AN EXPLORATION OF OBJECT RELATIONS AND THE EARLY WORKING ALLIANCE
IN A UNIVERSITY CLINIC SAMPLE

Kristin M. Niemeyer, M.S.

Dissertation Prepared for the Degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

August 2004

APPROVED:

Sharon Rae Jenkins, Major Professor
Randall J. Cox, Committee Member
Patricia L. Kaminski, Committee Member
Shane Koch, Committee Member
Linda Marshall, Chair of Psychology Department
Sandra L. Terrell, Dean of the Toulouse School of Graduate Studies

The current study investigated the relationship between clients’ object relations functioning and the working alliance. The Social Cognition and Object Relations Scale (SCORS; Westen, 1991), an object relations scoring system for the Thematic Apperception Test (TAT), was used to assess object relations functioning. Forty-eight therapy clients at a university-based training clinic were administered the TAT, Adult Attachment Scale (AAS), Symptom Checklist 90-Revised® (SCL-90-R®) instrument (L. Derogatis, Riderwood, MD), and the short form of the Marlowe-Crowne Social Desirability Scale (MCSD; Crowne & Marlowe, 1960). Following the initial assessment of client characteristics shortly after intake, clients and their therapists rated the working alliance 3 sessions later. Results indicated that the SCORS was significantly correlated with client and therapist ratings of the working alliance. The current study also assessed the predictive validity of the SCORS by examining how its various scales are related to aspects of the working alliance and the other measures used in this study. The findings suggest that the relationship between object relations functioning, the working alliance, symptom severity, and attachment disturbance depends on the aspect of object relations that is being assessed.
ACKNOWLEDGMENTS

I would like to thank those whose help made completion of this dissertation possible. Jessica Mitchell was responsible for collecting data from 15 participants when I was unable to continue collecting data due to internship. Laura Howe and Lauren Dobbs put in a large amount of time coding the TAT stories and deserve significant credit. I would also like to thank the graduate therapists who volunteered to participate and helped to identify potential clients for participation. Sharon Rae Jenkins also deserves thanks for all of her support and encouragement.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>ii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
<tr>
<td>CHAPTER 1: INTRODUCTION</td>
<td></td>
</tr>
<tr>
<td>1. Overview</td>
<td>1</td>
</tr>
<tr>
<td>2. The Alliance in Psychotherapy</td>
<td>2</td>
</tr>
<tr>
<td>3. Research and the Working Alliance</td>
<td>6</td>
</tr>
<tr>
<td>4. Contributors to the Working Alliance</td>
<td>18</td>
</tr>
<tr>
<td>5. Interpersonal Functioning and the Working Alliance</td>
<td>25</td>
</tr>
<tr>
<td>6. Object Relations and the SCORS</td>
<td>34</td>
</tr>
<tr>
<td>7. The Proposed Study and Hypotheses</td>
<td>51</td>
</tr>
<tr>
<td>CHAPTER 2: METHOD</td>
<td></td>
</tr>
<tr>
<td>1. Participants</td>
<td>56</td>
</tr>
<tr>
<td>2. Measures and Materials</td>
<td>57</td>
</tr>
<tr>
<td>3. Procedure</td>
<td>62</td>
</tr>
<tr>
<td>CHAPTER 3: RESULTS</td>
<td></td>
</tr>
<tr>
<td>1. Descriptive Analyses</td>
<td>67</td>
</tr>
<tr>
<td>2. Hypothesis Testing Analyses</td>
<td>72</td>
</tr>
<tr>
<td>3. Research Questions</td>
<td>77</td>
</tr>
<tr>
<td>CHAPTER 4: DISCUSSION</td>
<td></td>
</tr>
<tr>
<td>1. Research Questions/Exploratory Analyses</td>
<td>87</td>
</tr>
<tr>
<td>2. Additional Findings</td>
<td>94</td>
</tr>
</tbody>
</table>
3. Summary of Findings................................................................. 97
4. Implications for Research and Clinical Practice.............................. 100
5. Limitations............................................................................. 106
APPENDICES............................................................................... 111
REFERENCE LIST....................................................................... 149
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Demographic Characteristics of Client Sample</td>
<td>112</td>
</tr>
<tr>
<td>2.</td>
<td>Clients’ Previous Therapy Experience</td>
<td>113</td>
</tr>
<tr>
<td>3.</td>
<td>Number of Clients per Therapist</td>
<td>114</td>
</tr>
<tr>
<td>4.</td>
<td>Average Reliabilities for SCORS Variables Across TAT Cards</td>
<td>115</td>
</tr>
<tr>
<td>5.</td>
<td>Expected and Observed Means and Standard Deviations</td>
<td>116</td>
</tr>
<tr>
<td>6.</td>
<td>Correlations between Time 1 Variables</td>
<td>117</td>
</tr>
<tr>
<td>7.</td>
<td>Correlations Among SCORS Subscales Controlled for Story Length</td>
<td>118</td>
</tr>
<tr>
<td>8.</td>
<td>Correlations Among Patient and Therapist CALPAS Scores</td>
<td>119</td>
</tr>
<tr>
<td>9.</td>
<td>Correlations between Time 1 Variables and SCORS Variables</td>
<td>120</td>
</tr>
<tr>
<td>10.</td>
<td>Summary of Hierarchical Regression Analysis for Variables Predicting GSI</td>
<td>121</td>
</tr>
<tr>
<td>11.</td>
<td>Correlations between CALPAS-P and SCORS Variables</td>
<td>122</td>
</tr>
<tr>
<td>12.</td>
<td>Correlations between CALPAS-T and SCORS Variables</td>
<td>123</td>
</tr>
<tr>
<td>13.</td>
<td>Summary of Hierarchical Regression Analysis for Variables Predicting CALPAS</td>
<td>124</td>
</tr>
<tr>
<td>14.</td>
<td>Summary of Hierarchical Regression Analysis Comparing SCORS and GSI as CALPAS Predictors</td>
<td>125</td>
</tr>
<tr>
<td>15.</td>
<td>Summary of Hierarchical Multiple Regression Analysis of CALPAS-P on Story Length, Social Desirability, Symptoms, Attachment, and Object Relations</td>
<td>126</td>
</tr>
</tbody>
</table>
16. Summary of Hierarchical Multiple Regression Analysis of CALPAS-T on Story Length, Social Desirability, Symptoms, Attachment, and Object Relations ................................................................. 127

17. Correlations between Predictor Variables and CALPAS-P .................. 128

18. Correlations between Predictor Variables and CALPAS-T .................. 129
CHAPTER 1

INTRODUCTION

Overview

The formation of a strong working alliance has been identified as one of the crucial ingredients for successful psychotherapy across theoretical orientations. Given the important role of the working alliance, it is necessary to identify client variables that might contribute to a successful working alliance so that therapists can formulate their interventions with these variables in mind. The client’s capacity to engage in a healthy relationship has been identified as a key variable that contributes to early working alliance formation. However, there is a need for assessment tools that can better identify the relationship between client interpersonal functioning and the working alliance. In order to address this question, the current study will evaluate the relationship between the Social Cognition and Object Relations Scale (SCORS), an object relations scoring system for the Thematic Apperception Test (TAT), and the working alliance.

Because object relations involve the affective and cognitive processes that mediate interpersonal functioning, it seems apparent that an individual’s object relations functioning would be directly applicable to the psychotherapy relationship. Although they have been used infrequently in the alliance literature, projective measures such as the TAT may provide information about relationship functioning that is less susceptible to defensive styles or self-presentation biases. The SCORS may be an ideal measure to assess object representations as they relate to the working alliance because it was designed to assess the multi-dimensional nature of object relations.

This literature review is organized into five major sections. The first section will trace the developmental history of the alliance concept. The second section includes a description of
current working alliance measures and a review of the working alliance literature. The
importance of early working alliance formation will be highlighted because of its relevance to
the current study. The third section will review variables that have been investigated as
contributors to the development of the working alliance. Next, the fourth section of this review
will focus on the link between aspects of clients’ interpersonal functioning and the development
of the working alliance, a topic that is central to the current study.

In the final section I will make a connection between object relations theory and the
working alliance. Finally, the TAT and the SCORS system will be presented as an ideal method
for assessing object relations as they relate to the working alliance.

The Alliance in Psychotherapy

*The Alliance in Psychotherapy: Historical Conceptualizations*

The concept of the therapist-client relationship as an important factor in psychotherapy
can be traced back to the writings of early psychoanalytic theorists. Although Freud primarily
focused on the neurotic transference, he identified another type of transference that was
categorized by the friendly and affectionate feelings that the client had toward the analyst.
Freud (1913) believed that the therapist should not interpret these feelings, rather, they could be
used to help interpret the neurotic transference. Freud would go on to suggest that the client’s
attachment to the analyst was a major first step in successful treatment; “it remains the first aim
of the treatment to attach him (the client) to it and to the person of the doctor” (pp. 139-140).

It was not until the later analytic writers that the attachment of the client to the therapist
was viewed as a real aspect of the relationship that was separate from the irrational and
transferential aspects. Sterba (1934) approximated the modern conception of the working
alliance by identifying an “ego-alliance.” This term referred to the alliance between the “reasonable” aspects of both patient and therapist. Sterba emphasized the importance of the patient’s capacity to work in psychotherapy and proposed that the ego-alliance allowed the therapist and client to overcome the obstacles of resistance and countertransference. Zetzel (1956) introduced the term “therapeutic alliance” and described this phenomenon as a repetition of the positive aspects of the mother-child relationship. She also believed that the alliance depended on the patient’s basic trust in relating to others, mature ego functioning, and the therapist’s participation and partnership.

While the psychoanalysts were placing more emphasis on the role of the therapeutic relationship, early behaviorists emphasized the role of techniques, suggesting that interpersonal factors were, at most, “placebo-like.” The therapist’s role was simply to serve as a coach and the therapist’s contribution was measured in terms of the technical expertise that he or she had to offer (Horvath, 2000). One important reason for the behaviorists’ attitude towards the therapy relationship is that it is difficult to operationalize and observe, especially compared to techniques and other more observable behavior. Later behaviorists, such as Goldfried (1982), developed a more positive view of the role of the relationship in psychotherapy. The quality of the relationship between therapist and client was believed to increase the likelihood that the client would comply with homework and other tasks. Thus, the relationship in psychotherapy was beginning to be conceptualized as important to some behaviorists but certainly not as a change mechanism in and of itself.

In the 1950’s, Carl Rogers, the leader of the humanist movement, provided a strikingly different conceptualization of the role of the relationship in psychotherapy. In his influential 1957 paper, Rogers stated that the therapist’s ability to provide empathy, congruence, and
unconditional positive regard was both necessary and sufficient for bringing about change, regardless of the theoretical orientation of the therapist. For Rogers, the relationship was not just important, he believed that it was the primary mechanism through which change occurred in psychotherapy. In fact, Rogers believed that because the therapist’s ability was sufficient to produce change, it was not necessary to consider the diagnosis of the client (Kahn, 1991). This viewpoint is considered extreme by most modern theorists, who believe that it is necessary to consider client characteristics as well as therapist characteristics in determining the success of psychotherapy. Extensive research has generally shown that Rogers’ three factors are not sufficient for successful psychotherapy (Gelso & Hayes, 1998). Regardless of his seeming over-emphasis on the role of the therapist, Rogers’ work contributed significantly to a new understanding of the relationship in psychotherapy.

The Working Alliance

The notion of a working alliance captures the collaborative aspect of the relationship in psychotherapy. Greenson (1967), a psychoanalytic theorist, was first to use the term “working alliance” and believed that it should be given equal importance with the transference. Greenson (1967) distinguished between the neurotic or transferential relationship and the working alliance by referring to the working alliance as the aspect of the therapist-client relationship that enables the patient to identify with the analyst’s point of view and to work with the analyst despite transference reactions. Although Greenson was the first to use the term “working alliance,” it was not until Bordin (1979) that this concept was viewed apart from psychoanalytic theory and was generalized to other forms of therapy. The impetus for the extension of the working alliance concept across forms of therapy is described briefly below.
Horvath (2000) provides a good overview of the events leading up to the birth of the modern conceptualization of the working alliance. He describes a growing emphasis on developing psychotherapy outcome research starting in the 1950s, partly resulting from Eysenck’s (1952) claim that dynamic therapy may be no more effective than placebo conditions. Research programs were developed with the intention of improving methodology in order to compare the efficacy of different forms of therapy. The result of numerous of these so-called “horse race” studies was that, by the 1970s, there was growing awareness that no one form of therapy could claim superiority (Bergin & Garfield, 1994). Because different therapies appeared to be essentially equal in their efficacy, research efforts were soon directed towards identifying the common factors that contribute to successful therapy across theoretical orientations. The therapeutic alliance was identified as one of these factors and there was a push towards developing an alliance concept that could be applied across different forms of therapy. This concept would be come to be the working alliance.

Although it was Greenson (1967) who was the first to use the term “working alliance,” Bordin (1979) is responsible for promoting and providing a cross-theoretical definition of the working alliance. Bordin refers to his concept of the working alliance as a “collaboration for change” with three different aspects: mutual agreement on tasks, mutual agreement on goals, and the affective bond between therapist and client (Bordin, 1979). Bordin explicitly states that his use of the term working alliance is intended to be a general description of the therapeutic alliance, which is applicable to all forms of psychotherapy, not just psychoanalytic therapy. He also noted that the working alliance is not only a means of integrating various forms of therapy but also served as a description of the process of change that takes place in psychotherapy (Bordin, 1979).
Mutual agreement on goals, the first aspect of Bordin’s proposed working alliance, refers to both the “clarity” and the “mutuality” of the agreement between therapist and client about the desired changes that will occur in therapy. The next aspect, mutual agreement on tasks, is also clear and refers to the agreement on how these goals will be obtained. Bordin (1979) emphasizes that it is necessary for the client to understand the connection between the assigned tasks and the goals. In addition, the client must be able to complete the tasks or the therapist must be able to modify tasks in order to fit each individual client. The third aspect of the working alliance, the quality of the bond between therapist and client, refers to “the feelings of liking, caring, and trusting that the participants share” (p. 36). The bond aspect of the alliance is intended to capture the more affective part of the alliance, whereas the tasks and goals aspects refer to the more cognitive dimensions (Gaston, 1990). Bordin’s definition of the working alliance can be applied to many forms of therapy because it allows for the possibility of numerous different kinds of tasks and goals across theoretical orientations by not specifying the nature of the tasks and goals that are required.

Research and the Working Alliance

*Measuring the Working Alliance*

After the concept of the working alliance was proposed by Bordin, multiple theorists began to formulate their own operational definitions with the goal of developing research measures. There has been some controversy over the proper definition of the working alliance, especially regarding its different components. For instance, Frieswyk et al. (1986) prefer to define the alliance in terms of the patient’s active collaboration in the tasks of treatment, whereas Luborsky (1976) emphasizes the client’s perception of the therapist as being helpful. According
to Gaston (1991), this divergence exists in large part because the concept of the working alliance is not embedded within a particular theory of change. To further the confusion, the working alliance is sometimes referred to with multiple terms “often meaning the same thing and yet often meaning somewhat different things” (Gelso & Hayes, p. 27). These terms include working alliance, therapeutic alliance, helping alliance, and simply, the alliance. Gelso and Hayes (1998) use the term working alliance because it captures the idea of the therapist and client coming together for the work of therapy.

There have been numerous measures developed to capture the concept of the working alliance in action. The first measures were designed to be rated by judges who viewed videotapes of therapy sessions. Later, researchers developed measures that could be rated by both therapist and client. Most measures were constructed by developing items that reflected aspects of the working alliance, administering the items, and using factor analysis to identify underlying dimensions. Four major alliance scales were developed as part of different psychotherapy research programs in the 1980s. These measures include the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983), the Penn Helping Alliance Rating Scale (Penn; Alexander and Luborsky, 1986), the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986), and the California Psychotherapy Alliance Scales (CALPAS; Marmar, Gaston, Gallagher, & Thompson, 1989).

The VTAS was developed from the Vanderbilt Psychotherapy Process Scale (VPPS; Strupp, Hartley, & Blackwood, 1974), which measures various aspects of the therapy process from the perspective of clinician observers listening to taped therapy sessions. Hartley and Strupp (1983) developed the VTAS specifically to measure the working alliance. The items on the VTAS were based on the work of several theorists including Bordin (1976), Greenson
Like the VPPS, the VTAS is rated by two judges and contains three components including contributions of the patient, contributions of the therapist, and the interaction between patient and therapist.

The Penn is based on Luborsky’s (1976) conception of the working alliance, which he referred to as the “helping alliance.” It consists of two types of alliance: the patient’s perception of the therapist as providing the needed help (Ha1), and the patient’s experience of treatment as a collaboration with the therapist on the goals of treatment (Ha2). Both scales are rated by trained judges using a 10-point rating system. Compared to other measures, the Penn focuses more on the client’s perception of the experience of therapy rather than the collaborative aspects of the working alliance (Tichenor & Hill, 1989). The Penn is also the shortest alliance instrument with a total of 10 items.

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) was modeled directly after Bordin’s three components of the working alliance. The three factors are Bond, Agreement on Goals, and Agreement on Tasks. The WAI has three parallel forms to be rated by the client, the therapist, or an observer. The factor structure of the WAI has generally not been supported. Specifically, the Agreement on Goals and Agreement on Tasks factors appear to be highly correlated and it has been suggested that they can best be conceptualized as one factor (Gaston, 1991).

The California Psychotherapy Alliance Scale (CALPAS; Marmar, Gaston, et al., 1989) will be described in more detail because it will be used as a measure of the working alliance in this study. The CALPAS has four dimensions including Patient Commitment (PC), Patient Working Capacity (PWC), Therapist Understanding and Involvement (TUI), and Working Strategy Consensus (WGSC). The four subscales were designed to address the separate
contributions of the client and therapist to the alliance and the extent of mutual agreement on the working strategies and goals of therapy. The researchers who developed the CALPAS were particularly interested in combining definitions of alliance from various theoretical perspectives to form a comprehensive alliance measure. The PC and PWC scales reflect dimensions emphasized by Greenson (1967) and Zetzel (1956), TUI captures the aspect of the alliance emphasized by Rogers (1957) and WGSC reflects the collaborative aspect of the alliance emphasized by Bordin (1979). The CALPAS has parallel versions that are rated by the client (CALPAS-P), therapist (CALPAS-T), or an observer (CALPAS-O) on a 7-point scale.

Patient Commitment was designed to reflect the capacity of the client to value coming to therapy, to perceive hope, and to sustain a view of the therapy as worthwhile in the face of momentary confusion, doubt, or mistrust. Patient Working Capacity describes the client’s capacity to disclose important material in therapy, not to feel criticized by the therapist, and to make use of the therapist’s comments to see difficulties from a new perspective. Therapist Understanding and Involvement (TUI) reflects the therapist’s capacity to understand the client’s point of view, to demonstrate a nonjudgmental acceptance of the client, and not to use therapy for his or her own needs. Working Strategy and Consensus measures the patient-therapist agreement on goals and how therapy should proceed.

Gaston (1991) found support for the criterion-related validity of the Patient version of the CALPAS, the CALPAS-P. This measure was not associated with a number of therapist variables that the author did not expect it to be related to, including therapist gender, theoretical orientation, or number of years in practice. In addition, the CALPAS-P was not associated with a client-rated measure of social desirability. The PC, PWC, and WSC scales were negatively correlated with global adjustment, as measured by the Symptom Checklist-10 (SCL-10), or
problems with intimacy on the IIP Intimate scale. All CALPAS-P scales were related to a measure of patient satisfaction with treatment. The CALPAS-P scales were only moderately correlated with each other, providing some support to the notion that they reflect relatively independent aspects of the alliance.

Although all of these alliance measures are intended to reflect distinct definitions of the working alliance, there is a general agreement that they are all designed to measure the collaboration between client and therapist and the capacity of the client and therapist to agree on a contract for therapy (Horvath & Symonds, 1991). In their meta-analysis, Horvath and Symonds (1991) grouped studies using the same “families” of instruments and found that effect sizes were homogeneous within the families but differed across families. The authors stated that unique aspects of the alliance are being tapped by the different instruments and they emphasized a need to investigate the differences in the theoretical underpinnings of the different alliance instruments. However, other studies have found that different alliance measures are highly intercorrelated (Tichenor and Hill, 1989). It would make sense that there would be some difference between measures because they are based on somewhat different definitions of the alliance and the various studies used different client populations.

Working Alliance and Therapy Outcome

The notion of the working alliance was originally conceptualized by Bordin as a key ingredient for successful psychotherapy. There has been consistent evidence that the formation of a positive working alliance contributes significantly to outcome in both brief and long-term psychotherapy. Horvath and Symonds (1991) conducted a meta-analysis of 24 studies that related the quality of the working alliance to therapy outcome. They found an overall effect size of .26 between a good working alliance and positive therapy outcome. The authors described
this relationship between alliance and outcome as “moderate but reliable” and noted that it may represent a conservative estimate of effect size because they were highly selective in including studies in their meta-analysis. Results of the meta-analysis indicated that the relationship between alliance and outcome was not a function of length of treatment, type of therapy, or whether the research was published. Overall, this important study confirmed that the alliance is a robust factor in treatment outcome across a variety of dimensions. According to Greenberg and Pinsof (1986), “what is particularly impressive is the capacity for the Alliance to be related to outcome when it is being measured in so many different ways at different research centers on different types of therapy” (p. 11).

An important question in studying the relationship between alliance and outcome is how this relationship changes based on the source of the alliance rating (client, therapist, or observer). Studies have typically found that clients’ ratings of alliance are more predictive of outcome than either observer or therapist ratings. Horvath and Symonds (1991) found that in 9 of 13 studies in which alliance was rated by more than one source, clients’ ratings of alliance were superior predictors of outcome. Furthermore, four out of six studies reported observer ratings of alliance as superior predictors compared to therapist ratings.

In general, studies have found surprisingly low correlations between client and therapist ratings of the alliance, with client ratings of the alliance typically higher than therapist ratings (Bachelor & Salame, 2000; Tryon & Kane, 1993). Tryon and Kane (1993) suggest that this lower than expected convergence between client and therapist ratings may be due to the different sources of comparison that clients and therapists use. For example, the client compares the alliance to relationships outside of therapy and the therapist compares ratings to the alliance with other clients. Thus, the client may be more accurate in rating the alliance because he or she has
more information about how the therapy relationship compares to his or her experience outside of therapy. It has also been suggested that this discrepancy may reflect the degree to which the therapist misjudges the client’s experience of the relationship (Horvath, 2000). If the therapist misjudges the alliance, he or she is also likely to miss the need to make interventions that might strengthen the alliance.

Despite the potential problems associated with therapists’ misperceptions of the alliance, few studies have focused on better understanding how the therapist perceives the alliance. In a review of the existing literature, Hatcher (1999) reported that the therapist’s sense of the patient’s active, confident involvement in treatment is the aspect of therapist-rated alliance that is most closely related to outcome, as rated by patients and observers. Bachelor (1991) reported that these features of the alliance also appear to be the most important to the therapist’s sense of the client’s progress in treatment. Hatcher (1999) conducted an investigation that focused on the therapist’s views of the alliance using the WAI and the CALPAS. He created a scale called Therapist’s Confident Collaboration by combining aspects of the WAI and the CALPAS. This scale reflected the therapist’s confidence that the client is invested in treatment. Results indicated that therapist-rated Confident Collaboration was the most closely linked to the therapist’s sense of progress and also the most highly associated with patient-rated alliance measures compared to all other dimensions of therapist-rated alliance. In contrast, the two therapist-rated scales that related to the bonding aspects of the alliance (Bond and Therapist Understanding and Involvement) had the lowest association with both patient’s ratings of alliance and patient’s ratings of improvement.

Few studies have investigated how therapists and clients perceive the alliance differently. Dyke (1996) identified client characteristics that were differentially related to therapist-rated
alliance versus client-rated alliance on the WAI. Client-rated alliance was associated with a factor of the Adult Attachment Scale (AAS; Collins & Read, 1990) that measures the capacity to tolerate closeness with others, and problems with intimacy rated on the Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988) However, client-rated alliance was not associated with clients’ quality of object relations as measured by the Mayman Object Representation Scale or the overall severity of interpersonal problems on the IIP. In contrast, therapist alliance-ratings were associated with overall severity of interpersonal problems and the quality of object relations. In addition, therapist-rated alliance was not related to any aspect of the AAS or to ratings of symptom severity on the Global Assessment of Functioning Scale. These differences are intriguing and suggest that further investigation of these factors may illuminate important differences in the way therapist and their clients view their alliance. The current study will address this particular question.

Another important question in considering the role of the alliance in therapy outcome is whether the alliance plays a greater role in certain forms of therapy. Gelso and Hayes (1998) suggest that certain therapies are more “difficult” and place greater demands on clients and these types of therapy will require a stronger alliance than less difficult therapies. For example, they proposed that insight-oriented therapies that require self-exploration are more threatening for the client than action-oriented therapies. However, there is little research that investigates this question directly and the evidence does not support the notion that the alliance is more important in certain kinds of therapy.

In their meta-analysis, Horvath and Symonds (1991) investigated whether the type of treatment had a significant impact on the relationship between alliance and outcome. When comparing effect sizes between studies that used psychodynamic, eclectic, cognitive, and Gestalt
therapies, they found no significant differences in the relationship between alliance and outcome, indicating that type of treatment did not moderate the relationship between alliance and outcome. Thus, although the concept of the working alliance developed from psychoanalytic theory, there is little evidence to support the idea that the quality of the alliance is more important in analytic therapies. This finding supports the notion that the alliance is an important non-specific factor across theoretical orientations. Horvath (2000) noted that the question still remains whether certain therapies are more closely associated with different aspects of the alliance or whether individual clients are differentially challenged by certain demands. It appears that future researchers will attempt to identify whether the demands that certain therapies impose can be matched with the personal characteristics of the clients as Bordin (1979) predicted.

While the positive effect that the alliance has on outcome appears to be a clear finding, it is less clear exactly how the alliance affects outcome. Although a thorough review of this area of the alliance literature is beyond the scope of this dissertation, it is of interest to note several hypotheses reviewed by Gaston (1990) and Gelso and Hayes (1998). First, the alliance appears to be therapeutic in and of itself, regardless of other technical interventions. Second, the alliance appears to help the clients to be more receptive to the therapist’s technical interventions, whether this means “taking in” the therapist’s interpretations in analytic therapy or completing homework assignments in behavior therapy. A third way that the alliance may contribute to outcome is by serving as a buffer against the stress and strains that will occur during treatment. Generally it is agreed that the establishment of an alliance allows the client to engage in the more difficult work of therapy. The second two functions of the alliance suggest that it serves as a prerequisite for other aspects of treatment to occur; thus, it would logically follow that it is
important to establish an alliance early in treatment so that the rest of therapy will be successful. The importance of establishing an early alliance is reviewed below.

Course of the Working Alliance

One important area of focus in the research literature on the therapeutic alliance has been the development and course of alliance across sessions. A detailed understanding of how the alliance changes over time is likely to provide more information about the role that the alliance plays in outcome. According to Luborsky (1976), the alliance changes over time in response to different phases of therapy. Gelso and Carter (1994) as well as Horvath et al. (1993) suggest that the course of the alliance is characterized by an initial increase during approximately the first five sessions followed by a second phase in which the alliance weakens as the therapist challenges the client’s maladaptive patterns. According to this theory, therapy will most likely be successful if the therapist and client repair the alliance after it is weakened by the therapist’s challenges. These authors also suggest that the alliance will return to a high level if it is repaired. From this perspective, the alliance is viewed as having a cyclical pattern in which it is high, then low, then high again. Numerous studies have investigated the course of the alliance by assessing the alliance at certain intervals and then identifying patterns of change. In a review of these studies, Bachelor and Salame (2000) noted that the findings are inconsistent in that some studies showed a linear increase in alliance and some support the cyclical model. Bachelor and Salame (2000) point out that results varied based on whether the client or therapist rated the alliance and according to different dimensions of the alliance. It is evident that the developmental process of the alliance is complicated and more sophisticated research is needed to clarify this question.

Although there is inconclusive evidence about the developmental course of the working alliance, there is strong consensus that it should be established early in treatment (Hartley and
Findings have generally indicated that ratings of the working alliance that are made early in
treatment (1-5 sessions) are predictive of alliance across treatment, and there is typically little
change after the fifth session (Horvath and Symonds, 1991). Klee, Abeles, and Mueller (1990),
using a sample of 30 individuals in short-term dynamic therapy, found that clients’ ability to
develop a working alliance in the first session is predictive of their capacity to maintain an
alliance throughout treatment. In a study that focused on the clients’ perspective, the working
alliance was largely determined by the first therapy session (Sexton et. al., 1996) As a result of
the strong evidence regarding the early formation of the working alliance, most studies have
chosen to measure it after the third session.

The empirical evidence that the working alliance is established early in successful
treatment is not surprising from a theoretical standpoint. The early analysts proposed that the
formation of the alliance is crucial in the beginning of therapy because it forms the basis for the
more difficult work of therapy to occur (Hartley & Strupp, 1983). Gelso and Hayes (1998)
suggest that it is necessary to establish a “good enough” alliance within the first few sessions in
order for therapy to progress. These authors make the point that the working alliance may need
to deepen after the initial sessions, however, it needs to initially be “good enough” so that
groundwork for the process of therapy is established. What happens if the therapist and client
fail to form a working alliance at the outset of treatment? According to Bordin (1979) and
Horvath (2000), the client might either drop out of therapy or will fail to commit the energy
necessary to change.

The issue of early client termination holds obvious importance because clients who do
not stay in treatment are less likely to show improvement. It is not uncommon in a variety of
mental health settings for nearly 50% of clients to leave treatment without informing their therapists (Pekarik, 1983). Studies examining the relationship between alliance formation and early client termination have reported inconsistent results. Hartley and Strupp (1983) found that alliance scores on the VTAS for a group of clients who left therapy by or before the fifth session did not differ from scores of those who remained in therapy. Kokotovic and Tracey (1990) supported these findings. They used the WAI to measure the alliance after the first session and found no relationship between client or therapist ratings of alliance and termination before the fourth session.

In contrast to the above findings, Tryon and Kane (1990; 1993; 1995) found that ratings of the working alliance did predict early client termination. In their first study, these researchers found that low client-rated working alliance on the Penn Helping Alliance Scale differentiated clients who terminated early and without the mutual agreement of their therapists from clients who stayed in therapy longer (Tryon & Kane, 1990). However, therapist-rated working alliance was not related to early versus later termination. The authors replicated these findings in a second study where both client and therapist-rated working alliance on the WAI differentiated clients who terminated unilaterally from clients who terminated mutually with their therapists (Tryon & Kane, 1995). The authors suggested that the discrepancy between their findings and those of other researchers may be related to the use of different alliance measures as well as to the effects of rating the alliance at different points in time. More research is needed in order to determine how early alliance might affect early termination and the later success of therapy. Despite the reasons for these findings, the relationship between working alliance and early termination remains unclear.
Another important implication of early working alliance formation concerns brief psychotherapy. Gelso and Hayes (1998) suggest that early alliance formation is especially important in brief therapy because the therapist does not have the luxury of developing a stronger alliance over a period of time. These authors state that the briefer the therapy, the earlier a “good enough” alliance needs to be formed so that work can proceed quickly. The relationship between brief therapy and working alliance formation is quite salient in the current climate of managed care. Gelso and Hayes suggest that it may become increasingly important for clinicians to identify factors that contribute to more rapid alliance formation in order to develop interventions that might speed the process. Because this area of the literature is such an important area of investigation and is relevant to this dissertation, it will be reviewed below.

Contributors to Working Alliance

Given the important role that early working alliance formation plays in successful treatment, it is evident that identifying factors that contribute to its formation is crucial. As the research that supports the contribution of the working alliance to outcome continues to accumulate, so does the research that investigates the question, “what makes a good working alliance?” The main areas that have been investigated include therapist characteristics, client characteristics, and studies that look at the congruence between certain patient and therapist characteristics.

Therapist Characteristics

Although there are currently few studies that focus on characteristics of therapists in isolation, Carl Rogers (1951) clearly viewed therapist characteristics as a key factor in determining the success of psychotherapy. According to Rogers (1951), the therapist’s ability to provide empathy, congruence, and unconditional positive regard was sufficient to bring about
change in psychotherapy. As noted earlier, this view likely places too much emphasis on the therapist and does not sufficiently account for the client’s perception of therapy. The results of numerous studies that tested Rogers’ hypothesis demonstrated that it is not the objectively measured level of therapist empathy, congruence, or unconditional regard but the client’s perception of these qualities that has the greatest impact on outcome (Horvath, 2000). Although it can be concluded that the therapist is not solely responsible for the alliance as Rogers proposed, it is important to consider the therapist’s role in contributing to the alliance. According to Gelso and Hayes (1998), therapist contributions to the alliance can be broken down into the two broad categories of technical activity and personal characteristics.

Therapist technical activity refers to the way that therapists interact with clients according to a theoretical position (Kivilighan, 1990). One therapist factor that is associated with technical activity is the therapist level of training. Mallinckrodt and Nelson (1991) proposed that therapists in the early stage of training may lack the technical skills for forming the most effective working alliances. In order to test this hypothesis, these authors grouped 50 counselors into three training levels: novices in their first practicum; advanced trainees in their second practicum through predoctoral internship; and experienced counselors and postdoctoral staff. Therapeutic alliance was measured using client and therapist ratings of the Working Alliance Inventory (WAI) after the third session. Findings indicated that there was no difference on the bond dimension of the WAI, but the task and goal ratings were significantly higher for the more experienced therapists. These findings held for both client and therapist ratings. The authors suggested that trainees may be better able to form bonds with clients than to collaborate on tasks and goals because this ability has more to do with personal characteristics of the therapist than technical skill.
Dunkle and Friedlander (1996), also using the WAI to measure working alliance across therapist experience level, found that experience level of therapists was not predictive of clients’ ratings on the goals and tasks components of the WAI. These authors suggested that their findings may have been discrepant with those of Mallincrodt and Nelson (1991) due to the greater number of therapists and more variance in experience level in their study. Despite the discrepant findings regarding early alliance formation, Horvath (2000) suggests that less trained therapists are more likely to misjudge the relationship, which may result in less ability to manage the alliance over the course of treatment. It may be that alliance is less affected by therapist training level in the earlier stages of treatment and becomes more important in the later phases.

Kivlighan (1990) investigated the impact of therapist intentions on the formation of the working alliance. Therapist’s intentions, which represent the reasons why therapists make particular interventions, were used as a measure of therapist technical activity. The Intentions List, a measure of 19 pantheoretical therapist intentions developed by Hill and O’Grady (1985), was rated by three judges who viewed tape recorded therapy sessions and compared to client ratings of WAI at the end of the second therapy session. Results indicated that the assessment, support, and explore intentions were significant negative predictors of client-rated working alliance. Kivlighan suggested that the assessment and explore intentions were probably associated with low ratings of alliance because they are associated with more therapist activity and may be overly intrusive during the very early phases of therapy. In contrast, it was less clear why the support intention was inversely related to positive alliance. The author suggested that the support intention may have placed the client in a more passive role where the working alliance involves therapist and client actively working together. While these findings are of
important clinical relevance, it should be noted that this study had significant threats to external validity because it used volunteer “clients” instead of actual patients presenting for therapy.

A small number of studies have investigated the impact of various therapist personal characteristics on the formation of the working alliance. According to Orlinsky and Howard (1986), therapists’ personal characteristics are most closely related to Bordin’s (1979) bond aspect of the alliance because of the interpersonal nature of this aspect of the alliance. Lawson and Brossart (2003) found that Dunkle and Friedlander (1996) assessed therapist level of perceived social support, degree of comfort with attachment, and self-directed hostility and clients completed the WAI between the 3rd and 5th sessions. As predicted, all three therapist variables were predictive of the bond component of the working alliance. Thus, clients whose therapists were more comfortable with closeness and reported less hostility and more social support, were more likely to report a strong emotional bond with their therapists early in treatment. The authors suggested that therapists’ own internalized expectations about relationships play a role in the formation of the working alliance, as do clients’ expectations, which will be reviewed extensively below.

Client Characteristics

Compared to the number of studies focusing on therapist characteristics, there have been far more studies investigating client contributions to the working alliance. The early psychoanalytic theorists held the view that certain patient pre-treatment characteristics were important in determining the development of the alliance. For instance, Zetzel (1956) believed that the mature functioning of the patient’s ego was the most important determinant of the patient’s contribution to the alliance. Other theorists have suggested that, on a more basic level, clients need to have a desire to grow and a willingness to cooperate with the therapist (Gelso &
Hayes, 1998; Hartley & Strupp, 1983). In line with clinical observations and theory, a range of client characteristics has been shown to be important in forming and maintaining sound alliances. On the other hand, and perhaps as informative, some characteristics have not been shown to have an impact on alliance formation.

One of the most important pre-treatment characteristics to consider in working alliance formation is the client’s level of symptom severity. It seems logical that clients with more severe symptoms might have a diminished capacity to develop a positive working alliance with the therapist. However, research has generally shown that client pre-treatment symptom level does not have a significant impact on alliance formation. Moras and Strupp (1982) found no relation between counselor ratings of overall psychological health and the establishment of a working alliance. Marmar et al. (1986) reported a lack of association between patient initial symptom severity and patient contribution to the alliance in brief dynamic therapy and Kokotovic & Tracey (1990) reported that clients’ ratings on the Problem Severity Rating Scale (a measure of overall adjustment) were not related to clients’ ratings of positive working alliance on the WAI in a sample of 144 clients at a university counseling center. Horvath (2000) suggests that these findings are hopeful because it may be that strengthening the alliance can at least partially compensate for the severity of client’s symptoms. More research may be needed to determine whether this lack of relationship holds for patients with more severe impairment versus samples taken from university counseling centers.

Various client personality characteristics and attitudes towards treatment have been found to have an impact on working alliance formation. Defensiveness has been identified as an important characteristic that affects the client’s contribution to the alliance (Gaston et al., 1988). Ryan and Cicchetti (1985) reported that a combined group of client variables including
psychological mindedness, hope for success, psychic pain, and intrapsychic flexibility accounted for 11% of the variability in alliance ratings. Kokotovic and Tracey (1990) found that therapist-rated client hostility, as measured by the Interpersonal Relationships Scale (IRS), was related to both client and therapist perceptions of poor working alliance. Most research on client pre-treatment characteristics has focused on a broad range of aspects related to interpersonal functioning. Because of the relevance of this literature to this dissertation, client interpersonal functioning will be reviewed in more depth in a later section.

Combined Factors

Because the working alliance is conceptualized as a collaborative construct, several investigators have attempted to look at therapist and client characteristics in combination. These studies are useful because researchers seek to capture the complex nature of the relationship between therapist and client. The researchers also attempt to understand how different therapist interventions may have different effects on certain types of clients. This knowledge could contribute to an increased ability for therapists to use techniques that maximize alliance formation with different clients. Despite the potentially useful information to be gained, few studies have included client and therapist variables in combination. This may be due to the complicated nature of these studies.

One question that would be useful to answer is whether certain therapist interventions interact with client characteristics to either hinder or strengthen the alliance. One such study found that, with highly motivated clients, the working alliance was strengthened by an examination of negative transference; however, with poorly motivated clients, the working alliance was strengthened by positive therapist attitudes (Horowitz et al., 1984). In a somewhat similar study, Piper et al. (1995) found different effects of therapists’ transference interpretations.
on the alliance in clients with high versus low quality of object relations. For clients with high quality object relations, as rated by a structured interview, high proportions of therapist transference interpretations were related to low ratings of alliance. For clients with low quality of object relations, proportion of therapist transference interpretations did not affect alliance ratings.

Another question worth answering is how the working alliance is affected by the level of congruence between therapist and client attitudes, values, and expectations. Gelso and Carter (1985) suggested that the congruence between the “world view” of the therapist and the client is likely to facilitate the working alliance. One aspect of the world-view involves different expectations that the client and therapist might have for therapy. Al-Darmaki and Kivlighan (1993) compared client and therapist ratings on the Psychotherapy Expectancy Inventory with ratings on the Working Alliance Inventory after the third therapy session. As hypothesized, results indicated that congruence in client and counselor expectations that the client will self-disclose in the context of an egalitarian relationship contributed significantly to positive client and therapist ratings of alliance. It would be interesting to extend this research by looking at client and therapist congruence on different types of expectations.

In summary, general measures of adjustment and symptom severity appear to be less predictive of the working alliance than particular characteristics such as client defensiveness and hostility. It has also been shown that certain client and therapist factors have interesting interaction effects on the working alliance. Of all client and therapist characteristics, the broad area of client pre-therapy interpersonal functioning has received the most research and may be the most important factor in determining the quality of the alliance. This area of the literature will be reviewed below.
Interpersonal Functioning and the Working Alliance

Because the working alliance involves two individuals working together in a relationship, it follows that the clients’ ability to form relationships should be a fundamental factor in forming the alliance. The early analytic theorists placed a great deal of importance on the client’s ability to form a secure attachment to the therapist. Zetzel (1956) argued that patients displaying high functioning object relations could develop good-enough alliances, and respond effectively to interpretations. In contrast, patients lacking basic trust in others needed more supportive interventions in order to foster a secure attachment to the therapist and to develop a capacity to work in treatment. With the development of time limited dynamic therapies and the influence of object-relations theory, there has been a growing emphasis on the importance of the social context in therapy that spreads beyond the analytic therapies (Horvath, 2000). A number of studies have investigated the link between relationship functioning and the alliance by assessing pre-therapy aspects of clients’ current relationship functioning, attachment styles, quality of object relations, or a combination of these variables.

Current Relationship Functioning

One way to assess clients’ ability to enter into a productive relationship with the therapist is to assess aspects of their current relationship functioning. Pre-therapy evaluation of a client’s interpersonal relationships is encouraged by brief dynamic therapists because of the importance of the client’s ability to form a therapeutic alliance quickly so that the work of therapy can proceed. Some of the important characteristics that brief dynamic therapists view as signs of suitability involve the presence of meaningful relationships that involve mutuality, emotional relatedness, and trust (Moras and Strupp, 1982). In one of the early studies investigating client contribution to the alliance, Moras and Strupp (1982) measured clients’ pre-therapy interpersonal
relations using a semi-structured interview conducted by an independent clinician. A combination of clinical ratings of current social relationships, family relationships, and hostile or resentful attitudes towards others were summed to provide an index of interpersonal relations. The authors reported that quality of clients’ interpersonal relations was a better predictor of alliance than psychological health and accounted for 25% of the variance in the Patient Involvement scale of the Vanderbilt Psychotherapy Process Scale (VPPS). These findings seem to support the idea that interpersonal functioning may have more of an effect on alliance formation than do global levels of symptom severity. However, this study is somewhat limited in that the participants were thirty-three males between the ages of seventeen and twenty-four.

Several other studies have investigated clients’ current relationship functioning, with mixed results. Gaston et al. (1988) assessed interpersonal functioning in a sample of depressed elderly patients across behavioral, cognitive, and brief dynamic therapies. Interpersonal functioning was measured with the Young Loneliness Inventory, which addresses attitudes towards intimacy and reflects the capacity to initiate and deepen relationships. Alliance was measured with the CALPAS-P and CALPAS-T after the fifth session and statistical tests were performed on the Patient Commitment and Patient Working Capacity scales. Results indicated that pre-treatment interpersonal functioning was not related to alliance measures in any of the three forms of therapy. The authors suggested that the lack of relationship between interpersonal functioning and alliance may be attributable to the fact that the clients in this sample were seeking treatment for depression rather than interpersonal difficulties. However, it seems difficult to separate depression from interpersonal difficulties because they are often closely related. Alternatively, the lack of association between interpersonal functioning and alliance
may have been due to a restricted range of variance in a homogeneous sample of depressed elderly individuals.

Kokotovic and Tracey (1990) assessed relationship functioning with the Interpersonal Relationships Scale (IRS) and clients and therapists rated the WAI after the first session in a sample of 144 clients at a college counseling center. The IRS was used by counselors to rate clients’ level of hostility, quality of interpersonal relationships, and quality of relationship to family members. Ratings on all three of the IRS factors related to the establishment of the working alliance. The IRS factors were better predictors of alliance ratings than client-rated adjustment or type of presenting problem, neither of which was associated with alliance scores. One possible limitation of this study involves the decision to have therapists rate both interpersonal functioning and alliance after the first session at the same point in time. The relationship between these two scales could reflect a response set bias. In addition, it is questionable how accurate therapist ratings of interpersonal functioning could be after one session.

In a validation study of the patient version of the CALPAS, Gaston (1991) assessed problems with intimacy on the Inventory of Interpersonal Problems (IIP) in a sample of 147 clients from private practices. Results indicated that clients with self-reported problems with intimacy also reported poorer alliance on the Patient Commitment and Patient Working Capacity dimensions of the CALPAS. While this finding adds support to the notion that pre-treatment interpersonal difficulties have a negative effect on the patient’s perception of the alliance, it is unclear at what point in therapy the alliance was assessed. It appears that ratings were obtained from clients who were already being seen for an unreported number of sessions. In addition, ratings of alliance and interpersonal functioning were also assessed at the same point in time.
In general, it appears that certain measures of client interpersonal functioning have been found to be more predictive of working alliance ratings than were global measures of adjustment and symptom severity. Thus it may be that interpersonal functioning is more relevant to the formation of the alliance than are global measures of functioning. Discrepant findings in this area of the literature may be largely due to the use of different populations with varying ranges of psychopathology and the use of different methods and measures for assessing interpersonal functioning. In addition to assessing the current status of clients’ relationships, a growing body of research has investigated the relationship between client attachment and the formation of the working alliance.

*Attachment and the Working Alliance*

Attachment theory has important relevance for patient contributions to the working alliance. Because the psychotherapy relationship is an interpersonal attachment, it is not surprising that attachment theory has generated so much research and clinical interest in the field of psychotherapy. Although a thorough review of attachment theory and literature is beyond the scope of this dissertation, it will be briefly discussed here, especially regarding its relevance to the client’s ability to engage in a working alliance with the therapist.

Originated by John Bowlby (1969), attachment theory centers on the notion that human beings have an inherent need to form attachments in order to feel secure. Attachment theorists emphasize the importance of infant-caregiver bonding experiences in the formation of working models of self and others. Based on her research with infants, Ainsworth and colleagues (Ainsworth et al., 1978) identified three basic attachment styles that infants develop: secure, anxious-ambivalent, and avoidant. Children who have secure attachments have a greater ability
to explore their world and effectively regulate their emotions because their attachment figures have provided them with a secure base (Bowlby, 1988).

More recent work has focused on how attachment styles function in adulthood. The working models that develop during infancy and childhood are theorized to guide and shape how the individual establishes subsequent interpersonal relationships, and to continue to organize behavior in adults’ close relationships. Bartholomew and Horowitz (1991) identified a taxonomy of adult attachment styles based on working models of self and others. These styles include secure, preoccupied, dismissing, and fearful. Later research indicated that clients with these different attachment styles exhibited different patterns of interpersonal problems that have been shown to relate to important differences in how amenable individuals are to brief dynamic psychotherapy (Horowitz, Rosenberg, & Bartholomew, 1993). Other researchers have supported a connection between childhood and adult attachment. Using their measure of adult attachment, The Adult Attachment Scale (AAS), Collins and Read (1990) found that childhood attachment experience may strongly affect the quality of adult attachment in close friendships and romantic relationships.

Attachment theory provides an excellent model for what occurs within the relationship in psychotherapy. Bowlby (1988) discussed how the psychotherapy relationship is an example of the client’s capacity for intimate attachment. The client’s working models influence expectations about the therapist and the therapeutic relationship. If the client can effectively use the therapist as a secure base, he or she can proceed with the work of inner exploration. Based on this theory, it would be expected that clients with less secure attachment histories would have more trouble forming an alliance in which the therapist serves as a secure base (Gelso and Hayes, 1988). According to the working models theory of development, pathology occurs when
the working models of non-securely attached individuals become increasingly resistant to disconfirming information. Individuals with non-secure attachment styles, based on their working models, may expect the therapist to be unresponsive and possibly harmful despite contradictory evidence (Bowlby, 1988).

Research on client attachment and the working alliance has coincided with the development of measures for adult attachment. One popular measure used to assess adult attachment in studies relating to the working alliance is the previously mentioned Adult Attachment Scale (AAS). The AAS is an 18-item self-report inventory developed to measure three dimensions of adult attachment: (a) Depend, the extent to which individuals trust others and depend on their availability when needed, (b) Anxiety, the extent to which the individual fears being abandoned, and (c) Close, the extent to which the individual is comfortable with closeness and intimacy.

Satterfield and Lyddon (1995) investigated the relationship between AAS ratings and working alliance in a sample of 60 clients at a university-based counseling center. Results indicated that the Depend dimension of the AAS was positively associated with high WAI ratings. The investigators concluded that clients whose working models were characterized by a lack of trust in the dependability in others were more likely to evaluate the therapy relationship in negative terms early in treatment. Contrary to their expectations, the Anxiety and Close dimensions were not related to WAI ratings. The authors only reported the relationship of AAS to global ratings on the WAI. It might have been more informative to examine how the different WAI factors may have related differently to AAS dimensions. For instance, perhaps the Depend dimension of the AAS was differentially related to the Bond dimension of the WAI versus the Task and Goal dimensions.
One way to measure attachment is to assess clients’ recollections of childhood emotional bonds with parents. The Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979) was developed to assess bonding on two dimensions related to Bowlby’s secure base theory: care and overprotection. Care refers to memories of parents’ emotional responsiveness, warmth, and attention to clients needs, and Overprotection refers to memories of parents’ intrusive control. Clients rate each parent on the basis of early memories. Mallinckrodt, Coble, and Gantt (1995) assessed attachment using both the PBI and AAS in a sample of 76 women. The WAI was also administered after at least the fifth session. The investigators reported that the Anxiety and Close dimensions of the AAS were unique significant predictors of the working alliance. Father care and overprotection from both parents were also significant unique predictors. Interestingly, father overprotection was a negative predictor and mother overprotection was a positive predictor of client-rated working alliance. Results also indicated that parental bonds accounted for 23% of the variance in alliance ratings. In order to recruit participants, the investigators posted signs in the reception areas describing the study as an investigation of how “emotional bonds formed between persons in childhood with their parents affect preferences for types of relationships as adults, and the types of counseling relationships that they develop.” This description may have introduced demand characteristics that could have inflated the relationship between alliance and attachment measures.

Overall, the literature appears to support the notion that client pre-therapy interpersonal functioning is an important contributor to the early formation of the working alliance. However, there are some common methodological limitations that need to be addressed. First, a majority of these studies assessed both client pre-therapy characteristics and working alliance with self-report measures. The relationships between these variables may be confounded due to the
problem of common method variance in which multiple measures taken from one participant are more likely to be correlated, especially if they are both self-report instruments (Orlinsky and Howard, 1986). For example, clients who report healthy attachment on the AAS may be more likely to also rate alliance measures in the positive direction. Thus, it may be unclear whether correlations on these self-report measures identify a relationship between the constructs that the researchers are interested in or whether correlations capture a general mental health-distress factor (Shedler, Mayman, & Manis, 1993). This problem may be particularly salient in studies that assess pre-therapy characteristics and alliance at the same point in time.

A second important methodological concern involves the accuracy of client’s self-report on measures of interpersonal functioning, especially those that assess memories of parental bonding. Clients with low levels of interpersonal functioning may lack insight into the severity of their problems. In addition, clients may be likely to deny or repress some of the most negative memories about their attachments to parents (Main et al., 1985). It has also been suggested that the behaviors assessed by self-report attachment measures are influenced by the individual’s quality of current relationships. Kirkpatrick and Hazan (1994) found that relationship crises affect attachment scores on self-report questionnaires. Thus, the degree to which internal working models are being accurately assessed with self-report measures seems unclear. It would be interesting to compare the relationship between self-report and projective measures of client interpersonal functioning and ratings of the working alliance. Important issues surrounding self-report versus projective assessment will be discussed in more detail in a later section.

Another possible limitation of existing studies on pre-therapy interpersonal functioning involves the level of specificity of the constructs being assessed. For example, a previously reviewed study conducted by Moras and Strupp (1982) used a semi-structured clinical interview
to assess various aspects of relationship functioning including current social relationships and ability to form and sustain close or intimate relationships. These and other aspects of relationship functioning were rated by an interviewer and summed to form an overall score. The global scores were then used to rank clients into poor, fair, and good relationship functioning categories. A problem with this methodology is that global scores are likely to assess more quantitative differences in client interpersonal functioning while neglecting the more qualitative differences. If the goal of assessing pre-therapy client characteristics is to identify important targets for therapist intervention, it would seem advantageous to measure more qualitative aspects of relationship functioning. For instance, knowing that clients have “good” or “poor” relationship functioning is not likely to be as useful as knowing what particular areas of interpersonal functioning are compromised.

In summary, several important limitations of the existing literature on client pre-therapy contributors to the alliance are common method variance, over-reliance on self-report measures, and the use of overly-global measures that do not appear to assess the complex, qualitative nature of interpersonal functioning. One way to address the first problem would be to use a projective measure to assess pre-therapy characteristics. It is likely that projective measures would provide valuable information, particularly regarding constructs such as attachment and object relations, which may not be adequately assessed through self-report. One projective measure that might be particularly useful in linking client pre-therapy relationship functioning to the working alliance is the Thematic Apperception Test (TAT). The SCORS is a rating system that was designed for use with the TAT. Because the SCORS focuses on measuring developmental levels of object relations along a number of discrete dimensions, it may also address the problem of overly-
global assessments. The TAT and the SCORS system will be presented below as a proposed method for assessing client’s pre-therapy interpersonal functioning.

Object Relations and the SCORS

Similar to attachment theory, object relations theory provides a useful framework for understanding the client’s contribution to the working alliance. Object relations assessment has received relatively little attention in the alliance literature, perhaps because of the complexities associated with assessing this broad construct. As will be discussed later in this section, the SCORS offers a promising new method of assessing object relations phenomena designed to address these complexities. The SCORS will be used in this dissertation to assess clients’ object relations functioning. In the following section, object relations theory will be briefly reviewed with particular emphasis on aspects that are relevant to the dimensions that will be assessed in this study. Object relations measurement issues will then be discussed along with a review of existing measures. Projective methods will be described in regard to their applicability for measuring internal object representations. The TAT and the SCORS will then be introduced with a brief presentation of SCORS theory and a description of its scales. The section will conclude with an overview of existing research that supports the validity of the SCORS.

Object Relations Theory

Object relations theory concerns cognitive, affective, and emotional processes that mediate interpersonal functioning in close relationships (Stricker & Healy, 1990). Coming out of traditional psychoanalytic theory, object relations theory represented a departure from the Freudian emphasis on drive and ego functions. The object relations tradition emphasized the notion that an individual’s need for contact with others is primary and cannot be reduced to the gratification of instincts (Fairbairn, 1954). The central concept of *internal objects*, first proposed
by Klein (1932), assumes that early relationships are internalized and become intra-psychic schemas, which enable individuals to feel connected to others even in their absence. The term object representation refers to this inner domain of schemas or templates that are proposed to operate outside of awareness and to serve as a map to define self and others (Kelly, 1997). The scope of object relations theory is broad and extensive, containing both cognitive and affective as well as conscious and unconscious elements (Blatt & Lerner, 1983).

The developmental course of object representations is a major focus in the writings of object relations theorists. In the 1960s and 1970s Mahler’s research, based on the observation of infants and young children, contributed to the important developmental concept of separation-individuation. According to Mahler and her colleagues (Mahler, Pine, & Bergman, 1970), the separation-individuation process requires a child to develop a sense of independent selfhood and autonomy while maintaining a sense of connectedness to the primary caretaker. As normal object representations develop through the process of separation-individuation, internal schemas become more complex and there is an increasing articulation of a sense of self as distinct from others. The continuing development of internal representations increases the individual’s capacity to sustain constructive behavior without external reinforcement and to tolerate separation from others.

As seen in Borderline Personality Disorder, the failure of self-object differentiation results in a lack of self-cohesion and makes it difficult for the individual to function on a number of levels. Kernberg’s (1976) developmental model describes the important concept of “splitting”, in which the self and others are viewed at certain times as either all good or all bad. Because the individual with poor object relations has not developed complex representations of self and others, there is a limited capacity to integrate opposite-valenced thoughts and feelings.
The result is that these individuals are likely to have rigid and distorted perceptions of object representations as well as difficulty regulating their emotions. Individuals with poorly-formed object representations may also demonstrate deficits in their ability to appreciate characteristics of others apart from the needs of the self (Kernberg, 1976).

The faulty development of object representations has clearly negative implications for interpersonal relationships, including the therapy relationship. In fact, object relations theory developed out of attempts to account for clinical observations of patients whose pathology was manifest interpersonally and appeared more pervasive than neurotic symptoms such as phobias or compulsions (Westen, 1991). These patients had fundamental difficulties in their ability to trust others, including the therapist. Object relations theory suggests that this type of character pathology results from underlying disturbances in the mental representations of self and others as well as the affects attached to these representations. Balint (1968) suggested that these individuals have a “basic fault” in their experience of self and others that began in the first years of life in relation to the primary caregiver.

Individuals with poor developmental levels of object representations may have significant difficulty trusting the therapist and may be unable to form a “good enough” alliance in the early stages of treatment. According to Masterson (1990), the therapeutic relationship can be defined as a “real object relationship” (p. 182) and is thus likely to activate clients’ object representations. Based on theory, clients whose object representations are characterized by a lack of trust are also likely to have difficulty trusting the therapist. Indeed, individuals with this kind of character pathology have a reputation for being difficult to treat. According to Westen (1991); “clinically, these various interpersonal difficulties manifest in a tumultuous therapeutic relationship, in which patients may accuse the therapist of intending to abuse or destroy them,
withdraw suddenly from the relationship because of a peculiar or malevolent attribution, or alternate among such patterns” (p. 431). Pre-therapy assessment of object relations may provide information that will help therapists target interventions that may improve early alliance formation. The assessment of object relations will be reviewed below.

**Advantages of Assessing Object Relations**

According to Kelly (1997), object representation information “serves as a guide-informing and directing the ensuing therapeutic course and providing a perspective on what the therapeutic odyssey will be like” (p. 42). Object relations information may provide the more qualitative assessment of interpersonal functioning that is lacking in more global measures of attachment or parental bonding. Furthermore, assessing object relations is likely to provide information that will assist in treatment planning beyond that of global Axis I diagnoses. For instance, it would be important to identify the differences between a depressed patient who is able to maintain committed relationships versus one whose depression is part of a broader symptomatic picture, including negative expectations of relationships (Westen et al., 1991). One would want to develop different treatment plans for these two individuals based on specific deficits in interpersonal functioning rather than solely based on their diagnosis of depression. In addition, object representation information has the potential advantage of allowing clinicians to develop theory-based treatment formulations, whereas DSM diagnoses do not provide such information (Kelly, 1997).

Given the significance that object representation information may have for treatment formulation, it follows that pre-treatment object relations assessment is clinically valuable. However, obstacles in assessing object relations involve developing a method that is consistent with a coherent theoretical position and with accepted standards of psychological measurement.
that account for the complexity of object relations theory (Bell, Billington, & Becker, 1986; Stricker & Healy, 1990). Furthermore, because object representations are proposed to operate partly outside of awareness, they may be difficult to measure. Despite these obstacles, a variety of assessment tools have been developed to evaluate object relations and research efforts have increased in the last ten years. Measures of object relations have been used for a variety of purposes, such as enhancing theory, differentiating diagnostic groups, and assessing change following therapy (Stricker & Healy, 1990). Methods of measuring object relations can be separated into the two broad categories of self-report and projective measures.

**Self-Report Measures**

Several self-report inventories have been developed to measure various aspects of object relations [Inventory of Personality Organization (IPO; Kernberb & Clarkin, 1995); Bell Object Relations Inventory (BORI; Bell, Billington, & Becker, 1986); Separation-Individuation Test of Adolescence (SITA; Levine, Green, & Millon, 1986)]. The BORI, a 45-item measure, is probably the most widely used in the literature. The BORI was derived from an interview for assessing relationships and is composed of four factors: alienation, egocentrism, insecure attachment, and social incompetence. This measure has been used to discriminate borderline subjects from other comparison groups based on their higher scores on alienation, egocentrism, and insecure attachment (Bell, Billington, & Cicchetti, 1988).

Despite the research that supports the validity of self-report object relations measures, it seems unclear whether they are measuring the internal, unconscious elements of object representations. As discussed previously in relation to self-report measures of attachment, the validity of self-report object relations measures may be compromised due to variables such as defensiveness and social desirability. Projective measures such as the TAT may provide
information about relationship functioning that is less susceptible to defenses or self-presentation biases. In comparing the TAT to self-report methods, McClelland et al. (1989) stated, “stories written to pictures …are more successful than self-reports in reflecting implicit motives because they provide a more direct readout of motivational and emotional experiences than do self-reports that are filtered through analytic thought and various concepts of the self and others” (p. 66). Because of their relevance to the current study, projective object relations measures will be reviewed below.

*Projective Measures*

Projective measures are the more common method for assessing object relations. The fundamental assumption of all projective methods is the “projective hypothesis,” which proposes that stimuli in the environment are perceived and organized by the individual’s specific needs, motives, feelings, perceptual sets, and cognitive structures, and that in large part this process occurs automatically and outside of awareness (Frank, 1948). Given that projective measures are designed to assess internal processes and structures, it seems that they are most appropriate for measuring object representations, which are predominately considered to be outside of awareness. Projective measures of object relations include a number of scoring systems that were developed to assess a variety of projective data including Rorschach data, TAT stories, early memories, dreams, and interview data. A comprehensive review of these measures is beyond the scope of this dissertation but the two most common Rorschach measures will be briefly discussed. For a full review see Stricker and Healy (1990) and Fisher, Sperling, & Carr (1990).

The Rorschach Inkblot Test has been used to assess various dimensions of object relations. Two common measures used to score Rorschach responses are the Concept of the
Object on the Rorschach (COR; Blatt, Breneis, Schimek, & Glick, 1976) and the Mutuality of Autonomy Scale (MOA; Urist, 1977). The COR is composed of six scales that are used to score human and human and humanoid Rorschach responses. The six scales are Differentiation, Articulation, Motivation of Action, Object-Action Integration, Content of Interactions, and Nature of Interactions. The MOA is based on Mahler’s (1974) separation-individuation theory and is primarily focused on the developmental progression of separation-individuation to highly differentiated representations. The MOA evaluates kinetic responses by rating all human, animal, and inanimate movement responses along a 7-point scale ranging from 1 (positive, separate, and autonomous relatedness) to 7 (relatedness characterized by malevolence and overpowering envelopment).

These Rorschach measures have been studied extensively and research has been focused primarily on differentiating different diagnostic groups. For example, data from the COR was used to identify differences between individuals with borderline and narcissistic personality disorders and the MOA has been shown to differentiate between subgroups of individuals with Borderline personality disorder (Spear & Sugarman, 1984). According to Westen (1991), the Rorschach measures of object relations are limited because they “provide a relatively crude index of object relations and can offer insight into only a limited number of relevant dimensions of object relations” (p. 445). Westen developed the SCORS system with the objective of improving upon this specific limitation of object relations assessment.

Given the above limitations of assessing object relations phenomenon by self-report and Rorschach-based measures, a TAT based system may be a suitable alternative for measuring object relations. According to Westen (1991), “the use of stories in response to pictures seems particularly suited to assess internal representations of relationships because the stories provide
considerable access to cognitive and affective-motivational patterns related to interpersonal functioning in intimate relationships” (p. 56). A TAT-based measure such as the SCORS is likely to be particularly relevant to this study because the TAT stimuli are primarily designed to elicit interpersonal schema, which may be most applicable to the therapy alliance. A general discussion of the TAT is presented below, followed by an introduction of the SCORS system.

*Thematic Apperception Test*

The TAT stimuli, introduced in the 1930s, popularized the idea that telling a story to pictured scenes involving social situations would reveal important aspects of personality. Since its introduction, numerous scoring systems have been developed and used by clinicians to interpret TAT data. While personality researchers such as McClelland adhered to strict psychometric standards and well-defined and reliably coded criteria, clinicians generally preferred to use the TAT as a flexible tool for eliciting information that would then be interpreted on the basis of professional training and experience, rather than scored (Teglasi, 2001). Despite the popularity of the TAT among clinicians and its potential usefulness as a clinical tool, there has been limited consensus among clinicians on a reliable scoring system that is based on both theory and research. As will be discussed below, recent advances in the development of scoring systems for the TAT and subsequent research have sought to resolve this problem in an attempt to bridge the gap between theory and practice (Kelly, 1997).

The potential utility of the TAT and other projective measures for assessing object relations may best be understood in terms of schema theory, which posits that mental schema are used to interpret current stimuli (Teglasi, 2001). Object representations, like schemas, serve as internal structures that organize an individual’s experience in the absence of external support or guidance. The task of coming up with stories for relatively ambiguous pictures of social
scenarios is likely to tap internal relationship schema. A similar process can be applied to the therapy relationship, where the client may use existing internal relationship schema (or object representations) to organize the experience of the relationship with the therapist. When an individual has poorly developed representations, he or she may interpret the therapy relationship in negative and inaccurate terms. Thus, a the use of a TAT scoring system that measures internal representations (or schemas) seems an ideal candidate for assessing the client’s potential to form a good working alliance with the therapist. The SCORS provides a multi-dimensional system for coding the TAT data that combines object relations and social cognitive theory.

**SCORS**

Initially developed in 1985 and revised in 1995, the SCORS was derived from clinical observation, object relations theory, and research in developmental social cognitions. One of the unique features of the SCORS is that it was designed to assess various levels of personality functioning independently rather than assuming that if one area of functioning is impaired all areas of functioning will be equally impaired (Ackerman et al., 1999). The SCORS will be used to assess object relations in the current study because it appears to have the advantage of providing more specific information about personality functioning that may clarify the relationship between client interpersonal functioning and working alliance formation.

The SCORS has undergone several revisions. The original version of the SCORS was developed in 1985 and contained 4 scales including: Complexity of Representations of People (Complexity), Affective Quality of Representations (Affect Tone), Capacity for Emotional Investment in Relationships and Moral Standards (Relationships and Morals), and Understanding of Social Causality (Causality). The newest version of the SCORS, revised by Westen in 1995, separated Emotional Investment in Relationships and Capacity for Emotional Investment in
Values and Moral standards into two separate scales and added three additional scales including: Experience and Management of Aggressive Impulses, Self-esteem, and Identity and Coherence of Self. Each scale is rated on a 7-point scale and a mean score across stories is totaled for each dimension. In addition to TAT data, the SCORS system can also be used to code memories, interview data, and therapy transcripts. The individual scales will be described below.

The Complexity scale assesses an individual’s relational boundaries and the ability to integrate both positive and negative attributes of the self and others. Complexity involves the capacity to see the self and others as psychologically distinct beings who possess complex motives and unique subjective experiences. At the lowest levels, individuals have difficulty distinguishing between people and perspectives and the ability to make distinctions between one’s own thoughts and feelings and those of others is poor. For instance, characters are not clearly identified and are often described as having the same thoughts and feelings. At the highest levels, the individual describes people as having different feelings and characters’ subjective experience is described as multi-dimensional and enduring.

The Affective Quality of Representations (Affect Tone) scale assesses an individual’s expectations from others in relationships as well as how the individual describes significant relationships. Simply stated, this scale represents the affective coloring of an individual’s object world, which determines the extent to which the individual expects relationships to be threatening or safe. Responses that are assigned the lowest scores describe the interpersonal world as threatening and people are depicted as abusive and abandoning with little reason other than lack of concern or malicious intent. At the highest level, responses contain a range of affect and interpersonal expectations and the general affect-tone is notably positive. As will be elaborated later in this section, the Affect Tone scale appears to be the SCORS dimension that is
most closely associated with Borderline Personality Disorder (Kelly, 1997). In addition, the Affect scale may be the most directly related to the formation of the early working alliance because it assesses an individual’s expectations regarding relationships.

The Capacity for Emotional Investment in Relationships (Relationships) scale identifies an individual’s level of commitment and emotional sharing in relationships. It measures the distinction between the capacity for mature emotional connectedness versus the use of relationships for need gratification. The importance of developing mutual, mature object relatedness was emphasized in the work of Fairbairn (1954). At the lowest level characters are depicted as primarily concerned with need gratification. The highest level of development of this dimension is characterized by stories that stress “the goal of self-development, mastery, autonomy occurring within the context of a mature, loving, and committed relationship” (Kelly, 1997).

Emotional Investment in Values and Moral Standards (Morals) assesses themes of flexible problem-solving, in which parties recognize conflicting interests, beliefs, or attitudes but are able to resolve the conflict effectively. The theory underlying this scale is largely based on cognitive-developmental theory and research (Westen, 1991). At the lowest level of development, individuals demonstrate a lack of moral values and concern for the needs of others, and may behave aggressively without remorse. At the highest levels of development, individuals express guilt for hurting others and have conventional moral views.

Understanding of Social Causality (Causality) assesses the individual’s ability to demonstrate complex and logical causal attributions and intentions to behaviors, motives, thoughts and emotions. This scale was influenced by object relations theory as well as research in developmental-social cognition. Clinical and empirical findings suggest that individuals with
severe personality disorders tend to make illogical and inaccurate assumptions about the intentions of others (Kelly, 1997). At the lowest levels, individuals either do not seem to understand why feelings, behavior, or thoughts are relevant or their explanations are highly illogical. At the highest levels of development, individuals describe complex thoughts, feelings, and actions in which characters have the ability to understand self and others’ behavior as caused by psychological factors. Responses that reflect the highest developmental levels on this scale describe emotions that are both internal to the characters and complex in nature.

There has been limited research on the three new scales: experience and management of aggressive impulses, self-esteem, and identity and coherence of self. The present study will include these scales because it may be useful to understand how these aspects of object relations may relate to the working alliance. Experience and management of aggressive impulses assesses the extent to which anger and aggression are expressed impulsively and/or violently versus the appropriate recognition and expression of anger. Self-esteem assesses the degree to which characters view themselves as globally bad or tend to have realistically positive feelings toward the self. Identity and coherence of self assesses the degree to which individuals have a stable sense of self and demonstrate stable commitments to relationships, values, and goals.

*Reliability and Validity*

The issue of reliability as it relates to the TAT does not apply to the traditional types of reliability that are typically used with other measures. For instance, reliability based on internal consistency (the degree to which individual items of the test correlate with each other) is not relevant to TAT data because the TAT cards were not intended to measure the same trait as would items on a personality scale. There is no reason to expect that scores on one card will be identical to scores on another card that pulls for a different theme. In a similar manner, issues of
test-retest reliability are not applicable. The most appropriate method to determine the reliability of TAT data is similar to the method used to test the reliability of observational data (Cramer, 1999). Reliability in observational methods is based on inter-rater reliability, where scores of two or more independent raters are correlated. The SCORS has consistently demonstrated good inter-rater reliability. When raters are trained with the use of detailed manuals, reliabilities for the SCORS have been reported in the range of .80 to .95 (Westen, 1991).

There is a wide body of research accumulating that supports various aspects of the SCORS validity. According to Cramer (1999), the most appropriate approach to establishing validity for TAT measures is through testing theoretical predictions related to the underlying constructs being measured, rather than through examining correlations with self-report measures. As will be discussed in the following paragraphs, studies that serve to validate the SCORS as a useful clinical measure also serve to test and enhance various aspects of object relations and other developmental theories. The broad areas of research in which the SCORS has been used include studies that test developmental theories of object relations, studies that use the SCORS to differentiate various clinical and non-clinical criterion groups, and studies that use SCORS data to assess variables related to psychotherapy.

The SCORS has been shown to correlate with numerous other measures of constructs that it should theoretically be related to. For instance, they have been shown to correlate with clinician-rated and self-report social adjustment measures (Westen, 1991), number of physical health symptoms, and overall severity of psychological functioning (Evans & Porcerelli, 2002). SCORS variables have also been correlated with other measures of object relations including Loevinger’s (1976) test for Ego Development (Westen, 1991), Blatt’s (1976) Concept of the Object on the Rorschach (Hibbard et al., 1995), and a self-report measure of object relations.
Interestingly, Bridgman (2001) found that the SCORS variables were not correlated with a self-report attachment measure (Relationship Questionnaire) in a sample of adolescent females with conduct disorder. It is possible that scores on the self-report measure may have been particularly affected by the degree of defensiveness in conduct-disordered adolescents, whereas the SCORS data may not have been equally affected.

As mentioned previously, object relations theorists have focused much of their attention on building theories of development. Empirical tests of these theories have been limited but research efforts in this area have increased in the past 20 years (Westen, 1991). Westen and colleagues have accumulated a body of research in which the SCORS is used to assess developmental changes in children of different ages. For example, in one study, all scales from the original SCORS system with the exception of the Affect scale were shown to differ systematically between second and fifth graders and between ninth and twelfth graders (Westen et al., 1991). Studies that assess the impact of traumas on object representations suggest that significant historical events may have an important impact on the development of object representations. Studies that examine abused versus non-abused individuals have replicated the finding that sexually abused individuals tend to score lower on Affect than non-abused controls (Ornduff & Kelsey, 1996; Higgins, 1995) This finding makes theoretical sense, since individuals who have had experiences with abuse are more likely to view relationships as potentially harmful.

The validity of the SCORS has been supported in numerous studies in which its variables are used to differentiate various clinical and non-clinical criterion groups. In several studies, Westen and his colleagues have demonstrated that the SCORS variables can successfully distinguish borderline patients from other psychiatric groups and normal comparison groups in
both adult and adolescent samples. Using discriminant function analysis, the SCORS variables have discriminated borderlines from each of these comparison groups with approximately 80% accuracy (Westen, 1991). The SCORS has also differentiated between individuals in abusive versus non-abusive relationships (Cogan & Porcerelli, 1996), borderline inpatients versus borderline outpatients (Ackerman et al., 2002), and clinical and nonclinical college student samples (Fowler, Hilsenroth, & Handler, 1995).

Since the earlier validation studies, subsequent research has used the SCORS to gain more specific information about the deficits involved in personality disorders and to potentially enhance diagnostic criteria. Most of the research in this area has focused on Borderline personality disorder (BPD). Based on theory, the affective quality of object representations has been proposed as a central area of disturbance in borderline pathology. Westen, Lohr, Silk, Gold, & Kerber (1990) found that the Affect scale distinguished individuals with BPD from individuals with Major Depressive Disorder and from individuals without a diagnosis. This finding was replicated in a sample of adolescents in which BPD was compared to adolescents with other psychiatric diagnoses (Westen, Ludolph, Lerner, Ruffins, & Wiss, 1990). While Capacity for Emotional Investment in Relationships and Understanding of Social Causality variables distinguished individuals with BPD from normal controls, only the Affect variable discriminated individuals with BPD from other psychiatric groups. Nigg et al. (1992) extended findings using the Early Memories test to assess malevolent object representations and found that borderline individuals had early memories that were often characterized by deliberate injury and portrayed potential helpers as less helpful. In summary, the notion that the negative affective coloring of the object world is a central deficit in BPD has been well supported in the literature.
Ackerman et al. (1999) extended this line of research to make comparisons across different personality disorders in a study that assessed the relationship between SCORS variables and DSM-IV cluster B personality disorders. The SCORS differentiated Antisocial PD, Borderline PD, and Narcissistic PD. The Affect and Relationships variables were found to be significantly predictive of the total number of DSM-IV Borderline PD and Antisocial PD diagnostic criteria. The Self-Esteem and Identity variables were found to be significantly related to self-report measures of Borderline PD and Narcissistic PD. This study supports the clinical utility of the SCORS for assessing various personality disorders. Furthermore, the findings support the validity of different SCORS scales because they were differentially associated with certain personality disorders. The authors suggested that the SCORS information is likely to aid in the development of more thorough treatment plans as well as to enhance the conceptual understanding of personality disorders.

There is limited research that has focused specifically on differences between the SCORS scales; however, there is a body of SCORS research which suggests that the cognitive components and affective components of object relations should be clearly differentiated. When examining the correlations between the SCORS scales, Hibbard, Hibbard et al. (1995) reported a clear divergence between the more cognitive Complexity and Causality scales, and the more affective Affect and Relationships scales. Porcerelli, Cogan, & Hibbard (1998) found that only the affective dimensions of the SCORS were related to outpatient personality pathology. Similarly, Hibbard et al. (1995) suggested that there is evidence for the construct validity of object representations and an affective, but not a cognitive linkage between object representations and pathology. Other researchers have also suggested that a failure to distinguish between cognitive and affective variables may confound object relations measures that provide a
global mean score of object relations functioning (Stuart et al., 1990). The current study will attempt to determine whether these dimensions are differentially related to the working alliance and other variables.

In comparison to research assessing differences in diagnostic groups, fewer studies have used the SCORS to investigate variables related to psychotherapy. A body of literature that links SCORS variables to psychotherapy is beginning to accumulate. For instance, a number of studies have used the SCORS to assess changes in object relations following therapy (Evans & Porcerelli, 2002; Hsi, 1996; Conklin, 2001). These researchers have compared SCORS ratings on TAT’s administered before and after therapy and results have generally supported the notion that therapy contributes to improved object relations functioning.

SCORS data have been used to investigate the relationship between pre-therapy object relations functioning and therapy outcome. Kabasakalian (1996) found that the Relationships variable was associated with therapy outcome in a group of depressed patients. Specifically, pre-therapy assessment with the SCORS indicated that higher scores on this variable were associated with improvements on the Hamilton Depression Rating Scale and the Global Assessment of Functioning scale for women but not for men. SCORS data have also been associated with the number of therapy sessions that clients attend. Ackerman et al. (2000) found that two scales on the SCORS predicted the number of therapy sessions attended in a sample of individuals with a personality disorder diagnosis. Low scores on Affect contributed the most variance and were related to fewer number of sessions attended. High scores on Relationships were related to a greater number of sessions attended. The other six SCORS variables were not related to the number of sessions attended. One hypothesis for these findings in that the Affect and
Relationships variables are more closely related to the client’s ability to form a working alliance with the therapist and to stay committed to therapy. The current study will address this question.

In summary, research findings have produced substantial support for the validity of the SCORS. The SCORS is a promising measure that has the potential to enhance theories of object relations development and to improve the assessment of personality disorders. Research regarding how individual SCORS variables may be related to different disorders, object relations development, trauma histories, and processes occurring in psychotherapy is beginning to accumulate. Given the potential clinical utility of the SCORS, more research is needed to determine how the SCORS might function as an assessment tool to inform treatment planning. For instance, it will be important to determine if the SCORS variables can predict how clients will respond to psychotherapy. With this knowledge, therapists may be able to enhance treatment plans by targeting specific deficits that have been identified with the SCORS. The present study will investigate whether the SCORS variables predict various aspects of the working alliance.

Proposed Study and Hypotheses

The primary purpose of the current study is to examine the relationship between client object relations functioning and the strength of early working alliance in a sample of therapist-client pairs. This review of the literature supports the connection between object relations and the working alliance and also highlights the need for measures that will enhance the link between assessment and therapy. The goal is to contribute to the working alliance literature by using the TAT and the SCORS scoring system as an alternative method for investigating the relationship between client interpersonal functioning and the working alliance.
In addition to object relations functioning, the current study will assess other client variables that might be related to the working alliance. The Symptom Checklist 90-Revised\textsuperscript{®} (SCL-90-R\textsuperscript{®}) instrument (L. Derogatis, Riderwood, MD), will be administered as a measure of global symptom severity. It will be important to determine how the SCORS relates to clients’ self-reported distress and also to determine the relative association that these variables have with the working alliance.

The Adult Attachment Scale (AAS) will be administered as a measure of client attachment. There is a significant amount of literature on the relationship between attachment and the working alliance, and it would be interesting to determine the relative utility of a self-report attachment measure versus a projective object relations measure in predicting the working alliance. In order to address the previously discussed limitation of using self-report measures to predict working alliance formation, this study will investigate the susceptibility of the AAS and the SCORS to the effects of social desirability, as measured by a short form of the Marlowe-Crowne Social Desirability Scale (MCSD). The MCSD will serve as a control to examine the differential effects of response set biases on self-report versus projective assessment measures. As of yet, no existing research has investigated how the SCORS might be related to social desirability.

Working alliance ratings will serve as the outcome variable in this study. The working alliance will be measured early in treatment because the literature highlights the importance of early alliance formation. The working alliance will be assessed from both therapist and client perspectives because research has indicated that therapists and clients tend to view the alliance differently. Thus, an additional goal of this study will be to investigate variables that might explain why clients and therapists view the alliance differently. The CALPAS will be used as a
measure of the working alliance because it is designed to separate client and therapist contributions and may help us to better address how client and therapist ratings differ.

In addition to contributing to the literature on the working alliance, this study will serve to extend the construct validity of the SCORS by assessing its clinical utility in predicting the working alliance. It appears that this is an important question that has not been investigated in the SCORS research. Exploratory analyses will be used to investigate differences between the SCORS scales by determining how they may relate differently to different aspects of the working alliance. For instance, analyses will address whether cognitive or affective components of object relations are better predictors of working alliance formation.

As mentioned in the above literature review, it is not uncommon for nearly 50% of clients to leave treatment without informing their therapists. Thus, it is likely that it will not be possible to obtain alliance ratings from a portion of the participants who were administered the initial assessment measures. Because it may be interesting to identify factors that contribute to early client termination, a secondary goal of the current study will be to determine how client characteristics in this study might differentiate clients who continue with therapy from those who terminate early.

**Hypotheses**

**Hypothesis #1**

a. Lower levels of object relations functioning should be associated with higher levels of global symptom severity.

b. Affective dimensions of clients’ object relations should be more predictive of global symptom severity than the cognitive dimensions.
Hypothesis #2

a. Lower levels of object relations functioning should be associated with higher levels of attachment disturbance.

b. Affective dimensions of clients’ object relations should be more predictive of attachment disturbance than the cognitive dimensions.

Hypothesis #3

Self-reported attachment ratings are expected to be more susceptible to social desirability effects than the projective object relations measure.

Hypothesis #4

Individuals with lower object relations functioning are more likely to drop out of therapy prematurely than clients with higher object relations functioning.

Hypothesis #5

a. Higher quality of clients’ object relations functioning is expected to predict higher levels of the working alliance.

b. The affective dimensions of clients’ object representations should be more predictive of the quality of the working alliance than the cognitive dimensions.

Hypothesis #6

It is expected that clients’ object relations functioning will predict the alliance even when global symptom levels are controlled.

Hypothesis #7

When social desirability is controlled, object relations functioning is expected to be a better predictor of the working alliance than attachment.
Research Questions

In addition to the hypotheses outlined above, exploratory analyses will be used to investigate research questions that involve the relationship between a combination of client characteristics and outcome variables.

Research Question #1

How are different aspects of clients’ object relations functioning differentially related to the components of the working alliance?

Research Question #2

What client pre-therapy characteristics in this study relate differently to therapist versus client-rated working alliance?

Research Question #3

How might the client characteristics examined in this study be related to early client termination?
CHAPTER 2

METHOD

Participants

Forty-eight therapy clients (31 females, 17 males) volunteered to participate (see Table 1, Appendix A). The mean age was 32 years (SD = 13.37) with a range of 19 to 70 years. Thirty-five (73%) reported that they were Caucasian, 8.3% Black, 4.2% Hispanic, 6.3% Asian or Pacific Islander, and 8.3% categorized their ethnicity as “Other”. Forty-six percent of participants reported that they were single, 23% were divorced, 19% were married, 10% were in a committed relationship, and 2% were widowed. Thirty-one percent had children and 69% had no children. Ten percent had masters’ degrees, 13% had bachelors’ degrees, 71% had completed some college, 2% had completed high school or obtained a GED, and the remaining 4% had completed the 10th grade. Twenty-three percent of participants reported that they were in school full time, 21% were employed part time, 15% employed full time or more, 13% were unemployed, 13% were in school full time and employed part time, 6% were retired or disabled, 6% were self-employed, and 4% described themselves as “homemakers.”

Sixty-four percent of therapy participants reported that they had previous therapy and 35.4% reported that they had no previous therapy (see Table 2). Of those that had previously had therapy, the mean number of previous therapists was 2.1, with a range of 1 to 15. Seven percent of participants had less than 6 months of previous therapy, 19% had 6-11 months, 23% had 1-2 years, 42% had 2-5 years of previous therapy, and 10% had more than 5 years. Seventy-two percent of participants reported that they had never been hospitalized for a psychiatric condition and 27% had previously been inpatients.
Of the 48 who completed Time 1, 8 participants did not remain in therapy long enough to complete Time 2. Of those 8 participants, 6 were female, 2 were male. The mean number of sessions prior to Time 1 was 2.19 and the mean number prior to Time 2 was 5.4.

Therapists were 26 practicum students (21 females, 5 males) in counseling or clinical psychology from the University of North Texas. The mean age was 29.7 (SD = 7.1) with a range of 24 to 45 years. Thirty five percent of therapist reported that they were married, 25% were single, 23% were in a committed relationship, and 8% were divorced. The mean graduate year for therapists was 3.3 with a range of 2nd year to 6th year. Twenty three percent of therapists had seen 1-3 clients, 31% percent had seen 4-6 previous clients, 15% had seen 7-9 clients, 4% had seen 10-15 clients, 8% had seen 16-20 clients, and 12% had seen more than 30. Four percent of therapists had 1-10 hours of therapy experience, 19% had 11-20 hours, 27% had conducted 21-30 hours of therapy, 4% had 31-40 hours, 8% had 41-60 hours, 15% had 61-100 hours, and 23% had more than 100 hours of therapy experience. Some of the therapists had more than one client participating in the study. The mean number of clients per therapist was 1.85 with a range of 1 to 6 (see Table 3).

Measures and Materials

*Demographics Questionnaire-Client.* The demographic questionnaire included questions involving marital status, age, ethnicity, and level of education. The questionnaire also included questions regarding previous therapy experience and physical health (see Appendix B).

*Demographics Questionnaire-Therapist.* A brief therapist questionnaire included basic demographic information and assessed the therapists’ theoretical orientation and number of individual therapy hours that therapists had previously conducted (see Appendix C).
UNT Psychology Clinic Intake Packet. As part of the standard intake procedure, clients completed intake forms that are then kept in their clinic files. Some information included in the standard intake packet was used as demographic data for the current study; for instance, to obtain answers to questions that were left unanswered on demographic questionnaires.

Access to clients’ files was needed to track clients’ therapy attendance. This information was gathered from the contact sheets where therapists are required to record dates of therapy sessions as well as missed or cancelled sessions.

Social Cognitions and Object Relations Scale (SCORS). The latest version of the SCORS (Westen, 1995) was not used because no training manual was available to provide enough information to train raters adequately. As an alternative, the 1991 version was used. This version had 5 scales, including Complexity of Representations (Complexity), Affect Tone, Capacity for Emotional Investment in Relationships (Relationships), Capacity for Emotional Investment in Moral Standards (Morals), and Understanding of Social Causality (Causality). Each scale is coded for developmental level, for each story. Scale scores are obtained by calculating a mean score across stories for each scale. A composite mean for all scales can also be computed. Based on findings from previous research (Hibbard et al., 1995), the scales will be grouped into affective and cognitive sub-factors. SCORAFF will be computed by obtaining the mean of Affect Tone, Relationships, and Morals. SCORCOG will be computed by obtaining the mean of Complexity and Causality.

TAT cards 1, 2, 3BM, 4, 6BM, 7GF, 12M, 13MF, and 10 were used in this study. These cards are standard in research with the SCORS and it has been suggested that they are particularly applicable for use with the SCORS (Westen, Lohr, et al., 1990; Hibbard et al., 1995). Administration of the TAT followed procedures outlined by Murray (1943). Instructions were:
I am going to show you some pictures, one at a time, and your task will be to make up a story for each card. In your story be sure to tell what has led up to the event shown in the picture, describe what is happening at the moment, what the characters are feeling and thinking, and then give the outcome. Tell a complete story with a beginning, middle, and end. Do you understand? I will write your stories verbatim as you tell them. Here’s the first card. (The examiner hands the picture to the client).

As reported in the above literature review, the reliability and validity of the SCORS have been well supported. The SCORS has consistently demonstrated good inter-rater reliability. When raters are trained with the use of detailed manuals, reliabilities for the SCORS have been reported in the range of .80 to .95 (Westen, 1991) and Cronbach’s alpha’s have ranged from .64 to .86 (Westen, Klepser, et al., 1991).

After TAT administration, the records were transcribed and reorganized to group them by picture for coding. Prior to scoring the TAT two raters participated in practice scoring sessions using the criteria outlined in the SCORS manual (Westen, 1991). Each narrative was then scored independently by the same two raters on each of the five SCORS variables. Scorers met to compare scores and reconcile discrepancies by discussion, and these latter were used for data analysis. In the current study, the average reliability for each scorer with the consensus scores ranged from .78 (Morals) to .87 (Affect Tone), with a mean of .82 (see Table 4). Reliabilities were computed based on Spearman’s Rho. These values are slightly lower than those found in previous studies.

*Adult Attachment Scale (AAS)*. The AAS (Collins & Read, 1990) was used to measure clients’ self-reported style of forming close attachments. The AAS consists of 18 items scored
along a 5-point Likert-type scale ranging from “not at all characteristic of me” to “very characteristic of me.” The original factor analysis identified three subscales of six items each. The Depend subscale measures the extent to which participants trust others and rely on them to be available if needed. The Close subscale assesses comfort with intimacy and emotional closeness. The third subscale, labeled Anxiety, measures fears of being abandoned in relationships. Because the AAS does not provide a composite score of attachment, the subscales were examined independently.

The AAS appears to have adequate reliability and validity. Internal consistency reliabilities of .75, .69, and .72, respectively, have been reported for the Depend, Close, and Anxiety subscales. Test-retest reliabilities after a 2-month interval were .71, .68, and .52, respectively (Collins & Read, 1990). AAS subscale scores were correlated in the theoretically expected directions with measures of self-esteem, instrumentality, openness, expressiveness, and satisfaction in romantic relationships (Collins & Read, 1990). For the current study, alpha internal consistency values for Depend, Anxiety, and Close were .54, .63, and .74, respectively.

Symptom Checklist 90-Revised® (SCL-90-R®) instrument (L. Derogatis, Riderwood, MD). The SCL-90-R (Derogatis, 1977) is a self-report inventory designed to measure current psychological symptom status. The 90 items are rated on a 5-point (0 = not at all, 4 = extremely) indicating the degree to which they have distressed the respondent in the last week. Each question loads onto one of nine clinical scales (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism). An average score of the 90 items, the Global Severity Index (GSI), was used in this study as a measure of current level of psychological distress.
The reliability and validity of the GSI has been well established (Derogatis, 1983; Derogatis, Rickels, & Rock, 1976). GSI internal consistency and test-retest reliability have each been reported at .84. In the current study, Alpha internal consistency for GSI was .96.

*Marlowe-Crowne Social Desirability Scale (MCSD).* The Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) is a true-false measure of a participant’s tendency to seek social approval by endorsing items that are socially desirable. The Marlowe-Crowne has been used extensively in research for the past 40 years. Items were originally selected for scale inclusion on the basis that they described culturally approved behaviors that have a low incidence of occurrence and that response to the items in either direction has minimal implication of psychopathology (Reynolds, 1984).

This study used the 13-item short form, which has adequate reliability and validity and is an acceptable substitute for the 33-item version of the scale (Reynolds, 1982). Scores can range from 0 to 13, with higher scores reflecting a higher need for social approval. A sample item is “there have been occasions when I took advantage of someone.” Internal consistency reliability estimates of .82 and .74 have been reported (Reynolds, 1982; Zook & Sipps, 1985). The MCSD short form has been correlated with the L scale on the MMPI at .54 (Robinette, 1991). The Kuder-Richardson 20 (KR-20) internal consistency for the current study was .65.

*California Psychotherapy Alliance Scales.* The CALPAS was used as a measure of the working alliance. The CALPAS (Gaston & Marmar, 1991) has parallel forms for the client and the therapist (CALPAS-P and CALPAS-T). Both scales contain 24 items and ratings are based on a 7-point Likert-type scale from “not at all” to “very much.” The four subscales for both versions include Patient Commitment, Patient Working Capacity, Working Strategy Consensus, and Therapist Understanding and Involvement. The instructions for both therapists and clients
state that the information is confidential, however, clients are invited to discuss items or their reactions with their therapists if need be. The CALPAS-P and CALPAS-T both yield global alliance scores as well as component subscale scores.

Internal consistency reliability for the CALPAS-P has been reported at .84 for the total scale. The CALPAS-P has also been shown to have adequate validity. In a validation study, the CALPAS-P scores were not associated with patients’ age, level of education, gender, or marital status, or social desirability (Gaston, 1991). All CALPAS-P scales were related to a measure of patient satisfaction with treatment. The CALPAS-P scales were only moderately correlated with each other, providing some support to the notion that they reflect relatively independent aspects of the alliance. CALPAS-T has also demonstrated adequate reliability and validity. Subscales PC, PWC, and WSC correlated with each other in the mid .70’s and with the TUI subscale from .55 to .60 (Hatcher, 1999). The following are alpha internal consistency values obtained for the CALPAS-P subscales in the current study: PWC .82, PC .77, PWC .82, TUI .70. The following are alpha internal consistency values obtained for the CALPAS-T subscales in the current study: PWC .89, PC .91, WSC .66, TUI .87.

Procedure

The study design involved two data collection points. Time 1, which was ideally to occur between participants’ first and second therapy sessions, included the administration of the client demographic questionnaire, the TAT, AAS, SCL-90-R, and MCSD short-form. Time 2 data was collected three sessions following Time 1 data collection, and included the administration of client and therapist versions of the CALPAS and another measure that was not included in the analyses for the current study.
The researcher first recruited therapists for participation by placing a flyer in therapy practicum students’ boxes in the UNT Psychology Clinic (see Appendix D). Therapists were also given an informed consent form prior to completing their ratings (see Appendix E). Therapists who agreed to participate were asked to notify the researcher when they were assigned a new therapy client who met the eligibility requirements (over 18 yrs of age and not acutely suicidal). Therapists were also asked to obtain permission from their supervisors for the new client to participate in the study. The office staff was asked to include a letter of invitation for client participation with the standard intake packets of the incoming therapy clients who had been identified by their therapist as potential participants.

Although it was originally proposed that invitation letters would be given to clients at the time of their initial intake sessions, some difficulties were encountered with this method. As therapists often did not inform the researcher of new clients until after they had already completed the intake, it was necessary to invite some clients to participate after their first session. In these cases, the letter of invitation was given to the clients by the office staff when he or she checked in for their next session. Although it was ideal to recruit clients before the first session, it was judged to be too unfeasible to obtain an adequate amount of participants with this method. Subsequently, a cut-off point was established and clients were not recruited after their 3rd session. In order to account for the variability in data collection times, the impact of number of sessions prior to Time 1 on study variables was analyzed statistically and results will be described.

The invitation letter given to potential participants gave a brief description of the study including benefits of participation (see Appendix F). The letter also stated that participants would be given $15 for participation in the study. The letter asked the client to indicate whether
he or she gave consent to be contacted for participation in the study by checking a box and providing a signature. Office staff placed completed invitation letters in the researcher’s clinic mailbox.

If the client agreed to be contacted by providing a signature, the researcher contacted the client by telephone. At this time, the researcher gave the client more specific information about what would be required and answered any questions that the client may have had. If the client agreed to participate, an appointment was scheduled to administer Time 1 data. When the researcher met with the client, written consent to participate in the study was obtained (see Appendix G). It was made clear that participation is voluntary and in no way would affect the client’s ability to receive services at the Clinic. The clients were also informed that his or her therapist did not know details about the study, so questions should be directed to the researcher rather than the therapist.

If the client agreed to participate and signed the consent form, the brief demographic questionnaire, TAT, AAS, MCSD Short-Form, and SCL-90-R were administered. The TAT was first administered by the researcher and the clients were then left alone to complete the questionnaires. Upon completion of the Time 1 session, clients were given $15 for their participation in the study. They were reminded that they would be asked to complete additional questionnaires in a few weeks.

Client attendance information, including the number of sessions attended and/or the number of sessions that the client had missed was recorded on a tracking form. This information was used to determine Time 2 data collection as well as to track number of sessions missed (to determine when/if client has terminated).
Prior to the Time 2 data collection, the researcher provided the therapist with a packet containing the therapist demographic form, CALPAS-T questionnaire, a similar scale not used in this study, and a cover letter (see Appendix H) to remind therapists that their ratings would be anonymous and not revealed to the client. The therapists were asked to complete the questionnaires following their scheduled session and return them to the researcher’s clinic box. A similar packet was given to the clients by office staff when they checked in for the identified session. This packet contained the CALPAS-P, a similar scale not used in this study, and a cover letter (See Appendix I). Clients were asked to return completed packets as soon as possible, preferably before leaving the Clinic or at their next session. Clients were asked to return packets to office staff, who placed them in the researcher’s clinic mailbox.

Confidentiality and anonymity of participants was protected by assigning codes to the research materials. A tracking form was used to match client file numbers with research code numbers. The researcher used the intake information from the client’s file to supplement any incomplete demographic information. Consent to obtain information from the clients’ file was obtained when the client signed the Informed Consent Form to receive services at the Clinic, as part of the standard intake procedures. Therapists’ completed alliance ratings were assigned the same code as the participant that they were rating.

The cover letter for the client Time 2 packet reminded clients that their responses on the CALPAS would remain anonymous. The letter also required the clients to choose whether or not they would like their questionnaires and TAT stories from Time 1 to be copied and put in their file and/or whether they would also like feedback from the researcher. Completed CALPAS forms remained research data and were not returned to the clients’ files. If the client chose for their data to be placed in their files, the AAS, SCL-90-R, and TAT stories were copied and
placed in their clinic files. Of the 40 participants who completed Time 2, 30 requested feedback from the researcher and 10 did not.

Due to the vulnerable nature of the population (therapy clients), precautions were taken to avoid potential hazards. Clients who were acutely suicidal or whose risk might otherwise be increased by participating in this study were excluded from participation. This determination was made by therapists and their supervisors following the intake session. It was made clear in the informed consent forms that, if at any point the client experienced distress as a result of participation in the study, his or her participation would be discontinued. No participants were dropped from the study due to these factors.

Caution was taken throughout the study to avoid interfering with the therapy process. For instance, the therapists were not asked to recruit clients as research participants, and clients’ and therapists’ ratings of the therapy process were not revealed to one another. All data collection occurred in the clinic setting in which the client was usually seen, at hours when the clinic was open. Thus, all of the clinic’s routine emergency procedures and resources were readily available.

The author of the current study collected data from 33 of the participants. Due to the author moving to another city for internship, another clinical psychology graduate student was recruited to assist in completing data collection. This individual was trained by the author and provided with a detailed description of data collection procedures. She recruited and collected data for the remaining 15 participants.
CHAPTER 3
RESULTS

Descriptive Analyses

Before evaluating the hypotheses, it was first necessary to determine whether the sample was typical or atypical. The measures used in this study were expected to yield means and standard deviations similar to those previously reported by studies using the same measures with similar populations. The expected and observed means and standard deviations for each measure used in this study are shown in Table 5. T-tests revealed some significant differences between this population and the expected means. First, this sample rated themselves significantly higher on the Anxiety dimension of the Adult Attachment Scale (AAS) than did Satterfield and Lyddon’s (1995) sample of clients from a university-based counseling clinic, $t(47) = 2.16, p = .04$. This sample also had significantly lower scores on the Close dimension of the AAS compared to the above sample, $t(47) = -6.5, p < .001$.

T-tests revealed significant differences between the California Psychotherapy Alliance Scale (CALPAS) ratings in this sample and those of a previous sample. Patient-rated Working Strategy Consensus (WSC) was lower in this sample compared to Bachelor and Salame’s (1999) sample of clients at a university counseling service, $t(39) = -2.2, p < .04$. Therapist-rated Working Strategy Consensus (WSC) was also somewhat lower in this sample than in the above comparison sample, $t(39) = -4.2, p < .01$. These findings suggest that therapists and clients in this study did not feel quite as positive about their agreement on the tasks and goals of therapy than did the comparison sample. However, the mean scores from the current sample are quite high. It is unclear why the WSC scores from the current sample are lower than the comparison sample,
since both populations include clients in university-based training clinics and graduate-level therapists. Alliance ratings were also collected after approximately the same number of sessions.

In addition to comparing the sample's parameters to previous studies, it was also necessary to determine whether demographic variables were normally distributed. Therapist age was positively skewed, with a range of 24 to 45 and a mode of 29.7. The variable Time 2 Session Number (number of sessions at which Time 2 data was collected) had two outliers. Two of the participants did not complete their CALPAS-P questionnaires until well after they were given. It will be necessary to remove these two outliers when performing analyses involving the CALPAS variables.

It was necessary to determine whether the sample's scores on measures used were normally distributed. Frequency distributions were examined to determine whether the distribution of scores for variables in this study represented a normal or non-normal distribution. Based on histograms and measures of skewness and kurtosis, it was determined that scores on most measures were approximately normally distributed. The distribution for the Social Cognition and Object Relations Scale (SCORS) Morals scale was positively skewed, suggesting that participants in this sample tended to receive low scores on this dimension. The distribution had 2 outliers who received much higher scores than the rest of the sample. The distribution was also platykurtic and otherwise, the entire range without the 2 outliers fell within two standard deviations of the mean in either direction. The 2 outliers were recoded to the value 2 standard deviations above the mean, 3.13, leaving them still almost 1 standard deviation above the next highest value.

Analyses were run to determine any unexpected associations between demographic variables that might affect relationships between demographic variables and measures. Results
of these analyses revealed that the male therapists who participated in this study were significantly further along in their graduate year than female therapists, \( t(34) = 7.65, p < .001 \). There were no additional unexpected relationships among demographic variables for clients or therapists.

To further detect any unhypothesized associations, t-tests were conducted between categorical demographic variables and the measures used in this study. Participants who did not have children had higher Global Symptom Index (GSI) scores than participants who had children, \( t(46) = 2.11, p = .04 \). However, when controlled for age by partialling, this relationship was no longer significant. No other unexpected associations were found. For instance, there were no effects for the following variables: previous therapy (yes/no), patient gender, and inpatient history (yes/no).

One way Analyses of Variance (ANOVAs) were computed between continuous and categorical variables having more than 2 categories. Because the frequency totals for non-Caucasian ethnicities were too low to maintain these categories for analysis, patient ethnicity was recategorized into Caucasian and “Other.” There were 34 Caucasian participants, and 14 categorized as “Other.” The category “Other” was comprised of four African-Americans, three Asian/Pacific Islanders, three Hispanics, and four who originally classified themselves as “Other.” Non-Caucasians had higher GSI scores than Caucasians, \( F (1, 46) = 5.40, p < .03 \).

For a similar reason, patient Marital Status was recoded into three categories, single, married/committed, and divorced. There was a significant effect for GSI score by patient Marital Status. Single participants had significantly higher GSI scores than the other two groups, \( F (2, 45) = 4.20, p = .021 \). Single participants also had higher scores on AAS Anxiety than married/committed individuals, \( F (2, 45) = 3.56, p < .04 \). Because divorced participants were
older than single participants, $F(2, 45) = 6.69, p < .04$, the analyses were re-run controlling for age. When the relationships between Marital Status, GSI, and AAS Anxiety were controlled for age, the above findings were no longer significant.

The data were analyzed to determine whether there were any unhypothesized correlations between the demographic variables and the other measures used in the study. There was a significant negative relationship between age of participant and GSI score, $r(48) = -.29, p < .05$. There was also a significant positive correlation between age and Marlowe-Crowne Social Desirability (MCSD) score, $r(48) = .36, p < .05$. Thus, as previously demonstrated, it is necessary to control for participant age when computing statistics involving GSI and MCSD scores.

There was an unexpected correlation between the SCORS mean and one of the client demographic variables. Among clients who reported having had previous therapy, the number of previous therapists was negatively correlated with the SCORS mean, $r(31) = -.39, p < .05$. This finding indicates that the participants with a greater number of previous therapists tended to exhibit more impaired object relations functioning.

Of note, the number of sessions at Time 1 was not correlated with any of the measures used in this study, including CALPAS ratings. This suggests that the variability in Time 1 did not impact pre-therapy characteristics or outcome measures. Similarly, the number of sessions completed at Time 2 was not correlated with any of the measures.

In order to identify unhypothesized associations between the measures, correlations were computed (see Table 6). As shown in Table 6, AAS Anxiety was positively correlated with GSI score.
Correlations were also computed among the SCORS variables and the average number of words across participants’ TAT stories (Story Length). All of the SCORS subscales, with the exception of Affect Tone, were significantly positively correlated with TAT Story Length. Correlations ranged from .34 (Capacity for Investment in Relationships) to .44 (Capacity for Investment in Moral Standards). These correlations are reasonably expected given the nature of these variables. Nevertheless, it will be necessary to control for Story Length when running analyses that involve the SCORS variables in order to remove variance that might be due to other variables such as verbal intelligence.

Because they are included in the main hypotheses, correlations between the SCORS variables and the other measures will not be presented here. Table 7 presents the internal correlations among the individual SCORS variables. The correlations were computed with Story Length partialled out. With the exception of Affect Tone, the subscales were all intercorrelated. As expected, the two cognitive subscales, Complexity of Representations (Complexity) and Understanding of Social Causality (Causality), were very highly correlated. Capacity for Investment in Relationships (Relationships) and Capacity for Investment in Moral Standards (Morals) were also very highly correlated. Again, this was expected because these two subscales were originally combined as one subscale in Westen’s (1985) system. The internal correlations obtained in this sample are similar to those of Hibbard et al. (1995) except that Affect Tone was significantly correlated with Causality and Complexity in the other sample.

In order to determine how therapist and client alliance ratings were related, a series of correlations was run among CALPAS-P and CALPAS-T mean scores. As seen in Table 8, clients’ and therapists’ alliance ratings were strongly correlated. The only scale on which clients’ and therapists’ scores were not significantly correlated was Patient Working Capacity.
Otherwise, mean scale scores were highly correlated on Patient Commitment, Working Strategy Consensus, and Therapist Understanding and Involvement.

On a final note, it was proposed that therapist effects would need to be controlled for. For instance, it would be important to know whether different therapists gave systematically higher CALPAS-T ratings across participants. It would also be important to know if certain therapists received systematically higher CALPAS-P scores from their clients. However, the analyses required to test this question are beyond the scope of this dissertation. Most of the therapists were represented by only 1-2 clients (see Table 3), providing inadequate sample sizes for such an analysis. Furthermore, it is likely that differences between clients accounted for much more variance than differences between therapists did. In addition, this question was not central to the purpose of this dissertation.

Hypothesis-Testing Analyses

*Hypothesis 1a:* Lower levels of object relations functioning should be associated with higher levels of global symptom severity.

This hypothesis was not supported as the SCORS mean, with Story Length partialled, was not significantly correlated with the GSI value, $r(48) = -.13$, $p = \text{ns}$. However, when correlations were computed between the GSI value and the individual SCORS subscales (see Table 9), there was a significant negative relationship between GSI and Affect Tone, $r(48) = -.43$, $p = .003$. A significant negative relationship was also found for GSI and Relationships, $r(48) = -.28$, $p < .05$. Thus, individuals with more malevolent object representations and difficulty investing in relationships reported higher global symptom levels.
Hypothesis 1b: Affective dimensions of clients’ object relations functioning should be more predictive of global symptom severity than the cognitive dimensions.

To test this hypothesis, a step-wise multiple regression analysis was computed controlling for Story Length and regressing GSI first on the combined cognitive dimension of the SCORS (SCORCOG), then on the combined affective dimension (SCORAFF), (see Table 10). The partial correlation values for the SCORCOG and SCORAFF with GSI were .01 and -.41, respectively. When the contribution of SCORCOG to the prediction of GSI was controlled by partialling, SCORAFF contributed significant unique variance, Beta = -.46, p = .004. Thus, Hypothesis 1b was supported.

Hypothesis 2a: Lower levels of object relations functioning should be associated with higher levels of attachment disturbance.

Three separate correlations were computed between the SCORS mean and AAS-Depend, AAS-Anxiety, and AAS-Close. The overall SCORS mean was not significantly correlated with any of the three Adult Attachment Scale subscales, r(48) = .07, r(48) = -.13, and r(48) = -.05, p = ns, respectively. Thus, Hypothesis 2a was not supported.

However, when correlations were computed for AAS subscales and the SCORS subscales (see Table 9), a significant negative relationship between AAS Anxiety and SCORS Affect Tone was found, r(48) = -.29, p < .05. This finding suggests that individuals who have more malevolent object representations also tend to experience more anxiety about being abandoned in relationships.
Hypothesis 2b: Affective dimensions of clients’ object relations should be more predictive of attachment disturbance than the cognitive dimensions.

This hypothesis was tested with 3 separate multiple regression analysis with AAS-Depend, AAS-Anxiety, and AAS-Close as the dependent variables. When the contribution of the combined cognitive dimension of the SCORS to each of the AAS scales was controlled by partialling, the combined affective dimension did not contribute significant unique variance, \( r(48) = -.06 \), \( r(48) = -.23 \), and \( r(48) = -.12 \), \( p = ns \), respectively. This finding indicates that Hypothesis 2b was not supported.

When the separate relationships were examined through correlations, the combined affective dimension (SCORAFF) was significantly negatively correlated with AAS-Anxiety, \( r(48) = -.24 \), \( p = < .05 \), whereas the associations between the combined cognitive dimensions (SCORCOG) and the AAS subscales did not approach significance (see Table 9). Thus, the affective dimensions of the SCORS do appear to be more closely related to the AAS Anxiety subscale than the cognitive dimensions. At least 1 correlation would be expected to reach significance by chance given the large number of correlations computed, thus, the results should be interpreted with caution.

Hypothesis 3: Self-reported attachment ratings are expected to be more susceptible to social desirability effects than the projective object relations measure.

None of the AAS subscales or the SCORS subscales were correlated with MCSD scores in this study (see Tables 6 & 9). This finding suggests that neither participants’ responses on the AAS nor their TAT stories were confounded by a motive for social approval.
Hypothesis 4: Individuals with lower object relations functioning are more likely to drop out of therapy prematurely than clients with higher object relations functioning.

To test this hypothesis a univariate ANCOVA was computed controlling for TAT Story Length. Individuals who dropped out of therapy before Time 2 scored significantly lower than completers on the overall SCORS mean, F(1, 45) = 6.83, p < .02. When evaluating this relationship for the independent SCORS subscales, only the Relationships variable accounted for the finding, F(1,45) = 2.38, p = .02. This finding should be interpreted with caution because the cell sizes of drop-outs versus those who remained in the study, 8 versus 40 respectively, were notably discrepant. However, homogeneity of variance was not violated.

Hypothesis 5a: Higher quality of object relations functioning is expected to predict higher levels of working alliance.

The SCORS mean was significantly correlated with the CALPAS-P mean, r(40) = .32, p < .03, and the CALPAS-T mean, r(40) = .28, p < .05. Therefore, hypothesis 5a was supported (see Tables 11 & 12).

Hypothesis 5b: The affective dimensions of clients’ object relations functioning should be more predictive of the quality of the working alliance than the cognitive dimensions.

The hypothesis was tested using two regression analyses with CALPAS-P and CALPAS-T as the dependent variables and the combined cognitive dimension of the SCORS (SCORCOG) and combined affective dimension (SCORAFF) variables as predictors (see Table 13). Results indicated that the hypothesis was not supported as SCORAFF did not contribute significant unique variance to the prediction of CALPAS-P or CALPAS-T means when SCORCOG was
entered first. Both regression models were non-significant and neither variable contributed significant unique variance to the prediction of CALPAS-P or CALPAS-T means.

When analyzing the independent relationships through correlations, SCORCOG was significantly correlated with the client-rated CALPAS, $r(40) = .32, p < .03$, and the therapist-rated CALPAS, $r(40) = .28, p < .04$. In contrast, SCORAFF was not significantly correlated with client or therapist-rated CALPAS, $r(40) = .17, r(40) = .17, p = ns$, respectively. Thus, the findings were in the opposite direction of the hypothesis, with cognitive dimensions of the SCORS being correlated with CALPAS ratings and affective dimensions uncorrelated. At least 1 correlation would be expected to reach significance by chance given the large number of correlations computed, thus, the results should be interpreted with caution.

**Hypothesis 6**: It is expected that clients’ object relations functioning will be a better predictor of the working alliance than global symptom severity.

The first regression equation was computed with CALPAS-P mean as the dependent variable (See Table 14). When the contribution of GSI to the prediction of CALPAS-P mean was controlled by partialling, the SCORS mean did not contribute significant unique variance. Thus, Hypothesis 6 was not supported for the client-rated alliance scores.

The second regression equation was computed with CALPAS-T mean as the dependent variable (See Table 14). When the contribution of GSI to the prediction of the CALPAS-T mean was controlled by partialling, the SCORS mean did not contribute significant unique variance. Thus, Hypothesis 6 was not supported for the therapist-rated alliance scores.

However, there was partial support for this hypothesis in regard to therapist-rated alliance. The SCORS mean was correlated with therapist-rated alliance, $r(37) = .28, p < .05$, 
whereas the GSI mean was not, $r(40) = -.15, p = ns$. These relationships will be described in more detail in the research question section below.

**Hypothesis 7:** When social desirability is controlled, object relations functioning is expected to be a better predictor of the working alliance than attachment.

This hypothesis was tested by computing two separate multiple regression analyses with CALPAS-P and CALPAS-T scores as the dependent variables. In both analyses, MCSD score was entered first, followed by the AAS scales, and then the SCORS mean. The SCORS mean did not contribute significant unique variance, thus, Hypothesis 7 was not supported. As reported in Hypothesis 3, neither the AAS or the SCORS was significantly related to MCSD scores in this study.

Research Questions:

**Research Question #1:** How are different aspects of object relations functioning differentially related to the components of the working alliance?

Two separate correlation matrices were computed for CALPAS-P variables and CALPAS-T variables and the SCORS variables (see Tables 11 & 12). As reported in Hypothesis 5a, there was a significant association between CALPAS-P mean and CALPAS-T mean and the overall SCORS mean. Tables 11 and 12 illustrate significant associations between the individual SCORS subscales and CALPAS subscales.

For the analyses involving the client-rated CALPAS, the SCORS variables were most predictive of the Patient Commitment scores. As seen in Table 11, Complexity had a
particularly large association with Patient Commitment. Relationships and Causality were also correlated with Patient Commitment.

For analyses involving the therapist-rated CALPAS scores, Complexity of Representations and Capacity for Investment in Relationships were the only SCORS subscales that were significantly correlated with the CALPAS mean (see Table 12). Patient Working Capacity and Working Strategy Consensus were the two CALPAS scales that were correlated with these SCORS variables.

It is important to note that at least 1 significant finding would be expected by chance given the 30 correlations computed for each table. Thus, the results should be interpreted with caution.

Research Question #2: What client pre-therapy characteristics in this study relate differently to therapist versus client-rated working alliance?

Two multiple regression equations were computed with the CALPAS-P mean and CALPAS-T mean as dependent variables (See Tables 15 & 16). The Time 1 variables including the cognitive and affective combined dimensions of the SCORS (SCORCOG and SCORAFF) were entered together in a standard fashion. As in previous analyses, the contribution of TAT Story Length was controlled. For the first equation, with CALPAS-P as the dependent variable, the overall model was statistically significant from zero, F(7, 32) = 3.23, p < .05. This model produced an R² of .43. Three of the seven variables produced statistically significant beta weights. The beta weight for GSI was the largest, at -.43, p < .01. AAS Depend produced a beta weight of -.38, p = < .05. Finally, SCORCOG produced a beta weight of .43, p < .05. Thus, GSI was the most predictive of patient-rated CALPAS mean, with AAS Depend and the combined
cognitive dimension of the SCORS contributing approximately equal amounts of additional variance.

Results from the regression equation with CALPAS-T as the dependent variable indicate that this model was not statistically significant but was near significant, F(7, 32) = 2.12, p = .06 (see Table 16). The model produced an R^2 of .32. In this equation, only MCSD produced a significant beta weight of -.46, p = .005.

Correlation matrices were produced to analyze the independent relationships between predictor variables and the individual scales of the CALPAS. SCORS variables were left out of this analysis as their relationship to CALPAS scales are illustrated in Tables 11 and 12. As shown in Table 17, none of the CALPAS-P scales were correlated with MCSD scores, whereas all of the CALPAS-P scores were negatively correlated with GSI mean. There were some significant correlations between CALPAS-P scores and AAS subscales. AAS Depend was negatively correlated with PWC, WSC, TUI, and Mean. AAS Close was negatively correlated with Patient Working Capacity. AAS Anxiety was not correlated with any of the CALPAS-P scores.

As shown in Table 18, there were significant correlations between CALPAS-T scores and MCSD. All of the CALPAS-T scale scores, except for WSC, were significantly negatively correlated with MCSD. There were no other significant correlations between CALPAS-T scale scores and other Time 1 variables.

Research Question #3: How might client characteristics examined in this study be related to early client drop-out?

To evaluate additional contribution made by combining variables, a discriminant function was run despite the small sample size (8 drop outs, 40 Time 2 completers). The variables
entered in a step-wise equation were: MCSD, AAS Anxiety, AAS Depend, AAS Close, GSI, and all five SCORS variables. SCORS Relationships was the only variable that contributed significant unique variance to the prediction of drop-out vs. completer, $F(1, 46) = 8.93, p = .004$. The equation was not efficient at classifying group membership as only 1 of the participants who dropped out was classified correctly. However, all 40 of Time 2 completers were classified correctly. This finding should be interpreted with caution given the largely unequal cell size (8 vs. 40) and the small sample size.
CHAPTER 4

DISCUSSION

The primary purpose of this dissertation was to determine the relationship between therapy clients’ object relations functioning, as measured by the Thematic Apperception Test (TAT)-based Social Cognition and Object Relations Scale (SCORS) system, and the strength of the early working alliance in a sample of therapist-client pairs. The mean of the five SCORS scales, measured shortly after intake, was correlated with both therapist and client-rated alliance 3 sessions later, thus providing support for the hypothesis that clients with higher levels of object relations functioning tend to form a stronger working alliance in the early stages of therapy. A secondary goal was to test the construct validity of the SCORS, based on projective data, by examining its relationship with structured, self-report measures of global symptom severity, attachment, and the working alliance. The results of hypotheses linking the SCORS with other variables were mixed and illustrate the importance of examining different aspects of object relations independently. The remainder of this section will examine each hypothesis in detail, followed by a discussion of limitations and implications for research and clinical practice.

Based on theory and previous research, it was first hypothesized that individuals with lower levels of object relations functioning would have higher levels of symptom severity (Evans & Porcerelli, 2002). This hypothesis was not supported as clients’ total score across the SCORS dimensions was not significantly related to clients’ ratings of their global symptoms. Based on previous findings suggesting that the affective dimensions of the SCORS should be distinguished from the cognitive dimensions and might be more closely linked to pathology than the cognitive dimensions (Hibbard et al., 1995; Porcerelli, Cogan, & Hibbard, 1998), the second part of this hypothesis predicted that the affective dimensions would be more closely linked to global
symptom severity in this sample. This part of the hypothesis was supported as clients with more disturbed affective object relations dimensions tended to have higher global symptoms whereas there was no relationship between cognitive aspects and symptom severity. Furthermore, when the SCORS dimensions were examined independently, Affect Tone was the only variable that was linked to global symptom severity. This finding has important implications because it suggests that the link between object relations development, as operationalized in the SCORS system, and general levels of symptom severity is dependent on the specific dimension that is targeted.

Given the close theoretical relationship between attachment theory and object relations theory, the second hypothesis stated that individuals with lower levels of object relations functioning would also have higher levels of attachment disturbance. This hypothesis was not supported when the relationships between the combined SCORS value and the three Adult Attachment Scale (AAS) subscales were examined. This finding is consistent with that of Bridgman (2001) who found that the SCORS variables were not correlated with a structured self-report attachment measure. One possible explanation for the lack of significant relationship is that different methods were used to assess attachment and object relations. Structured self-report measures and scores based on less structured projective measures may not be related because each contains different method error variance rather than a lack of relationship between the two constructs being assessed. Thus, self-reports on structured attachment measures may represent the same construct as internal representations elicited by projective measures, but each may also represent contrasting error variance that dilute or cancel the statistical association. It may not mean, however, that the underlying constructs are unrelated. It should be noted, however, that the underlying constructs of attachment and object relations differ to some degree.
Despite the lack of relationship between the combined SCORS value and the AAS subscales, further analyses indicated that there was a significant inverse relationship between the SCORS Affect Tone variable and the AAS Anxiety scale. Thus, participants with more malevolent object representations also tended to rate themselves as having more anxiety about being abandoned in relationships. This finding is consistent with object relations theory that links the malevolent quality of internal representations with a fear of being abandoned. For instance, Masterson (1976) describes how the empathic failure of the borderline individual’s primary caretaker leaves the individual fearful of a malevolent and abandoning maternal object who can leave the person helpless, empty, alone, and abandoned. Individuals with this dynamic, as encompassed by the Affect Tone variable, are also likely to fear abandonment, as captured in the AAS Anxiety scale. On the other hand, the cognitive aspects of object relations were not related to participants’ self-report ratings of their relationship difficulties. As the results of the first hypothesis suggested, it is important to distinguish between the cognitive and affective dimensions of the SCORS in determining the relationship with other constructs.

The third hypothesis predicted that self-report attachment ratings would be more susceptible to the effects of social desirability than the projective object relations measure. This hypothesis was based on previous research which suggests that self-report ratings are more likely to be influenced by response styles and a desire to appear socially acceptable than are projective measures (McClelland et al., 1989). As expected, none of the SCORS variables were correlated with Marlowe-Crowne Social Desirability Scale (MCSD) scores. However, the AAS scales were also uncorrelated with MCSD scores. This finding suggests that the therapy clients in this study responded in a manner that was not confounded with a desire to obtain social approval. It may
be that therapy clients respond to the MCSD in a manner that is less susceptible to effects of social desirability than non-patients, since entering therapy implies undesirable disclosures.

Another explanation for the lack of connection between AAS scores and MCSD scores is that the MCSD may not adequately measure the construct that was of interest when this hypothesis was formulated. There is some inconsistency in the literature regarding what the MCSD actually measures. While it was originally developed to measure a need for social approval (Crowne & Marlowe, 1960), it has also been characterized as a measure of psychological defensiveness (Weinberger, Schwartz, & Davidson, 1979). On a cautionary note, Barger (2002) recommends that the MCSD not be used to control for response set bias because, “it does not measure one dimension of personality”, and, “available evidence suggests that the dimensions captured by the MC(SD) scale are not response biases in need of adjustment” (p. 300).

The seventh hypothesis will be discussed at this point because it is closely related to the above hypothesis. This hypothesis stated that, when social desirability is controlled for, object relations would be a better predictor of working alliance than attachment. In proposing this question, the goal was to compare the utility of the projective measure, which was thought to be less susceptible to defenses and response-set biases, to the self-report measure in predicting the therapy alliance. However, because attachment ratings were not confounded by social desirability in this sample, this hypothesis did not turn out to be as important as expected. Despite this, two regression analyses were computed and it was determined that the combined SCORS did not contribute significant unique variance to either client or therapist-rated alliance above and beyond the variance contributed by attachment scores.
The fourth hypothesis stated that individuals with lower object relations functioning would be more likely to drop out of therapy prematurely than clients with higher object relations functioning. Researchers and clinicians have suggested that individuals who have difficulty forming relationships may have difficulty tolerating the relationship with the therapist (Westen, 1991; Zetzel, 1956). This hypothesis was supported, as participants who dropped out of therapy and did not complete Time 2 had significantly lower average ratings on the combined SCORS than those who completed Time 2. This finding is similar to that of Ackerman et al. (2000) who found that the SCORS Relationships scale predicted the number of therapy sessions attended in a sample of individuals with a personality disorder diagnosis. Specifically, high scores on the Relationships variable were related to a greater number of sessions attended. The results of this hypothesis should be interpreted with caution due to the small and discrepant cell size of the two groups. The relationship of the SCORS and other variables to the prediction of dropout status will be further discussed in the Research Question section.

The fifth hypothesis predicted that higher quality of clients’ object relations functioning would be associated with higher levels of working alliance. This hypothesis was based on research and theory linking object relations functioning to the therapy relationship (Masterson, 1990; Ryan & Cicchetti, 1985). This hypothesis was indeed supported. Participants whose stories were given higher average ratings on the combined SCORS also tended to rate the alliance more positively. In addition, clients’ level of object relations functioning was predictive of therapists’ positive ratings of the alliance.

The second part of the fifth hypothesis stated that the affective dimensions of the SCORS would predict the alliance better than the cognitive dimensions. This hypothesis was based on the conceptual nature of the affective dimensions of the SCORS, especially Affect, which was
designed to assess, “the extent to which the person expects relationships to be destructive and threatening or safe and enriching;” and Relationships, which was designed to assess, “an individual’s level of commitment and emotional sharing in relationships” (Westen, 1991). It seems logical that these variables would be more closely related to the client’s ability to form an initial alliance with the therapist. This prediction was also based on previous research in which investigators have identified a link between the affective dimensions and not the cognitive dimensions of the SCORS and psychopathology (Ackerman et al., 2000). Multiple regression analyses revealed that this hypothesis was not supported, as the cognitive dimensions of SCORS accounted for the prediction of alliance scores, whereas the affective dimension did not. The above finding was in the opposite direction of what was expected. Furthermore, it is surprising given that the affective variables were related to anxious attachment and global symptom levels whereas the cognitive variables were not.

The sixth hypothesis stated that object relations functioning would be a better predictor of the working alliance than global symptom severity. This hypothesis was based on the idea that the object relations would be more specific to the relationship between therapist and client and thus be more closely linked with the alliance than general symptom levels would be. Also, previous research has indicated that object relations functioning contributes more variance to the prediction of the early alliance than general symptom levels (Ryan & Cicchetti, 1985). This hypothesis was unsupported when regression analyses revealed that the combined SCORS did not contribute significant unique variance to alliance scores when global symptom scores were entered first. However, independent correlations indicated that the combined SCORS was significantly correlated with the therapist-rated alliance mean whereas global symptom levels were not.
In general, when multiple regression analyses were computed, added predictor variables did not account for significant amounts of variance. This is likely related to the modest effect sizes and the low power analysis due to the small sample size. In addition, it is important to consider the influence of Type I error in analyses that involved computing multiple correlations among the different scales used in this study. Many of the significant findings made theoretical sense but it is important to interpret these results with caution, especially those demonstrating marginal significance.

Research Questions/Exploratory Analyses

Exploratory analyses were conducted to test several research questions. The first research question was designed to determine how specific aspects of object relations functioning were differentially related to the components of the working alliance. The combined SCORS was positively correlated with overall client and therapist-rated alliance, however, the question of how specific aspects of each measure were related was worth investigating in order to provide a better understanding of how these constructs are related. For instance, it would be important to know whether different components of the working alliance, such as the client’s ability to become actively engaged in the process of therapy, might be affected by deficits in one area of object relations functioning but not another.

Regarding the client-rated alliance, the SCORS variables were only correlated with the Patient Commitment scale of the CALPAS. Thus, clients’ object relations functioning was related to their perception that they were confident that their efforts would lead to change, and they were willing to make sacrifices and commit to the process of therapy. Patient Commitment was quite strongly related to the two cognitive SCORS variables, especially Complexity of
Representations. One of the more affective variables, Capacity for Investment in Relationships, was also correlated with Patient Commitment, whereas Affect Tone and Morals were not. Interestingly, the Affect Tone variable did not approach a significant relationship with any of the CALPAS-P scales. It may be that Affect Tone is more influenced by a client’s presenting symptoms, such as anxiety or depression, and does not have as much effect on the client’s ability to engage in a working alliance with the therapist.

For analyses involving therapist-rated alliance, SCORS variables were correlated with two CALPAS scales: Patient Working Capacity (PWC) and Working Strategy Consensus (WSC). The PWC scale represents the patient’s capacity to self-disclose, to explore one’s contribution to problems, and to work towards resolution of problems. Thus, it makes sense that this aspect of the alliance would be related to the Relationships variable of the SCORS, which involves the capacity to be committed and to emotionally share in relationships. The WSC scale represents an agreement between client and therapist regarding how people are helped and how therapy should proceed. Similar to client-rated alliance, the two SCORS variables that were correlated with therapist-rated alliance were Complexity of Representations and Capacity for Emotional Investment in Relationships. Interestingly, there was no link between the SCORS variables and Therapist Understanding and Involvement for either the client or therapist-rated alliance. This finding is consistent with that of Gaston (1991) in which TUI was the only scale not significantly correlated with symptom severity or the Inventory of Interpersonal Problems. This may be due to the fact that the TUI scale was developed to represent the therapist’s contribution to the alliance (Marmar, Gaston, et al., 1989).

The lack of relationship between Affect Tone and the working alliance ratings was quite unexpected as it was predicted that this would be the aspect of object relations functioning that
was most important to forming a positive therapy relationship. Perhaps clients’ capacity to invest in relationships was more important than the emotional tone of their relationships, as this variable was predictive of alliance for both therapist and client. Thus, individuals who have strengths in this area may be able to engage in a positive working alliance regardless of the affective quality of their object representations.

One explanation for the strong relationship between the cognitive SCORS variables and the working alliance is that the cognitive variables may also relate to the functions of the *observing ego*, which make an important contribution to an individual’s ability to engage in successful therapy. According to Horner (1991), the *observing ego* can enable the patient to, “stand back and ally himself or herself with the interviewer (therapist) to explore the patient’s wishes, feelings, beliefs, and actions” (p. 106). These functions sound strikingly similar to the descriptions of the construct that is tapped by the Patient Working Capacity scale of the CALPAS. Sterba (1934) emphasized the importance of the patient’s capacity to oscillate between observing and experiencing in therapy, which can be referred to as the “working alliance” and is the construct that the PWC scale is intended to measure (Gaston, 1991). Thus, it appears that there may be a link between the cognitive functions of object relations, as measured by the SCORS system, and the “working” aspect of the alliance.

When object relations theory is considered, it is not surprising the cognitive functions of internal representations are very important for therapy. For instance, complex cognitive functions are necessary for a client to make sense out of intensely negative affect. Horner (1991) describes the importance of cognition in the process of therapy:

> Cognition is one of the basic, innate capacities of the human brain. It is a resource we count on in the treatment process. As a basic tool, attention to
disordered cognition must be attended to first and foremost….Attention to the cognitive dimension of mental functioning is a sine qua non for structural change (p. 108).

The second research question was designed to investigate how Time 1 variables differentially relate to therapist versus client-rated alliance scores. Although clients and therapists generally agreed about the quality of the alliance, it was of interest to determine what factors contributed to the formation of the alliance from the perspective of the client versus the therapist. Analyses indeed revealed that the relationships between Time 1 variables and client versus therapy alliance perceptions were quite discrepant. For instance, global symptom severity, the combined cognitive SCORS variables, and AAS Depend all contributed significant unique variance in predicting the clients’ perception of the alliance. In contrast, only clients’ scores on a measure of social desirability were a significant unique predictor for therapists’ perception of the alliance. Few previous studies have compared client versus therapist alliance perceptions in this manner. One such study, Dyke (1996), found that client-rated Working Alliance Inventory (WAI) scores were related to the AAS Close dimension as well as to self-reported problems with intimacy but were not related to their object relations functioning, as measured by the Mayman Object Representation Scale. On the other hand, therapist WAI ratings were not related to Global Assessment of Functioning scores (GSI) or AAS scores but were correlated with object relations scores. There are some consistencies between the current findings and that of Dyke (1996) in that neither measures of global symptoms nor adult attachment were predictive of therapists’ alliance ratings.

Separate correlations were also examined to provide a more detailed look at these relationships. There was a strong relationship between global symptom severity and client
alliance ratings, as all 4 CALPAS-P scales were negatively correlated with GSI. This finding is consistent with Gaston’s (1991) validity study, in which the CALPAS-P was negatively correlated with a measure of global symptoms. The AAS Depend dimension was the only AAS scale correlated with the mean CALPAS-P score. This is consistent with Satterfield and Lyddon (1995) who found that only the Depend dimension was significantly correlated with the mean score on the Working Alliance Inventory. This finding suggests that the extent to which one feels that they can depend on others may be more important to the development of the working alliance than whether one is comfortable with closeness or fears being abandoned. However, results also suggested that discomfort with closeness, similar to avoidant attachment, predicts how capable the patient feels engaging in the therapy process. This is a similar finding compared to Gaston (1991) who found that patient-rated intimacy problems, as measured by the Inventory of Interpersonal Problems, were negatively correlated with Patient Working Capacity and Working Strategy Consensus. These findings suggest that patients who fear intimacy may not enter fully into the process of therapy, which involves revealing aspects of one’s internal self to another person. Interestingly, AAS Anxiety was not related to any of the CALPAS-P scales. This was inconsistent with previous findings (Eames & Roth, 2000; Satterfield & Lyddon, 1998) in which AAS Anxiety was correlated with ratings on the Working Alliance Inventory. It may be that differences between the alliance measures account for the discrepant findings.

In general it appears that specific aspects of clients’ perceptions of their symptoms and interpersonal problems are related to their perceptions of their ability to form an alliance with the therapist and engage in the process of therapy. It seems logical that clients’ self-perceived attributes would tend to be more related to each other than to the therapists’ perceptions of the alliance. Indeed, clients’ perceptions of their symptoms and attachment problems were not
related to therapists’ perceptions of the alliance. Therapists and clients base their ratings from
difference reference points. Clients may base their ratings on personal experience and other
relationships in their life history whereas therapists base ratings on clients’ progress (Bachelor &
Salame, 2000). Therapists are also likely to base alliance ratings on comparisons to other clients,
their knowledge of theory, and on their own life experiences. A better understanding of how
therapist-related variables contribute to their alliance perceptions should be pursued in future
research.

The strong relationship between therapist alliance ratings and clients’ scores on the social
desirability measure is unexpected and intriguing. It is possible that the MCSD is capturing an
element of defensiveness as well as a lack of psychological mindedness. As mentioned
previously, the MCSD has been viewed as a measure of defensiveness (Weinberger, Schwartz, &
Davidson, 1979). Therapists may be likely to perceive these characteristics in their interactions
with clients who score high on the MCSD and may view this presentation in a negative manner.
In addition, therapists with less experience may be more likely to be put off by a client who
presents in a defensive manner because of possible doubts about their own abilities to handle
such a client. It would be interesting to see if this finding is replicated in a study involving more
experienced therapists. Clients who are defensive and looking for social approval might also be
unlikely to provide negative ratings for the alliance, thus explaining the lack of correlation
between MCSD and client-rated alliance scores. Regardless of the reasons for this finding, it is
quite interesting and worthy of future exploration. The question arises, what does the MCSD
really capture, especially in relation to the therapy process?

Research Question #3 was formulated with the intention of determining whether
differences in Time 1 variables predicted those who did not complete Time 2 because they
dropped out of therapy prematurely. Although the drop-out rate was only 16%, a discriminant function analysis was computed to determine whether any of the Time 1 variables predicted drop-out status. When the three AAS scores, MCSD score, GSI, and the five SCORS variables were entered into the discriminant equation, only the SCORS Capacity for Investment in Relationships (Relationships) variable was retained as a significant unique predictor. T-tests also revealed that drop-outs and completers only differed significantly on their Relationships scores. Given that this variable is intended to measure the ability to engage in emotional sharing and commitment in relationships, the conceptual link with therapy drop-out is apparent. In fact, Westen (1991) described the highest level of functioning on this dimension as reflecting a motivation to pursue, “self-development and autonomy within the context of a mature, committed relationship.” This description also reflects the goal of psychotherapy. Perhaps individuals with very low scores on this dimension take longer to develop an alliance with the therapist or are not able to engage in the psychotherapy process for even a brief period of time.

Although this finding makes theoretical sense and provides compelling support for the construct validity of the SCORS Relationships variable, it is also very tenuous and should be interpreted with caution. From a statistical standpoint, the very discrepant size of the two groups (drop-outs versus completers) makes it difficult to place confidence in results of any analyses that compare them. Another statistical problem is that the discriminant function was not efficient in predicting drop-out status, as only one drop-out was accurately predicted. Apart from statistical considerations, the finding remains difficult to interpret because the reasons for client drop-out are unknown. It is possible that some of the 8 clients dropped out of therapy for reasons entirely unrelated to their object relations functioning or other symptoms. For instance, clients may have dropped out because of a change in their schedule or because of financial
difficulties. At any rate, the link between the Relationships variable and drop-out should be pursued in future research with a larger sample.

Additional Findings

In addition to the hypotheses and exploratory analyses, there were other significant findings that may be relevant for future research. Some unexpected relationships were found among demographic variables and measures. For instance, client age was negatively correlated with global symptom severity and positively correlated with social desirability. In order to determine whether older participants rated their symptoms as less severe due to the effects of social desirability, a partial correlation was computed. Results indicated that when social desirability was controlled for, the relationship between age and global symptom severity was no longer significant. These findings suggest that older individuals may have minimized the severity of their symptoms in an attempt to appear socially acceptable. It is not clear why older individuals scored higher in social desirability. This may be due to generational differences in the extent to which symptoms are endorsed.

Exploratory analyses revealed that among clients who reported previous therapy, the number of previous therapists was inversely related to the SCORS mean. In other words, the greater the number of previous therapists that clients reported, the poorer their developmental level of object relations. One possible explanation for this interesting finding is that the clients with a greater number of previous therapists were also more impaired with regard to personality functioning. Personality disturbances typically necessitate a longer course of treatment in comparison to Axis I disturbances. The longer course of therapy is likely associated with a greater number of therapists. In addition, individuals with personality disturbances, such as
Narcissistic or Borderline personality disorders may be less likely to maintain a long-standing relationship with one therapist due to their interpersonal difficulties and a tendency to quickly devalue the therapist.

Prior to testing hypotheses, it was necessary to determine whether the variability in data collection times would have a significant impact on alliance ratings. Analyses indicated that data collection time did not significantly impact any of the variables in this study, including therapist or client alliance ratings. This result is consistent with findings in similar studies (Bachelor & Salame, 2000; Mallincrodt, Coble, & Gantt, 1995). It should be noted that the variability in data collection times was small (1-3 sessions). There would likely have been a larger difference in alliance ratings had the data collection involved points in other phases of therapy. It has been suggested that the alliance is a dynamic process that changes over the course of therapy and much research has been devoted to exploring the course of the alliance (Gelso & Carter, 1994; Horvath et al., 1993; Luborsky, 1976). However, the lack of relationship between the number of sessions attended at Time 2 and alliance ratings lends support to the notion that there is little consistent, systematic change in the alliance from session to session in the early phase of treatment.

Although not significantly different, clients’ mean alliance scores were slightly higher than therapists’. In general, there was a great deal of agreement between clients and therapists on their alliance ratings. The only scale on which clients’ and therapists’ ratings did not correlate significantly was Patient Working Capacity. Clients rated this dimension significantly higher than did therapists, indicating that they had a more positive assessment of their ability to engage in therapy than did the therapists. Bachelor and Salame (2000) also found that clients and therapists in their study perceived the alliance similarly with the exception of alliance
variables involving clients’ self-reflection and self-exploration, with clients rating these
dimensions higher than did therapists. As mentioned previously, this phenomenon might be
attributed to the different comparisons that clients and therapists use to judge alliances, with
clients using their own life history and experience and therapists using theory and other clients.

Of interest were the significant correlations between four of the SCORS variables and the
average number of words per TAT story. The only variable that was not related to TAT story
length was Affect Tone. Hibbard et al. (1995) found that Complexity and Social Causality were
significantly correlated with Verbal Comprehension on the WAIS-R but not with Performance
IQ. The combination of these findings suggests that these scales are confounded to some degree
by verbal fluency and verbal intelligence. It is difficult to know whether this represents
construct-related variance or systematic measurement error because those with more complex
representations are likely to use more words to convey a more differentiated object world. One
issue for future research in the SCORS is to determine how to separate these constructs.
Regarding the relationship between the SCORS variables, the lack of relationship between
Affect Tone and story length adds further support to the notion that this variable is significantly
different across a number of dimensions.

Summary of Findings

In discussing the findings from the analyses, the results for each hypothesis were
considered in terms of consistency with the research literature and with theory. Clients who had
higher levels of object relations functioning, as measured by the SCORS mean, also tended to
rate the alliance more positively and received higher alliance ratings from their therapists. Thus,
the major hypotheses that linked object relations functioning to the quality of the early alliance were supported. In contrast, and in the opposite direction as expected, the cognitive variables were more predictive of client and therapist perceptions of the alliance. A more detailed analysis of these variables indicated that the cognitive dimensions of the SCORS and also the Relationships scale, were predictive of the working alliance in the early phases of treatment, whereas Affect Tone and Moral Standards were not. Overall, it appears that the link between object relations development and the working alliance is largely dependent on the dimension of object relations functioning that is being assessed.

Regarding the relationships among the SCORS variables, results of the current study point towards a clear distinction between the SCORS Affect Tone variable and the other four variables. In contrast to the findings regarding alliance ratings, Affect Tone was related to global symptom severity and anxious attachment, whereas the other SCORS variables were not. This distinction is further supported by lower correlations between the Affect Tone variable and the other SCORS variables. Furthermore, Affect Tone was the only variable that was not associated with the average number of words that clients used in their TAT stories. The implications of these findings will be discussed in the following section.

One of the goals of this study was to compare the SCORS with a self-report attachment measure in terms of their relationship with each other and with the working alliance. Results of hypotheses involving the SCORS and Adult Attachment Scale were somewhat surprising in that these measures were less strongly related than expected. Results also indicated that the measures were not globally related with each other but only in terms of specific relationships between individual scales. Affect Tone was the only SCORS variable that was correlated with an adult attachment scale and this variable was only correlated with the Anxiety subscale of the AAS.
This relationship suggests that individuals with malevolent object representations also tended to rate themselves as experiencing anxiety regarding abandonment. The conceptual relationship between Affect Tone and AAS Anxiety was further supported by the additional findings that they were both correlated with global symptom severity and not with therapist or client-rated alliance.

The Adult Attachment Scale was used to compare the predictive validity of a self-report measure versus a projective measure of relationship functioning in predicting the quality of the alliance. The question was: which measure can provide more useful information in predicting the alliance? A measure of social desirability was used to control for the effects of response set bias that might inflate the relationship between the Adult Attachment Scale and the self-report based alliance measure. Surprisingly, the measure of social desirability was unrelated to the Adult Attachment Scale ratings. In terms of comparing the predictive validity, both measures were related to client-rated alliance but only the SCORS was related to the therapist-rated alliance.

Exploratory analyses revealed more specific relationships between the measures used in this study and provided intriguing directions for future research. Capacity for Emotional Investment in Relationships, Understanding of Social Causality, and Complexity of Representations were the three SCORS variables that were significantly correlated with both therapist and client-rated alliance. For client ratings, these variables were correlated with their perceived level of commitment to the therapy process. For therapist ratings, these variables were related to perceptions of the clients’ ability to engage in the tasks required for therapy and a sense of agreement about the goals and tasks required for therapy. These findings provide a more specific understanding of how the complex phenomenon of object relations development
and the working alliance may be connected. Results of analyses involving multiple correlations should be interpreted with caution, as the large number of correlations increases the likelihood that significant findings will occur by chance. It will be important to replicate the findings in future studies.

Factors contributing to client versus therapist perceptions of the alliance were also investigated. Clients’ alliance ratings were predicted by their global symptom severity and perceived difficulty trusting others. Surprisingly, therapists’ alliance ratings were only predicted by clients’ scores on a measure of social desirability. In combination, these findings provide strong support to the notion that different factors contribute to client versus therapist perceptions of the alliance and that their perceptions are likely based on different points of reference.

Finally, a discriminant analysis was computed to determine whether Time 1 variables could predict whether clients dropped out of therapy before Time 2 or remained to complete Time 2. Results revealed that the SCORS variable, Capacity for Investment in Relationships, was the only Time 1 variable that was retained in the analysis as a significant predictor of drop-out status. The link between the capacity to invest in relationships and premature drop-out makes theoretical sense, however, there are several limitations of this finding. For instance, the cell sizes were small and unequal and the reasons why clients dropped out of therapy were not known.

In sum, results suggest that the SCORS system demonstrated utility in predicting the quality of the early working alliance from the perspective of both clients and therapists. It was clear that the nature of this link is dependent on the specific relationships between subscales of these measures. Additionally, separating Affective versus Cognitive dimensions of the SCORS
may not be efficient, as Affect Tone demonstrated discrepant relationships with the other variables that are considered “affective.”

Implications for Research and Clinical Practice

The findings in this study have important implications for research on the working alliance and the SCORS system, and also inform clinical practice through addressing the link between assessment and therapy. Very limited research has been conducted in which the SCORS variables are linked to psychotherapy, especially in relation to the working alliance. There was also a need in the literature for more informative instruments to assess clients’ pre-therapy dynamics in relation to the development of the working alliance. This study was intended to address a gap in both areas of research. The following section will include a discussion of how this study contributed to these areas of the literature as well as the implications for clinical practice. Suggestions will also be made for future research.

The primary intent of choosing the SCORS system for use in the current study was to assess more specific deficits in clients’ interpersonal functioning in order to clarify the relationship between client pre-therapy characteristics and the working alliance. Based on the findings of the current study, the notion that it is important to assess specific areas versus global functioning was supported. The development of complex cognitive representations and the ability to invest in mutual relationships predicted both therapist and client alliance ratings.

Surprisingly, the affective quality of a client’s object representations did not have an impact on therapist or client perceptions of the working alliance. This was unexpected because the Affect Tone variable was proposed to represent the degree to which an individual perceives their interpersonal world as safe versus threatening. It is unclear why low scores on this measure would not predict early alliance difficulties. It is possible that the ability of a client to invest in
mutual and sharing relationships is more important in predicting engagement in successful therapy and supercedes the degree to which a client perceives the world as safe or threatening. It may also be that some individuals who have an expectation that relationships will be harmful, and thus obtain low scores on Affect Tone, may also have well developed and integrated cognitive representations, which are reflected in higher scores on the cognitive SCORS variables. The cognitive strengths of this individual may help them to organize and make sense of intense negative affect, and thus be able to work productively in therapy (Santostefano, 1991). In line with this reasoning it follows that knowing information about only one aspect of object relations functioning limits our ability to predict an individual’s behavior. Instead, we need to know how an individual differs on each dimension and how these strengths and weaknesses relate to the ability to engage in a productive working alliance.

Future research should seek to examine individuals’ strengths and deficits across the SCORS dimensions and to determine how these factors interact to predict how clients will engage in the therapeutic relationship. One possible method for clarifying some of these questions is to focus on configurations of individuals’ scores across the five dimensions rather than looking at overall means across a sample. Westen (1991) suggested that a focus on discrete variables allows one to explore interactions of cognitive and affective functions and enables researchers and clinicians to identify individual differences that may allow us to form subgroups of patients with particular disorders. For example, a person can have difficulty investing in other people emotionally while still being able to take the perspective of others, a dynamic that is often seen in the antisocial personality. An example from the current study may be an individual who perceives relationships as threatening but also has complex internal representations that allow the person to engage in the therapy process. Again, the important point that arises is that we can’t
Another important question that was not addressed in this study was how the relationships among object relations functioning and the working alliance would change over the course of psychotherapy. As mentioned in the literature review, the alliance typically fluctuates over time in response to different tasks that must occur at different stages in therapy (Luborsky, 1976). For instance, it has been suggested that the course of the alliance is characterized by an initial increase during approximately the first five sessions followed by a second phase in which the alliance weakens as the therapist challenges the client’s maladaptive patterns (Gelso & Carter, 1994; Horvath et al., 1993). It may be that individuals with poor interpersonal functioning are sometimes able to form an initially positive alliance but are less likely to maintain a positive alliance during the later phases of therapy when the therapist challenges maladaptive patterns (Bachelor & Salame, 2000). To further complicate this picture, object relations, like the working alliance, is not a static phenomenon, and levels of object relations are likely to fluctuate from one session to the next (Waldinger & Gunderson, 1987).

One important consideration for the findings of this study is the possibility that some individuals, such as those with traits of Borderline Personality Disorder, may tend to idealize the therapist in the early phases of treatment. This dynamic would attenuate the relationship between object relations functioning and the development of the working alliance and may account for the lack of relationship between the Affect Tone variable and the alliance ratings in the current study. It has been theorized that individuals with borderline pathology assign a positive transference towards their therapist in order to protect themselves from the negative transference (Kernberg, 1979). Thus, it is possible that some individuals, despite having poorly
developed object relations, may initially respond very positively to alliance questionnaires due to the tendency to see the therapist as “all good.” This relationship might change in later phases of therapy when the therapist makes a mistake and is then seen as “all bad.” Rather than assessing the true working relationship between therapist and client, what might be assessed in these clients is the early transference relationship and the primitive defense mechanism of splitting. Greenson (1965) recognized this phenomenon when he emphasized the importance of distinguishing between the real aspects of the therapy relationship and the unfolding transference relationship.

Regarding implications for the SCORS system as an assessment tool to inform psychotherapy, a number of important questions are posed by the current findings. For instance, what do the SCORS variables really mean and how are they related to each other and the process of psychotherapy? Future research should seek to determine why the cognitive variables may be more closely related to the alliance than the Affect Tone variable, and whether there are other variables, such as intelligence or psychological mindedness, that confound this relationship. Is the Affect Tone variable more unstable over time and more likely to vary with symptom levels as measured by GSI? It would also be informative to determine how affective versus cognitive object relations functioning changes over the course of and in response to psychotherapy. Although previous researchers have suggested a lack of relationship between the cognitive SCORS variables and psychopathology (Hibbard et al., 1995), the current study contributes to research on the SCORS because it identified a link between the cognitive SCORS variables and the strength of the working alliance.

In regard to future research with the SCORS, it is apparent that the mean of the SCORS may not be very informative because the subscales demonstrate a great deal of variability in their
relationships to other constructs. There seems to be a clear distinction between Affect Tone and the two cognitive variables but there is not much distinction between the two cognitive variables. Complexity and Social Causality are highly intercorrelated and it is unclear whether they are assessing meaningfully different constructs. At the same time, it should be noted that one should be cautious in discussing cognitive versus affective aspects of object relations as discrete categories as these processes are closely interrelated (Westen, 1991). As mentioned previously, Hibbard et al. (1995) suggested that affective versus cognitive variables of the SCORS should be distinguished from each other due to their different relationships with aspects of psychopathology. Results of this study suggest a somewhat different distinction among SCORS variables. Specifically, it appears that the Affect Tone variable is distinct from the other SCORS variables in its relationship to other constructs such as attachment, self-reported symptoms, and therapy alliance. This is not surprising because the Affect Tone variable is also the only SCORS dimension that is not theoretically connected to a developmental progression.

This study contributes to object relations theory because it underscores the risks of assuming that individuals with developmental deficits in one area of functioning will necessarily be impaired in all areas. For instance, Westen (1991) describes the limitations of object relations theory and questions the assumption that borderline pathology lies on a continuum of development between psychosis and neurosis. To illustrate this point, Blatt, Brenneis, and Schimek (1976) found that on one dimension of a Rorschach based scoring system, malevolence, borderline individuals were more disturbed than psychotic individuals but the object representations of borderline subjects were more advanced cognitively than the representations of healthier subjects. Clinicians are well aware that there is not one type of borderline individual but, instead, there is a great deal of variability in the way that borderline pathology is manifested
(Waldinger & Gunderson, 1987). It would be a mistake to apply one set of rules about how to conduct therapy with a borderline individual to all individuals assumed to have borderline dynamics.

In approaching treatment planning, it will be necessary for clinicians to understand that not all individuals with borderline dynamics should be treated in the same manner. For instance, an individual can have internal representations that are characterized by malevolence yet also have an observing ego that will allow them to engage in the task of therapy despite their fears of being harmed or abandoned. In contrast, the client who has malevolent object representations but also a lack of observing ego may not be able to engage in the tasks of therapy for many months or even years. The present findings highlight the fact that clinicians will lose important information if they do not consider how different aspects of deficits and strengths interact to predict each individual’s response to therapy. In line with the above argument, future research should focus on how therapists can use information gleaned from the SCORS to tailor their interventions for individual clients. Such a line of research may further increase our knowledge of the interplay between object relations phenomenon and important aspects of the therapy process, such as the working alliance.

Regarding implications for clinical practice, research involving the SCORS helps to further develop object relations theory by enhancing our ability to discriminate between different types of pathology. Fine tuning the assessment process in such a way should also contribute to an increase in our understanding of how assessment can contribute to tailoring treatment approaches. Because it can identify various strengths and weaknesses in object relations functioning, the SCORS may also be used by clinicians to identify clients who are successful candidates for brief dynamic psychotherapy. Individuals with various deficits in personality
development are not likely to respond to this type of therapy and should be excluded at the outset (Henry & Strupp, 1990). This function is quite relevant in the current climate of managed care where such short-term modalities are increasingly utilized.

Limitations

There were several important limitations of the current study. First, there was a possible selection bias as clients who had the most severe interpersonal deficits may have been among those who did not volunteer to participate. Simply put, those who have difficulty trusting others may also be unlikely to trust participation in a research project. Additionally, clients who volunteer to participate may tend to be more agreeable in general and more likely to experience an initially positive alliance with their therapists. Clients who participated did tend to rate alliance scores quite positively and it may be that the range of variance in alliance scores was restricted due to the effects of this selection bias. Furthermore, the alliance ratings of those who dropped out of therapy before Time 2 were not obtained, which may have further limited the range of variability in alliance scores. Had some of the clients who did not participate or dropped out been included in the sample, the relationships between poor object relations development and working alliance may have been more pronounced.

Another limitation was the variability in the point at which Time 1 and Time 2 data was collected. Reasons for this variability included difficulty contacting clients by telephone, scheduling conflicts, missed appointments, and failure of two clients to complete Time 2 questionnaires when they were given. This problem reflects the general pitfalls of conducting clinical research but also the constraints of conducting clinical research in a clinic that does not serve primarily as a research facility. Despite this limitation, results of the analyses indicated
that the variability in data collection times did not have an impact on alliance ratings. It is possible that the impact of collection times was present but was not statistically significant due to the small sample size.

An important constraint in the current study was the lack of statistical control for therapist effects. The study involved a nested design in which some therapists gave alliance ratings for more than one client. However, some therapists had only one client participating whereas some therapists had four or five clients participating. This design is commonly seen in studies involving the therapy alliance (Busseri & Tyler, 2004; Greenberg & Webster, 1982; Hartley & Strupp, 1983; Marmar, Weiss, & Gaston, 1989). Unfortunately, when the therapist effects are not tested, the findings of such studies are confounded by therapist effects (Crits-Christoph & Mintz, 1991). The statistical procedures required for this analysis were beyond the scope of this dissertation. Although therapist effects were not a central part of the hypotheses, it would have been informative to assess whether the individual therapists or their demographic characteristics had a systematic impact on their alliance ratings. Had the number of participants been greater, the statistical analyses required for answering these questions would have been feasible. In a similar vein, this study is limited in that it did not investigate the therapists’ attachment or object relations functioning. Many researchers and theorists emphasize the importance of how the therapists own experiences and representations affect the process of the therapy and also the perception of the alliance (Bordin, 1979; Orlinsky & Howard, 1986; Wallerstein & Gunderson, 1987).

The limited experience level of the therapists participating in this study reduces the generalizability of the current findings. Most of the therapists had less than one year of therapy experience and were just beginning their training. Experienced therapists may be more accurate.
in rating the quality of the alliance because they are more likely to be aware of significant factors that contribute to a client’s ability to benefit from therapy. Trainees have been found to progress from a developmental stage of self-focus to client-focus (Stoltenberg & Delworth, 1987), thus is likely that in the stage of self-focus a beginning therapist is less aware of important aspects of the client involvement in the therapy process. There has been some inconsistency in the literature regarding the effects of therapist experience on alliance scores. Mallinckrodt and Nelson (1991) found that more experienced therapists received and gave higher ratings on the Tasks and Goals dimension of the Working Alliance Inventory whereas Dunkle and Friedlander (1996), also using the WAI to measure working alliance across therapist experience level, found that experience level of therapists was not predictive of clients’ alliance ratings. Horvath (2000) suggests that alliance is less affected by therapist training level in the earlier stages of treatment and becomes more important in the later phases. Regardless of the discrepant findings regarding therapist experience level, it would be important to replicate this study with a more experienced therapist population to increase the generalizability of the current findings.

In a similar vein, it is a potential constraint that the two raters for the TAT stories had limited clinical experience. Raters with more clinical experience might be more accurate in judging the level of pathology along the dimensions of development that were assessed with the SCORS system. This is particularly because the constructs being measured are complex and require an advanced understanding of psychopathology. Furthermore, it would have been preferable to have one or two more raters to increase reliability, which was lower in the current study than in previous studies using the SCORS. These limitations were difficult to avoid due to the extensive time commitment required for the coding process and the limited resources available to compensate raters.
The relatively small sample size can also be seen as a limitation. The small sample size limited statistical power and may have prevented some of the small effect sizes from reaching significance. The small sample size also limits the generalizability of the findings. Had the sample size been larger it also would have been possible to address the nested nature of the data and control for therapist effects on alliance ratings. Because of the small sample size, hierarchical linear modeling techniques were not used to address this aspect of the data. The hypotheses involving participant drop-out were also somewhat tenuous given the small sample size, especially regarding the small number of participants who dropped out of the study.

One aspect of the current study worth critical examination is the use of self-report measures such as the CALPAS and the Adult Attachment Scale to assess the construct validity of a scoring system that is based on a projective measure. According to McClelland (1980) and Cramer (1996), it is best not to assess the construct validity of a TAT scoring system by looking at its relationship to self-report measures. For instance, how a client’s self-report of his or her relationship with the therapist is related to processes that are proposed to operate outside of awareness, such as internal object representations, is unclear. It would be informative in future research to assess more qualitative aspects of the therapy process, observer ratings of the therapy process, or various outcome dimensions that are not based on self-report results.

On a final note, the working alliance is a very complex and dynamic process involving an interaction between two people and it is important to emphasize the limitations of this study. For instance, it only provided a snapshot of one point of time in the early stage of therapy, therapists generally had very limited experience, and the impact of therapist characteristics on the alliance formation was not examined. Despite these problems, this study contributes important
information for future research and clinical practice regarding the working alliance, personality assessment, object relations phenomenon, and the validity of the SCORS system.
Table 1

Demographic Characteristics of Client Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Female</td>
<td>31</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>32.31</td>
</tr>
<tr>
<td>Range</td>
<td>19-70</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>35</td>
</tr>
<tr>
<td>African-American</td>
<td>4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>22</td>
</tr>
<tr>
<td>Married</td>
<td>9</td>
</tr>
<tr>
<td>Committed Relationship</td>
<td>5</td>
</tr>
<tr>
<td>Divorced</td>
<td>11</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Masters’</td>
<td>5</td>
</tr>
<tr>
<td>Bachelors’</td>
<td>13</td>
</tr>
<tr>
<td>Some college</td>
<td>34</td>
</tr>
<tr>
<td>Highschool</td>
<td>2</td>
</tr>
<tr>
<td>10th grade</td>
<td>4</td>
</tr>
</tbody>
</table>
Table 2

Clients’ Previous Therapy Experience

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Therapy</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
</tr>
<tr>
<td># Previous Therapists</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>2.1</td>
</tr>
<tr>
<td>Range</td>
<td>1-15</td>
</tr>
<tr>
<td>Amount Previous Therapy</td>
<td></td>
</tr>
<tr>
<td>&lt;6 months</td>
<td>3</td>
</tr>
<tr>
<td>6-11 months</td>
<td>9</td>
</tr>
<tr>
<td>1-2 years</td>
<td>11</td>
</tr>
<tr>
<td>2-5 years</td>
<td>20</td>
</tr>
<tr>
<td>&gt; 5 years</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 3

Number of Clients per Therapist

<table>
<thead>
<tr>
<th># Clients per Therapist</th>
<th>Frequency Therapists</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12</td>
<td>46.2</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>38.5</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>3.8</td>
</tr>
</tbody>
</table>
Table 4

Average Reliabilities for SCORS Variables Across TAT Cards

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>6</th>
<th>7</th>
<th>10</th>
<th>12</th>
<th>13</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex</td>
<td>.83</td>
<td>.88</td>
<td>.76</td>
<td>.88</td>
<td>.71</td>
<td>.73</td>
<td>.78</td>
<td>.81</td>
<td>.79</td>
<td>.80</td>
</tr>
<tr>
<td>Affect</td>
<td>.83</td>
<td>.90</td>
<td>.91</td>
<td>.72</td>
<td>.89</td>
<td>.89</td>
<td>.89</td>
<td>.88</td>
<td>.91</td>
<td>.87</td>
</tr>
<tr>
<td>Rlshps</td>
<td>.73</td>
<td>.86</td>
<td>.70</td>
<td>.73</td>
<td>.88</td>
<td>.68</td>
<td>.83</td>
<td>.81</td>
<td>.86</td>
<td>.79</td>
</tr>
<tr>
<td>Morals</td>
<td>.67</td>
<td>.75</td>
<td>.81</td>
<td>.80</td>
<td>.75</td>
<td>.85</td>
<td>.83</td>
<td>.81</td>
<td>.75</td>
<td>.78</td>
</tr>
<tr>
<td>SocialC</td>
<td>.80</td>
<td>.86</td>
<td>.86</td>
<td>.70</td>
<td>.87</td>
<td>.77</td>
<td>.85</td>
<td>.80</td>
<td>.87</td>
<td>.82</td>
</tr>
</tbody>
</table>

*Note.* Analyses based on Spearman’s rho.

Table 5

Expected and Observed Means and Standard Deviations

<table>
<thead>
<tr>
<th>Measure</th>
<th>Cell n</th>
<th>Expected Mean</th>
<th>Expected Std. Dev.</th>
<th>Cell n</th>
<th>Observed Mean</th>
<th>Observed Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCSD-SF</td>
<td>399</td>
<td>5.39</td>
<td>2.85</td>
<td>48</td>
<td>5.75</td>
<td>2.77</td>
</tr>
<tr>
<td>AAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depend</td>
<td>60</td>
<td>19.73</td>
<td>4.75</td>
<td>48</td>
<td>19.7</td>
<td>4.49</td>
</tr>
<tr>
<td>Anxiety</td>
<td>60</td>
<td>15.30&lt;sub&gt;b&lt;/sub&gt;</td>
<td>5.19</td>
<td>48</td>
<td>17.0&lt;sub&gt;b&lt;/sub&gt;</td>
<td>5.33</td>
</tr>
<tr>
<td>Close</td>
<td>60</td>
<td>21.43&lt;sub&gt;b&lt;/sub&gt;</td>
<td>3.99</td>
<td>48</td>
<td>16.3&lt;sub&gt;b&lt;/sub&gt;</td>
<td>5.51</td>
</tr>
<tr>
<td>SCL-90-R</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GSI&lt;sup&gt;c&lt;/sup&gt;</td>
<td>400</td>
<td>1.26</td>
<td>.68</td>
<td>48</td>
<td>1.29</td>
<td>.64</td>
</tr>
<tr>
<td>CALPAS-P&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TUI</td>
<td>29</td>
<td>6.49</td>
<td>.68</td>
<td>40</td>
<td>6.23</td>
<td>.82</td>
</tr>
<tr>
<td>PWC</td>
<td>29</td>
<td>5.38</td>
<td>.86</td>
<td>40</td>
<td>5.34</td>
<td>.72</td>
</tr>
<tr>
<td>PC</td>
<td>29</td>
<td>6.06</td>
<td>.88</td>
<td>40</td>
<td>5.86</td>
<td>.82</td>
</tr>
<tr>
<td>WSC</td>
<td>29</td>
<td>6.20&lt;sub&gt;b&lt;/sub&gt;</td>
<td>.93</td>
<td>40</td>
<td>5.78&lt;sub&gt;b&lt;/sub&gt;</td>
<td>1.19</td>
</tr>
<tr>
<td>CALPAS-T&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TUI</td>
<td>29</td>
<td>5.81</td>
<td>.69</td>
<td>40</td>
<td>5.51</td>
<td>.85</td>
</tr>
<tr>
<td>PWC</td>
<td>29</td>
<td>4.72</td>
<td>1.09</td>
<td>40</td>
<td>4.58</td>
<td>1.22</td>
</tr>
<tr>
<td>PC</td>
<td>29</td>
<td>5.25</td>
<td>1.30</td>
<td>40</td>
<td>4.88</td>
<td>1.23</td>
</tr>
<tr>
<td>WSC</td>
<td>29</td>
<td>5.29&lt;sub&gt;b&lt;/sub&gt;</td>
<td>.98</td>
<td>40</td>
<td>4.70&lt;sub&gt;b&lt;/sub&gt;</td>
<td>.87</td>
</tr>
<tr>
<td>SCORS&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complexity</td>
<td></td>
<td>2.75</td>
<td>.53</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affect Tone</td>
<td></td>
<td>3.02</td>
<td>.46</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationships</td>
<td></td>
<td>2.19</td>
<td>.48</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morals</td>
<td></td>
<td>2.36</td>
<td>.29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Causality</td>
<td></td>
<td>2.80</td>
<td>.65</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. The information presented in this table was gathered from the following sources:

MCSD-SF (Ballard, 1992): sample of undergraduates.

AAS (Satterfield & Lyddon, 1995): sample from university-based clinic.


CALPAS-P and CALPAS-T (Bachelor & Salame, 1999); sample from university-based clinic.

<sup>a</sup>Comparison means for SCORS were not available.

<sup>b</sup>Means with subscripts differ at \( p < .05 \).
Table 6

Correlations Between Time 1 Variables

<table>
<thead>
<tr>
<th></th>
<th>MCSD</th>
<th>AAS-D</th>
<th>AAS-A</th>
<th>AAS-C</th>
<th>GSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCSD</td>
<td>------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAS-D</td>
<td>-.15</td>
<td>------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAS-A</td>
<td>-.28</td>
<td>.13</td>
<td>------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAS-C</td>
<td>-.10</td>
<td>.47**</td>
<td>.20</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>GSI</td>
<td>-.18</td>
<td>.27</td>
<td>.34*</td>
<td>.28</td>
<td>------</td>
</tr>
</tbody>
</table>

Note: AAS-D = AAS-Depend, AAS-A = AAS-Anxiety, AAS-C = AAS Close.

High scores on AAS scales represent greater attachment disturbance.

N = 48.

*p < .05. **p < .01.
Table 7
Correlations Among SCORS Subscales Controlled for Story Length

<table>
<thead>
<tr>
<th>Complexity</th>
<th>Affect Tone</th>
<th>Relationships</th>
<th>Morals</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity</td>
<td>-----</td>
<td>-.01</td>
<td>.57**</td>
<td>.58**</td>
</tr>
<tr>
<td>Affect Tone</td>
<td>-.01</td>
<td>-----</td>
<td>.53**</td>
<td>.56**</td>
</tr>
<tr>
<td>Relationships</td>
<td>.57**</td>
<td>.53**</td>
<td>-----</td>
<td>.84**</td>
</tr>
<tr>
<td>Morals</td>
<td>.58**</td>
<td>.56**</td>
<td>.84**</td>
<td>-----</td>
</tr>
<tr>
<td>Causality</td>
<td>.85**</td>
<td>.01</td>
<td>.50**</td>
<td>.51**</td>
</tr>
</tbody>
</table>

N= 40.
*p < .05. **p < .01.
Table 8
Correlations Among Patient and Therapist CALPAS Scores

<table>
<thead>
<tr>
<th>Therapist Alliance Scales</th>
<th>PWC</th>
<th>PC</th>
<th>WSC</th>
<th>TUI</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>PWC</td>
<td>.28</td>
<td>.26</td>
<td>.63**</td>
<td>.53**</td>
<td>.62**</td>
</tr>
<tr>
<td>PC</td>
<td>.25</td>
<td>.53**</td>
<td>.54**</td>
<td>.46**</td>
<td>.55**</td>
</tr>
<tr>
<td>WSC</td>
<td>.35*</td>
<td>.44**</td>
<td>.49**</td>
<td>.42**</td>
<td>.52**</td>
</tr>
<tr>
<td>TUI</td>
<td>.17</td>
<td>.49**</td>
<td>.58**</td>
<td>.32**</td>
<td>.52**</td>
</tr>
<tr>
<td>Mean</td>
<td>.29</td>
<td>.55**</td>
<td>.61**</td>
<td>.50**</td>
<td>.60**</td>
</tr>
</tbody>
</table>

Note. PWC = Patient Working Capacity, PC = Patient Commitment, WSC = Working Strategy Consensus, TUI = Therapist Understanding and Involvement.
N = 40.
*p < .05. **p < .01.
Table 9
Correlations Between Time 1 Variables and SCORS Variables

<table>
<thead>
<tr>
<th></th>
<th>MCSD</th>
<th>AAS-D</th>
<th>AAS-A</th>
<th>AAS-C</th>
<th>GSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity</td>
<td>-.06</td>
<td>.06</td>
<td>-.01</td>
<td>-.02</td>
<td>-.04</td>
</tr>
<tr>
<td>Affect Tone</td>
<td>.15</td>
<td>-.08</td>
<td>-.29*</td>
<td>-.11</td>
<td>-.42**</td>
</tr>
<tr>
<td>Relationships</td>
<td>.07</td>
<td>-.12</td>
<td>-.17</td>
<td>-.13</td>
<td>-.28*</td>
</tr>
<tr>
<td>Morals</td>
<td>.20</td>
<td>.03</td>
<td>-.11</td>
<td>-.04</td>
<td>.20</td>
</tr>
<tr>
<td>Causality</td>
<td>-.14</td>
<td>.19</td>
<td>.14</td>
<td>.02</td>
<td>.04</td>
</tr>
<tr>
<td>SCORAFF</td>
<td>.15</td>
<td>-.09</td>
<td>-.23</td>
<td>-.12</td>
<td>-.38**</td>
</tr>
<tr>
<td>SCORCOG</td>
<td>-.11</td>
<td>.14</td>
<td>.07</td>
<td>.00</td>
<td>.01</td>
</tr>
</tbody>
</table>

*Note.* Correlations controlled for TAT Story Length.

AAS-D = AAS-Depend, AAS-A = AAS-Anxiety, AAS-C = AAS Close.

High scores on AAS scales represent greater attachment disturbance.

SCORAFF = mean of Affect Tone, Relationships, and Morals; SCORCOG = mean of Complexity and Causality.

N = 48.

*p < .05., **p < .01.
Table 10

Summary of Hierarchical Regression Analysis for Variables Predicting GSI

<table>
<thead>
<tr>
<th>Step</th>
<th>R²</th>
<th>Change in R²</th>
<th>F</th>
<th>Zero Order</th>
<th>Partial</th>
<th>Beta</th>
<th>t</th>
<th>sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Story Length</td>
<td>.02</td>
<td>.02</td>
<td>1.03</td>
<td>.15</td>
<td>.15</td>
<td>.15</td>
<td>1.02</td>
<td>.32</td>
</tr>
<tr>
<td>SCORCOG</td>
<td>.02</td>
<td>.00</td>
<td>.00</td>
<td>.07</td>
<td>.01</td>
<td>.01</td>
<td>.04</td>
<td>.97</td>
</tr>
<tr>
<td>SCORAFF</td>
<td>.19</td>
<td>.17</td>
<td>9.02**</td>
<td>-.32</td>
<td>-.41</td>
<td>-.46</td>
<td>-3.0</td>
<td>.004</td>
</tr>
</tbody>
</table>

Note: Story Length = Average number of words across TAT stories.
SCORCOG = Mean of Complexity and Causality.
SCORAFF = Mean of Affect Tone, Relationships, and Morals.
N = 48.
Table 11

Correlations Between CALPAS-P and SCORS variables

<table>
<thead>
<tr>
<th></th>
<th>PWC</th>
<th>PC</th>
<th>WSC</th>
<th>TUI</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity</td>
<td>.29</td>
<td>.52**</td>
<td>.31</td>
<td>.27</td>
<td>.39*</td>
</tr>
<tr>
<td>Affect Tone</td>
<td>.15</td>
<td>.11</td>
<td>.03</td>
<td>.03</td>
<td>.09</td>
</tr>
<tr>
<td>Relationships</td>
<td>.31</td>
<td>.40*</td>
<td>.27</td>
<td>.23</td>
<td>.35*</td>
</tr>
<tr>
<td>Morals</td>
<td>.16</td>
<td>.24</td>
<td>.04</td>
<td>.04</td>
<td>.13</td>
</tr>
<tr>
<td>Causality</td>
<td>.12</td>
<td>.37*</td>
<td>.17</td>
<td>.13</td>
<td>.23</td>
</tr>
<tr>
<td>SCORS Mean</td>
<td>.25</td>
<td>.44**</td>
<td>.22</td>
<td>.19</td>
<td>.32*</td>
</tr>
</tbody>
</table>

Note. PWC= Patient Working Capacity, PC = Patient Commitment, WSC= Working Strategy Consensus, TUI = Therapist Understanding and Involvement. 
N= 40. 
*p < .05, **p < .01.
<table>
<thead>
<tr>
<th></th>
<th>PWC</th>
<th>PC</th>
<th>WSC</th>
<th>TUI</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity</td>
<td>.32*</td>
<td>.30</td>
<td>.34*</td>
<td>.22</td>
<td>.32*</td>
</tr>
<tr>
<td>Affect Tone</td>
<td>-.06</td>
<td>.02</td>
<td>.10</td>
<td>.03</td>
<td>.02</td>
</tr>
<tr>
<td>Relationships</td>
<td>.32*</td>
<td>.26</td>
<td>.43**</td>
<td>.25</td>
<td>.34*</td>
</tr>
<tr>
<td>Morals</td>
<td>.10</td>
<td>.10</td>
<td>.21</td>
<td>.09</td>
<td>.13</td>
</tr>
<tr>
<td>Causality</td>
<td>.25</td>
<td>.18</td>
<td>.28</td>
<td>.19</td>
<td>.24</td>
</tr>
<tr>
<td>SCORS Mean</td>
<td>.25</td>
<td>.23</td>
<td>.36*</td>
<td>.21</td>
<td>.28*</td>
</tr>
</tbody>
</table>

*Note.* PWC = Patient Working Capacity, PC = Patient Commitment, WSC = Working Strategy Consensus, TUI = Therapist Understanding and Involvement.

N = 40.

*p < .05, **p < .01.
Table 13

**Summary of Hierarchical Regression Analysis for Variables Predicting CALPAS**

### CALPAS-P

<table>
<thead>
<tr>
<th>Step</th>
<th>R²</th>
<th>Change in R²</th>
<th>F</th>
<th>Zero Order</th>
<th>Partial</th>
<th>Beta</th>
<th>t</th>
<th>sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Story Length</td>
<td>.01</td>
<td>.01</td>
<td>.52</td>
<td>-.12</td>
<td>-.12</td>
<td>-.12</td>
<td>-.72</td>
<td>.48</td>
</tr>
<tr>
<td>SCORCOG</td>
<td>.11</td>
<td>.10</td>
<td>4.09</td>
<td>.22</td>
<td>.32</td>
<td>.35</td>
<td>2.02</td>
<td>.05</td>
</tr>
<tr>
<td>SCORAFF</td>
<td>.12</td>
<td>.01</td>
<td>.44</td>
<td>.17</td>
<td>.11</td>
<td>.12</td>
<td>.66</td>
<td>.51</td>
</tr>
</tbody>
</table>

### CALPAS-T

<table>
<thead>
<tr>
<th>Step</th>
<th>R²</th>
<th>Change in R²</th>
<th>F</th>
<th>Zero Order</th>
<th>Partial</th>
<th>Beta</th>
<th>t</th>
<th>sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Story Length</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>-.05</td>
<td>.00</td>
<td>.00</td>
<td>.99</td>
</tr>
<tr>
<td>SCORCOG</td>
<td>.08</td>
<td>.08</td>
<td>3.36</td>
<td>.26</td>
<td>.24</td>
<td>.25</td>
<td>1.36</td>
<td>.18</td>
</tr>
<tr>
<td>SCORAFF</td>
<td>.09</td>
<td>.01</td>
<td>.13</td>
<td>.15</td>
<td>.07</td>
<td>.08</td>
<td>.40</td>
<td>.67</td>
</tr>
</tbody>
</table>

*Note:* Story Length = Average number of words across TAT stories.
SCORCOG = Mean of Complexity and Causality.
SCORAFF = Mean of Affect Tone, Relationships, and Morals.
N = 40.
Table 14
Summary of Hierarchical Regression Analysis Comparing SCORS and GSI as CALPAS Predictors

### CALPAS-P

<table>
<thead>
<tr>
<th>Step</th>
<th>R²</th>
<th>Change in R²</th>
<th>F</th>
<th>Zero Order</th>
<th>Partial</th>
<th>Beta</th>
<th>t</th>
<th>sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Story Length</td>
<td>.01</td>
<td>.01</td>
<td>.52</td>
<td>-.12</td>
<td>-.12</td>
<td>-.12</td>
<td>-.72</td>
<td>.48</td>
</tr>
<tr>
<td>GSI</td>
<td>.18</td>
<td>.16</td>
<td>7.21</td>
<td>-.42</td>
<td>-.40</td>
<td>-.41</td>
<td>-2.7</td>
<td>.01</td>
</tr>
<tr>
<td>SCORMEAN</td>
<td>.23</td>
<td>.06</td>
<td>2.68</td>
<td>.23</td>
<td>.26</td>
<td>.27</td>
<td>1.63</td>
<td>.11</td>
</tr>
</tbody>
</table>

### CALPAS-T

<table>
<thead>
<tr>
<th>Step</th>
<th>R²</th>
<th>Change in R²</th>
<th>F</th>
<th>Zero Order</th>
<th>Partial</th>
<th>Beta</th>
<th>t</th>
<th>sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Story Length</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>-.01</td>
<td>.99</td>
</tr>
<tr>
<td>GSI</td>
<td>.02</td>
<td>.02</td>
<td>.85</td>
<td>-.15</td>
<td>-.15</td>
<td>-.15</td>
<td>-.93</td>
<td>.36</td>
</tr>
<tr>
<td>SCORMEAN</td>
<td>.08</td>
<td>.06</td>
<td>2.40</td>
<td>.24</td>
<td>.25</td>
<td>.28</td>
<td>1.55</td>
<td>.13</td>
</tr>
</tbody>
</table>

N = 40.
*p < .05., **p < .01.
Table 15
Summary of Hierarchical Multiple Regression Analysis of CALPAS-P on Story Length, Social Desirability, Symptoms, Attachment, and Object Relations.

<table>
<thead>
<tr>
<th>Step</th>
<th>Zero Order</th>
<th>Beta</th>
<th>t</th>
<th>R²</th>
<th>Adj. R²</th>
<th>Change in R²</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Story Length</td>
<td></td>
<td>- .12</td>
<td>- .12</td>
<td>- .72</td>
<td>.01</td>
<td>-.01</td>
<td>.01</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCSD</td>
<td>- .10</td>
<td>- .18</td>
<td>- 1.25</td>
<td>.43</td>
<td>.28</td>
<td>.42</td>
<td>3.23*</td>
</tr>
<tr>
<td>AAS-D</td>
<td>- .38</td>
<td>- .38</td>
<td>-2.39*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAS-A</td>
<td>.03</td>
<td>.16</td>
<td>1.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAS-C</td>
<td>- .12</td>
<td>.10</td>
<td>.62</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GSI</td>
<td>- .42</td>
<td>- .43</td>
<td>-2.62*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCORAFF</td>
<td>.17</td>
<td>- .10</td>
<td>- .56</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCORCOG</td>
<td>.22</td>
<td>.43</td>
<td>2.49*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: AAS-D = AAS-Depend, AAS-A = AAS-Anxiety, AAS-C = AAS Close.
SCORCOG = Mean of Complexity and Causality.
SCORAFF = Mean of Affect Tone, Relationships, and Morals.
N = 40.
*p < .05, **p < .01.
Table 16
Summary of Hierarchical Multiple Regression Analysis of CALPAS-T on Story Length, Social Desirability, Symptoms, Attachment, and Object Relations.

<table>
<thead>
<tr>
<th>Step</th>
<th>Zero Order</th>
<th>Beta</th>
<th>t</th>
<th>R²</th>
<th>Adj. R²</th>
<th>Change in R²</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td>.00</td>
<td>-.03</td>
<td>.00</td>
<td>.99</td>
</tr>
<tr>
<td>Story Length</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td>.32</td>
<td>.15</td>
<td>.32</td>
<td>2.12</td>
</tr>
<tr>
<td>MCSD</td>
<td>-.41</td>
<td>-.46</td>
<td>2.90**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAS-D</td>
<td>.02</td>
<td>-.04</td>
<td>-.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAS-A</td>
<td>.06</td>
<td>.03</td>
<td>.20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAS-C</td>
<td>.10</td>
<td>.15</td>
<td>.88</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GSI</td>
<td>-.15</td>
<td>-.30</td>
<td>1.67</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCORAFF</td>
<td>.15</td>
<td>.10</td>
<td>.41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCORCOG</td>
<td>.26</td>
<td>.25</td>
<td>1.36</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: AAS-D = AAS-Depend, AAS-A = AAS-Anxiety, AAS-C = AAS Close.
SCORCOG = Mean of Complexity and Causality
SCORAFF = Mean of Affect Tone, Relationships, and Morals
N = 40.
*p < .05, **p < .01.
### Table 17
Correlations Between Predictor Variables and CALPAS-P

<table>
<thead>
<tr>
<th></th>
<th>PWC</th>
<th>PC</th>
<th>WSC</th>
<th>TUI</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCSD</td>
<td>.12</td>
<td>-.25</td>
<td>-.13</td>
<td>-.04</td>
<td>-.10</td>
</tr>
<tr>
<td>AAS-D</td>
<td>-.33*</td>
<td>-.24</td>
<td>-.33*</td>
<td>-.36*</td>
<td>-.38*</td>
</tr>
<tr>
<td>AAS-A</td>
<td>-.02</td>
<td>.04</td>
<td>.02</td>
<td>.04</td>
<td>.03</td>
</tr>
<tr>
<td>AAS-C</td>
<td>-.39*</td>
<td>-.02</td>
<td>.00</td>
<td>-.07</td>
<td>-.12</td>
</tr>
<tr>
<td>GSI</td>
<td>-.26*</td>
<td>-.33*</td>
<td>-.35*</td>
<td>-.45**</td>
<td>-.42**</td>
</tr>
</tbody>
</table>

Note: PWC= Patient Working Capacity, PC = Patient Commitment, WSC= Working Strategy Consensus, TUI = Therapist Understanding and Involvement.

AAS-D = AAS-Depend, AAS-A = AAS-Anxiety, AAS-C = AAS Close.

N = 40.

*p < .05, **p < .01.
Table 18
Correlations Between Predictor Variables and CALPAS-T

<table>
<thead>
<tr>
<th></th>
<th>PWC</th>
<th>PC</th>
<th>WSC</th>
<th>TUI</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCSD</td>
<td>-.37*</td>
<td>-.41**</td>
<td>-.29</td>
<td>-.40**</td>
<td>-.41**</td>
</tr>
<tr>
<td>AAS-D</td>
<td>-.01</td>
<td>-.01</td>
<td>.08</td>
<td>-.03</td>
<td>.02</td>
</tr>
<tr>
<td>AAS-A</td>
<td>.10</td>
<td>.11</td>
<td>-.03</td>
<td>-.03</td>
<td>.06</td>
</tr>
<tr>
<td>AAS-C</td>
<td>.10</td>
<td>.03</td>
<td>.07</td>
<td>.19</td>
<td>.10</td>
</tr>
<tr>
<td>GSI</td>
<td>-.18</td>
<td>-.11</td>
<td>-.11</td>
<td>-.14</td>
<td>-.15</td>
</tr>
</tbody>
</table>

Note: PWC= Patient Working Capacity, PC = Patient Commitment, WSC= Working Strategy Consensus, TUI = Therapist Understanding and Involvement.

AAS-D = AAS-Depend, AAS-A = AAS-Anxiety, AAS-C = AAS Close.

N= 40
*p < .05., **p < .01.
APPENDIX B
Appendix B

Demographic Questionnaire-Client

Please answer these questions by marking one line.

1. Gender: _____ 0) Male _____ 1) Female

2. Years of age: _______

3. In which group do you mostly place yourself?

_____ 1) African-American/Black
_____ 2) American Indian/Alaskan Native
_____ 3) Asian/Pacific Islander
_____ 4) Caucasian
_____ 5) Hispanic/Latino
_____ 6) Other _______________________

4. What is your current marital status?

_____ 1) Single (never married)
_____ 2) Married
_____ 3) In committed relationship
_____ 4) Widowed
_____ 5) Divorced
_____ 6) Separated

5. Do you have any children? _____ 0) No _____ 1) Yes (including step or adopted)

6. How many children? ______

7. How far did you go in school?

_____ 1) Less than 10th grade
_____ 2) Completed 10th grade
_____ 3) High school graduate of GED
_____ 4) Some college, associate degree
_____ 5) Bachelors degree
_____ 6) Masters degree
_____ 7) Ph.D., doctorate, M.D., J.D.
_____ 8) Other _______________________

8. Current employment:

_____ 1) Employed full time or more
_____ 2) Employed part-time (less than 35 hours per week)
_____ 3) Self-employed
_____ 4) In school full time
_____ 5) Homemaker
_____ 6) Unemployed
_____ 7) Retired or disabled

9. Please list any current medical problems that you have:

_________________________________________________________________

10. Have you ever received outpatient psychotherapy before your current therapy at the UNT Psychology Clinic?
11. If yes, how many different therapists have you seen? _______

12. How long would you estimate your total time in therapy? _______

13. Have you ever been an inpatient in a psychiatric hospital or unit?
   _____ 0) No  _____ 1) Yes
Appendix C

Demographics-Therapist

Please answer these questions by marking one line.

1. Gender: _____ 0) Male  _____ 1) Female

2. Years of age: ________

3. In which group do you mostly place yourself?
   _____ 1) African-American/Black  _____ 4) Caucasian
   _____ 2) American Indian/Alaskan Native  _____ 5) Hispanic/Latino
   _____ 3) Asian/Pacific Islander  _____ 6) Other _________________

4. What is your current marital status?
   _____ 1) Single (never married)  _____ 4) Widowed
   _____ 2) Married  _____ 5) Divorced
   _____ 3) In committed relationship  _____ 6) Separated

5. What year of graduate school are you in? (if in summer session, mark higher year)
   _____ 1) 1st year  _____ 5) 5th year
   _____ 2) 2nd year  _____ 6) 6th year
   _____ 3) 3rd year  _____ 7) 7th and beyond
   _____ 4) 4th year

6. Approximately how many adult therapy clients have you seen; including the ones you are currently seeing?
   _____ 1) 1-3  _____ 5) 16-20
   _____ 2) 4-6  _____ 6) 21-30
   _____ 3) 7-9  _____ 7) more than 30
   _____ 4) 10-15

7. Approximately how many hours of client contact do you have with adult therapy cases?
   _____ 1) 1-10  _____ 5) 40-60
   _____ 2) 11-20  _____ 6) 60-100
   _____ 3) 21-30  _____ 7) more than 100
   _____ 4) 31-40

8. What orientation do you mostly identify with?
   _____ 1) Cognitive-behavioral  _____ 5) Humanistic
   _____ 2) Psychodynamic  _____ 6) Constructivist
   _____ 3) Interpersonal Process  _____ 7) Other
   _____ 4) Gestalt
Appendix D

Practicum Students

OPPORTUNITY TO PARTICIPATE IN RESEARCH ON PSYCHOTHERAPY

What is the study about?
We are interested in exploring the relationship between clients’ ideas about people and important aspects of psychotherapy. The results of this study may provide information that will:

• help therapists tailor their interventions to better meet the needs of their clients.
• help us understand how assessment can inform and improve psychotherapy

What is involved?
We will be collecting data from clients and their therapists.

• If you are interested in participating, you will be asked to inform me and the office staff of your therapy clients who are eligible. An invitation to participate and consent form for contact will be included in the client’s intake packet. The researcher will contact the client to schedule an appointment. (You will not be responsible for recruiting the clients to participate.)

• The researcher will schedule an appointment with clients to administer the TAT and some brief questionnaires shortly after your therapy intake session.

• You and your client will then be asked to complete two brief questionnaires about the therapy process several sessions after the TAT and other measures are administered. (Your only responsibility will be to complete the two brief self-report questionnaires.)

What types of clients can participate?
Your individual therapy clients can participate if they are over the age of 18 and judged not to be acutely suicidal. We prefer that you exclude clients if they are among the first three that you have ever seen for therapy. If you are interested in participating, you must receive your practicum supervisor’s permission for participation in this study.

Benefits?
Benefits for you and your client include assessment information that may be of use in treatment. You and your supervisor can decide whether and how this information can be used. In addition, therapists will be entered in a raffle for $50 and clients will receive $15 for participation.

If you are interested in participating, please get in touch with me in room 124 or leave a message in my box. Thanks, Kristin Niemeyer

This study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.
Appendix E

STORY-TELLING AND THE PSYCHOTHERAPY PROCESS

THERAPIST’S CONSENT TO PARTICIPATE

Before agreeing to participate in this research study, it is important that you read and understand this explanation of what we are asking you to do. It describes the procedures, benefits, risks, and discomforts of the study. It also describes your right to withdraw from the study at any time. It is important for you to understand that no guarantees or assurances can be made as to the results of the study.

Purpose and Length of Study. The study examines how clients’ ideas about people may be related to aspects of psychotherapy. If you agree to participate, you will be asked to complete two brief questionnaires about the psychotherapy process.

Description of the Study. The researcher will schedule an appointment with your client to administer the Thematic Apperception Test (TAT) and three brief questionnaires. Several weeks after the initial session, you and your client will be asked to complete two brief questionnaires regarding psychotherapy. You will not be permitted to review the client’s responses, and the client will not be permitted to review your responses to these measures.

Potential for Discomfort and Forseeable Risks. While completing these questionnaires is an inconvenience, the risk of discomfort is minimal. If you become too uncomfortable, you may withdraw from the study without giving any reason and without losing any benefits you now have. These measures have been used in many studies without significant risk.

Benefits to You or Others. The study may help you and your client identify issues that may help your therapy. Your code number will also be entered in a raffle for $50. Finally, the study might help us to understand the relationship between clients’ ideas about people and their progress in psychotherapy. This information may contribute to therapists’ ability to improve their therapy practices.

Confidentiality of Research Records. Your information and that of your client will be identified only by a code number, without any names. The results of your questionnaires will not be revealed to your client.

Review for Protection of Participants. This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.

Research Subjects’ Rights. I have read all of the above. I have been told the risks or discomforts and possible benefits of this study. I understand that I do not have to take part in this study, and my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw at any time without penalty. The study personnel will stop my participation at any time if it appears to be harmful to me.
In case there are problems or questions, I have been told I can call Dr. Sharon Jenkins or Kristin Niemeyer, at (940) 565-2631.

I understand my rights as a research participant, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

____________________________________   __________________
Participant’s Signature      Date

____________________________________   __________________
Witness         Date
Appendix F

Dear Client:

Would you please consider participating in our research project about psychotherapy here at the UNT Psychology Clinic? Your participation would involve completing some surveys and a brief story-telling exercise. **For participation you would receive $15 for a one hour time commitment.** You may also choose to receive feedback about the results. To protect your privacy, all information that you provide would be kept confidential and anonymous.

If you think you might want to participate, please sign the form below and return to the clinic office before you leave today or when you come in for your next visit. We will contact you to provide more information about the study and perhaps schedule an appointment if you would like. This study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.

Sincerely,

Kristin Niemeyer     Sharon Rae Jenkins, Ph.D.
Student Researcher     Principle Investigator
Associate Professor of Clinical Psychology

☐ I consent for the researcher to contact me in order to answer my questions and perhaps schedule an appointment.

_______________________________________   ________
Signature         Date

**please return to clinic office**
APPENDIX G
Before agreeing to participate in this research study, it is important that you read and understand this explanation of what we are asking you to do. It describes the procedures, benefits, risks, and discomforts of the study. It also describes your right to withdraw from the study at any time. It is important for you to understand that no guarantees or assurances can be made as to the results of the study.

**Purpose and Length of Study.** The study examines how clients’ ideas about people may be related to aspects of psychotherapy. If you agree to participate, the researcher will ask you to tell stories about some pictures and ask you to complete some surveys. This first part is not expected to take longer than one hour. You will also be asked to complete two brief questionnaires in a few weeks.

**Description of the Study.** Today the researcher will first show you several pictures and ask you to tell stories about them. You will then be asked to complete some surveys about problems that you might be having. In a few weeks you will be asked to complete two brief questionnaires about your therapy experience.

**Potential for Discomfort and Forseeable Risks.** While we recognize that coming to this appointment is an inconvenience, the risk of discomfort is minimal. If you become too uncomfortable, you may withdraw from the study without giving any reason and without losing any benefits you now have. These measures have been used in many studies without significant risk.

**Benefits to You or Others.** The study may help you and your therapist identify issues that may help your therapy. You will also receive $15 for your participation. Finally, the study might help us to understand the relationship between clients’ ideas about people and their progress in psychotherapy. This information may contribute to therapists’ ability to improve their therapy practices.

**Confidentiality of Research Records.** Your information will be identified only by a code number, without any names. You may choose whether the information is made available to your clinician by including it in your file. The researcher will also be available to discuss the results with you and your therapist, if you would like that and you and your therapist agree that it may be useful.

**Review for Protection of Participants.** This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.

**Research Subjects’ Rights.** I have read all of the above. I have been told the risks or discomforts and possible benefits of this study. I understand that I do not have to take part in this study, and my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may
withdraw at any time without penalty. The study personnel will stop my participation at any time if it appears to be harmful to me.

In case there are problems or questions, I have been told I can call Dr. Sharon Jenkins or Kristin Niemeyer, at (940) 565-2631.

I understand my rights as a research participant, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

____________________________________   __________________
Participant’s Signature      Date

____________________________________   __________________
Witness         Date
Dear Therapist:

Thank you for your participation in our study. The pages that follow ask about your experience of therapy with your client. We would like you to complete the questionnaires as soon as possible and return them to the Clinic office in the envelope provided.

You are not obligated to complete these questionnaires. Remember, you can withdraw from participation at any time without losing any benefits that you now have. Remember not to put any identifying information on the questionnaires in order to protect your anonymity. Also, remember that the information on these questionnaires will not be revealed to your client. We thank you for your time and effort as a participant in our study.

Sincerely,

Kristin Niemeyer, M.S.  
Doctoral Researcher

Sharon Rae Jenkins, Ph.D.  
Principal Investigator

Associate Professor of Clinical Psychology
APPENDIX I
Appendix I

Dear Client:

Thank you for helping us with the first part of our study. We would now like you to complete the second part. The questionnaire that follows asks about your experience of therapy thus far. We are asking about normal things that many people may feel at different points in their therapy, depending on the problems that they are trying to solve and the therapy approach. There are truly no right or wrong answers, please just tell us how you feel now.

Your answers to the questions in this packet will not be shown to your therapist at any point.

Remember that you can stop at any time if you do not feel comfortable. Please do not put your name on the survey, your code number is at the top. We would greatly appreciate your completing this survey as soon as you can and returning it to the Psychology clinic office. We thank you for your time and effort.

Sincerely,

Kristin Niemeyer, M.S. Sharon Rae Jenkins, Ph.D.
Doctoral Researcher Principle Investigator
Associate Professor of Clinical Psychology

About the survey and story-telling exercise that you did before, all of the results will be kept as research data with code numbers. Remember, you can choose whether you want a copy of the results to be placed in your clinic file for your therapist to see. You may also choose to meet with the researcher to hear the results. Please check one or more boxes:

- I would like to know the results, please call me for an appointment
- I would like my therapist to know the results, please put a copy in my clinic file.
- Please do not put it in my clinic file. (your therapist will not see it)

**if you do not check a box, we will keep the information for research only.
REFERENCES


Mahler, M., Pine, F., & Bergman, A. (1970). The mother’s reaction to her toddler’s
Drive for individuation. In Anthony, E. J., & Benedeck, T. (Eds.), Parenthood: its
psychology and psychopathology. (pp. 257-274). Boston: Little, Brown.

infant. The Psychoanalytic Study of the Child, 29, 30-106.

Main, M., & Solomon, J. (1985). Discovery of an insecure-disorganized attachment pattern. In
Brazelton, T. B., & Yogman, M. W. (Eds.), Affective development in infancy. (pp. 95-
124).


parents, social support, and formation of the working alliance, Journal of Counseling
Psychology, 38, 401-409.

psychotherapy relationship: Development of the Client Attachment to Therapist Scale.

memories, and social competencies of women in brief therapy. Journal of
Counseling Psychology, 42, 79-84.

Therapeutic Alliance Rating System. In Greenberg, L. S, & Pinsof, W. M. (Eds.), The
psychotherapeutic process: A research handbook. (pp. 367-390). New York: Guilford
Press


