes as well as the effects of psychotherapy should be conceived in terms of interacting patterns of reciprocal modifications, rather than as an additive and cumulative collection of independent individual features. When dealing with reciprocal functional interactions, as is the case of psychotherapy, the attempt to isolate single variables has turned out to be problematic (Salvatore & Tschacher, 2012; Schiepek et al., 1997). In this sense, there is a growing need to develop new research

strategies that consider the patterned complexity as well as the contextuality, contingency, nonlinearity, and circularity of the therapeutic process (Greenberg, 1991; Stiles and Shapiro, 1994). As Jørgensen (2004) underlined, indeed, “It is impossible to pinpoint any single factor that is crucial in every therapy. What is needed is a non-dogmatic, multiple factor model that successfully incorporates the knowledge obtained from the many existing theories of psychotherapy-induced change” (p. 516).

On these grounds, the present doctoral thesis attempted to originally approach the psychotherapy process. This was done by taking an observational perspective on the treatment process in both group studies and single-case studies. In the reported studies, different measures related to the process (e.g., therapeutic alliance, patient metacognition, therapist interventions) and to the outcome (e.g., defensive mechanisms, psychopathological functioning) were included to explore any therapeutic changes over time. To do so, we developed research approaches that could capture the complex interactions between relational and technical factors (i.e., sequential analysis, ARIMA and structural equation models) and that could examine the role of multiple possible mediators as alternative methods for examining issues related to causation (i.e., mediation analysis). In this way, we were able to study the bi-directional and reciprocal influences between therapist and patient, in contrast to an out-dated notion that the therapist exerts a unidirectional influence on the patient. Critically, this research approach was guided by psychodynamic theory, allowing to test some key questions in psychotherapy, such as: what is the role of therapeutic alliance in psychotherapy process? How do the variables implicated in the psychotherapy interact?

## **1.1 The Micro-Analytic Level: Clues For Responsiveness In Therapy**

The studies presented in this thesis took a responsiveness approach (Stiles, Honos-Webb & Michael Surko, 1998) to explore the micro-analytic level of psychotherapy process. The term responsiveness describes all behaviors that are affected by emerging context, including emerging perceptions of others’

characteristics. Insofar as therapist and client respond to each other, responsiveness implies a dynamic relationship between variables, involving bi-directional causation and feedback loops (Stiles, Honos-Webb & Michael Surko, 1998).

Generally, human interaction is systematically responsive. For instance, people usually answer each other's questions, stay on related topics, and take turns speaking using an elaborate system of signals (e.g., Elliott et al., 1994; Goodwin, 1981; Grice, 1975; Labov & Fanshel, 1977; Sacks, Schegloff, & Jefferson, 1974). Responsiveness is therefore implicit in many commonly used clinical terms, such as accurate empathy, countertransference and timing.

In psychotherapy, by adopting the term responsiveness, we mean that the content and process emerge as treatment proceeds, although two clients never receive identical treatments and although two conversations are never identical. Notably, microanalysis of human interaction shows that participants frequently adjust their communication in light of on-going feedback from the other: for instance, Elliott et al. (1994) showed that therapists made adjustments in wording in the course of advancing interpretations, in response to clients' reactions.

To properly consider responsiveness in the psychotherapy context, in the studies included in this thesis we considered both therapist and client variables. More specifically, therapist-client interaction was acknowledged by considering sequences or patterns of events rather than isolated events, as well as by incorporating context (Stiles, Honos-Webb & Michael Surko, 1998). Findings from four studies showed that sequential analysis is as a powerful method to identify the responsiveness dynamics between therapist and patient. Sequential analysis, in fact, was able to describe the main interactive patterns of turn-to-turn exchange, and, at the same time, to guarantee a high sensibility in representing the specificity of the therapist-patient dyad. In this sense, the present thesis point to this methodological approach as an efficient method in measuring the inner dynamics of the therapy room, and in possibly bridging the gap between clinic and research.



## 1.2 The Macro-Analysis Level: Clues For Dynamic Interactionism And Action Theory

In exploring the therapeutic process at a macro-analytic level, we were particularly inspired by two theoretical perspectives, such as the dynamic interactionism (Magnusson & Endler, 1977; Zuroff, 1992) and the action-theory perspective (Brandtstadter, 1998; Lerner, 1982).

Briefly, the dynamic interactionism model assumes that genetic and early environmental factors reciprocally interact, leading to relatively stable personality dimensions or cognitive-affective schemas that, in interaction with life stress, pave the way to depression and other related disorders (e.g., Blatt & Zuroff, 1992; Kendler, Gardner, & Prescott, 2002; Luyten, Blatt & Corveleyn, 2005; Nemeroff et al., 2003). Action theory is a conglomeration of multiple perspectives, germinating in the context of several disciplines. Thus, the notion that individuals actively shape their own interpersonal environment has made an impact on philosophy (Dennett, 1987), sociology (Parsons, 1964), anthropology (Geertz, 1973), and behavioral genetics (e.g., Scarr & McCarthy, 1983; Plomin, Lichtenstein, Pedersen, McClearn, & Nesselroade, 1990). Historically, all these disciplines serve as a major source of influence on psychology in general and on clinical psychology in particular.

In psychotherapy research, the depiction of individuals as active contributors to their own distress has recently been shown to be highly useful (Blatt, Quinlan, Pilkonis, & Shea, 1995), as also informed by Zuroff's (1992) integration of Coyne's interpersonal theory with theory and research on the role of personality in depression. The development of integrative approaches for specific clinical problems can be viewed as a significant step, being closely associated with the movement of psychotherapy integration (Goldfried, 2010, Norcross & Goldfried, 2005). This has to be done by considering the treatment as a whole new theoretical building.

In the present thesis, the action theory perspective was taken to explore the effects of patient's variables, therapist's variables and relationship's variables on each other, during the therapy process. Hence, the macro-analytic level allowed to

observe the dynamic of the therapy room, by considering both technical and relational aspects.

## 2 | INTERACTIVE CYCLES: FROM INSIDE TO OUTSIDE OF THE THERAPY ROOM

As described above, in the present thesis we integrated the responsiveness approach with the action theory approach. The combination of the micro-analytic and the macro-analytic levels of psychotherapy process allowed us to investigate the real verbal exchanges between therapist and patient, along with all the imperceptible non-verbal dimensions that linger in the therapy room. In other words, we tried to integrate the conscious and concrete dialogues (i.e., micro-analytic level) with the impalpable dynamics of more general dimensions (i.e., macro-analytic).

What this present approach adds to the current debate on the nature of the psychotherapy process is that circular interaction dynamics characterize the relationship between the therapist and the patient. This evidence is in line with others theories that describe interactions between the therapist and the patient in terms of “circular” involvement. Indeed, relational psychoanalytic theorists are currently concerned about the ways in which individuals repeatedly find themselves recreating painful interpersonal exchanges, both within and outside treatment.

In a relatively early publication, Wender (1968) presented a compelling analysis of vicious and virtuous interpersonal cycles. In particular, Wender (1968) coined the term of deviant amplifying feedback (DAF), a term burrowed from the field of Cybernetics (Maruyama, 1963), for referring to a mechanism which explains how small variations in a system can become associated with large effects, i.e., how small perturbations can generate chains of events that can result in gross alterations. This is explained in terms of a process in which the output of the system is fed back (i.e., either directly or indirectly) into that system, in a manner such that

the output continues to increase or decrease.

Various authors have later described interpersonal schemas in adults (Horowitz, 1987; Luborsky, Crits-Christoph & Alexander, 1990; Young, 1990; Ryle & Kerr, 2002). The essence of these models is that an individual possesses a set of representations, a self-representation and an other-representation. These two representations would consequently shape a representation of the relationship under way and, hence, of the context in which it takes place and of the reciprocal roles activated.

Following this line, Safran and Muran (2000) talked of interpersonal cognitive cycles: the individual's construction processes lead to standard gestures and messages, eliciting foreseeable responses in the other. Individuals have expectations about how a relationship will go and expect certain responses. Their forecasts stimulate behavior, either automatic or conscious, which is consistent with their desires. Interaction is driven precisely by these desires, expectations and behaviour, even if individuals are unaware of this (Benjamin, 1998; Singer, 2005). On these grounds, Dimaggio and colleagues (2007) hypothesized that there are dysfunctional interpersonal cycles typical of each personality disorders.

Another circular interaction theory emerged from the psychotherapy research is the Mergenthaler's (1996) Therapeutic Cycles Model (TCM). The TCM is grounded in the assumption that the therapeutic change process is driven by the interaction between emotional experiencing and cognitive reflection on that experience. (e.g., Fonagy, Gergely & Jurist, 2004; Semerari, Carcione, Dimaggio, Nicolò & Procacci, 2007) The TCM posits that connecting word blocks are markers for periods of reflection on emotional experience, such as periods of "mentalization" (Fonagy, Gergely & Jurist, 2004) or "metacognitive function" (Semarari et al., 2003). These events are hypothesized, in the TCM, as markers of a microprocess of affect regulatory events that, over time, end up in change.

The theory of the therapeutic cycle easily can be integrated into other more elaborated theories describing therapeutic processes, such as Wilma Bucci's multiple code theory (Bucci, 1984, 1993). In her theory, Bucci conceived emotional insight as preceded by a phase of free association that can be measured by high

referential activity (concreteness, specificity, clarity, imagery) and simultaneous low or medium emotion and abstraction. Usually these are early memories, dreams, or narratives being reported by the patient that allow, according to the multiple code theory, a cognitive verbal access to emotional experience (Mergenthaler & Bucci, 1993).

Circular interaction seems to be a movement that involves therapist and patients at different level of contact: interpersonal, representational, affective and reflexive. In this thesis we provide novel evidence for the circular involvement of technical (i.e., therapist interventions and expertise), relational (i.e., therapeutic alliance, transference and relational structure) and functioning (i.e., patient's functioning level and defensive mechanisms) aspects. This involvement can be interpreted as a kind of "interpersonal cycle" and shows how the patient acts and reacts towards others, including the therapist, driven by well consolidated intrapsychic structures - i.e. "interpersonal schemes" (Dimaggio, Montano, Popolo & Salvatore, 2015; Safran & Muran, 2000). In this dynamic, the therapist has the potentiality to propose some elements of change, by means of his/her technical interventions, that are proved here to be crucial on the patient's functioning. Notably, the therapeutic alliance seems to act as a regulatory variable of this dynamic.

### **3 | THE KEY ROLE OF THERAPEUTIC ALLIANCE**

Safran and Muran (2006) have recently discussed the usefulness of therapeutic alliance construct, pointing to the necessity of an exploration of other dimensions to account for therapeutic change and outcome. Results of the present thesis partially challenge this claim, since in all four studies therapeutic alliance is found to be a key dimension of the therapeutic process, which can still likely provide answers to many outstanding issues.

We believe that a new role of therapeutic alliance might be attributed depending on its operationalization. Indeed, whereas previous studies have

traditionally considered alliance in terms of rupture or collaboration and, hence, as a dichotomous variable, here we opted for considering it on a three-level scale, differentiating between positive, neutral and negative alliance. Findings corroborate the existence of these three levels, by further showing that they related, at a micro-analytic level, with other dimensions in a specific way. That is, at a certain level of alliance corresponded certain levels of other variables, such as patient's defensive mechanisms or therapist interventions. In this sense, therapeutic alliance may be conceived as a multi-level variable that allows a dialogue between the other variables of the process, able to connect the micro-analytic and the macro-analytic levels of the therapy.

When applied to single-case studies, this operationalization allowed to examine in depth the relational and structural clinical functioning of the patient. More specifically, this also allowed to disconfirm the common view that a positive collaboration is necessarily associated to a positive relationship. Similarly, this led us to show that ruptures are often a window to transference patterns, but also to defensive pattern.

These results highlight the central role of therapeutic alliance in the dynamics of several constructs involved in treatment. As a cornerstone of the entire therapy, alliance is determined by the emotional and relational structure emergent from the intersubjective matrix of patient and therapist. Alliance moves, during the session, and sets the rhythm in which the other dimensions of the therapy move.

This approach can be well suited for many other studies in psychotherapy research, with a focus on different dimensions of the therapy room. An important future perspective should be the study of interactive dynamics not solely in the therapy room, but also outside of it. This would be paramount to explore the major causes of changes, along with the related effects, in patient's life.

Indeed, the most important question that psychotherapy researchers have been struggling with is not what works for whom, but why and how a given treatment works. Examining the specifics of what actually occurs within a treatment hour as determined by objective raters and relating these processes to outcome hold the most promise for unlocking the mysteries of the very effective intervention we call

psychotherapy, inside and outside of the therapy room.

#### 4 | PSYCHOTHERAPY PROCESS AND CHAOS THEORY

This thesis concerned the exploration of circular dynamics of psychotherapy process over time. In this sense, it has been frequently suggested that the study of client change process should strive toward an intensive description of patterns of client change over time, since conventional hypothesis-testing procedures have failed to produce findings that are clinically relevant (e.g., Mahrer, 1988; Rice & Greenberg, 1984). The evidence of the psychotherapy process as a nonlinear dynamic has led some authors to propose that chaos theory and nonlinear dynamic systems may offer a new method that allows the examination of psychotherapy empirical data (e.g., Galatzer-Levy, 1995; Levenson, 1994).

Chaos theory is a branch of mathematics used in natural and social sciences to observe and model the behavior of complex sets of interrelated phenomena (Goerner, 1995). Chaos theory represents a system of differential equations that describe the patterns of nonlinear and complex phenomena, by tracing the trajectory of the behavior of systems over time, along with the manner in which these systems seek or deviate from stable states (Goerner, 1995).

Chaos theory is based on two mathematical assumptions, which seem to also characterize the therapeutic process and which are, respectively: nonlinearity and interdependence. Nonlinear interdependence models allow modelling of a system without simplifying the nature of complex, mutually affecting variables (Iwakabe, 1999). This can be a good indication in the study of the complex interaction between therapist's variables, patient's variable and relational variables, as well as in the study of how they evolve and organize themselves over time. In this sense, the interaction between the micro-analytic and the macro-analytic level of analysis can unveil the mutual effect of different levels in therapy, i.e., from the global to the elemental and from the elemental to the global, Furthermore, through this model, elements go through changes, while the system as a whole simultaneously

continues to evolve as some of the client's presenting problems are resolved and other new problems emerge. Concepts central to chaos theory such as attractors, bifurcation, fractals, and the butterfly effect might be therefore crucial also in understanding psychotherapy. In particular, "attractors" and "bifurcations" might be important in that they may enable us to mathematically describe complex, qualitative, sudden, and abrupt changes in therapy. A bifurcation refers to a major change of a system rather than in just a small quantitative manner; it is a sudden reorganization of behavior that occurs when the movement of the system crosses critical points. Attractors generally refer to the points toward which all nearby trajectories tend (Abraham, 1995), and where the movement of forming distinguishable, cyclic patterns of movement. This two dynamics can reflect, in the first case, the extemporize change or the rearrangement of the relationship between therapist and patient, whereas in the second case, the cyclical interdependency that technical and relational dimensions create between therapist and patient interactions.





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