THERAPIST INTERPRETATION, PATIENT–THERAPIST INTERPERSONAL PROCESS, AND OUTCOME IN PSYCHODYNAMIC PSYCHOTHERAPY FOR AVOIDANT PERSONALITY DISORDER

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The authors examined the link between interpretive techniques, the therapeutic relationship, and outcome in psychodynamic psychotherapy. Two independent teams of judges each coded one early session from patients diagnosed with avoidant personality disorder. Results revealed (a) an inverse association between concentration of interpretation and favorable patient outcome; (b) that small amounts of disaffiliative patient–therapist transactions before, during, and after interpretations were reliably or meaningfully associated with negative patient change; and (c) concentration of interpretation was positively associated with disaffiliative therapy process before and during interpretation and negatively associated with affiliative patient responses to interpretation. The results suggest that therapists who persisted with interpretations had more hostile interactions with patients and had patients who reacted with less warmth than therapists who used interpretations more judiciously.

Keywords: interpretation, interpersonal process, treatment outcome, personality disorder

A large number of psychodynamically oriented authors have posited that the therapist's use of interpretation, particularly transference interpretation, is one of, if not the most powerful technical procedures for promoting patient improvement (Arlow, 1987; Bibring, 1954; Brenner, 1979; Clarkin, Yeomans, & Kernberg, 1999; Cooper, 1987; Davanloo, 1978; Freud, 1912, 1913, 1914, 1915; Gill, 1982; Klein, 1952; Kohut, 1984; Loewald, 1960; Malan, 1976; Mann, 1973; Sifneos, 1987; Strachey, 1934). However, only a limited number of investigations have empirically tested whether or not the use of interpretation is associated with therapeutic change in

psychodynamic psychotherapy[1], with many of these studies limiting themselves to examining the effects of the amount of interpretation provided on patient outcome. In some of the earliest works on this issue, Malan (1976) and Marziali (1984) each purported to find support for a link between the therapist's frequent use of interpretative interventions and patient improvement, specifically for interpretations that linked the patient's feelings toward the therapist with the patient's feelings toward his or her parents (T/P link). However, both Malan's (1976) and Marziali's (1984) studies were fraught with significant methodological and/or conceptual problems, making their conclusions tentative at best. For example, in Malan's (1976) study, raters were not blind to patient outcome and used process notes generated from therapists' memory rather than actual recordings or transcripts of sessions. In Marziali's study (1984), the use of interpretation only correlated with a subset of dynamic change scores. In addition, because raw frequency of interpretation was used as the predictor variable, it is possible that the findings were confounded by verbal activity of the therapist in general. Piper, Debanne, Bienvenu, de Carufel, and Garant (1986), who sought to correct many of the weaknesses inherent in these earlier studies, found little evidence to suggest that raw frequency or concentration of interpretation (including T/P interpretations) was directly associated with favorable outcome in a sample of patients receiving short-term individual dynamic treatment.

Stemming from these initial investigations other authors have explored potential mediators of the relationship between the amount of interpretation provided and therapeutic change, with the most common mediators explored to-date being (a) the patient's pretreatment level of interpersonal functioning (e.g., Connolly, et al., 1999; Høglend, 1993; Ogrodniczuk, Piper, Joyce, & McCallum, 1999; Piper, Azim, Joyce, & McCallum, 1991), (b) the suitability or "accuracy" of the therapist's interpretations (e.g., Crits-Christoph, Cooper, & Luborsky, 1988; Norville, Sampson, & Weiss, 1996; Silberschatz, Fretter, & Curtis, 1986), and (c) the patient's immediate response to interpretation (e.g., Luborsky, Bachrach, Graff, Pulver, & Christoph, 1979; McCullough et al., 1991; Winston, McCullough, & Laikin, 1993). As a whole, the results of these studies suggest that interpretive interventions in psychodynamic psychotherapy do not indubita-

bly produce "mutative" treatment effects but rather appear associated with positive change only for certain patients (i.e., depending on the patient's pretreatment levels of interpersonal relatedness) under certain conditions (i.e., depending on the frequency or concentration of interpretation, the degree of accuracy of the therapist's interpretations, and/or the patient's immediate reaction to interpretations).

Although these empirical findings have important implications for clinical practice (Schut & Castonguay, 2001), they have failed to provide a full investigation of the therapeutic context of interpretive work. For example, as discussed by Binder and Strupp (1997), researchers have not yet determined the effects of the therapist's communicative style or the effects of the momentary interpersonal context between patient and therapist within which interpretations are provided on the process of change. These aspects of interpretation have long been considered to be of import within the analytic clinical community (see Josephs, 1992, for a review), and a small body of empirical research guided by interpersonal and psychodynamic theories indeed suggests that such subtle patient–therapist interpersonal process variables may play an important role in the promotion of therapeutic change.

Henry, Schacht, and Strupp (1986) explored the moment-to-moment transactions between patients and therapists using Benjamin's (1974) Structural Analysis of Social Behavior (SASB). Interpersonal process was compared across good versus bad outcome cases seen by the same therapists. Henry et al. (1986) found that therapists' good outcome cases involved significantly more affiliative or friendly modes of therapist communication (i.e., communication that was more affirming and understanding, more helping and protecting, and less belittling and blaming), whereas therapists' poor outcome cases involved significantly more disaffiliative (e.g., hostile and controlling) communication patterns between patient

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[1] The term "psychodynamic psychotherapy" is broadly used here to define those treatments that are aimed at resolving unconscious conflict, strengthening ego functioning, consolidating representations of self and other, and/or providing cohesion of one's subjective sense of self. It is a more pluralistic designation in line with Wallerstein's (1992) observations regarding the preponderance of supportive and expressive elements in all psychoanalytically informed psychotherapies.

and therapist. In a follow-up study that explored a potential mechanism by which interpersonal process produces outcome changes, Henry, Schacht, and Strupp (1990) found that the presence of disaffiliative patient–therapist process was associated with lower levels of change in patient self-reported introject ratings (i.e., ratings of how the patient relates with him/her self). Therapist disaffiliative process was also highly correlated with the number of self-blaming and critical statements made by patients in session. Patients who showed positive changes in introject ratings, on the other hand, experienced interactions that were almost completely devoid of disaffiliative therapist process. The authors suggested that these findings were consistent with their theoretically derived predictions that disaffiliative therapist behaviors serve to confirm the patient's negative view of self through the process of interpersonal introjection. Although Henry et al. (1986, 1990) did not investigate the relationship between *specific* types of interventions (e.g., interpretations) and the quality of patient–therapist transactions, their results clearly suggest that the manner and context within which the therapist provides his or her interventions may yield radically different therapeutic outcomes.

Work by Piper et al. (1999) has shed light on the deleterious effects of disaffiliative therapy process following therapist interpretation. Informal inspection of sessions from patients who dropped out prematurely from time-limited psychodynamic treatment revealed that there frequently was a deteriorating transactional cycle between patient and therapist following therapist interpretations, particularly during those sessions judged to have the highest levels of patient and therapist focus on transference issues. According to Piper et al. (1999), a typical exchange was as follows: After the patient voiced his or her frustration about the therapy sessions and the therapist's repeated focus on his or her painful feelings, the therapist would address these patient concerns by focusing on the therapeutic relationship and the transference. The patient resisted the transference interpretations either through verbal disagreement or through silence, which led the therapist to persist even further with interpretations. This cycle led both parties to argue with one another, with the therapist often becoming ". . .drawn into being sharp, blunt, sarcastic, insistent, impatient, or condescending" (p. 120). At the end of the session, after the therapist attempted to encourage the pa-

tient to continue therapy, the patient submitted to the therapist's encouragement by agreeing to return but, in fact, never returned.

Such findings, while noteworthy, should be considered tentative given that the authors did not formally measure patient–therapist interaction patterns with a reliable measure of interpersonal process nor specifically examine the relationship between patient outcome and therapy process during interpretation. Nonetheless, we attempted in this study to expand on Piper et al.'s (1999) results as well as address some of the limitations of earlier empirical work on the link between therapist interpretation and patient outcome. Specifically, the present study examined the effects of the amount of interpretation provided as well as the interpersonal manner and context within which such interventions are provided on the process of change. Both transference and nontransference interpretations were explored given that previous studies have often neglected to examine these types of interventions concurrently and given that many authors have advocated the therapeutic value of both types of interventions (e.g., Wallerstein & DeWitt, 1997).

In the present study audiotapes and verbatim transcripts of early sessions of Supportive-Expressive (*SE*) psychodynamic psychotherapy for avoidant personality disorder (AVPD) were examined (Barber, Morse, Krakauer, Chittams, & Crits-Christoph, 1997). Using a well-established measure of psychodynamic interventions prescribed by the *SE* treatment approach (Connolly, Crits-Christoph, Shappell, Barber, & Luborsky, 1998), judges rated each therapist statement for the presence of interpretation. All patient and therapist statements from these selected sessions were also coded with the SASB (the same measure employed in Henry et al.'s [1986, 1990] studies) by a separate team of judges to examine the degree of affiliativeness versus disaffiliativeness in interpersonal communications between patient and therapist.

Based on the previously reviewed empirical and theoretical literature, the following predictions were made. First, raw frequency and proportion (i.e., concentration) of interpretation would not be reliably associated with therapeutic change. Second, therapist interpretations delivered in a disaffiliative (e.g., belittling and blaming) interpersonal manner would be associated with poor therapeutic outcome. Good outcome, on the other hand, would be associated with interpretations delivered in a more interpersonally

warm or affiliative (e.g., helping and protecting) manner. Third, the presence of disaffiliative interpersonal process between therapist and patient (e.g., therapist belittling and blaming, patient sulking and appeasing) immediately prior to the use of interpretations would be associated with poor therapeutic outcome. Good outcome, on the other hand, would be associated with more affiliative interpersonal process between therapist and patient (e.g., therapist affirming and understanding, patient disclosing and expressing) immediately prior to the use of interpretations.

Although the above methods attempt to identify the therapist's interpersonal process along with the relational context within which each interpretation is delivered, it was also of interest to elucidate the patient's interpersonal process immediately following these interventions and determine how such reactions relate to outcome. It could be, for example, that a patient becomes "resistant" when the therapist offers his or her interpretations in a disaffiliative (e.g., belittling or accusatory) interpersonal manner. On the other hand, patient "work" may occur when the therapist offers his or her interpretations in more affiliative interpersonal terms (e.g., when interpretations constructively stimulate the patient and/or show empathic understanding of the patient's experience). Such formulations are consistent with contemporary views on interpersonal complementarity (e.g., Benjamin, 1996; Kiesler, 1983; Pincus & Ansell, 2003), which posit that certain classes of interpersonal behavior from one participant "pull for" or "invite" similar responses from another participant.

The present study did not specifically measure dimensions of patient responses such as defensiveness or involvement, but it was believed that the quality of patient interpersonal process immediately following the use of interpretations could be used as analogues of such reactions. For example, patients who have therapeutically positive reactions to interpretations such as "work" or "involvement" presumably do not disaffiliatively protest, sulk, or wall-off in relation to the therapist but instead respond by trusting or disclosing to the therapist in an affiliative manner. Similarly, patients who become "resistant" following interpretations presumably do not affiliatively take in or disclose to the therapist but instead react by sulking, protesting, or walling him/her self off from the therapist. Accordingly, a fourth prediction was offered. Specifically, we predicted that the presence of disaffiliative patient reactions to interpretation would be associated with poor therapeutic outcome, whereas more affiliative reactions by the patient to interpretation would be associated with positive therapeutic outcome.

Methods

Participants

Data from 14 patients meeting *DSM–III–R* (APA, 1987) criteria for AVPD were examined in the present study. These data were gathered as part of an open trial examining the initial efficacy of a manualized form of *SE* therapy (Luborsky, 1984) adapted for patients with AVPD (see Barber et al., 1997 for complete details regarding patient recruiting and interview methods). In brief, patients who met AVPD diagnostic criteria were included in the treatment study without regard to Axis I pathology with the exceptions being diagnoses of substance abuse or dependence in the last 12 months, concurrent psychotic or bipolar disorder, organic dysfunction, or schizotypal or borderline personality disorders. Individuals with active suicidal plans were also excluded from participating in the treatment.

In terms of the sample's demographics, 9 of the 14 patients were female and 5 were male. The average age of the patients was 35.9 years. The majority (86%) of the patients were Caucasian; two female patients were African American. In terms of educational achievement, 7% had completed high school, 21% had completed some college, 43% had completed college, and 14% had completed a graduate degree. One person had not completed high school and educational data were not available for one additional patient. Forty-three percent of the sample had never married; 36% were married, 14% were divorced, and 7% were single. All but one patient (full-time student) was employed either full-time or part-time. In terms of additional psychopathology at the time of intake, 71% of the patients had at least one concurrent anxiety disorder and 86% had at least one concurrent depressive disorder. In addition, 64% of the patients met criteria for one additional personality disorder diagnosis.

Treatment

Six Ph.D.-level clinical psychologists (four female, two male) experienced in psychodynamic psychotherapy provided the treatment protocol. Each therapist saw two patients on average (three

female therapists saw three patients each, one male therapist saw one patient) and received close supervision and training following Luborsky's (1984) recommendations. Each patient who completed the treatment study received 52 weekly individual sessions lasting up to 16 months.[2] Treatment was based in large part on Luborsky's (1984) treatment manual for *SE* psychodynamic psychotherapy that incorporated recommendations from specific published and unpublished preliminary manuals for Axis I and II disorders.

In *SE* treatment, the therapist works at creating a supportive therapeutic relationship and then, after carefully identifying the patient's predominant narratives about self and other, generates a dynamic formulation of the patient's main relationship pattern. This dynamic formulation—entitled the Core Conflictual Relationship Theme (CCRT: Luborsky & Crits-Christoph, 1990)—consists of three components: The patient's main wishes, the patient's main perceived and expected responses of others, and the patient's main responses of self to these responses of others. Following the generation of the CCRT, the therapist interprets facets of the formulation with regard to the patient's past and present interpersonal relationships, including the patient's transferential relationship with the therapist. Specific attention is placed on helping the patient with AVPD see how his or her use of interpersonal avoidance as it appears in the transference relates to avoidance in other relationships in his or her life (Barber et al., 1997).

Measures

Beck Anxiety Inventory (BAI: Beck, Epstein, Brown, & Steer, 1988). The BAI is a 21-item self-report measure of the severity of clinical anxiety symptoms. Patients are asked to rate how much they are bothered by their anxiety symptoms over the past week using a four-point scale (0 to 3). High scores on the BAI indicate greater self-reported levels of anxiety. Beck et al. (1988) and Steer, Ranieri, Beck, and Clark (1993) have found the BAI has good-to-excellent internal consistency, test–retest reliability, and convergent and discriminant validity within several outpatient psychiatric samples.

Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The BDI is a 21-item self-report measure of depression. Pa-

tients are asked to endorse the extent to which statements describe their feelings over the past week using a four-point scale (0 to 3). High scores on the BDI indicate greater self-reported levels of depression. A meta-analysis of research studies using the BDI revealed that the measure has good-to-excellent internal consistency, test–retest reliability, and convergent and discriminant validity within psychiatric samples (Beck, Steer, & Garbin, 1988).

Global Assessment of Functioning (GAF: *DSM–III–R* [APA, 1987], Axis V). The GAF is a single global rating provided by an assessor that is used to estimate the patient's overall psychological, social, and occupational functioning currently and the patients' highest overall level of functioning within the past year. The GAF ranges from 1 (severe and persistent difficulties in functioning) to 100 (superior levels of functioning). For the present study, the GAF-current level of functioning was utilized for data analysis. Williams et al. (1992) reported high levels of interrater agreement using the GAF in a multisite study of *DSM–III–R* diagnosis.

Inventory of Interpersonal Problems (IIP: Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988). The IIP is a 127-item self-report questionnaire intended to operationalize various types of interpersonal problems that are commonly the focus of psychotherapy. Alden, Wiggins, and Pincus (1990) developed a shorter 64-item version of the IIP (IIP-C), which consists of eight 8-item scales intended to operationalize the octants of a circumplex of interpersonal problems. In both versions patients use a five-point scale to report their amount of distress related to behaviors they find hard to do with others (e.g., "It is hard for me to be assertive with another person") and for behaviors they do too much with others (e.g., "I put other people's needs before my own too much"). Studies have found the IIP and IIP-C exhibit high internal consistency, test–retest reliability, sensitivity to clinical change, and predictive validity (Alden et al., 1990; Alden & Capreol, 1993; Horowitz et al., 1988; Horowitz,

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[2] One patient did not finish the treatment protocol, having received only 30 therapy sessions. The patient had difficulty reliably attending sessions but remained an active patient in the protocol for one year. After careful consideration, it was decided that patient's outcome scores at the second midtreatment evaluation (approximately month 8) would be used to represent the posttreatment indices.

Rosenberg, & Bartholomew, 1993). The present study used the patient's average score on the 64 items common to the Horowitz et al., (1988) and Alden et al., (1990) versions of the IIP. This average score provides an estimate of the patient's overall level of interpersonal distress, with higher average scores reflecting greater levels of interpersonal distress (Gurtman & Balakrishnan, 1998).

Wisconsin Personality Disorders Inventory (WISPI: Klein, et al., 1993). The WISPI is a 240-item self-report questionnaire organized into 11 scales, with each scale corresponding to one of the *DSM–III–R* (APA, 1987) Personality Disorders. Although the WISPI items and scales were derived from the *DSM–III–R* Personality Disorder symptom criteria, they are different from other self-report measures of personality disorder (e.g., SCID-II) because they have been translated and reformulated according to an interpersonal theory of personality (Benjamin, 1993, 1996). Studies by Klein et al. (1993) and Barber and Morse (1994) have found that the WISPI scales have excellent internal consistency and test–retest reliability as well as good convergent and discriminant validity in samples of patients diagnosed with personality disorders.

Each item on the WISPI is rated on a 10-point scale (1 = "Never or not at all true of you"; 10 = "Always or extremely true of you") and patients are asked to rate their usual selves during the past five years or more. Raw summary scores for each scale (mean rating of the items for each scale) were computed and transformed to *z*-scores using normative data provided by Klein et al. (1993). For the present study only the AVPD subscale score was examined for data analysis, with higher scores reflecting higher levels of AVPD symptoms.

Selection of Sessions

Audiotapes and verbatim transcripts of one early session (e.g., Session 5) of *SE* treatment from each of the 14 patients were examined in the present study. The selection of early sessions for data analysis is consistent with other investigations that have explored the relationship between moment-to-moment interpersonal processes between patients and therapists and treatment outcome (e.g., Henry et al., 1986, 1990).

Process Measures

Therapist Interventions. Connolly et al. (1998) developed a method for assessing therapist interventions consistent with the techniques of *SE* treatment in order to provide a detailed, molecular-level description of individual *SE* sessions and to link such descriptive data with more molar measures of therapist adherence and competence. As described in Connolly et al. (1998), judges classify each therapist speaking turn into one of eight response mode categories: interpretation, clarification, question, restatement, role play, informational or directional statement regarding therapy, self-disclosure, or "other." Judges also rate each therapist speaking turn for the presence of persons (e.g., therapist, parent, significant other) and time frames (e.g., focus on childhood through adolescence, adult past to present, in session). In the present study two judges (second year graduate students at Penn State University) independently classified each therapist speaking turn using the above methods and reached consensus on any discrepant classifications. Only consensus scores were used for statistical analyses. Judges were blind to patient outcome and to the nature of the study.

As in Connolly et al. (1998), interpretations were defined as therapist statements that pointed out or suggested: (a) a patient thought, feeling, or behavior; (b) a link between a patient's thoughts, feelings, or behaviors; (c) that a thought, feeling, or behavior formed a pattern over settings or people; or (d) a link between a thought, feeling, or behavior to past life experiences. An example of a therapist interpretation taken from a transcript is: "You don't seem to think that your parents are capable of handling anything that is difficult or upsetting." Transference interpretations were defined as any interpretation that specifically included the therapist as an object of the statement (Connolly et al., 1999). An example of a therapist transference interpretation taken from a transcript is, "You seem to be worried that I will be critical of you if you express how you are truly feeling." Statements were considered interpretations (transference or nontransference interpretations) only if the judges felt that they went beyond the patient's level of awareness, that is, the statements needed to go beyond what the patient immediately verbalized and convey an intent to add awareness to the patient's understanding of what was being discussed. Simple references to
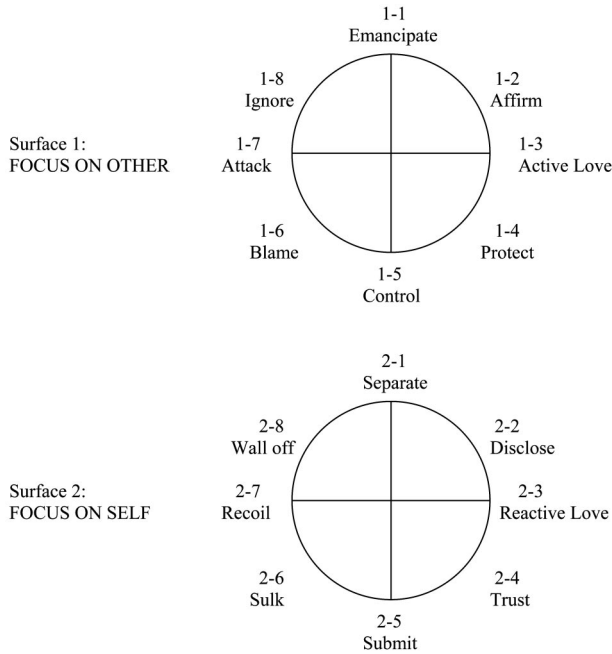
FIGURE 1. The SASB circumplex model, cluster version, interpersonal surfaces. Adapted from Benjamin (1993), *Interpersonal Diagnosis and treatment of personality disorders*. New York: Guilford Press.

patient thoughts, feelings, and/or behaviors were not sufficient to score as interpretations. Previous research has found that judges can reliably classify therapist statements into these interpretive categories, with intraclass correlation coefficients (ICC's) ranging from .66 to .88 (Connolly et al., 1998, 1999).

Patient–Therapist Interpersonal Process. Benjamin's (1974, 1993, 1996) SASB model was utilized to code interpersonal process between patients and therapists. SASB is a circumplex model of interpersonal and intrapsychic behavior that allows for fine-grained description of the quality of interpersonal communications between members of any dyad. Its roots lie within the interpersonal (e.g., Sullivan, 1953) and object relations (e.g., Fairbairn, 1952) psychoanalytic traditions as well as in the interpersonal/personality theories of Leary (1957), Murray (1938), and Schaefer (1965). A complete description of the history, development, and applications of SASB is beyond the scope of this study, and so the reader is directed to several excellent texts and articles reviewing this approach (Benjamin, 1996; Constantino, 2000; Henry, 1994; Pincus & Ansell, 2003; Pincus & Benjamin, 2001).

The present study utilized the SASB coding manual of Benjamin, Giat, and Estroff (1981) to code patient and therapist interpersonal process. The procedure for coding is as follows. First, each patient and therapist speaking turn is segmented into individual "thought units," which are defined as any portions of speech expressing one complete thought (usually about one spoken sentence). Next, each thought unit is coded in terms of its interpersonal focus, that is, whether the thought unit has reference to another person or to the speaker, and in terms of its accompanying levels of affiliation and interdependence, the two orthogonal dimensions underlying the SASB model. The two dimensions of affiliation and interdependence combine with interpersonal focus to form two interrelated circumplex surfaces designed to describe interpersonal behavior.[3]

Figure 1 presents these two circumplex surfaces of the SASB. Surface One: Focus on

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[3] There is a third circumplex surface of the SASB entitled "introject," which is intended to capture intrapsychic actions directed toward the self (cf. Sullivan, 1953). However, as described by Henry et al. (1986), this surface is typically used in content, rather than process analysis, and so the data from this surface were not utilized in the present study.

Other—describes transitive actions toward a directed object. Surface Two: Focus on Self—describes intransitive reactions to another person. As can be seen from the figure, these two surfaces are structurally similar in that both place the affiliation dimension on the horizontal axis and the interdependence dimension on the vertical axis. As one moves from left to right on either circumplex, interpersonal actions and reactions progress from being disaffiliative to affiliative in nature. As one moves from top to bottom on either circle, interpersonal actions and reactions progress from being differentiated to enmeshed in nature.

According to the SASB model, every interpersonal behavior (thought unit) can be described in terms of interpersonal focus and in terms of varying combinations of affiliation and interdependence. Each point around each circumplex reflects a blend of the two dimensions and is assigned a SASB code as well as a descriptive label. These codes/labels are the clinical data that the SASB approach allows coders and clinicians to generate. For the present study, the SASB cluster model was used, which yields SASB codes that consist of two numbers. The first number of the code reflects interpersonal focus (i.e., 1 = focus on other; 2 = focus on self) and the second number reflects the position (1 through 8) around the particular circumplex used to describe the thought unit in question. For example, SASB code 1–2 (Affirm) describes a combination of moderate affiliation and moderate differentiation focused on another person, whereas SASB code 2–7 (Recoil) describes a combination of extreme disaffiliativeness and neutral differentiation focused on the self. As can be seen, interpersonally complementary behaviors are represented at homologous points across the surfaces. For example, intransitive "submitting" to another (2–5) is the interpersonal complement of transitive "control" (1–5).

Benjamin et al. (1981) and Henry et al. (1986, 1990) have found coders to be reliable both in terms of the segmenting process and in terms of assigning SASB codes to patient and therapist thought units. For the present study, coding was conducted by a pair of advanced graduate students at the University of Utah who were extensively trained and supervised by L. S. Benjamin, the inventor of the SASB approach.

Judges used both the transcripts and the audiotapes to code for interpersonal process of patient and therapist. Each transcript was first segmented by one of the two judges. Judges then coded in tandem all thought units contained within patient and therapist dialogue. [4] To establish reliability between coders, judges independently coded 50 thought units (randomly selected within each transcript) of every other session. A weighted κ (Cohen, 1968) coefficient was computed to determine levels of interrater agreement on the assignment of SASB codes to thought units (see Results). All coding discrepancies between judges were resolved by consensus, and consensus scores were used for all statistical analyses. SASB judges were also blind to patient outcome and to the nature of the study.

Isolation of Specific SASB Variables and Patient and Therapist Thought Units

Because the study's hypotheses specifically concern the relationships between the degree of affiliativeness versus disaffiliativeness in patient–therapist interpersonal process and therapy outcome, a procedure was implemented to extract these aspects of patient and therapist communications. Based on the procedure of Hilliard, Henry, and Strupp (2000), the sum of all SASB codes falling in a given affiliative or disaffiliative cluster was multiplied by a weight representing the relative affiliativeness or disaffiliativeness of the respective cluster. These weighted sums were then added together, providing global affiliation and disaffiliation scores. Separate measures of affiliation and disaffiliation were calculated for therapist interpersonal process and patient interpersonal process according to the particular thought units and hypotheses being examined.

To test the hypothesis regarding the relationship between therapist interpersonal process during interpretation and outcome, all thought units

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[4] Note that while most thought units tend to be described with one SASB code (i.e., by one specific part of the SASB model), some thought units can be described with more than one SASB code if they convey more than one interpersonal message. An example of the latter would be when a message simultaneously communicates acceptance and rejection. Though units that have multiple SASB codes are called "complex" communications. In the present study, each part of a complex communication was treated separately (e.g., a 1-2/1-6 thought unit was counted as one instance of 1-2 and one instance of 1-6) to increase the frequency count of the corresponding clusters (Henry et al., 1990).

making up each therapist interpretation were isolated for data analysis. Measures of affiliation and disaffiliation for these thought units were computed and then divided by the total number of thought units within each therapist's interpretations in order to remove the artifact of differing amounts of therapist speech across patients.

In order to test the hypothesis regarding the relationship between therapist–patient interpersonal process prior to interpretation and outcome it was first necessary to define the number of patient and therapist statements to include in the analysis. For the present study, all thought units contained within one therapist and one patient statement preceding each interpretation were used to operationalize the "interpersonal context" within which the therapist offers his or her interpretations. However, when a therapist interpretation was immediately followed by another interpretation, the thought units used to define the interpersonal context of the second interpretation become overlapped with the thought units contained within the first interpretation. To prevent the inclusion of thought units associated with more than one interpretation, only interpretations separated by at least one noninterpretive intervention were analyzed in terms of the quality of their interpersonal contexts. Once these particular therapist and patient statements were identified, affiliation and disaffiliation scores for both therapist and patient communications preceding interpretations were computed and then divided by the total number of therapist or patient thought units contained within their respective statements to correct for amount of therapist and patient speech.

To test the hypothesis regarding the relationship between patient immediate response to interpretation and outcome, all thought units making up each patient initial speaking turn following each therapist interpretation were isolated for data analysis. Patient measures of affiliation and disaffiliation for the thought units contained within these statements were then computed and divided by the total number of thought units within these statements in order to remove the artifact of differing amounts of speech across patients.

Results

Judges exhibited good interrater agreement in terms of classifying therapist interventions as in-

terpretations ($\kappa = .72$) and in terms of assigning SASB codes to thought units (Weighted $\kappa = .79$). However, it should be noted that the measure of reliability for the classification of therapist statements into the category "interpretations" involved aggregating judges' ratings of transference and nontransference interpretations. This was done because of the low base rate of transference interpretations in the sessions sampled. To clarify, therapists averaged 189 turns of talk ($SD = 82.01$) per session, with roughly 25 of these turns (or 14.4% of all therapist turns) classified as interpretations ($M = 24.86$, $SD = 9.66$). However, the average number of transference interpretations provided by these therapists was only about two per session ($M = 2.29$, $SD = 3.41$). In fact, 36% of the patients did not receive any transference interpretations, and 50% of the patients received no more than one transference interpretation in their particular session studied. Thus the majority of interpretations (90.8% of all interpretations) focused on aspects of the patient's functioning outside of his or her immediate relationship with the therapist.

Despite the fact that transference interpretations occurred infrequently, it was believed that they should be included in the overall analyses examining the effects of the amount of interpretation and the effects of patient–therapist interpersonal process associated with interpretation on outcome. Consequently, all statistical tests described below involving "interpretations" considered both transference and nontransference interpretations together.

Kazdin (1994) suggested that researchers investigating theoretically important questions with small sample sizes might decide to reconsider the alpha level for their statistical analyses. The small N of the present study, coupled with its exploratory nature and theoretically derived predictions, led us to set alpha at $p < .10$ (two-tailed). However, based on the recommendations of Cohen (1988), greater emphasis was placed on the magnitude (effect size) rather than on the p value associated with each statistical test. Specifically, any measure of association between predictor and criterion variables that was equal to or greater than .30 (medium effect size: Cohen, 1988) was considered to be meaningful.

One patient had missing values on the IIP and WISPI at termination. It was decided to replace these missing values with the mean of the 13

remaining cases on each of the two variables. As described by Tabachnick and Fidell (2001), estimating missing values for ungrouped data using mean substitution is a conservative procedure in that the mean for the distribution as a whole does not change.

Prior to statistical analyses all predictor and criterion variables were examined for the presence of outliers. An outlier was defined as any score having a standardized score (*z*-score) with an absolute value greater than or equal to 3.25. Any case having an outlier on a given variable was assigned a raw score on the offending variable that was one unit larger (or smaller) than the next most extreme score in the distribution (Tabachnick & Fidell, 2001). This procedure resulted in the adjustment of one patient's posttreatment BAI score, a second patient's score on the amount of affiliation in reaction to interpretation, and a third patient's score on the amount of disaffiliation in the therapist's communications prior to interpretation.

Hypothesis 1: Relationship Between the Amount of Interpretation and Therapy Outcome

Partial correlations were conducted in which raw frequency and concentration of therapist interpretation were correlated with each outcome variable (controlling for pretreatment levels of each outcome variable) in order to determine whether or not the amount of interpretation would be significantly related to patient change. As predicted, raw frequency of interpretation was not associated with any of the patient outcome measures (see Table 1).

TABLE 1. Partial Correlations Between Raw Frequency and Proportion of Interpretation and Outcome

	Outcome variable				
	BAI	BDI	IIP	WISPI	GAF
Frequency of interpretation	.19	.08	−.16	.25	.19
Proportion of interpretation	.32	.08	.47	.62**	−.50*

Note. $N = 14$. BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; IIP = Inventory of Interpersonal Problems Average Score; WISPI = Wisconsin Personality Disorders Inventory: AVPD Subscale; GAF = Global Assessment of Functioning. High outcome scores are undesirable except on GAF. All meaningful partial correlations (i.e., $rs \geq .30$) are underlined.
* $p < .10$.   ** $p < .05$

However, statistically significant inverse relationships were found between concentration of interpretation and favorable outcome on the WISPI, $r(11) = .62$, $p < .05$, and on the GAF, $r(11) = -.50$, $p < .10$. Although not statistically significant, similar meaningful inverse relationships were found between concentration of interpretation and favorable outcome on the BAI and IIP.

Hypothesis 2: Relationship Between Therapist Interpersonal Process During Interpretation and Therapy Outcome

Partial correlations were conducted in which measures of therapist affiliativeness and disaffiliativeness during the use of interpretation were correlated with each outcome variable (controlling for pretreatment levels of the outcome variables) in order to test the hypothesis that interpretations offered in an affiliative manner would be positively associated with patient outcome whereas interpretations offered in a disaffiliative manner would be negatively associated with patient outcome. Consistent with the hypothesis, a statistically significant inverse relationship was found between therapist disaffiliativeness during interpretation and favorable outcome on the GAF, $r(11) = -.58$, $p < .05$ (see Table 2). Although not statistically significant, similar meaningful inverse relationships were found between therapist disaffiliativeness during interpretation and favorable outcome on the IIP and WISPI. Therapist affiliativeness during interpretation did not reliably or meaningfully correlate with favorable outcome.

Post hoc correlations were conducted in order to examine the relationship between concentration of interpretation and therapist levels of affiliation and disaffiliation during the use of interpretation. Concentration of interpretation was found to be positively associated with disaffiliative therapist process during interpretations, $r(14) = .70$, $p < .01$, and negatively associated with affiliative therapist process during interpretations, $r(14) = -.52$, $p < .10$, suggesting that persistent use of interpretation was related to higher levels of therapist hostility and lower levels of therapist warmth during the provision of interpretive techniques.

TABLE 2. Partial Correlations Between Measures of
Therapist Interpersonal Process During Interpretation
and Outcome

SASB process variable	Outcome variable				
	BAI	BDI	IIP	WISPI	GAF
Therapist affiliativeness	−.15	.05	−.03	−.26	.27
Therapist disaffiliativeness	.03	−.21	<u>.36</u>	<u>.40</u>	<u>−.58</u>**

Note. $N = 14$. BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; IIP = Inventory of Interpersonal Problems Average Score; WISPI = Wisconsin Personality Disorders Inventory: AVPD Subscale; GAF = Global Assessment of Functioning. High outcome scores are undesirable except on GAF. All meaningful partial correlations (i.e., $rs \geq .30$) are <u>underlined.</u>
** $p < .05$.

Hypothesis 3: Relationship Between Therapist–Patient Interpersonal Process Prior to Interpretation and Therapy Outcome

Partial correlations were conducted in which measures of therapist and patient affiliativeness and disaffiliativeness for statements occurring immediately before interpretations were correlated with each outcome variable (controlling for pretreatment levels of each outcome variable) in order to test the hypothesis that affiliative therapist–patient interpersonal process prior to interpretation would be positively associated with patient outcome whereas disaffiliative therapist–patient interpersonal process prior to interpretation would be negatively associated with patient outcome. Consistent with the hypothesis, a statistically significant direct relationship was found between patient affiliativeness prior to interpretation and favorable outcome on the GAF, $r(11) = .51$, $p < .10$ (see Table 3). Similar meaningful but nonstatistically significant direct relationships were also found between patient affiliativeness prior to interpretation and favorable outcome on the IIP and WISPI. Contrary to predictions, however, statistically significant inverse relationships were found between therapist affiliativeness prior to interpretation and favorable outcome on the BAI, $r(11) = .48$, $p < .10$, and on the BDI, $r(11) = .53$, $p < .10$.

With respect to patient and therapist levels of disaffiliativeness prior to interpretation, statistically significant inverse relationships were found between patient disaffiliativeness and favorable outcome on the IIP, $r(11) = .57$, $p < .05$, and on

the GAF, $r(11) = −.58$, $p < .05$. A similar meaningful but nonstatistically significant inverse association was found between patient disaffiliativeness prior to interpretation and favorable outcome on the BAI. Therapist disaffiliativeness prior to interpretation was not found to be reliably associated with any of the outcome variables, although several meaningful inverse associations were found between therapist disaffiliativeness prior to interpretation and favorable outcome on the BAI, IIP, and GAF.

A series of post hoc correlations were conducted in order to examine the relationship between concentration of interpretation and levels of patient and therapist affiliation and disaffiliation prior to interpretation. The main findings from these analyses were that concentration of interpretation was positively associated with disaffiliative therapist process before interpretation, $r(14) = .59$, $p < .05$, and disaffiliative patient process before interpretation, $r(14) = .60$, $p < .05$, suggesting that persistent use of interpretive techniques was related to higher levels of hostility in patient–therapist transactions prior to the use of interpretation.

Hypothesis 4: Relationship Between Patient Interpersonal Process Immediately Following Interpretation and Therapy Outcome

Partial correlations were conducted in which measures of patient affiliativeness and disaffili-

TABLE 3. Partial Correlations Between Measures of
Therapist-Patient Interpersonal Process Prior to
Interpretation and Outcome

SASB process variable	Outcome variable				
	BAI	BDI	IIP	WISPI	GAF
Therapist affiliativeness	<u>.48</u>*	<u>.53</u>*	−.06	−.21	.10
Therapist disaffiliativeness	<u>.30</u>	.24	<u>.42</u>	.19	<u>−.46</u>
Patient affiliativeness	−.22	−.18	<u>−.47</u>	<u>−.38</u>	<u>.51</u>*
Patient disaffiliativeness	<u>.36</u>	.29	<u>.57</u>**	.23	<u>−.58</u>**

Note. $N = 14$. BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; IIP = Inventory of Interpersonal Problems Average Score; WISPI = Wisconsin Personality Disorders Inventory: AVPD Subscale; GAF = Global Assessment of Functioning. High outcome scores are undesirable except on GAF. All meaningful partial correlations (i.e., $rs \geq .30$) are <u>underlined.</u>
* $p < .10$. ** $p < .05$

ativeness for statements immediately following interpretations were correlated with each outcome variable (controlling for pretreatment levels of the outcome variables) in order to test the hypothesis that affiliative patient process following interpretations would be positively associated with patient outcome whereas disaffiliative patient process following interpretations would be negatively associated with patient outcome. Patient levels of affiliativeness and disaffiliativeness immediately after therapist interpretation were not reliably associated with any of the outcome variables (see Table 4). Consistent with the above prediction, however, nonstatistically significant but meaningful relationships were found between patient levels of affiliation and disaffiliation immediately following interpretation and outcome on the BAI, with patient affiliativeness associated with lower patient levels of anxiety symptoms at termination and patient disaffiliativeness associated with higher levels of anxiety symptoms at termination.

Post hoc correlations were conducted in order to examine the relationship between concentration of interpretation and levels of patient affiliation and disaffiliation immediately after interpretation. Concentration of interpretation was found to be negatively related with affiliative patient process following interpretations, $r(14) = -.54$, $p < .05$, suggesting that persistent use of interpretations was associated with lower levels of patient interpersonal warmth immediately after interpretations were provided.

TABLE 4. Partial Correlations Between Measures of Patient Interpersonal Process Immediately Following Interpretation and Outcome

SASB process variable	Outcome variable				
	BAI	BDI	IIP	WISPI	GAF
Patient affiliativeness	−.44	−.22	.00	−.20	.12
Patient disaffiliativeness	.32	.16	.05	−.06	−.04

Note. $N = 14$. BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; IIP = Inventory of Interpersonal Problems Average Score; WISPI = Wisconsin Personality Disorders Inventory: AVPD Subscale; GAF = Global Assessment of Functioning. High outcome scores are undesirable except on GAF. All meaningful partial correlations (i.e., $rs \geq .30$) are underlined.

Discussion

Clinical experience and refinements to psychoanalytic metapsychology have led many clinicians and theoreticians to ordain interpretation as one of the most powerful agents of change in psychodynamic forms of treatment. The present study intended to empirically evaluate this core tenet underlying psychodynamic psychotherapy and extend the results of earlier research by utilizing a context-sensitive investigative approach as suggested by various psychotherapy process researchers (Binder & Strupp, 1997; Greenberg, 1986; Hill, 1990; Winston et al., 1993). Specifically, the present work sought to measure the effects of the amount of interpretation provided along with the effects of the moment-to-moment interpersonal process between patient and therapist before, during, and after such interventions were provided on the process of change within a sample of patients diagnosed with AVPD.

Several clear patterns emerged with respect to the associations between the amount of interpretation, patient–therapist interpersonal process surrounding interpretation, and patient change. First, as expected, raw frequency of interpretation was not found to be associated with any measure of patient outcome. On the other hand, higher concentration of therapist interpretation was associated with lower global ratings of patient functioning and higher levels of patient symptoms and interpersonal distress at treatment termination. This latter finding was somewhat surprising given that concentration of interpretation in and of itself has not been found to be a reliable predictor of patient outcome (e.g., Piper et al., 1986). However, as reviewed earlier, several studies have found that the effects of concentration of interpretation on patient outcome may depend on patients' pretreatment level of object relations (e.g., Connolly et al., 1999; Ogrodniczuk et al., 1999; Piper et al., 1991). Considering the study's sample, it is relevant to note that patients with personality disorders typically exhibit lower pretreatment levels of object relations than patients without personality disorders (Ogrodniczuk & Piper, 1999). Moreover, patients with low pretreatment levels of object relations tend to respond poorly to moderate-to-high levels of interpretive work, particularly when the focus of interpretation is on the therapeutic relationship (e.g., Connolly et al., 1999; Ogrodniczuk et al., 1999). Although patients' pretreatment level of

object relations was not directly used as a predictor variable in the present study, it could be that the AVPD patients had low quality of object relations, and that this variable accounted for the inverse relationship found between concentration of interpretation and favorable outcome. As stated earlier, however, therapists in the present study rarely focused directly on the therapeutic relationship when making interpretations, and Høglend (1996) has found that interpreting aspects of patients' lives outside the here-and-now therapeutic relationship can be useful for patients with personality disorders. At a minimum, the current findings suggest that clinicians should refrain from using a high concentration of interpretation with patients with AVPD at such an early stage of treatment.

The results also suggest that therapists should be mindful of the interpersonal manner and context within which their interpretations are provided. The data generated from the coding of early sessions for interpersonal process with the SASB were generally consistent with predictions that the degree to which exchanges between patient and therapist immediately before, during, and after interpretation are affiliative or disaffiliative can be differentially predictive of patient change. We find it interesting that many of the effects found with the SASB that were in the predicted direction occurred with the level of disaffiliation in patient and therapist process, despite the fact that the overall proportions of disaffiliative therapist and patient process before, during, and after interpretations were quite low. Prior to interpretation only 0.6% ($SD = 1.2\%$) of therapist communications and only 0.2% ($SD = 0.5\%$) of patient communications were disaffiliative. During interpretation only 2.1% ($SD = 3.9\%$) of therapist communications were disaffiliative. And immediately following interpretation only 0.7% ($SD = 1.4\%$) of patient communications were disaffiliative. Taken together, the results provide clear support for the importance of interpersonal transactions early in therapy during which interpretive techniques are being used. Moreover, the findings are consistent with the results of Henry and colleagues, who suggested that while the absence of disaffiliative patient or therapist process may not be sufficient for therapeutic change, the presence of even low levels of such disaffiliative interpersonal process may be sufficient to preclude patient change (Henry et al., 1990, p. 773).

The series of post hoc correlations between concentration of interpretation and SASB interpersonal process variables also suggest the importance of measuring the impact of therapist interpretive techniques within their interpersonal contexts. Analyses revealed several statistically significant associations between the amount of interpretation provided and the precise nature of patient–therapist interpersonal process before, during, and after interpretations. Specifically, therapists who persisted with interpretive interventions appeared to have significantly more hostile interaction sequences with their patients and had their patients react to interpretation with significantly less warmth than therapists who used interpretations more judiciously. These findings are consistent with the observations of Piper et al. (1999), who described disaffiliative transactions between therapists and patients during those sessions with the highest concentration levels of interpretive interventions.

It is our contention that these findings are noteworthy from a scientific as well as from a clinical standpoint. First, technical and relational aspects of psychodynamic psychotherapy, which have historically been difficult to operationalize and thus rarely empirically tested, were not only reliably assessed in our study but also meaningfully linked to patient change. Second, surprisingly small amounts of disaffiliative process were found to have a rather dramatic negative impact on treatment outcome. Third, the overall patterns found between concentration of interpretation, patient–therapist interpersonal process, and treatment outcome emerged from studying very early sessions of psychotherapy. Fourth, in contrast to those who may recommend actively using interpretation, particularly transference interpretation, our data suggest that clinicians need to be more actively mindful of the frequency, interpersonal manner, and relational context within which interpretations are offered.

Indeed, our results appear to lead to some practical clinical recommendations for therapists who may be involved in the treatment of patients with AVPD. In order to promote therapeutic change the therapist should refrain from using a disproportionate concentration of interpretations early in treatment. Interpretations should not be made under poor interpersonal contexts, that is, when the therapist and patient are engaging in disaffiliative interaction patterns, and the interpretations themselves should be devoid of disaf-

filiative process. Finally, the interpersonal reaction of the patient to interpretation should be monitored by the therapist and used as a potential marker as to whether he or she should proceed with further interpretive work or engage in alternative modes of intervening (e.g., supportive techniques). Although the strength of the relationship found between patient reaction to interpretation and outcome was relatively weak with the exception of the BAI, a consistent affiliative response by the patient to interpretation may be indicative of eventual positive outcome, whereas a consistent disaffiliative patient response may be indicative of eventual less positive outcome.

These findings, obviously, do not imply that interpretations should be avoided altogether in the treatment of patients with AVPD. On the contrary, interpretations that were provided in small concentrations under mutually affiliative therapist–patient interactions were generally associated with positive patient change. What the take home message appears to be is that the therapist should carefully consider the degree to which interpretations make up his or her overall intervention strategy as well as the interpersonal manner and relational context in which such interventions are used in the early stages of treatment of patients with AVPD.

Although speculative, it may be that the links found between high concentration of interpretation and negative therapist–patient process before, during, and after interpretation reflect the matrix of transference-countertransference dynamics stemming, in part, from these patients' habitual modes of relating. As described by Benjamin (1996), patients with AVPD often rely on social withdrawal and fearful restraint as a defensive adaptation to early experiences of being blamed, belittled, and/or rejected. Perhaps some of the therapists in our study may have unwittingly been pulled to disaffiliatively engage with patients via interpretation during moments when patients were becoming increasingly walled off from them, leading these patients to feel attacked by their therapists. Those therapists who persisted with interpretation may have then attempted to use the intervention to reengage the patient and/or repair a perceived rupture in the therapy relationship as a result of the initial interpretation(s), but, as our data suggest, such a strategy only exacerbated patient negative process, and, in turn, exacerbated therapist disaffiliativeness. Of course, it may be that the content of some of the interpretations themselves were experienced by some of the patients as accusatory. As described by Wile (1984), interpretations that are derived from theoretical views of the patient as being defensive, avoidant, and so forth, may serve to perpetuate patient self-criticism and increase disengagement between therapist and patient.

Binder and Strupp (1997) argue that negative exchanges between patients and therapists that involve overt or covert hostility, such as those found in the present study, may be unavoidable aspects of the therapy process. The key is whether such processes can be readily identified and managed therapeutically early enough in treatment so as to prevent further disengagement between patient and therapist from taking place. Clearly, the presence and impact of disaffiliative process early in the treatment of these AVPD patients suggests that therapists need to closely monitor their reactions to patients during the initial stages of the therapeutic process and be careful not to provide interpretations in a manner or negative interpersonal context that serves to maintain patients' disaffiliative self-states and interpersonal schemas. As described by Benjamin (1996), therapists working with patients with AVPD should be particularly sensitive to interactions in which they notice themselves feeling pulled to either ignore or blame the patient for his or her situation.

How might therapists come to readily identify and manage disaffiliative transactions in their therapeutic work with patients? This issue is of great significance given that previous research has found that projects designed specifically to help therapists detect and manage such negative interactions in session have not been particularly successful (Henry, Strupp, Butler, Schacht, & Binder, 1993). According to several authors (Binder & Strupp, 1997; Constantino, Castonguay, & Schut, 2001; Safran & Muran, 2000), one therapeutic strategy that shows great promise is the process of metacommunication. In metacommunication, the therapist processes his or her observations with the patient about their here-and-now interaction, which entails having both parties examine their own contribution to the unfolding of the relationship. In many ways metacommunication serves as a "disarming" strategy (Burns, 1990) in that it suggests to the patient that he or she is not the sole contributor to ruptures in the therapy process. However, as discussed by Binder and Strupp (1997), metacom-

munication is a complex skill that is difficult to acquire without substantial practice and supervision, as it requires that the therapist first be able to observe process as he or she is participating in it and then devise helpful strategies while he or she is engaged with the patient in the therapy hour. Binder and Strupp (1997) thus suggest that clinical researchers continue to intensively study sequences of therapist–patient interaction in cases where disaffiliative process is successfully and unsuccessfully managed in order to increase the field's understanding of the nature of negative process and the specific skills required to manage it (Binder & Strupp, 1997, p. 135).

Although coming from a tradition of understanding and effectively managing therapist countertransference, Gelso and Hayes (2001) have argued that five factors need to be considered and monitored in order to reduce the likelihood of therapist "acting out" negatively toward the patient, and thereby hindering the treatment process. They are: therapist self-insight (the extent to which the therapist is aware of his or her own feelings and their origins), therapist self-integration (the degree to which the therapist has a healthy character structure), anxiety management (the extent to which the therapist can experience anxiety but not let it take hold of his or her interventions), empathy (the extent to which the therapist can climb into the patient's world), and conceptualizing ability (the capacity to understand patient and therapy dynamics).

Given our data and the extant reviews of therapy process, it may be that therapists who find themselves entrenched in negative therapeutic process, the roots of which may stem from transference-countertransference dynamics or interpersonal complementarity, might need to first step back, offer validation to the patient of their present moment experience, including an acknowledgment of the therapist's own contribution to the patient's upset, and be open to refraining from offering interpretations of the patient's experience until more mutually affiliative transactions ensue.

Conceptual Issues and Limitations of the Present Study

Although the results suggest that clinicians need to be more actively mindful of the frequency, manner, and interpersonal context within which they offer interpretation, several caveats and limitations of the study warrant discussion. First, the results should be considered very preliminary given the small sample size and therefore low statistical power. On the one hand, with increased power perhaps more of the analyses would have been statistically significant. On the other hand, a large number of tests were conducted using a small N, and thus some of the findings reported above may be due to chance. In other words, while the findings as a whole form a cohesive and predicted pattern, one has to be tentative in making generalizations about the results. Second, it is possible that therapists varied in other important dimensions of interpretation. For example, it is not clear to what extent therapists were accurate in their interpretations or to what extent therapists offered interpretations of various depths (e.g., therapists may have differed in the degree to which their interventions highlighted highly defended material, archaic fantasies, preoedipal wishes and fears, etc.). Therapists might have varied in accuracy and/or depth of their interpretations, which, in conjunction with concentration, patient quality of object relations, and/or patient–therapist interpersonal process, led to the pattern of results. Third, it is unclear why therapist affiliation prior to interpretation was inversely associated with favorable outcome on the BAI and BDI. Although this unexpected finding could have been due to chance, future research should examine whether such results replicate. Specifically, given that the affiliation score reflects an aggregate of therapist actions and reactions, qualitative and quantitative studies should be conducted in order to delineate what specifically is taking place when therapists engage affiliatively with their patients prior to using interpretations. One possibility is that the therapists in the present study were too accepting and not challenging enough to help patients face their interpersonal fears and avoidant behaviors and that such responses resulted in poor change on the BAI and BDI (cf. Barber & Muenz, 1996). Other statistical techniques, such as sequential analyses, could be used to explore the moment-by-moment interaction sequences between patients and therapists to address this issue.

Future researchers should begin to address these conceptual and methodological issues and find more creative ways to examine the role and impact of patient and therapist interpersonal process associated with interpretation on the outcome of psychodynamic psychotherapy. Doing

so will allow psychodynamic clinicians to have something that they have lacked thus far in their work with patients: empirical evidence supporting the use and parameters of interpretive interventions. Continuing this line of research will also address the need to investigate the individual and combined roles of technical and relationship factors in effective forms of psychotherapy, a major concern voiced by numerous psychotherapy researchers (Hill, 1990).

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