Published in final edited form as:

Psychother Res. 2017 September ; 27(5): 620–641. doi:10.1080/10503307.2016.1152407.

Investigating an Approach to the Alliance Based on Interpersonal Defense Theory

Michael A. Westerman and

New York University

J. Christopher Muran

Derner Institute of Advanced Psychological Studies, Adelphi University

Abstract

Notwithstanding consistent findings of significant relationships between the alliance and outcome, questions remain to be answered about the relatively small magnitude of those correlations, the mechanisms underlying the association, and how to conceptualize the alliance construct. We employed qualitative, theory-building case study methodology (e.g., Stiles, 2007) to conduct a preliminary investigation of an approach to the alliance based on interpersonal defense theory, which is an interpersonal reconceptualization of defense processes (e.g., Westerman & Steen, 2007). We closely examined alliance processes at four time points in the treatment of a case in terms of a case formulation based on the theory. The results suggested that our approach made it possible to recognize key processes in the alliance and that it can help explain how the alliance influences outcome. Our analyses also provided a rich set of concrete illustrations of the alliance phenomena identified by the theory. We consider the advantages and limitations of the qualitative methodology we employed and offer suggestions about how future qualitative and quantitative investigations could build on this study.

Keywords

alliance; interpersonal defenses; coordination; theory-building case study; qualitative methods; case formulation; process research

Although the alliance has been found to predict outcome in psychotherapy, questions remain to be answered. Measures of the alliance only account for about 4–7% of variance in outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin, Garske, & Davis, 2000). There are outstanding issues about the mechanisms underlying alliance-outcome associations (Barber, Khalsa, & Sharpless, 2010). Also, there are unresolved conceptual issues (Doran, Safran, Waizmann, Bolger, & Muran, 2012; Henry & Strupp, 1994; Horvath, 2006; Stiles & Goldsmith, 2010).

Resolving the conceptual issues could provide the basis for addressing the other problems. Four of those issues seem especially important. The first is whether it is possible to

distinguish between the alliance and other therapeutic relationship processes, such as patients' defensive behavior, transference, and countertransference (Brenner, 1979; Henry & Strupp, 1994; Horvath, 2006). It does not make sense to view the therapy situation as if we have the alliance – how patient and therapist are working together – on one side of a divide and, on the other side, we have the problems they are working on, including the patient's interpersonal difficulties, because those difficulties are likely to occur in the therapy relationship itself.

This argument becomes even more clear if we consider measurement. Alliance measures include items that tap processes concerning defensive behavior, transference, and so forth. This is most obvious for negatively worded items, such as whether the patient “reacted negatively to the therapist's comments” and the therapist “explicitly tried to impose his or her values on the patient” on the Vanderbilt Psychotherapy Process Scales (O'Malley, Suh, & Strupp, 1983). The point also holds for many positively worded items, such as whether the patient “works toward resolution of issues” and the therapist “demonstrates nonjudgmental acceptance of the patient,” which are items from the California Psychotherapy Alliance Scales (Gaston, 1991), because ratings lower than optimal on those scales can reflect defensive behavior, countertransference, and so on, and optimal ratings on positive items may sometimes reflect a positive transference.

Different considerations apply in the case of the Working Alliance Inventory (WAI; e.g., Tracey & Kokotovic, 1989). It may seem that by assessing the patient-therapist bond and agreement on tasks and goals, the WAI measures the alliance as the “outcome” of whatever relationship processes may contribute to it, as if those relationship processes and their outcome are distinct, as Hatcher (2010) has suggested. This is a second important conceptual issue. We maintain that what counts as agreeing about tasks and goals and sharing a positive bond are not questions about free-standing, “end-product” facts that can be answered without characterizing the interpersonal processes involved, including defensive behavior, transference, and countertransference. Furthermore, treating agreement on tasks and goals as a crucial feature of a good alliance may not be on the mark (see also Doran et al., 2012).

A third conceptual point also played a guiding role in the present study: Investigations of alliance processes should be based on a theoretical perspective that directs our focus to the key features of constructive interpersonal processes. A fourth conceptual point calls for using a case formulation approach. As Stiles and Goldsmith (2010) pointed out, the relevance to the alliance of specific patient and therapist behaviors can differ greatly across cases.

This study was motivated by the view that proceeding along the lines of these four points has the potential to contribute in two ways. First, it could lead to a better characterization of alliance processes. This would help clinicians recognize how their patients and they themselves are contributing to the alliance. For researchers, it would contribute to better measurement. Improved measurement might lead to finding more robust alliance-outcome relationships, although it certainly may be the case that the moderate correlations obtained to date reflect the true magnitude of the association. Second, it might contribute to our

understanding of how the alliance affects outcome, which would be of great value to both practitioners and researchers.

Interpersonal Defense Theory

The present study investigated an approach to the alliance based on interpersonal defense theory (e.g., Westerman, 2005; Westerman & Steen, 2007, 2009). The theory is an interpersonal reconceptualization of defense processes. It draws on psychoanalytic theory but also differs from it in significant respects. Whereas traditional psychoanalytic theory conceptualizes defenses as intrapsychic processes that modulate inner experiences of anxiety, guilt, and self-esteem, interpersonal defense theory treats defenses primarily as interpersonal behavior patterns that influence the behavior of the other person in a relationship. In what follows, we first present the main tenets of the theory and then illustrate them with a brief clinical example.

The theory focuses on how individuals negotiate conflicts between pursuing a response of central importance to them in a relationship (their key wished-for outcome) and the possibility that doing so might result in a particular negative response (their central feared outcome). Some people negotiate these conflicts by employing interpersonal defenses. Defensive behavior is characterized by recurring patterns of *coordination* failures, that is, failures to make contributions to an exchange that mesh with the other's person's contributions and with one's own prior contributions. Breaches of coordination occur because the person is attempting to do two things at once that actually cannot both be accomplished. The individual is trying to pursue his or her wished-for response, and at the same time, attempting to do that in such a manner that it will be very unlikely that the feared outcome will occur – even though pursuing the wish opens up that possibility.

Failures of coordination “work” in the sense that they make it highly unlikely that the feared outcome will occur (this tenet contrasts with the self-fulfilling prophecy notion). However, recurring coordination breaches “feed forward” to affect how the other person in the relationship behaves in several other ways as well. Although defensive behavior includes recurring efforts to realize the individual's wished-for outcome, these patterns actually make it less likely that the other person will respond in the wished-for manner. Defensive patterns also promote certain negative outcomes distinct from the central fear. In addition, defensive behavior promotes certain positive outcomes distinct from the wish.

Defensive patterns do not necessarily lead to these feed-forward effects; they make it more likely that the other person will behave in the ways just described. If the other person does respond in these ways, his or her behavior, in turn, will serve to maintain the first person's defensive behavior because the first person avoids his or her central feared response while pursuing his or her wish. Also, although defensive behavior promotes certain negative responses, those outcomes are less salient for the individual than the central fear. In addition, defensive behavior leads to positive outcomes, even if not the wished-for outcome.

Every person has his or her own profile of wished-for outcome, feared outcome, noncoordinating pattern, and feed-forward effects, as we will illustrate shortly with an

example. This profile can be summarized in a case formulation. Broadly speaking, interpersonal defense theory is similar to other case formulation approaches, such as the Core Conflictual Relationship Theme method (Luborsky & Crits-Christoph, 1998) and the Plan Formulation method (Curtis & Silbershatz, 2007). However, interpersonal defense theory differs from those approaches in a number of ways, including its focus on coordination and the defensive functions played by coordination breaches and also its tenets about feed-forward effects. These features of the theory make it especially well-suited for studying processes of interaction over time.

In the therapy context, interpersonal defense theory provides a new way of conceptualizing the alliance. Regarding patients' contributions to the alliance, it focuses on whether a patient behaves in a coordinating or defensive, noncoordinating manner. With regard to therapists' contributions, the theory focuses on whether a therapist responds in ways that do not realize the patient's fear or wish, but which include positive behaviors distinct from the patient's wish and negative responses distinct from the fear. A therapist's responses are not necessarily characterized by these feed-forward effects, but if they are, they maintain the patient's defensive pattern and contribute to a circular process, as we explained above.

We can illustrate a number of the tenets of interpersonal defense theory with a brief clinical example (Westerman & Muran, 2012). In this case, the patient interacted with her therapist in a manner that was characterized by a particular noncoordinating pattern. Specifically, although many of her turns were marked by considerable emotional expressiveness, she also jumped from mentioning one thing that concerned her to another rather than picking up on replies by the therapist that were responsive to her previous contribution. Based on several sources of evidence, we were able to identify the patient's wished-for and feared outcomes. She wished that others would show concern and compassion for her, but she was afraid that if she pursued her wish by expressing her feelings in a straightforward manner, it would lead others to respond to her in angry, rejecting, attacking ways. Her defensive, noncoordinating pattern was an attempt to both pursue her wish by mentioning her feelings and concerns, while also avoiding her fear by jumping from one thing to another and, thereby, repeatedly derailing any real expression of what mattered to her.

The therapist responded to the patient in ways that conformed to the tenets about feed-forward effects, as follows: The therapist did not respond to her in an angry, attacking manner (her fear was averted), but also did not behave in a concerned, communing way (the patient's wished-for response). Instead, at times the therapist tried to benignly guide her towards acting more responsively (positive response distinct from the wish) and at other points responded with two kinds of negative responses distinct from the fear, ignoring the patient because her defensive pattern made it difficult for the therapist to appreciate the significance of anything she mentioned, and making bossy, controlling bids to get the patient to be more responsive.

A way to address concerns about alliance research to date.

An approach to the alliance based on interpersonal defense theory has the potential to contribute to our understanding of how the alliance influences outcome. One point here is that the coordination of contributions to an exchange makes possible clearly establishing

topics of discussion and forward movement on those topics, that is, continued discussion of topics in ways that build upon and expand on what's been said so far (Westerman, 2005, pp. 23–26). Defensive behavior by a patient works against these basic features of productive interaction. Without them it is unlikely that therapeutic exchange will be helpful. If a therapist responds in ways (negative responses distinct from the fear, positive responses distinct from the wish) that serve to maintain the patient's noncoordinating behavior, this contributes to the continuation of problems with topic establishment and forward movement. A second point is that patient-therapist interactions of this kind do not provide patients with corrective emotional experiences in which they pursue their wishes in a nondefensive manner and realize those wishes in their therapists' responses.

Our approach to the alliance also addresses the other concerns we raised about alliance research to date. If our approach identifies key alliance processes, then we could improve measurement of the alliance by directly assessing those processes and those assessments might lead to finding larger alliance-outcome associations. Also, our approach explicitly incorporates considerations about defensive behavior, transference, and countertransference, although those processes are conceptualized in new ways. Specifically, transference is viewed as the appearance of a patient's noncoordinating pattern in his or her relationship with the therapist. We view the therapist as engaging in countertransference behavior if he or she responds to the patient in ways that conform to the tenets about feed-forward effects, that is, if the therapist's behavior is marked by many negative responses distinct from the fear and positive responses distinct from the wish.¹

Note that our approach differs from the guiding ideas for the WAI, the approach to the alliance employed in most research to date. The focus on coordination and its role in topic establishment and forward movement identifies what we believe are more fundamental interaction processes than the focus on agreement. Topic establishment and forward movement are prerequisites for constructive agreement. People can agree without it being clear what they are agreeing on and without the ability to build on agreements through forward movement. When agreement is limited in these ways, the exchange will be lacking. Also, so long as topics are clearly established and there is forward movement, people can disagree and their interactions can still be constructive. In addition, the idea that alliance processes involve patients' wishes and fears provides the basis for a different view about what constitutes a positive bond than the ideas guiding the WAI.

Prior research on interpersonal defense theory.

To date, studies have investigated several tenets of the theory. In an experimental study, Westerman and Steen (2009) found support for the claim that conflict promotes noncoordinating interpersonal behavior. Findings from other experiments (Dahmen & Westerman, 2007; Westerman & Prieto, 2006) and two previous theory-building case studies (Westerman, 2011b, 2012) provided support for the tenets about feed-forward effects. Also,

¹Views of countertransference have focused either on therapist responses that result from the pull exerted by features of a patient's behavior or on therapist reactions that stem from the therapist's own conflicts. Our conceptualization is most similar to the former idea, but the second notion also is important because it helps explain why therapists do not always behave in ways that conform to the tenets about the feed-forward effects of patients' defensive behavior.

findings from a number of therapy studies suggest that *patient coordination*, the extent to which patients' in-session behavior is characterized by coordinating behavior as opposed to recurring coordination failures, is a key aspect of patients' contributions to the alliance (for a summary, see Westerman, 2011a, pp. 165–166). Most notably, results showed that, across a variety of treatment approaches, patient coordination-outcome associations were considerably larger than the correlations typically found between commonly used alliance measures and outcome (Hartmann, 2001; Westerman, Foote, & Winston, 1995; Westerman, Frankel, Tanaka, & Kahn, 1987; Westerman, Tanaka, Frankel, & Kahn, 1986).

The Present Study

We conducted a preliminary, exploratory study to investigate how interpersonal defense theory can contribute to our understanding of the alliance, using qualitative, theory-building case study methodology (Stiles, 2007, 2009; also see McLeod, 2011, pp. 229 & 237). We examined alliance processes at four time points in a poor outcome short-term therapy case. Our goals included determining whether observations would provide preliminary support for a set of predictions based on interpersonal defense theory. Also, insofar as our investigation provided evidence of the phenomena identified in the theory, it would contribute to another goal, which was illustrating our approach to the alliance. The theory offers a very different way of conceptualizing clinical material and, therefore, providing concrete illustrations would serve to clarify the theory's claims and also set the stage for future quantitative studies.

Based on previous studies cited earlier of the relationship between patient coordination and outcome, we expected to find that alliance processes, when analyzed in terms of interpersonal defense theory, were problematic in this poor outcome case. We predicted that the patient's contributions to the alliance would be marked by recurring coordination breaches in which the patient's behaviors would not mesh with the therapist's behaviors or with the patient's own prior contributions. We also predicted that we would be able to explain the failures of coordination by the patient as defensive attempts to pursue obtaining the patient's central wished-for interpersonal response from the therapist while avoiding the patient's central feared outcome, that the therapist's behavior would often include negative responses distinct from the patient's fear and positive responses distinct from the patient's wish and few if any instances of the patient's feared or wished-for responses, and that patient and therapist contributions to the alliance would work against clearly establishing topics and moving forward on those topics.

As these predictions show, the theory's tenets lead directly to hypotheses about problematic processes that are characteristic of poor outcome cases. They do not lead directly to predictions about how therapists' *should* respond to patients' defensive behavior. That issue can be explored most directly by studying good outcome cases, but we thought that our examination of a poor outcome case might suggest new hypotheses that could be investigated in the future.

Our primary goals, which we presented earlier, involved carefully examining clinical material to see what we could learn about our approach to the alliance itself. We also

compared our approach with the WAI. With regard to this comparison, our main objective was to use our analyses to clarify how our approach differs *conceptually* from the ideas underlying the WAI. In addition, we compared our analyses with therapist and patient WAI ratings. Although there are limits to what can be learned by considering such ratings on a single case, we anticipated that the ratings might shed some further light on the basic differences between the two approaches.

The study provided a way to go beyond previous research related to the alliance based on interpersonal defense theory. The nomothetic therapy process-outcome studies of patient coordination did not investigate the tenets about the defensive functions of noncoordinating patterns regarding patients' wishes and fears, therapist contributions to the alliance, or topic establishment and forward movement. Two previous theory-building case studies (Westerman, 2011b, 2012) provided support for some of those tenets, but they were more limited investigations that only examined one session from a case and did not consider the tenets about how the alliance influences outcome. Also, prior studies did not consider how our approach differs conceptually from the guiding ideas for the WAI or compare analyses based on interpersonal defense theory to WAI assessments.

Method

Umbrella Investigation

The case was part of a large study of three 30-session treatment approaches (short-term dynamic therapy, cognitive-behavioral therapy, and brief relational therapy) for patients with personality disorders (Muran, Safran, Samstag, & Winston, 2005). The patients had diagnoses of a Cluster C personality disorder or personality disorder NOS. Patients in all three treatment conditions showed significant improvement. Although some differences were found, overall the results suggested that the three therapy approaches were equal in effectiveness for patients who completed treatment. The case examined in the present study was selected from the short-term dynamic therapy condition, a brief psychodynamically-oriented treatment developed by Pollack, Flegenheimer, Kaufman, and Sadow (1992). We decided to study a case from this condition for several reasons. This treatment approach includes exploring patients' past relationships, which aids in arriving at a case formulation based on interpersonal defense theory (more on this later). Also, therapists conducting short-term dynamic therapy think about cases in ways that are similar enough, very broadly speaking, to our approach to the alliance that it is interesting to compare the two in ways that actually clarify the significant ways in which they diverge. We should note, however, that our approach to the alliance may be relevant across a variety of therapeutic orientations, as prior research on patient coordination suggests.

Measures

Diagnoses were determined using the Structured Interview for DSM-III-R (Spitzer, Williams, Gibbon, & First, 1990). Outcome was assessed on 6 measures at several time points. For the present study, we used assessments at intake and termination. The measures included patient and therapist ratings of Target Complaints (TC; Battle et al., 1966); therapist assessments on the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, &

Cohen, 1976); and patient reports on the Symptom Checklist-90-Revised (SCL-90R; Derogatis, 1983), the Inventory of Interpersonal Problems-64 (IIP; Horowitz, Alden, Wiggins, & Pincus, 2000), and the Wisconsin Personality Inventory (WISPI; Klein, Benjamin, Treece, Rosenfeld, & Greist, 1993). Patients and therapists completed the 12-item version of the Working Alliance Inventory (Tracey & Kokotovic, 1989) after every session.

Theory-Building Case Study Methodology

As Stiles (2007, 2009) explained, case studies can contribute to validating theories when they are conducted in a particular manner. In fact, he maintained that in some respects investigations of this kind, which are called theory-building case studies, are superior to hypothesis-testing group studies with regard to theory justification. Whereas those group studies typically examine whether observations provide support for a single tenet of a theory, investigators conducting theory-building case studies simultaneously compare observations to multiple tenets of a theory. Comparing observations to multiple tenets offers a powerful challenge to a theory because there are few degrees of freedom. When data from a case provide support for a whole set of tenets, this provides compelling evidence confirming the theory, although any one case study can only provide incremental support.

Investigators using theory-building case study methodology also can employ a process called abduction to revise theoretical tenets and develop new ones when they make observations that do not fit with the guiding theory or have not been addressed by it. Abduction involves the more familiar procedure of using case study material as the basis for generating new hypotheses.

The theory-building case study approach is a kind of qualitative research. As such, investigations of this sort are characterized by sensitivity to context. In addition, they can readily be used to examine theories based on case formulations. Investigators can determine whether phenomena predicted by the theory occur, taking into account what those phenomena would be like in specific concrete situations for a patient with a particular case formulation.

These features of theory-building case study methodology made it a good way to proceed given the purposes of the investigation and the current stage of this line of research. It gave us the opportunity to investigate the multiple theoretical propositions that are included in our alternative perspective on the alliance. It also provided us with a method of qualitative inquiry that was appropriate given the key role that case formulation plays in interpersonal defense theory and the need for context sensitive examination of the complex processes of interest. The methodology also was appropriate given our goal of providing concrete illustrations of the phenomena identified in our approach to the alliance in order to clarify the theory's tenets and also set the stage for future quantitative investigations. Regarding the point about setting the stage, at the present time, quantitative investigations efforts probably would include a good deal of error variance in assessments, but given a good, concrete grasp of what the processes of interest are like, it may well be possible to develop sound systematic measurement procedures in the future, notwithstanding the need to take context and case formulations into account.

Selecting the Case

Because we planned to investigate predictions about alliance processes in an unsuccessful treatment, our main criteria for selecting a case was poor outcome. In addition, we hoped to find a case with a near complete set of data. To qualify as “poor outcome,” we established the criterion that the patient showed clinically significant improvement on no more than one of the six outcome measures, using determinations of clinically significant change that had been made in the umbrella project (Muran et al., 2005, pp. 539–540). For two measures for which normative data were available, SCL-90 and IIP, a patient was considered to have achieved clinically significant change if his or her score at termination was closer to the mean of a functional population than the mean of the sample in the umbrella investigation at intake. Clinically significant change on the other measures was defined by termination scores that were more than two standard deviations in the desirable direction from the sample mean at intake in the umbrella study.

We selected one of the eleven poor outcome cases in the short-term dynamic therapy condition. We selected the case prior to consideration of how patient and therapist interacted on WAI scores and without viewing sessions from the other possible poor outcome cases or examining other information about those cases to decide which poor outcome case to select.

The data set for the case was very nearly complete, including videotapes of all sessions. With regard to outcome criteria, the patient in the case selected showed clinically significant improvement on only one outcome measure, patient TC. We calculated standardized effect sizes for change by the patient on each outcome measure by computing residualized gain scores (following traditional notation, we refer to these effect sizes with the symbol d). The effect sizes were as follows (signs have been adjusted so that for all measures change in the desirable direction is indicated by positive values): $d = +.32$ for patient TC, $d = -.67$ for therapist TC, $d = -.48$ for SCL-90, $d = -.56$ for GAS, $d = -.43$ for IIP, $d = -.10$ for WISPI.

Participants

The patient, Sharon (pseudonym), was a 28-year-old female. Her diagnosis included anxiety disorder NOS on Axis I, and avoidant, self-defeating (a Cluster C disorder at the time the umbrella investigation was conducted), and paranoid personality disorders on Axis II. Sharon’s target complaints included “guilt and agony” about a broken engagement, an engagement she had ended; problems moving forward in her life; and relationship difficulties in her family.

The therapist was a 39-year-old male psychiatrist. He had 9 years professional experience, including extensive experience with brief psychotherapy as therapist and supervisor and one previous case as therapist in the short-term dynamic therapy condition.

Session Selection

Our pre-established plan was to examine one session from each of four phases of the treatment, early (session 3), early-middle (sessions 8–14), late-middle (sessions 16–22), and near the end of treatment, but not the very last few sessions because behavior in those sessions might be more “scripted” by norms (sessions 23–27). We selected specific sessions

within this framework based on availability of videotapes and blind to how patient and therapist interacted in the sessions and WAI ratings. Also, for the three later phases of treatment we used a rough procedure to identify sessions in which the patient's central interpersonal wish might be especially relevant, because we were interested in seeing how the therapist behaved in those situations. We did this by referring to logs that were compiled by research assistants who were blind to the investigators' case formulation. The logs recorded very brief statements of the topic of each 5-minute segment of every session (e.g., "ex-fiancé"). The logs were a very indirect gauge of the relevance of the patient's wish because they concerned segment content, not process. They certainly did not include information about how the therapist behaved regarding the wish.

The four sessions were examined in entirety following the analysis procedures described in the next subsection. The excerpts presented in the Results section were selected because patient-therapist interactions in each excerpt exemplified the pattern that characterized most of the interactions in the session it came from. This way of selecting excerpts is common practice in theory-building case study research and many other qualitative research approaches as well. We acknowledge that it opens up a possibility of bias in the present exploratory study.

Analysis

Given that this study was based on qualitative examination of the clinical material, we should note that the first author has been involved in developing interpersonal defense theory for several years and the second author collaborated on this project because he viewed the theory to be a promising perspective. Although the authors believed that qualitative analysis of the processes of interest offered the most useful way to proceed with this line of inquiry at this time, they both have considerable experience using quantitative methods.

The method of analysis employed began with examining patient behavior to determine if her contributions meshed with the therapist's bids and with her own prior behaviors and whether these coordination breaches were characterized by a particular pattern.²

Another key part of the analysis was to determine whether it was possible to identify a wish that the patient was attempting to pursue by behaving in the noncoordinating manner and a fear that the patient was trying to avoid by acting that way. Identification of a wish and fear also was based on information provided by the patient on questionnaires that were part of the umbrella investigation (see Muran et al., 2005) and in her narratives in the sessions, including information about childhood experiences. According to interpersonal defense theory, central wishes and fears are formed in childhood prior to about 10 years of age as a result of repeated experiences in which a person nondefensively pursued a desired interpersonal response (which becomes the wish) and significant others responded in a particular negative manner (which becomes the fear).

²The method we employed for examining the patient's noncoordinating interpersonal behavior pattern shares some similarities with conversation analysis. In particular, both involve careful analysis of sequential features of interaction. However, whereas practitioners of conversation analysis attempt to identify "devices" that play a role in conversational practices across members of a given discourse community, our method focuses on identifying individual differences in patterns of coordination. Readers interested in comparing the two approaches can refer to Westerman (2011a).

Another part of the analysis included examining therapist behavior to see if it conformed to the tenets about feed-forward effects. The analysis procedures also included examining whether topics were established and there was forward movement on topics, and relationships between topic establishment/forward movement and patient and therapist behavior.

Regarding our examination of the therapist's behavior, recall that according to interpersonal defense theory, it is important to differentiate responses by the therapist a patient wishes for and other responses by the therapist that are also positive but distinct from the patient's wish. Similarly, we need to distinguish between feared responses by the therapist and other responses that are negative but distinct from the fear. To make these differentiations, our method of analysis followed – broadly speaking – along the lines of Benjamin's (e.g., 1979) Structural Analysis of Social Behavior (SASB). We did not employ SASB as a scheme for systematic coding, but rather as a conceptual framework for our qualitative analyses.

SASB suggests that therapist behaviors vary along two orthogonal dimensions – affiliation, which varies from loving to attacking, and interdependence, which varies from endorsing the patient's freedom or individuation to managing the patient. All the behaviors on the loving side of the affiliation dimension are positive and all the behaviors on the attacking side are negative, but because therapist behaviors also vary on interdependence, we can draw distinctions among kinds of positive behaviors and among types of negative behaviors.

In our analyses, we considered therapist responses in terms of three broad kinds of possible positive behaviors, including affirming and showing appreciation for the patient's independent actions and point of view, guiding and benevolently managing the patient (directing the patient to behave in ways the therapist believes would be good for the patient), and (in the midrange of interdependence) showing concern and compassion by communing with the patient. We also considered therapist responses in terms of three broad kinds of negative behaviors, including ignoring or neglecting the patient and/or being uninvolved with the patient, controlling the patient in a hostile manner (insisting that the patient go along with the therapist even though the patient does not want to do so), and (in the midrange of interdependence) behaving in an angry, attacking, threatening manner.

Although these ideas about distinguishing among kinds of behaviors provide some precision of terminology, our analyses of therapist responses were qualitative in nature as were the other parts of our analyses. We opted for maximizing context sensitivity rather than employing the procedures of systematic coding, such as formally defining units of behavior, making assessments about each unit, and employing coders who were blind to the motivating theory. Instead of assessing reliability, which is not applicable to the methods we used, in keeping with recommendations for qualitative research (see McLeod, 2011, ch 14), we took two steps: (1) With regard to characterizing therapist responses, after the first author, who has extensive experience with SASB, described certain therapist turns in the exchanges in terms of these notions about how to differentiate among therapist behaviors, the second author, who is a formally trained SASB coder, confirmed those characterizations. This "verification step" (McLeod, 2011, p. 268) offers a qualitative analogue to a form of consensus rating, and (2) More importantly, we provide as much transcript material as space

allows so that readers can evaluate for themselves the analyses of patient-therapist interactions presented in the Results section.

Results

Session 3: Sharon's Defensive, Noncoordinating Pattern

In the analysis of this session, we focus on Sharon's contributions to the alliance. We direct attention to the therapist's contributions as well as the patient's in our analyses of later sessions.

As predicted, we found that Sharon's contributions to the alliance in this session were characterized by a recurring pattern of coordination breaches. Our analysis of an excerpt from the session, which appears below, shows that Sharon's noncoordinating pattern can be described as follows: She persistently, stubbornly pressed on with her point of view and tried to get the interaction to proceed along the lines of what she wanted to pursue, while she also repeatedly appeared to agree with and defer to the therapist. In fact, she was not really responsive to the therapist but, rather, she actually was intransigent in her persistence. She provoked the therapist by appearing to go along and then being nonresponsive, often in a baiting manner. In addition, she did not clearly present where she stood.

In the first 6 minutes of the session, Sharon described events in the early stage of her relationship with Jeff (pseudonym), her former fiancé. At several points, the therapist commented that Sharon had acted in an accommodating manner and Sharon responded that he was right. Sharon then recounted a situation in which Jeff was alone when he came to pick her up, even though they had agreed to go out with a group. The exchange we will consider began at that point.

The entries in the parentheses before each turn refer to session number followed by turn number. The term "backchannel" refers to minimal responses by an individual that simply communicate that he or she is attending to the other person.

(3,1) Patient: it was like the best time I ever had and then then you know that was like the mid//dle of my vacation

(3,2) Therapist: // (interrupts) so even the first date you see as in some way accommodating to Jeff, that you wanted it with a group and//

(3,3) Patient: // (interrupts) well//

(3,4) Therapist// (interrupts) he showed up alone

(3,5) Patient: well (smiling) I wanted you know – it – I didn't want to sound pushy. I didn't know if I liked this guy as a boyfriend. I just thought

(3,6) Therapist: (backchannel) um huh (yes)

(3,7) Patient: let's get together and you know

(3,8) Therapist: (backchannel) right

(3,9) Patient: It's an easier thing if

(3,10) Therapist: (backchannel) um huh (yes)

(3,11) Patient: you're asking a guy out - it wasn't even my inten –that wasn't even what I wanted but just sort of

(3,12) Therapist: (backchannel) um hum (yes)

(3,13) Patient: fell into that and worked out and then he called me like the next day. We'd speak for an hour. He's the first person – like usually when I talk to people I might want to get off the phone. //We got along really well.

(3,14) Therapist: // (interrupts) It it's not so clear what you wanted//

(3,15) Patient: // (interrupts) no [agrees], oh I didn't know what I wan – it was just like a vacation thing//

(3,16) Therapist: //but you know what I mean

(3,17) Patient: (backchannel) yeah

(3,18) Therapist: it is never is really so clear what you want//

(3,19) Patient: // (interjects) no (smiling) [agrees]

(3,20) Therapist: It's the other person's always//

(3,21) Patient: // (interrupts) but//

(3,22) Therapist: // (interrupts) getting the need, the power, the ball

(3,23) Patient: (nodding) yeah (smiles)

(3,24) Therapist: It's not so clear what you want.

(3,25) Patient: Right, but [emphasized] I'm not always sure. At that point, I definitely my agenda was just to have a fun vacation

(3,26) Therapist: (backchannel) um huh (yes)

(3,27) Patient: And that was it. I was going back to college and [pause] then uh but so we went out a couple of times and you know you could tell you know there was like chemistry there or whatever and then – he – then I was leaving the next day

In turns 2 and 4, the therapist returned to the issue of accommodation. Although the patient previously indicated this issue was important, consider how she responded to this observation. The beginning of turn 5 (“I didn't want to sound pushy”) seems to address the therapist's comment, but in the remainder of turn 5 and in turns 7, 9, 11, and 13, Sharon

actually returned to her own agenda of recounting early events in her relationship with Jeff. In turn 14, the therapist attempted to return to accommodation by picking up on Sharon's suggestion in turn 11 that she wasn't clear about what she wanted. Sharon began turn 15 by appearing to agree with the therapist, saying "oh I didn't know what I wan," but she then negated her own assenting response and discounted the therapist's comment by saying that "it was just like a vacation thing." The therapist tried to pursue the matter in turns 16, 18, 20, 22, and 24, making the general point that the patient never pursues what she wants but rather gives other people "the need, the power, the ball." Again, Sharon initially seemed to agree in turns 17, 19, and 23. However, her apparent agreements in turns 19 and 23 were accompanied by smiling, which gave them a baiting quality. In fact, after apparently agreeing with the therapist at the beginning of turn 25, Sharon shifted away from the therapist's suggestions about accommodation. With turn 27, she derailed any real consideration of that issue, notwithstanding the multiple points at which she seemed to defer to the therapist's efforts to discuss it, in favor of continuing with recounting early events in her relationship with Jeff.

We predicted that it would be possible to account for failures of coordination by the patient as defensive attempts to pursue a wished-for response while she also tried to avoid a feared response that might result from pursuing the wish. As we explain in what follows, we can account for Sharon's noncoordinating pattern as a way of pursuing the wish that the therapist would behave toward her in a manner that affirmed and showed appreciation for her independent actions and point of view, while also trying to avoid the possibility that the therapist might respond to her efforts to pursue that wish by ignoring or neglecting her and remaining uninvolved with her, which was her fear. In addition to observations of Sharon's in-session behavior, this formulation of the wish and fear was supported by Sharon's questionnaire responses and her narratives in sessions. At a number of points, Sharon reported that what would make her happiest would be acting on her own accord in the ways she saw fit, which she referred to as being "free" or a "free spirit." However, she also voiced concerns that she would end up being left alone. Her comments about her childhood indicated that acting as a free spirit would be met by a lack of involvement by her mother, whom Sharon saw as vain and self-absorbed. Also, although Sharon's father was actively involved with her, Sharon felt that he would turn away from her if their involvement wasn't on his terms.

According to the SASB principle of complementarity, specific ways another person acts toward the self are likely to elicit and be elicited by particular responses by the self. Typically, in the therapy context the patient is treated as the self and the therapist as the other. Complementary behaviors have similar standing on both the interdependence and affiliation dimensions.

Taken by themselves, Sharon's efforts to press on with her point of view and get the interaction to move along lines she wanted to discuss are examples of acting independently and taking a stand. By itself, this aspect of her behavior made it more likely (but not necessary) that the therapist would respond in the complementary manner, which would be therapist responses that affirm and show appreciation for Sharon's independent actions and

point of view. In other words, this aspect of Sharon's behavior pattern included repeated attempts to pursue her wish.

Although behaving in this way might lead to the responses Sharon wished-for, it also opens up the possibility that the therapist might respond in the manner she feared by neglecting or ignoring her and staying uninvolved. Sharon negotiated this conflict by engaging in the complicated pattern we observed instead of pursuing her wish in a straightforward way. On the one hand, she persistently pressed on with her point of view and, thereby, pursued her wish. However, she also repeatedly derailed acting independently and taking a stand by appearing to agree with and defer to the therapist.³

This worked to avoid her feared outcome in two ways. First, acting independently/taking a stand actually requires behaving in certain ways over time – developing, clarifying, reasserting one's position – not just making isolated statements. The therapist could not neglect Sharon when she acted independently because she never fully behaved in that manner, but rather repeatedly derailed her own contributions by deferring to the therapist. For example, evidence in the excerpt and other parts of session 3 suggests Sharon wanted to talk about good things that happened early in her relationship with Jeff to make sure the therapist understood why coming to terms with the end of the engagement was so hard for her. If Sharon had made this clear, the therapist might have shown a lack of interest (i.e., her fear). As it was, this sequence of events could not occur because although Sharon persistently returned to recounting early events, she never directly responded to the therapist's efforts to redirect the exchange to the accommodation issue by saying something like "I want to tell you more about what happened so you'll see there were good things."

The second way in which Sharon's pattern worked against the feared outcome occurring was that by apparently deferring to the therapist, Sharon baited him to continue to try to engage her in a discussion about accommodation. In fact, the therapist did not neglect Sharon. We saw that he very actively attempted to engage her in discussing the accommodation issue.

It is interesting to note that the therapist's view that Sharon was accommodating was not really on target. Sharon responded in an accommodating manner at many points, but she also repeatedly derailed her accommodating remarks by shifting away from what the therapist was trying to pursue to press on with what she wanted to discuss.

Our analysis suggests that Sharon contributed to problems in the alliance of a fundamental nature because, as we predicted, her noncoordinating pattern worked against establishing clear topics for the exchange and moving forward on those topics. It was never clear whether patient and therapist were considering what happened in the early stages of Sharon's relationship with Jeff because although Sharon repeatedly made comments about that, she kept the exchange from clearly focusing in that direction by repeatedly appearing to defer to the therapist's attempts to treat accommodation as the topic. But it also was never clear

³When SASB is used for systematic coding, behaviors like this are given what are called "complex codes," a term that refers to the fact that two different SASB characterizations apply to the behavior. With regard to Sharon's defensive, noncoordinating pattern, using our broad SASB-based notions, we could say that it reflected two different kinds of behaviors, acting independently and taking a stand and also going along/complying with the other, which can be described as a passive-aggressive pattern.

whether the topic was accommodation because Sharon repeatedly turned to recounting events in her relationship with Jeff without making it clear that she was changing the topic. Without clear topic establishment, there could be no forward movement on the accommodation issue or on the subject of what the early phase of Sharon's relationship with Jeff was like. As a result, the exchange could not be productive.

The analysis we have offered, with its focus on coordination, topic establishment, forward movement, and processes related to the patient's wishes and fears, begins to show how our approach differs conceptually from the guiding ideas of the WAI about agreement and the bond. We will consider the conceptual contrasts at some length in the Discussion after we have presented our analyses for all four sessions.

At this point, we turn to comparing our analysis of session 3 to the WAI ratings. The ratings for this session by the therapist (5.08) and patient (5.25), respectively, were higher than and similar to the mean ratings for third sessions in the sample of 22 cases that completed treatment in the short-term dynamic therapy condition (therapist WAI: $M = 4.55$, $SD = .92$; patient WAI: $M = 5.23$, $SD = 1.01$). There are limitations in what can be learned from WAI ratings on a single case, and it should not be surprising if careful analysis of a session yields results that differ from ratings. Nevertheless, we can offer some tentative observations about the third session ratings. Our close examination of the patient-therapist exchange suggests that these relatively high ratings failed to index what we believe were significant problems in the alliance. Also, given that outcome was poor, these third session ratings are higher than what one might expect based on the view that the alliance is a good predictor of outcome. This observation has additional weight because some investigators have claimed that alliance ratings early in treatment are especially good predictors of outcome (Hartley & Strupp, 1983; Horvath & Symonds, 1991). In fact, therapist ratings for the case were similar to the ratings for the sample throughout the first third of treatment and patient ratings for the case were largely similar to the sample for the first 6 sessions (see Figure 1).

Session 11: Feed-Forward Effects in the Therapist's Behavior

Our analysis of session 11 brings in consideration of the therapist's contributions to the alliance in addition to further examination of Sharon's contributions. In this session, Sharon attempted to get the therapist to give his opinion about a letter Jeff sent her after she sent him a ticket to a show that she hoped he would go to with her. The therapist did not want to offer his opinion, but rather tried to get Sharon to say what she thought about Jeff's letter.

We will see that both patient and therapist contributed to the alliance in problematic ways. For her part, Sharon contributed to the alliance in session 11 in a manner that was similar to what we observed in session 3. With respect to the therapist's contributions to the alliance, recall that we predicted his behavior would conform to the tenets about feed-forward effects. Our analysis of session 11 provided support for this prediction. In what follows, we first offer a general account of what we observed in the therapist's behavior and later examine the therapist's behavior in an excerpt from the session.

In our analysis of session 3, we found support for one of the tenets about feed-forward effects – the therapist’s behavior did not include the kind of responses the patient feared. We will see that the therapist also did not behave in the manner Sharon feared in session 11.

Another tenet about feed-forward effects is that although an individual’s defensive pattern includes recurring efforts to realize wished-for responses, it actually makes it less likely that those outcomes will occur. In Sharon’s case, even though she persistently pressed on with her point of view, she also repeatedly derailed taking a stand/acting independently by appearing to defer to and go along with the therapist. Sharon did not act independently or take a stand over time – indeed, it was very difficult to know what her independent viewpoint was. As a result, she made it very unlikely that the therapist would affirm or appreciate her point of view (Sharon’s wish), and, in fact, the therapist did not behave in that manner.

Another tenet is that defensive patterns promote negative outcomes distinct from the central fear. Although acting in a noncoordinating manner “cancels out” how pursuing an interpersonal wish might lead to the key fear, the coordination breaches themselves have consequences. We will see that the therapist treated Sharon as someone who was difficult to relate to because he had to struggle with her to *get her* to be responsive to his point of view and more forthcoming/clear about her own point of view. He did not neglect her and stay uninvolved but, at times, he related to her in hostile controlling and angry, attacking ways.

According to one other tenet about feed-forward effects, defensive patterns promote positive outcomes distinct from the wish. Sharon’s therapist did not affirm her independent viewpoint but, at times, he behaved in ways that were positive in the sense that he acted in a benevolent managing manner. This occurred because Sharon’s noncoordinating behavior led him to treat her as someone who was difficult to relate to and, sometimes, this involved struggling to *help her* be more responsive.

The following excerpt begins about 11 minutes into the session. Prior to it, the patient showed the therapist the letter she received from Jeff in response to the ticket she sent him and asked the therapist for his opinion. The therapist commented that Sharon wasn’t clear about her own thoughts about the letter, but at two points he said he thought Jeff had rejected her invitation. Sharon agreed, but at each point raised further questions about the letter. The exchange then continued as follows:

(11,1) Patient: and what do you think? (smiles)

(11,2) Therapist: Well I don’t know if what I think is important because//

(11,3) Patient: //(interjects) it’s important (laughs)

(11,4) Therapist: because you know him much better than I do//

(11,5) Patient: //(interrupts) Right, but no, it’s an opinion I’m just curious//

(11,6) Therapist: yeah, I really have no idea other than what you’re telling me. You know what I mean...I think it’s hard for you to make a decision

(11,7) Patient: um huh (yes, backchannel)

(11,8) Therapist: for yourself...you know that you're um you know soliciting my opinion or your friend's opinion even though you know you really know him [patient nodding] much better than anybody else.

(11,9) Patient: True, but I think this just this is it's not definitive what it means so I am curious to see//

(11,10) Therapist: um huh (yes, backchannel)

(11,11) Patient: What other people are going to interpret as being...I mean, you're a man and if you wanted to hurt somebody umm (pause) would that be the choice of words you would use?

(11,12) Therapist: Well, I'm just not clear why you have a question about it even...you know why you're sort of so confused about it is uh what strikes me

(11,13) Patient: um huh (yes, backchannel)

(11,14) Therapist: but I think that's a kind of a feature throughout your uh everything we've talked about is a sense of confusion

(11,15) Patient: um huh (yes, backchannel)

(11,16) Therapist: around painful issues. I mean look this is a painful issue. You obviously are hoping//

(11,17) Patient: //(interjects) right

(11,18) Therapist: to get together with Jeff and now this [patient nodding] is a cold rejecting letter, right? So you feel you know you have this uncertainty you know we were talking last time about your passing out you know about your tremendous anxiety

(11,19) Patient: um huh (yes, backchannel)

(11,20) Therapist: and confusion in certain situations where there are upsetting things happening...like whether it's a physical thing

(11,21) Patient: um huh (yes, backchannel)

(11,22) Therapist: which could be upsetting or a health thing. It seems like in the face of upsetting, painful issues

(11,23) Patient: um huh (yes, backchannel)

(11,24) Therapist: you get into a confused state.

(11,25) Patient: Well that could be true, but I...but this (points to letter) isn't obvious to me

(11,26) Therapist: What isn't?

(11,27) Patient: the letter isn't obvious [therapist nodding]

The exchange continued in a similar vein for about two minutes and then went on as follows:

(11,28) Therapist: ...so I'm wondering if//

(11,29) Patient: //(interjects) well

(11,30) Therapist: you like to be in a kind of confused state in order to avoid upsetting topics

(11,31) Patient: while by being confused I'm not putting an ending again to it

(11,32) Therapist: nods (backchannel)

(11,33) Patient: and definitely does serve a purpose.

(11,34) Therapist: Right.

(11,35) Patient: I guess it (pause) but he's (smiles) helping that along//

(11,36) Therapist: //(interrupts) So you don't have to feel pain.

(11,37) Patient: Right, but he's helping that along because he he has//

(11,38) Therapist: //(interrupts) maybe

(11,39) Patient: well//

(11,40) Therapist: //(interrupts) We're not here to analyze Jeff, we're here to look at you...

Once again, we see Sharon's defensive, noncoordinating pattern. She pressed on with trying to get the therapist to offer his thoughts about Jeff's letter while repeatedly appearing to agree with bids by the therapist that pointed in different directions, first to Sharon's thoughts about the letter and later to why Sharon kept herself in a confused state. Although Sharon returned repeatedly to asking questions about the letter, it was never clear what she wanted to say about it. However, it seems that Sharon thought the letter might not be a simple rejection of her invitation, but rather an angry response indicating that Jeff still had feelings for her.

Two examples of coordination failures occur in turns 5 and 9, both of which start with the patient voicing agreement with the therapist's suggestions that Sharon's views on the letter are key but then turn back to asking the therapist for his thoughts. Turns 11, 18, 25, and 27 offer another example of the noncoordinating pattern. In turn 11, Sharon probably actually put forward her own view, but did so in the form of a question. In turn 18, the therapist offered his opinion, saying that Jeff's response was "a cold rejecting letter." Sharon appears to agree with the therapist's comments about her confused state in the beginning of turn 25, but then returns to her focus on the letter in that turn and turn 27 without connecting those

comments to the therapist's remark about the letter in turn 18. In this example, Sharon persists in pursuing her point of view in the exchange while appearing to defer to the therapist and also not really putting forward her own stand – which might have become clear if she had responded to what the therapist had said in turn 18, e.g., by saying “I’m not sure it was cold and rejecting.” One more example occurred when Sharon appeared to go along with the therapist's comments about the role played by her confused state in turns 31, 33, the beginning of 35, and the beginning of 37, but then negated her own apparent agreement and insistently returned to her focus on Jeff's letter with her comments about how Jeff was “helping that along” in turns 35 and 37.

The excerpt also provides support for the prediction about feed-forward effects. The therapist by no means ignored the patient (her feared outcome). He was very actively engaged. Unfortunately, it also was the case that he did not behave towards the patient in her wished-for manner, although we can see that it would have been difficult for him to encourage her point of view given that although Sharon pressed on with attempts to get the exchange to go in a certain direction (i.e., for the therapist to say what he thought about the letter), she derailed any efforts on her own part to take a stand about that.

Instead, the therapist behaved in ways that differed from both the responses the patient feared and wished-for. His countertransference included ways in which he struggled in the face of Sharon's defensive pattern to help her be more responsive to him and more clear about her own point of view. This aspect of his responses included benevolently guiding interventions directed toward helping Sharon see things along the lines he thought were important in turns 6, 8, 12, 14, 16, 18, 20, 22, 24, 28 and 30, and 36.

We have seen that although Sharon initially appeared to respond positively to many of those bids, she repeatedly derailed any apparent readiness to go along with the therapist. It isn't desirable, but it is understandable that the therapist's responses also included less benign behaviors aimed at “getting” Sharon to be more responsive. The clearest example is the last turn of the excerpt (turn 42), in which he pronounced “We're not here to analyze Jeff, we're here to look at you.” This is an example of hostile controlling behavior in which the therapist tried to get Sharon to go along with him even though she did not want to do so. Other examples are more subtle, but the therapist's responses in turns 2 and 4 have a hostile controlling quality because they try to stop the patient from proceeding in the direction she wanted to pursue; his comment in turn 8 that the patient was soliciting other people's opinions “even though” she knows Jeff the best criticizes or blames her; and turn 12 (“...I'm just not clear why you have a question about it even...”) also has the quality of blaming her.

As we predicted, both Sharon's contributions to the alliance and the therapist's worked against clearly establishing topics and moving forward with them. Although Sharon repeatedly tried to get the therapist to voice his opinion about the letter, she also shifted away from that topic again and again, and although she often seemed to be go along with the therapist's view that her thoughts about the letter were what mattered and that they should talk about the role played by Sharon's confusion, she also repeatedly returned to asking about the therapist's opinion about the letter. In addition, the therapist's behavior, including both his benevolently managing and hostile controlling efforts, readily fit in with Sharon's

pattern rather than serving to change it, because Sharon could repeatedly defer to his bids but then move away from them. Moreover, as we discussed in the Introduction, the feed-forward effects of Sharon's defensive behavior on the therapist's behavior served to promote the continuation of her pattern because by eliciting hostile controlling and benevolently managing behavior from the therapist, Sharon's defensive pattern avoided her feared response of being neglected. Furthermore, the therapist's benevolently managing responses provided Sharon with positive responses, even if not her central wished-for outcome.

Therefore, one upshot of Sharon's noncoordinating behavior and the therapist's responses that served to maintain it was that no topic was clearly established and, in turn, there was no forward movement on a topic. Given these problems, there could be no productive exchange about any of the possible lines of discussion (the therapist's thoughts about the letter, Sharon's own views about the letter, Sharon's confusion). Another upshot was that the exchange did not lead to a corrective emotional experience in which Sharon nondefensively pursued her wish and the therapist responded in the wished-for manner.

The therapist's WAI ratings for this session (5.22) were higher than the mean for therapist ratings in the sample for 11th sessions ($M = 4.76$, $SD = .98$). Sharon's ratings for the session (4.67) were lower than the sample mean for patient ratings ($M = 5.21$, $SD = .89$). Our close examination of patient-therapist interaction suggests that the WAI ratings by the therapist failed to capture the extent to which the alliance was problematic. The patient's ratings seem more on the mark. Based on our analysis, we suggest an abduction, that is, a new proposition that could be explored further in future research. In general, the abduction maintains that WAI ratings may depart from accurately assessing alliance quality as a result of countertransference reactions. With regard to this session, the therapist may have given what we believe were overly positive WAI ratings because his benevolently managing/guiding bids led him to feel he was successfully helping the patient. For her part, Sharon's ratings may have reflected how she felt about the therapist's hostile controlling behavior.

Some final points about session 11 concern a comparison of our analysis with the therapist's view that Sharon remained confused, that is, unable to make decisions, in order to avoid painful feelings. As we see it, that formulation fails to recognize Sharon's interpersonal fear of being ignored. Furthermore, it does not include consideration of her wish.⁴ What the therapist referred to as Sharon's confusion included efforts on her part to do something along the lines of taking a stand (albeit in a very unclear, non-straightforward manner) by persistently returning to her questions about Jeff's letter, which is to say, efforts to pursue her wish. Our analysis suggests that things might have gone very differently (better) if the therapist had recognized this.

If he had, for example, he might have offered his own view of the letter at any of several different points (e.g., turns 2, 4, or 6) in response to Sharon's requests and then say, "How

⁴Some clarification of terms is useful here. We would not describe this formulation in itself as a countertransference reaction on the therapist's part because we use that concept to refer to how a therapist acts toward a patient (e.g., validating independence, guiding, attacking, and so forth). Taken by itself, we consider it to be an inaccurate formulation. However, the *manner* in which the therapist offered his interpretation about Sharon's confusion in turns 12, 14, 16, 18, 20, 24, 30, and 36 makes it a countertransference response because he behaved in a guiding way towards the patient, which is a positive response distinct from her wish.

does this compare to your thoughts about it?" The therapist also might have picked up on parts of certain comments Sharon made that *did* include some statement of her own point of view. For example, at turn 12, the therapist might have said, "Oh I see, you're suggesting [based on what Sharon said in turn 11] that he was trying to hurt you. I think you might be right. What do you think is going on about that?" These hypothetical responses by the therapist would affirm and show appreciation for Sharon taking a stand and encourage her to continue acting independently, i.e., they would realize her wish and encourage her to continue to pursue her wish.

Session 20: Struggling that is More Obvious

Almost throughout session 20, patient and therapist engaged in a tug of war. Although it was especially obvious that they were struggling with each other in this session, our analysis will suggest that there actually was considerable continuity between this session and the earlier sessions in how patient and therapist contributed to the alliance.

We will consider an excerpt that took place about eight minutes after the start of the session. Prior to the excerpt, Sharon told the therapist that she left a phone message for Jeff when his favorite sports team won a big game. The therapist repeatedly asked Sharon how she thought he (the therapist) would react to this news, trying to get her to acknowledge that she knew he thought it was a bad idea. In response, at several points Sharon seemed to acknowledge that she realized the therapist was opposed to her contacting Jeff, but she also repeatedly derailed these acknowledgments by persistently voicing her belief that the therapist had not made it clear that he thought communicating with Jeff was a bad idea. It was not clear what Sharon hoped to accomplish with these persistent comments, but consideration of all of her remarks suggests that those bids were extremely indirect, vague attempts to call upon the therapist to change his view and recognize how important it was for Sharon to communicate with Jeff.

Just before the excerpt that follows, the therapist made another attempt to get Sharon to acknowledge that she knew he thought it was a bad idea for her to contact Jeff, this time, by suggesting that Sharon was afraid of his (the therapist's) disapproval.

(20,1) Therapist: // ((interrupts)) or that's what you're assuming? That I disapprove?

(20,2) Patient: Right...well yeah (quietly) (nods yes, smiles)

(20,3) Therapist: aha...so I mean you know it's interesting also to you know in terms of the pattern that we've been looking at for you is that on the surface you try to be accommodating

(20,4) Patient: (nodding yes, backchannel)

(20,5) Therapist: but really under the surface you're not accommodating. You know, you do things pretty much the way you want to so that (patient smiles) really fits right in with it, doesn't it?

(20,6) Patient: (smiles) yeah (nods yes)

(20,7) Therapist: That on...that you're hoping for my approval but you think I don't approve

(20,8) Patient: (nodding yes, backchannel)

(20,9) Therapist: and you're going to do what you want anyway which you do do.

(20,10) Patient: but I certainly

(20,11) Therapist: um hum (yes, backchannel)

(20,12) Patient: would hear you out if you disapproved

(20,13) Therapist: um huh (yes, backchannel)

(20,14) Patient: and take it into consideration, but if I still felt after hearing that

(20,15) Therapist: um huh (yes, backchannel)

(20,16) Patient: which I haven't heard directly, "that's a bad idea"

(20,17) Therapist: um huh (yes, backchannel)

(20,18) Patient: or whatever//

(20,19) Therapist: // (interrupts) You haven't heard that directly from me?

(20,20) Patient: No, I don't think so.

(20,21) Therapist: Really?

(20,22) Patient: (smiling) Do you think you've...well? (laughs)

(20,23) Therapist: No, I mean that's pretty amazing. I think you know we've talked about Jeff you know acting in pretty scary ways (patient looking down and smiling) and we've talked about how much Jeff you know the obsession with Jeff uh stands on the way from you having any other relationship, right?

Sharon's defensive, noncoordinating interpersonal pattern is evident in this excerpt. In turn 2, she seemed to go along with the therapist's suggestion that she thought the therapist disapproved of her contacting Jeff. In turns 3, 5, 7, and 9, the therapist then brought in a new idea, maintaining that Sharon was accommodating on the surface, but actually did whatever she wanted to do. In response, Sharon appeared to agree with this new observation (turns 4, 6, and 8) and went on to assure the therapist that she took what he said into consideration (turns 10, 12, and beginning of 14). With the second part of turn 14, it seems that Sharon was about to assert that if she saw things differently from the therapist after taking his view into consideration, she would act according to her own beliefs. But Sharon did not continue along these lines at all. Instead, in turns 16, 18, 20, and 22, she shifted back to saying that the therapist still had not made clear how he felt about her contacting Jeff. This breach of coordination did not mesh with the fact that the therapist had expressed his negative opinion several times shortly before the excerpt began and it negated Sharon's own acknowledgment

in turn 2 that she knew the therapist disapproved. There's a troubling irony here because this coordination breach was an example of the therapist's point about how Sharon did not listen to him.

In large measure, the therapist's contributions to the alliance in this session followed along the lines of our analysis in session 11, but we will see that his behavior differed in one respect. Here again, he was very actively engaged with the patient and certainly did not ignore her (her fear). Also, once again he most definitely did not behave in the manner Sharon wished for by affirming her independent viewpoint. Instead, he responded countertransferentially to Sharon's defensive pattern by struggling to both "help her" and "get her" to be more responsive.

We see examples of what could be described as benign "helping her" responses in turns 3, 5, 7, and 9 because the therapist is trying to guide Sharon towards a better understanding of herself. But the negative "getting her" aspects of the countertransference are much more evident in this session. The therapist's frustration with Sharon returning yet one more time in turns 14 and 16 to her claim that he had not made his opposition clear appeared in his responses in turns 19, 21, and especially 23, which are examples of hostile control (criticizing, accusing, and blaming). In fact, we also can say that even the therapist's new observation in turns 3, 5, 7, and 9 about how the patient really did whatever she wanted to do was not solely an example of benign guidance because there was an accusing, blaming quality to it.

After the transcribed excerpt, the therapist's attempts to "get" Sharon to be more responsive became more pronounced. He was critical, badgering, and attacking, although the patient's defensive pattern certainly contributed to this. For example, at one point, the therapist said "see I think ultimately in some way your whole interpersonal relationship life has been about rejecting what people have to offer and doing what you want." At another point, when Sharon once more assured the therapist that she was open to hearing what he had to say, the therapist responded sarcastically "Sure...sure...You really believe that?"

Here again in this session, one upshot of Sharon's defensive interpersonal pattern and the therapist's countertransference responses was that no topics were clearly established and there was no forward movement on any topic. The therapist did not succeed in establishing as topics his point that Sharon had contacted Jeff even though she knew the therapist thought that was a bad idea or his observation that Sharon really was not accommodating. At the same time, Sharon's view that the therapist had not expressed his opinion about her attempts to communicate also did not become a clear topic, nor did how important it was for her to communicate with Jeff. Another upshot concerned Sharon's wish. Because she did not pursue discussing her viewpoint about communicating with Jeff in a straightforward fashion, Sharon's pattern worked against the therapist showing appreciation for her independent stand. Hence, the interaction did not provide a corrective emotional experience.

The WAI ratings by the therapist (4.00) and patient (4.25) for this session were lower than their ratings for other sessions (see Figure 1) and clearly lower than the means for the sample for 20th sessions (for therapists' ratings: $M = 4.96$, $SD = .69$; for patients' ratings: M

= 5.26, $SD = .95$). Our analysis of this session suggests that the ratings probably should have been even lower, but the main point we wish to make about those ratings extends the abduction we proposed earlier. The dip in ratings in session 20 may have resulted from the fact that, as compared to the earlier sessions we analyzed, in this session the balance between benevolently managing as compared to hostile controlling and attacking responses by the therapist tipped more towards the latter, although both those positive and negative kinds of behavior are problematic in the sense that they work against topic establishment and forward movement and also against change in the defensive pattern. Sharon might have given lower WAI ratings because the therapist behaved more negatively towards her (although not in the manner she most feared). The therapist may have given lower ratings because he was frustrated in his efforts to “get” her to be responsive. The dip registers a real change, but there also was considerable continuity across the sessions we have examined in how patient and therapist contributed to the alliance and in the unsuccessful upshot of their efforts.

It is useful to consider the therapist’s new formulation that Sharon actually did whatever she wanted to do, although she appeared to be accommodating. In some respects, this formulation is more accurate than his earlier view that Sharon was accommodating. However, note that the therapist treated the non-accommodating aspects of Sharon’s behavior as though they were entirely undesirable and he believed that she really did whatever she wanted to do. In fact, the non-accommodating features of Sharon’s behavior were attempts – defensive attempts, to be sure – to pursue her wish by doing something like acting independently. The therapist should have helped Sharon find non-defensive ways of pursuing her wish, because the main problem with the non-accommodating aspects of Sharon’s behavior was that she did *not* do what she wanted to do, but only pursued her wish in very limited, halting, non-straightforward ways.

For example, the therapist could have encouraged Sharon to pursue her wish and also realized her wish if he had said in turn 3, “I do disapprove, but I would like to understand your point of view on this.” Another example of how the therapist might have responded differently concerns turn 19. Instead of replying to the part of Sharon’s prior comments about how he hadn’t said directly that contacting Jeff was a bad idea, the therapist might have responded to the part in which she said “if I still felt after hearing that.” Even though Sharon herself shifted away from finishing that remark, the therapist might have said, “I’m glad that you would have stuck to your guns if you still felt the same way given what I had to say.”

These suggestions about alternative responses the therapist might have offered in this session and our suggestions about possible alternative responses in session 11 lead to another abduction: In response to defensive patient behavior, it may be desirable for a therapist to behave in ways that realize the patient’s wish and encourage him or her to pursue that wish.

Session 25: More of the Same

Even though session 25 occurred near the end of therapy when one might hope that relationship processes had changed, we will see that this was not the case. We will consider an excerpt that took place after about 28 minutes had transpired. Prior to that, Sharon talked

about sending Jeff a note asking him to call her. She also talked about attending a wedding. She said she didn't call her parents or sister over the wedding weekend, which was a departure from her typical behavior. She also talked about how Jeff sometimes got very angry over small concerns during the time they were going out. She said that he often blamed her sister, Lorraine [pseudonym], for problems in their relationship. The therapist tried to get Sharon to focus on her own role in the difficult parts of her relationship with Jeff. The exchange repeatedly went back and forth between Sharon (a) seeming to agree with the therapist, acknowledging ways she contributed to the difficulties, and (b) shifting the focus to Jeff and what she called his irrational anger. Along the former lines, Sharon said that she used her sister as a "scapegoat." Right before the following excerpt, Sharon acknowledged that it made sense that Jeff got angry on one occasion when she invoked her responsibilities to her sister as the reason why she had to go home early one night.

(25,1) Patient: Right (pause) that that definitely is a valid (pause) thing

(25,2) Therapist: um huh (yes, backchannel)

(25,3) Patient: but these other situations where he would do something that made no sense if he loves me to make a big deal// about

(25,4) Therapist: // (interrupts) I'm not trying to justify his behavior//

(25,5) Patient: // (interjects) right

(25,6) Therapist: I just think it's more fruitful for us to try to understand your behavior. You know//

(25,7) Patient: // (interrupts) Yeah and I agree, but//

(25,8) Therapist: // (interrupts) You know it's interesting because one of the things that I've pointed out to you over and over is I have the sense that Jeff is used by you to kind of stand in between you and me or stand in between you and these other guys you know the other guys that you start to date that your mind is always on him which kind of makes it that you don't let anybody get that close to you. And now in a way if you think about it in your relationship with Jeff you were bringing Lorraine into the middle of it you know and that in some way prevented you from - you know it was a problem in the relationship and so it seems like it's not an infrequent thing that you have a third party when you try to be intimate with one other person that you're bringing in a third party to uh you know that somehow prevents you from really being intimate with that other person you know and I you know I think you talked about that in terms of your relationships you know like as a kid with your parents or even today you know like with your father you're worrying about you mother what she's going to think

(25,9) Patient: um huh (yes, backchannel)

(25,10) Therapist: or how she's going to react or vice versa with your mother then you're worrying about your father (pause). I don't know what you think about//

(25,11) Patient: // (interrupts) Right, well...well I think that that definitely somehow makes my um relationships less intense if I do get this other party sort of involved then they're not as serious as they could be but um but I think also one of the points I was trying to get across is that one of my frustrations in getting over my thing with Jeff is that is remembering um the times with him when these fights just shouldn't have occurred and that if only he would have understood how stupid they were I keep thinking that maybe one day

(25,12) Therapist: um huh (yes, backchannel)

(25,13) Patient: he would wake (pause) like we had a fight about this and I'm not using him as (laughs) keep us (gestures back and forth between therapist and herself) from getting close this was

(25,14) Therapist: um huh (yes, backchannel)

(25,15) Patient: what really concerns me.

(25,16) Therapist: See but I think – see the the point I'm trying to look at is I think you kind of get bogged down with the trees and you miss the forest. You you know what I mean? I think that there's an overall something

(25,17) Patient: hm (yes, backchannel)

(25,18) Therapist: that goes on in relationships that you need to start to examine which is the issue of using one relationship to ward off another. (pause) You know? And I'm not saying it's a conscious thing.

(25,19) Patient: um huh (yes, backchannel)

(25,20) Therapist: but I think it's a repeated pattern that bears some looking at. See I think on an unconscious level you don't want to end it with Jeff cause he's a perfect second party to introduce between you and other people right now so that you know it keeps you from getting involved too deeply and from getting into conflict with your family. You know even though like you went away this weekend and you were at the wedding and you didn't call them for a couple of days and you you were anticipating that they would be upset

(25,21) Patient: um huh (yes, backchannel)

(25,22) Therapist: but then it turns out that they weren't

(25,23) Patient: right (backchannel)

(25,24) Therapist: but in your mind if you get too far away from them, they're gonna get upset so you focus on Jeff or you know you focus on other things like Jeff particularly or Lorraine.

Examination of this exchange indicates that patient and therapist continued to relate to each other in the ways that characterized their contributions to the alliance all along. We clearly see Sharon's defensive, noncoordinating pattern of persistently trying to get the interaction

to proceed along lines she wanted to pursue (talking about Jeff's angry outbursts) while appearing to agree with and defer to the therapist. In turn 1, she confirmed her prior acknowledgement of her role in Jeff getting angry, but then shifted in turn 3 to "other situations" in which Jeff's behavior made no sense (i.e., not something she contributed to). The pattern was about to repeat with Sharon deferring to the therapist in turns 5 and the beginning of turn 7 but then starting to shift again with the "but" in turn 7, when the therapist interrupted Sharon in turns 8 and 10 with a particular suggestion about her role in her relationship problems – the idea that Sharon avoided getting close to anyone by bringing a third party into the middle of the relationship. In response, Sharon appeared to agree with the therapist in the beginning of turn 11, but then once again switched the focus back to Jeff in the middle of turn 11 and the beginning of turn 13. In this part of the exchange, Sharon came close to clearly presenting the reason for her insistent returns to focusing on Jeff. It seems that she wanted the therapist to understand that she believed her relationship with Jeff could work out because Jeff might change ("I keep thinking that maybe one day he would wake (pause)"). However, Sharon shifted back to the therapist's idea about third parties and assured him she was not using her comments about Jeff to come between her and the therapist (see the end of turn 13). In turn 15, Sharon was about to return to her persistent focus on Jeff yet again, when the therapist began a series of comments about his third party idea that continued for the remainder of the excerpt.

The therapist's contributions to the alliance also were similar to the way he behaved in the earlier sessions, although they followed more closely along the specific lines we observed in session 11 than session 20. He did not neglect Sharon (her fear), but was quite actively engaged. Also, he definitely did not behave in the manner Sharon wished-for by affirming her independent viewpoint. Instead, he behaved in benevolently managing and hostile controlling ways, trying, respectively, to "help" and "get" Sharon to be more responsive.

As compared to session 20, the balance was tipped more in the direction of benevolent managing. We see instances of benign guidance at a number of points, including turns 6, 8 and 10, 16, and 18 and 20. The therapist's behavior also included examples of hostile control. For example, although turn 6 seems to be an example of helpful guidance, turns 4 and 6 together were an attempt to stop Sharon from proceeding in a direction she wanted to pursue. The most important example of hostile control concerns the last part of turn 20 ("You know even though...") through the end of the transcript. Here, the therapist focused on a step the patient took (attending a wedding and not calling her parents or sister during that weekend), which we view as an example of acting independently, and criticized it because, notwithstanding the change in her behavior, she continued to have certain concerns on her mind.

Again in this session, one upshot of how patient and therapist contributed to the alliance was that no topic was clearly established and there was no forward movement on topics. As a result, there was no constructive exchange about any of the possible lines of discussion – Sharon's desire to talk about Jeff's angry outbursts and her belief that he could change, or the therapist's efforts to discuss Sharon's role in her relationship difficulties, including how she brought third parties into things. Another upshot was that Sharon did not have the

experience of pursuing her wish in a straightforward way and realizing her wish in the therapist's behavior.

The therapist's WAI ratings for this session (5.08) were about the same as the mean for therapist ratings in the sample for 25th sessions ($M = 5.14$, $SD = .80$). Sharon's ratings (5.08) were somewhat lower than the sample mean for patient ratings ($M = 5.62$, $SD = .90$). As compared to session 20, the balance between benign guidance and hostile control shifted towards the former. Following along the lines of our abduction about WAI ratings, we believe this explains why therapist and patient WAI ratings were higher for session 25 than session 20, even though the therapist's efforts at benevolent guidance, like his efforts at hostile control, served to maintain Sharon's defensive pattern and thereby worked against change. As we suggested about session 11, the therapist may have given what we believe were overly positive ratings for session 25 because he felt that his benevolently managing/guiding bids were helping, and Sharon's ratings, which were somewhat lower than the ratings in the sample for 25th sessions but higher than her ratings for the 20th session, may have reflected how she felt about the therapist's hostile controlling behavior, which was present in session 25 although not to the same extent as in session 20.

The excerpt includes a new formulation by the therapist – the idea that Sharon brought third parties into her relationships to avoid “getting involved too deeply” and, thereby, avoid conflict (turn 20). Our analysis suggests that this formulation fails to recognize Sharon's fear of being ignored. As we see it, Sharon behaved in ways that actually *promoted* conflict (recurring struggles with Jeff and others, including the therapist) as part of how she avoided her key fear. The therapist's formulation also fails to include any reference to what Sharon *hoped would happen* in her relationships (her wish). We would argue that Sharon brought in third parties much in the way she persistently returned to certain topics in her interactions – she invoked third parties as an unclear, but insistent way of doing something like taking a stand/acting independently vis à vis the second party.

Our claim that the therapist did not understand Sharon's wish is supported most clearly in the excerpt by how he failed to respond in an affirming/validating manner (and, indeed, was critical) regarding the step she took in the direction of acting independently by attending a wedding and not calling her parents or sister. Our abduction about how therapists should respond to defensive behavior suggests that it would have been desirable for the therapist to affirm the patient for acting independently in this way, which would have realized her wish and encouraged her to continue to pursue it.

Discussion

The results of this preliminary theory-building case study investigation suggest that our alternative approach based on interpersonal defense theory identifies key processes in the alliance. As predicted, we found that the patient's contributions to the alliance in this poor outcome case were characterized by a recurring pattern of failing to coordinate her turns in the exchange with the therapist's bids and with her own prior bids, and we were able to explain this transference pattern in terms of defensive processes aimed at negotiating a conflict between pursuing her wished-for interpersonal response and the possibility that

pursuing that outcome might result in her feared response. Also as we predicted, we found that the therapist's contributions to the alliance included neither the kinds of responses the patient feared nor wished for, but rather negative responses distinct from the patient's fear and positive responses distinct from her wish. Our examination of patient-therapist interactions suggested that these feed-forward effects of the patient's defensive behavior pattern served to maintain that pattern.

Our approach to the alliance also offers suggestions about how it influences outcome. As we noted at the outset, there are unanswered questions about the mechanisms that account for alliance-outcome associations. In fact, some investigators (e.g., Barber et al., 2010) have suggested that those associations might reflect a direction of effects from outcome (patients' symptomatic improvement during treatment) to alliance ratings. Our analysis suggests two mechanisms that may explain how the alliance affects outcome. One point is that if a patient is behaving defensively in his or her relationship with the therapist and the therapist responds countertransferentially, then the alliance will not provide the patient with corrective emotional experiences in which the patient pursues what he or she wishes for in that relationship and the therapist responds in the wished-for manner. A second point is that problematic alliance processes interfere with constructive work on the issues a patient needs to address because they work against establishing clear topics and moving forward on those topics.

In the case we considered here, regarding the first point, Sharon did not pursue her wish in a straightforward manner by taking a stand/acting independently and the therapist did not affirm or appreciate her independent viewpoint. Regarding the second point, we saw that, as predicted, the ways in which the patient and therapist contributed to the alliance worked against basic features of successful interaction – establishing topics and moving forward on those topics – and that as a result there was little to no progress on every one of the issues that seemed to be of interest to either Sharon or her therapist.

Our primary goals for this study concerned learning about our approach to the alliance itself, but we also compared our approach to the WAI. With regard to our main goal for that comparison, our analyses clarified how our approach differs conceptually from the ideas about the bond and agreement on tasks and goals that underlie the WAI. We agree that the bond is important, but our analyses suggest that interpersonal defense theory specifies what a positive bond is like in novel ways – the patient behaves nondefensively and the therapist responds at times in the patient's wished-for manner and makes few countertransference responses (and this includes not often responding with positive behaviors distinct from the wish).

Our analyses also suggest that rather than focusing on whether patient and therapist agree or disagree on tasks and goals, investigators should attend to more fundamental issues concerning coordination, topic establishment, and forward movement on topics. As noted above, we found that problems in these basic processes worked against productive exchange. They also resulted in interactions in which it was never clear whether patient and therapist agreed or disagreed about discussing, for example, the issue of accommodation (session 3), the role played by Sharon's confusion (session 11), how communicating with Jeff meant a

lot to Sharon (session 20), or the therapist's idea that Sharon played a role in her relationship difficulties with Jeff (session 25).

Note that in other cases, questions about agreement versus disagreement are even more clearly not the central issues of concern. Sharon's pattern of repeatedly moved between agreeing with the therapist and then shifting away from going along with him was a feature of this particular case, not a general characteristic of noncoordinating patterns. For example, in the case briefly described in the Introduction, the patient's noncoordinating pattern made what mattered to her very unclear because although she mentioned feelings and concerns, she repeatedly jumped from mentioning one concern to another. The problems in the alliance in that case did not have anything at all to do with the issue of agreement but, in that case too, problems in what we believe are more fundamental processes (coordination, topic establishment, forward movement) were evident.

As a secondary part of comparing our approach with the WAI, we also considered therapist and patient WAI ratings. Although there are limits to what can be learned from such ratings on a single case, our analyses suggested that our approach helped us recognize that the alliance was more problematic than the ratings for several sessions indicated. We suggested that sometimes high WAI ratings may not actually reflect a good alliance but rather countertransference responses that included many positive responses distinct from the patient's wish, an idea we arrived at through the process of abduction.

To be sure, these suggestions about possible problems with WAI ratings need to be investigated in further research. However, putting aside our comments about the ratings in this case, the fact that our analyses appear to have identified important processes that differ *conceptually* from the guiding ideas for the WAI opens up the possibility that future studies may find that alliance assessments based on our approach (a) do not overlap a great deal with WAI ratings, and (b) result in obtaining alliance-outcome associations that are more robust than the current literature suggests. Recall from the Introduction that the latter point about more robust associations is supported by previous nomothetic process-outcome studies on patient coordination, even though, as we noted earlier, those studies did not include consideration of the defensive functions of noncoordinating behavior regarding wishes and fears, or therapists' contributions to the alliance.

Our analysis of the case suggests implications for clinical practice. It suggests that therapists should avoid behaving in a countertransferential manner, as that is understood in interpersonal defense theory, because responding in ways that are positive but distinct from a patient's wish and in negative ways distinct from a patient's fear serve to maintain a patient's defensive pattern. Instead, in another abduction, we suggested that a therapist should respond in the patient's wished-for manner and encourage the patient to continue to pursue his or her wish.

As Wachtel (2008) suggested, therapists probably frequently become "accomplices" in their patients' problematic ways of contributing to the alliance. Therefore, the goal for therapists is not to behave in the manner we have just recommended throughout a treatment, but rather to find ways to shift in that direction over time. In order to do this, a therapist needs to

develop a good understanding of a case. In particular, our analyses suggest that it is important to recognize that problematic contributions to the alliance by a patient are attempts to influence interpersonal outcomes and that they are likely to include efforts to pursue a wished-for outcome, not just attempts to avoid a feared response.

Note that our suggestion about responding in the manner the patient wishes for, does not necessarily refer to specific, concrete requests, such as a request to extend a session beyond the agreed upon length of time, but rather to the broad characterizations of positive behaviors we employed in our analyses. Even so, our suggestion implies that in a given case it might be desirable for a therapist to behave in ways that depart from his or her usual manner. For example, although a particular therapist may believe it is important to affirm patients' independent actions and points of view (which we have maintained would have been very helpful for Sharon), in some cases it may be crucial to limit such responses in favor of showing concern and compassion. Also note that we are not suggesting that a therapist respond in the patient's wished-for manner without regard to how the patient behaves. All of our hypothetical examples of more helpful ways the therapist might have responded to Sharon were suggestions about how he could have built upon the aspects of Sharon's behavior that pursued her wish.

Although the method we employed was well-suited to our goals in a number of respects, there are limitations to this preliminary, qualitative, theory-building case study. There is a question of whether results for this case generalize to other cases. Also, as is also true for other established qualitative approaches, in theory-building case studies the "main tool of inquiry is the researcher...continually engaged in sense-making and finding meaning" (McLeod, 2011, p. 77). Investigators are not blind to considerations about theory when they examine raw data. Also, sampling typically is treated differently than it is in quantitative research, with qualitative researchers putting more emphasis on identifying samples that exemplify meaningful phenomena investigators have observed in some larger corpus and quantitative researchers emphasizing random selection. These features of the approach we took open up the possibility of bias in ways that are not present in systematic quantitative studies.

One of the main ways qualitative researchers address questions about the validity of their findings is by triangulating with results from other qualitative investigations and from quantitative studies (McLeod, 2011, ch 14). Along these lines, we can point out that findings from the present study are consistent with the previous investigations based on interpersonal defense theory reviewed in the Introduction. To be sure, there is a need for continuing the process of triangulation with further investigations of our approach to the alliance.

Future research should include additional theory-building cases. These investigations should include good outcome cases and good outcome-poor outcome pairs of cases treated by the same therapist. Studying good outcome cases would provide an excellent opportunity to investigate our abduction about how therapists should respond to defensive behavior.

In addition, future quantitative studies using group designs could make important contributions to the triangulation process. The present study helps set the stage for such

efforts because it provides concrete illustrations of the relationship processes identified in our approach, which was one of our main goals. The concrete illustrations we have offered should prove helpful in future attempts to develop systematic coding schemes, although those efforts will have to address difficult challenges, including the task of taking into account each patient's case formulation.

Nomothetic-idiographic studies using such measurement procedures would be able to arrive at quantitative assessments of coordination on the part of patients, countertransferential responses on the part of therapists, and therapist responses that realize patients' interpersonal wishes, and then go on to investigate relationships between those processes and outcome. Future studies could also investigate discriminant and discriminant predictive validity, comparing typical measures of the alliance (e.g., the WAI) with measures based on our alternative approach to see whether the two sets of measures share only a modest amount of variance, if assessments based on our approach are better predictors of outcome, and whether scores on commonly used alliance measures are correlated with the balance between therapist responses that are positive but distinct from the wish and responses that are negative but distinct from the fear. Other future investigations could explore our approach to the alliance in a variety of treatment approaches, because although our approach is based on a particular theoretical perspective, it may prove to be relevant across different therapeutic orientations.

The research was supported in part by a grant from the National Institute of Mental Health (MH071768) to the Beth Israel Psychotherapy Research Program (Principal Investigator: J. Christopher Muran). The authors thank Barry Cohen, William Jock, and Sumru Tufekcioglu for their assistance with data analysis.

References

- Barber JP, Khalsa S-R, Sharpless BA (2010). The validity of the alliance as a predictor of psychotherapy outcome In Muran JC & Barber JP (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 29–43). New York: The Guilford Press.
- Battle CC, Imber SD, Hoehn-Saric R, Stone AR, Nash ER, & Frank JD (1966). Target complaints as criteria of improvement. *American Journal of Psychotherapy*, 20, 184–192. [PubMed: 5906081]
- Benjamin LS (1979). Structural analysis of differentiation failure. *Psychiatry: Journal for the Study of Interpersonal Processes*, 42, 1–23.
- Brenner C (1979). Working alliance, therapeutic alliance, and transference. *Journal of the American Psychoanalytic Association*, 27(Suppl.), 137–157. [PubMed: 263963]
- Curtis JT, & Silberschatz G (2007). Plan formulation method In Eells TD (Ed.), *Handbook of psychotherapy case formulation* (2nd ed., pp. 198–220). NY: Guilford.
- Dahmen BA, & Westerman MA (2007). Expectations about the long-term consequences of recurring defensive interpersonal behavior. *Journal of Research in Personality*, 41, 1073–1090.
- Derogatis LR (1983). *The Symptom Checklist –90 Revised: Administration, scoring and procedures manual II*. Baltimore: Clinical Psychometric Research.
- Doran JM, Safran JD, Waizmann V, Bolger K, & Muran JC (2012). The Alliance Negotiation Scale: Psychometric construction and preliminary reliability and validity. *Psychotherapy Research*, 22, 710–719. [PubMed: 22861685]
- Endicott J, Spitzer RL, Fleiss JL, & Cohen J (1976). The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry*, 33, 766–771. [PubMed: 938196]

- Gaston L (1991). Reliability and criterion-related validity of the California Psychotherapy Alliance Scales – Patient Version. *Psychological Assessment*, 3, 68–74.
- Hartley DD, & Strupp HH (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy In Masling J (Ed.), *Empirical studies of psychoanalytic theories* (Vol. 1, pp. 1–37). Hillsdale, NJ: The Analytic Press.
- Hartmann HA (2001). Clients' contribution to the alliance and the role it plays in outcome. (Doctoral dissertation, Adelphi University, The Institute of Advanced Psychological Studies, 2000.) *Dissertation Abstracts International-B*, 61/08, 4406.
- Hatcher RL (2010). Alliance theory and measurement In Muran JC & Barber JP (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 7–28). NY: Guilford.
- Henry WP, & Strupp HH (1994). The therapeutic alliance as interpersonal process In Horvath AO & Greenberg LS (Eds.), *The working alliance: Theory, research and practice* (pp. 51–84). New York: Wiley.
- Horowitz LM, Alden LE, Wiggins JS, & Pincus AL (2000). *Inventory of Interpersonal Problems*. New York: The Psychological Corporation.
- Horvath AO (2006). The alliance in context: Accomplishments, challenges, and future directions. *Psychotherapy*, 43, 258–263. [PubMed: 22122094]
- Horvath AO, Del Re AC, Fluckiger C, & Symonds D (2011). Alliance in individual psychotherapy. *Psychotherapy: Theory, Research, Practice, and Training*, 48, 9–16.
- Horvath AO, & Symonds BD (1991). Relations between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38, 139–149.
- Klein MH, Benjamin LS, Treece C, Rosenfeld R, & Greist J (1993). The Wisconsin Personality Disorder Inventory: Development, reliability and validity. *Journal of Personality Disorders*, 7, 285–303.
- Luborsky L, & Crits-Christoph P (Eds.) (1998). *Understanding transference: The CCRT method* (2nd edition). New York: Basic Books.
- Martin DJ, Garske JP, & Davis KM (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438–450. [PubMed: 10883561]
- McLeod J (2011). *Qualitative research in counselling and psychotherapy* (2nd ed.). London, England: Sage.
- Muran JC, Safran JD, Samstag LW, & Winston A (2005). Evaluating an alliance-focused treatment for personality disorders. *Psychotherapy*, 42, 532–545.
- O'Malley SS, Suh CS, & Strupp HH (1983). The Vanderbilt Psychotherapy Process Scale: A report on the scale development and a process-outcome study. *Journal of Consulting and Clinical Psychology*, 51, 581–586. [PubMed: 6619366]
- Pollack J, Flegenheimer W, Kaufman J, & Sadow J (1992). *Brief adaptive psychotherapy for personality disorders: A treatment manual*. San Diego, CA: Social & Behavioral Documents.
- Spitzer RL, Williams JBW, Gibbon M, & First MB (1990). *Structured clinical interview for DSM-III-R – patient edition (with psychotic screen) – SCID-P (w/psychotic screen) – version 1.0*. Washington, DC: American Psychiatric Press.
- Stiles WB (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research*, 7, 122–127.
- Stiles WB (2009). Logical operations in theory-building case studies. *Pragmatic Case Studies in Psychotherapy*, 5, 9–22. Retrieved from jrul.libraries.rutgers.edu/index.php/pcsp/article/view/973/2384
- Stiles WB, & Goldsmith JZ (2010). The alliance over time In Muran JC & Barber JP (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 44–62). NY: Guilford.
- Tracey TJ, & Kokotovic AM (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment*, 1, 207–210.
- Wachtel PL (2008). *Relational theory and the practice of psychotherapy*. NY: Guilford.
- Westerman MA (2005). What is interpersonal behavior? A post-Cartesian approach to problematic interpersonal patterns and psychotherapy process. *Review of General Psychology*, 9, 16–34.

- Westerman MA (2011a). Conversation analysis and interpretive quantitative research on psychotherapy process and problematic interpersonal behavior. *Theory & Psychology*, 21, 155–178.
- Westerman MA (2011b). Defenses in interpersonal interaction: Using a theory-building case study to develop and validate the theory of interpersonal defense. *Pragmatic Case Studies in Psychotherapy*, Vol. 7 (4), Article 3, 449–476. Available: <http://hdl.rutgers.edu/172.1/pcsp-journal>
- Westerman MA, & Muran JC (2012, 6). An alternative approach to the alliance based on interpersonal defense theory. Paper presented at the meetings of the Society for Psychotherapy Research, Virginia Beach, Virginia.
- Westerman MA, Foote JP, & Winston A (1995). Change in coordination across phases of psychotherapy and outcome: Two mechanisms for the role played by patients' contribution to the alliance. *Journal of Consulting and Clinical Psychology*, 63, 672–675. [PubMed: 7673546]
- Westerman MA, Frankel AS, Tanaka JS, & Kahn J (1987). Client cooperative interview behavior and outcome in paradoxical and behavioral brief treatment approaches. *Journal of Counseling Psychology*, 34, 99–102.
- Westerman MA, & Prieto DM (2006). Expectations about the short-term functional role played by defensive behavior in interpersonal interactions. *Journal of Research in Personality*, 40, 1015–1037.
- Westerman MA, & Steen EM (2007). Going beyond the internal-external dichotomy in clinical psychology: The theory of interpersonal defense as an example of a participatory model. *Theory & Psychology*, 17, 323–351.
- Westerman MA, & Steen EM (2009). Revisiting conflict and defense from an interpersonal perspective: Using structured role plays to investigate the effects of conflict on defensive interpersonal behavior. *Psychoanalytic Psychology*, 26, 379–401.
- Westerman MA, Tanaka JS, Frankel AS, & Kahn J (1986). The coordinating style construct: An approach to conceptualizing patient interpersonal behavior. *Psychotherapy*, 23, 540–547.

Figure 1.

Therapist and patient WAI ratings by session for (a) case under investigation and (b) means for all cases that completed treatment in the short-term dynamic psychotherapy condition.