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Use of a psychotherapy process q-set to discover the impact of personality characteristics on the therapy process

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Use of a Psychotherapy Process Q-Set to Discover the Impact of Personality Characteristics on the Therapy Process

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Thesis Certification

I, Anne Devlin, declare that this thesis, submitted in partial fulfilment of the requirements for the award of Doctor of Psychology (Clinical), in the School of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institute.

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Abstract

The aim of this study was to use an empirically validated process tool to discover the impact of attachment styles and introjective and anaclitic personality configurations on the therapy process. Introjective and anaclitic personalities have their origins in attachment history. Attachment patterns exert considerable influence on personality development; however, the specific impact of attachment patterns on the therapy process requires further research. This is an important area of study, as the literature consistently demonstrates that clients with insecure attachment styles and clients with introjective personality styles are vulnerable to depression and are more likely to have a poor response to treatment (Blatt & Shahar, 2005; Cyranowski et al., 2002; Santor & Zuroff, 1997). In order to enhance the treatment of depression, there is a need to discover the personality-driven processes that impede or enhance engagement with therapy. Study 1 (N = 62) examined the relationship between depressed clients' scores on two personality measures. The impact of personality differences on the working alliance was also examined. Study 2 extended the findings of study 1 by examining the therapy process in a subgroup of clients, where ten clients had a rapid response to therapy and ten made modest gains. The therapy process was examined using the Psychotherapy Process Q-Set (PQS) (Jones, 2000). The PQS is a pan-theoretical measure that assesses client behaviour, therapist behaviour and the interaction between the client and the therapist. Personality characteristics were assessed with the Relationship Questionnaire (RQ) and the Depressive Experience Questionnaire (DEQ). Study 3 examined the impact of personality on response to treatment. Study 1 demonstrated that introjective clients in this sample demonstrated either a fearful or a dismissing attachment style. Study 2 showed that the therapy process could be differentiated by personality characteristics, which did not affect the therapist's use of generic skills, but did appear to interfere with the use of specific techniques that characterise psychotherapy. Introjective clients who had a fearful attachment style appeared to engage more with the therapy process than introjective clients who had a dismissing attachment style. Study 3 indicated that fearfully attached clients had a slower response to therapy, and that they may need a longer course of therapy. In conclusion, this study provides further evidence for the interactional patterns between patients and therapists in psychotherapy, and highlights the profound influence of attachment models of personality on the speed and depth of psychotherapeutic work.

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List of Abbreviations

AAI	Adult Attachment Interview
AAS	Adult Attachment Scale
BDI	Beck Depression Inventory
CBT	Cognitive behaviour therapy
DAS	Dysfunctional Attitude Scale
DEQ	Depressive Experience Questionnaire
D-R	Differentiation-Relatedness
DSM-IV	Diagnostic and Statistical Manual IV
ICB	Inventory of Countertransference Behaviour
NIMH	National Institute of Mental Health
PQS	Process Q-Set
RQ	Relationship Questionnaire
SCID	Structured Clinical Interview
SPSS	Statistical Package for the Social Sciences
TDCRP	Treatment of Depression Collaborative Research Program
WAI	Working Alliance Inventory

Chapter 1: Introduction

This study aims to discover the influence of personality characteristics on the psychotherapy process. Attachment patterns exert considerable influence on personality development, and there is growing interest in the impact of attachment patterns on the therapy process (Reis & Grenyer, 2002). Research is confounded by the use of different measures to assess attachment patterns (Daniel, 2006), and impeded by a focus on discrete variables without considering the complex interaction of factors that affect the therapy process (Jones, Cumming & Horowitz, 1988). An additional confounding factor is that a client's attachment style may not be activated in the therapy process. It has been suggested that an attachment style will only guide behaviour when it is activated (Collins & Read 1990; Mikulincer, 1998). Moreover, it is not known if an attachment pattern has a direct impact on the therapy process or if it is a mediating or moderating variable (Daniel, 2006). This is an important area of study, as the literature consistently demonstrates that clients with insecure attachment styles and clients with self-critical personality styles are vulnerable to depression and have a poor response to treatment (Blatt & Shahar, 2005; Conradi & de Jonge, 2009; Cyranowski et al., 2002; Santor & Zuroff, 1997). In order to enhance the treatment of depression, there is a need to progress this area of inquiry to improve understanding of the personality-driven processes that impede or enhance engagement with therapy.

Attachment Theory

Attachment theory is based on Bowlby's (1969) pioneering work on the influence of early parenting on the personality. He hypothesised that the desire for attachment and the desire for

separation are two fundamental processes that underpin development. According to this conceptualisation, psychopathology can be understood as the overdevelopment of one process at the expense of the other. Bowlby (1973) proposed that the attachment style in adulthood is best described as an internal model that guides an individual's approach to relationships, whereas the attachment style in early childhood is a function of the relationship between the parent and child. Early work in observing infants and parents, which was conducted by Ainsworth in collaboration with Bowlby, led to three classifications of infant-parent relationships: secure, avoidant or anxious-ambivalent. Main, Kaplan and Cassidy (1985) were instrumental in developing the Adult Attachment Interview (AAI) to operationalise Ainsworth's categories in adults.

Hazan and Shaver (1987; 1990) developed a brief self-reporting measure of adult romantic attachment that was based on Ainsworth's three classifications. Bartholomew and Horowitz (1991) demonstrated that adult attachment is best conceptualised in four categories. Their Relationship Questionnaire (RQ) measured adult attachment in relation to representations of self (positive or negative) and representations of others (positive or negative). Secure individuals have a positive view of self and others, preoccupied individuals have a negative view of self and a positive view of others, dismissing individuals have a negative view of others and a positive view of self, and fearful individuals have a negative view of self and others. Although preoccupied, dismissing and fearful attachment styles are collectively referred to as insecure attachment styles, they have also been differentiated by some authors as anxious attachment (preoccupied) and avoidant attachment (fearful and dismissing) (Brennan, Clark & Shaver, 1998).

Introjective and Anaclitic Personalities

Blatt and Felsen (1993) proposed two personality configurations, namely anaclitic and introjective, that reflect two normal developmental interactive processes. The anaclitic process involves developing the ability to engage in satisfying relationships, while the introjective process involves developing a positive, differentiated and integrated identity. Individuals with anaclitic psychopathology are preoccupied with relationship issues, that is, difficulties relating to issues of trust and intimacy. They are susceptible to somatic symptoms, feelings of helplessness, and anxiety regarding separation and loss. In contrast, individuals with introjective psychopathology struggle with issues of identity, self-concept and achievement. At the core of an introjective personality is a tendency towards harsh self-scrutiny and unreasonably inflated standards of performance that create vulnerability towards feelings of guilt and inferiority (Blatt & Zuroff, 1992). A sense of competency is integral to the sense of self (Dunkley, Zuroff & Blankstein, 2003); they are reluctant to ask for help (Santor & Zuroff, 1997) and they avoid intimacy by engaging with achievement-orientated partners (Zuroff & de Lorimier, 1989).

Beck's (1983) description of sociotropic and autonomous styles are conceptually similar to Blatt's (1974) anaclitic and introjective personality configurations. A sociotropic personality is characterised by excessive dependency on others, a need for approval and fear of abandonment, whereas an autonomous personality style is characterised by a need for achievement. There is a particular overlap between characteristics of sociotropic and anaclitic personality styles, as both are characterised by excessive dependency on others, a need for approval and fear of abandonment.

There are some differences in the autonomous and introjective personality styles. Murphy and Bates (1997) note that Blatt's introjective personality style emphasises a negative self-concept, whereas Beck's construct incorporates an autonomous style that does not necessarily involve a negative self-concept. Both Blatt's (1974) and Beck's (1983) personality theories were influenced by Bowlby's work on early parenting experiences, and are in accord with Bowlby's (1969) hypothesis that mediating the desires for attachment and separation are fundamental processes that underpin normal development.

Comparison of Attachment Styles and Anaclitic and Introjective Personalities

The descriptions of anaclitic and introjective personalities are similar to the need to connect or to separate, which underpins attachment theory. Indeed, Blatt (1974) proposed that the anaclitic configuration originated from a preoccupied attachment style, and the introjective personality originated from an avoidant attachment style. This postulation is strengthened by research indicating that two dimensions, avoidance and anxiety underpin attachment styles (Mikulincer & Shaver, 2007; Roisman et al. 2007). The basic premise for both approaches is that mental representations of self and others are based on early relationships with caregivers (Levy, Blatt & Shaver, 1998). Developmental disruption leads to distorted representations of self and others (Blatt, Zuroff, Hawley & Auerback, 2010). Thus, an anaclitic depression is associated with a view of self as helpless and significant others as unavailable, whereas an introjective depression is associated with a view of self as unworthy and others as intrusive or controlling (Blatt, 1974; Blatt, Wein, Chevron & Quinlan, 1979). The Differentiation-Relatedness (D-R) scale (Diamond, Blatt, Stayner & Kaslow, 1991) is a ten-point scale that assesses the degree of differentiation and relatedness in descriptions of self and others. In a

nonclinical sample scores on the D-R scale were significantly related to attachment style (Levy et al., 1998). Fearful individuals had more complex and differentiated views of their parents, whereas dismissing individuals maintain higher self-esteem by distorting information in a defensive way (Levy et al., 1998). The authors concluded that although individuals with a fearful attachment style are viewed as the most distressed, they share features of a secure attachment style. Exploring the impact of this on the therapy process is imperative, given the possibility that introjective clients may operate from either a fearful attachment style or a dismissing attachment style.

Evidence for the impact of attachment history on outcome is also supported by a 30 year longitudinal study exploring the impact of early attachment on later development. This study noted that individuals with a secure attachment history had higher scores on a measure of social competence than individuals with a history of insecure attachment (Sroufe 2005). The competence score was based on ratings derived from direct observation, interviews, and teacher and counselor reports. During preschool, individuals with a history of anxious attachment struggled with novel situations and had a less flexible approach to problem solving than individuals with a history of secure attachment. In addition they tended to be viewed as helpless and easily frustrated by preschool teachers. Individuals with a history of avoidant attachment were observed to find tasks that required interpersonal closeness particularly challenging.

During the preschool or middle years, both individuals with anxious and avoidant attachment histories were described as dependent, however dependence was

manifested differently. Those with a history of anxious attachment frequently appeared to be upset by minimal challenges and readily sought help from teachers. In contrast individuals with an avoidant attachment history sought help in a more indirect manner. They did not seek help when upset, but made attempts to engage with the teacher during quiet times. Teachers had a differential response: they were nurturing towards individuals with a history of anxious attachment, relating to them as if they were needy and immature. In contrast they were less nurturing and less tolerant of the misbehaviour of individuals with a history of avoidant attachment.

In terms of peer relationships, individuals with an avoidant attachment history tended to isolate themselves, and did not initiate contact; their friendships were characterized by exclusivity (Shulman, Elicker, & Sroufe, 1994). In comparison individuals with a history of anxious attachment tended to gravitate towards peers but their low frustration tolerance impeded their social relationships. In addition, the 30 year study indicated that attachment history had an impact on the quality of romantic relationships in adulthood. Based on the observation that there was a moderate relationship between depression and avoidant and anxious attachment (Duggal, Carlson, Sroufe & Egeland 2001), Sroufe (2005) postulated two different pathways for depression, one characterized by hopelessness and alienation and the other characterized by helplessness and anxiety. These descriptions are commensurate with descriptions of introjective and anaclitic depression.

In addition, the 30 year study provides compelling evidence in relation to the stability of attachment style. There was a significant link between attachment history and objective measures of functioning across each stage of development from early

childhood to adulthood. There was not a one to one relationship between attachment and outcome measures, the relationship occurred in the context of an interaction with other developmental processes. This was particularly evident when researchers explored the impact of stress and social support on outcome. Changes in life stress, in combination with a history of secure attachment accounted for most of the variance in recovery from stress (Sroufe, Egeland & Kreutzer 1990). In addition the strongest predictor of recovery during kindergarten for infants identified as anxiously attached was an increase in social support from the primary caregiver. Sroufe (2005) also noted that although environmental influences had an impact on attachment behaviour, early attachment style was evident after periods of stress. Other research indicates that relationship difficulties trigger lower levels of security in people (Ruvolo, Fabin & Ruvolo, 2001) and that attachment representations are influenced by stressors such as parenthood (Rholes, Simpson, Campbell, & Grich, 2001). The impact of stress on attachment behaviour is a likely explanation for the low test-retest correlation on self-report measures of attachment (Baldwin & Fehr 1995). In a review of the evidence regarding the stability of attachment, Fraley, Vicary, Brumbaugh & Roisman (2011) concluded that attachment is not a state or trait, rather it represents a combination of environmental and enduring factors. This concurs with the idea that attachment style will only guide behaviour when it is activated (Collins & Read 1990; Mikulincer, 1998) and reinforces the importance of exploring whether or not the attachment style a client identifies with, has an impact on the therapy process.

Personality Factors and the Working Alliance

Bowlby (1988) suggested that the therapeutic relationship is a form of attachment bond, where the therapist acts as a secure base from which clients explore painful emotions and difficult memories and experiences. This has spawned a considerable body of research that explores the impact of the client attachment style on the therapeutic alliance. These studies are reviewed in study 2.

The difficulty with studies that explore attachment styles is that there is a tendency to group together individuals that have a fearful and dismissing attachment style under the umbrella term of 'avoidant attachment style'. This reflects the factor analytic work, which suggests that there are two main attachment factors: one factor taps an anxious orientation, while the other factor taps avoidant orientation (Brennan et al., 1998). However, individual variations in the two styles that might affect the alliance are not evident. Other studies have compared securely attached individuals with insecurely attached individuals (Fonagy et al 1998; Meyer, Pilkonis, Proietti, Heape & Egan, 2001), concluding that insecurely attached clients have a poorer treatment response than securely attached clients. While they demonstrate the impact of the attachment style on the working alliance and outcome, they do not elucidate the specific way in which a particular attachment style affects the working alliance.

Blatt's (1992) work on the impact of the personality on the therapy process was originally based on his work with clients in long-term psychotherapy, where he noted a differential therapy response that reflected personality differences. Anaclitic clients respond to supportive aspects of therapy whereas introjective clients respond to interpretative aspects (Blatt & Luyten, 2009). Blatt and Felsen (1993) demonstrated that introjective clients had a better

response to psychoanalysis than to psychotherapy. They concluded that this was a reflection of the introjective client's preference for a less interactive approach due to their need for autonomy and separation. Greater improvement in each client group was associated with more benign mental representations of others pre-treatment (Shahar & Blatt 2005). Therapeutic change appears to be congruent with personality configuration (Blatt & Luyten 2009); thus, anaclitic clients demonstrate a difference in the quality of their relationships, whereas introjective clients have changes pertaining to cognitive functioning (Blatt ,Ford, Brennan, Cook, Cramer & Robins 1994) It has also been suggested that once a strong relationship has been established, introjective clients are able to disclose information without fear of criticism from the therapist (Hawley, Ho, Zuroff & Blatt, 2006). The capacity for introjective clients to relate in a different way to the therapist over the course of therapy supports the notion that effective therapy targets personality traits that create a vulnerability to depression (Blatt et al., 2010). Blatt's (1992) work on the central role of the personality to the therapy process was strengthened by the findings from the Treatment of Depression Collaborative Research Program (TDCRP).

Treatment of the Depression Collaborative Research Program

The TDCRP was a randomised clinical trial, sponsored by the National Institute of Mental Health (NIMH), which compared four treatment conditions: cognitive behaviour therapy (CBT), interpersonal therapy, imipramine with clinical management and placebo with clinical management. Of the original sample of 250 depressed individuals, 162 were randomly assigned to one of these treatment conditions. Initial analysis indicated little difference in outcomes between the active treatments (Elkin, 1994). The difficulty in distinguishing

measurable differences between different treatments underscores the importance of elucidating the change mechanism.

Further analysis of the TDCRP indicated that perfectionism, as assessed by the Dysfunctional Attitude Scale (DAS) (Weissman & Beck, 1978), had an adverse effect on the outcome in all four conditions (Blatt, Quinlan, Pilkonis & Shea, 1995; Blatt, Zuroff, Bondi, Sanislow & Pilkonis, 1998). The DAS (Weissman & Beck, 1978) is a measure based on Beck's (1983) work on cognitive vulnerability to depression that assesses the need for approval and perfectionism. Clients who are identified with high levels of perfectionism have also been described as introjective (Blatt, 1992; Blatt, Ford, Berman, Cook, Cramer & Robins 1994; Blatt & Shahar, 2004; Blatt & Zuroff, 1992; Blatt & Zuroff, 2002). Re-analysing the TDCRP data demonstrated how the introjective trait of perfectionism affected the therapy process (Blatt et al., 2010). Two interpersonal processes mediated the detrimental impact of perfectionism: contribution to the therapeutic relationship (Zuroff et al., 2000), and the ability to maintain close relationships outside therapy (Shahar, Blatt, Zuroff, Krupnick & Sotsky, 2004). For individuals with moderate scores on a measure of perfectionism, the number of hours clients spent in satisfying social relationships buffered the negative impact of perfectionism on outcome (Shahar, Blatt & Zuroff, 2007). Perfectionism significantly predicted contribution to the alliance (Shahar, Blatt, Zuroff & Pilkonis, 2003) and client-rated perceived quality of the therapeutic relationship predicted outcome (Zuroff & Blatt, 2006). Moreover, the impact of perfectionism on these two processes was not predicted by personality disorders (Shahar, Blatt, Zuroff & Pilkonis, 2003). In addition, perfectionism predicted rate of change in depression throughout the course of therapy (Hawley et al., 2006). Shahar et al. (2003) suggested that difficulty engaging with the therapy process was due to a negative representation of self and a negative representation of others that made it difficult to

respond to positive interpersonal cues. This creates a tendency to act in a hostile manner (Zuroff & Duncan, 1999) and is likely to elicit a hostile response from others, thereby reinforcing a negative view of others and contributing to problems within the therapeutic relationship (Blatt & Shahar, 2005).

Reanalysis of TDCRP data highlighted the importance of developing a better understanding of how personality factors affect the therapy process. Moreover, it highlights the need to have a broader view of therapeutic change, for example, by considering the impact of the working alliance on personality structure, rather than measuring change by primarily focusing on symptom reduction (Blatt et al., 2010).

This is an important area to explore, as there is a move towards developing interventions tailored to an individual client's needs rather than developing an intervention that targets a particular disorder (Roth & Fonagy, 2005; Kirchmann, Schreiber-Willnow, Seidler & Strauss, 2011; Norcross & Wampold, 2011). In addition, improving the effectiveness of treatment for depression involves integrating the literature on interventions with literature on the process. The poor outcome for introjective clients in the TDCRP appears to be at odds with Blatt's (1992) suggestion that introjective clients are more reflective and have a more rapid response to therapy than anaclitic clients. However, it is also possible that the good response noted with introjective clients in Blatt's (1992) study reflects an approach to therapy that is more appropriate for managing introjective clients than the two psychotherapies available in the TDCRP study. In support of this suggestion, the analysis of therapy sessions in the TDCRP using a process tool called the Psychotherapy Process Q-Set (PQS) indicated that the therapy outcome was determined by similarity to a psychodynamic prototype (Ablon & Jones, 2002). This suggests that the TDCRP study results reflects a failure, in all treatment conditions to

address personality factors that created a vulnerability to depression, leading to difficulty with alliance formation and poor outcome (Luyten & Blatt, 2012).

Research on Alliance-building Techniques

In a review of techniques that enhance the alliance, Hilsenroth and Cromer (2007) noted that, in an initial session, techniques that conveyed trust, appreciation and warmth had a positive impact on the alliance. Specific interventions that improved treatment retention included speaking 'emotional as well as cognitive content', conducting deeper interviews at the initial assessment, maintaining a focus on treatment-related issues, exploring the 'in-session' process and affect, and identifying clinical issues that foster deeper levels of insight. In contrast, therapists who appeared less involved, providing general or superficial information or using statements 'devoid of emotional content', or who were consistently silent, had a detrimental impact on the therapeutic alliance.

Other studies demonstrated that the intervention training identified in this study has an impact on the therapist's capacity to enhance the alliance (Crits-Christoph, Gibbons & Hearon, 2006; Hilsenroth, Ackerman, Clemence, Strassle & Handler, 2002). In his treatise on the working alliance, Bordin (1994) highlighted the importance of addressing client characteristics when developing treatment goals. He stressed the importance of building a strong alliance by identifying a change goal that encompasses a client's primary struggle. Although the work on therapy interventions that promote a good alliance are impressive, research on the impact of personality factors on the therapy process suggests that, rather than using a particular set of techniques with all clients, it is important to tailor techniques to the personality of the client.

Jones et al., (1988) argued that it is the interaction of a therapist's intervention with the patient's personality characteristics that predicts change, not a particular intervention. There are a number of descriptions in the literature on how client characteristics affect the therapy process. Investigating how these particular qualities affect the therapy process is an important first step.

Personality-driven Engagement Strategies

Harris's (2004) description of the type of approach to take with avoidant clients is similar to Blatt's (1992) suggestions for managing an introjective client. He postulated that as avoidant clients prefer distance, early interpretations are likely to feel intrusive. Harris suggested that reflective comments should initially relate to people in the environment, before reflecting on the client's emotions and motivations. The overlap between these two approaches is expected, given Blatt's (1974) suggestion that introjective clients have their origin in an avoidant attachment style. Empirical research supports the idea that attachment style has an impact on the efficacy of a particular intervention. In an inpatient psychoanalytic group program, patients with a preoccupied attachment style rated altruism and cohesion as more helpful than clients with a dismissing attachment style (Strauss et al., 2006).

The preference for a particular type of intervention concurs with a study conducted by Bachelor (1988), who noted that clients varied in the extent to which a particular intervention was perceived as helpful. Some clients found it helpful when the therapist recognised private experiences such as 'motivation', others found it helpful when the therapist responded to their feelings, and some found that the therapist's self-disclosure facilitated empathy. Other clients found each of these therapist responses unhelpful. Bachelor (1988) did not assess personality

characteristics in her study; however, her study did demonstrate that a good alliance is not just a matter of the therapist utilising a list of interventions. Interventions have to take into consideration personality factors; this will determine the effectiveness of a particular intervention. Moreover, Blatt's (1992) work suggested that a particular intervention will not be effective early in therapy, but may be effective at a later stage. This concurs with Luborsky's (1976) description of the dynamic nature of the alliance.

Changes in Alliance over the Course of Therapy

Luborsky (1976) described the therapeutic alliance as 'a dynamic response to the changing demands of different phases of therapy', and he described type one and type two alliances. Luborsky (1976) suggested that the challenge for the therapist in the early phase of therapy (type one alliance) was to engage supportively with the client. In the later stage of therapy (type two alliance), the challenge for the therapist is to work with the client in a joint struggle. Embedded within this description is the notion of a strategic change in therapy emphasis, with the therapist moving from a position of support to a position of supportive challenge as the therapy and the relationship progress. The clinical implications of challenging a client without bolstering support are that it is likely to be detrimental to the therapeutic alliance. Reandeau and Wampold (1991) supported this idea, noting that high-alliance clients had a better response to the challenge than low-alliance clients. Other research indicates that low-alliance clients are more guarded in the initial phase of therapy than high-alliance clients (Sexton, Hembre & Kvarme, 1996).

The detrimental impact of not tailoring responses to the client's personality is evident in a study by Coombs, Coleman and Jones (2002), who noted that the intensity of a client's

emotional response had an impact on the therapy outcome. They concluded that there is an optimal level of client emotion in psychotherapy, above which there is a worse outcome. In a study exploring the impact of emotional arousal on the therapy process, Missirlian, Toukmanian, Warwar and Greenberg (2005) noted that emotional arousal predicted a reduction in symptoms of depression. The work on personality and outcome indicates that a client's personality has a considerable effect on the type of intervention that will provoke an emotional response. For example, Blatt's (1992) process work with introjective clients and Harris's (2004) process work with avoidant clients suggested that challenging clients with this personality configuration during phase one of the alliance will have a detrimental effect on the working alliance.

Although Luborsky (1976) distinguished between alliance early and late in therapy, much of the research exploring working alliance has focused on measuring alliance during the early phases of therapy. This reflects the observation that early alliance is a better predictor of outcome (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Duan and Hill (1996) postulated that a client's need for empathy changes with time. The importance of the temporal sequencing of empathy has interesting parallels with Luborsky's (1976) idea that the alliance changes over time. This parallel underscores the importance of empathy in building the therapeutic alliance, particularly as empathy is related to the bond aspect of the alliance (Horvath & Bedi 2002). Moreover, it highlights the possibility of enhancing the alliance by targeting the response to the personality style of the client. This is particularly important in the early phase of therapy, when there is a moderate to strong correlation between client-perceived empathy and alliance (Horvath, 1981; Horvath & Greenberg, 1989). A recent review of the literature highlighted the importance of the early phase of therapy in developing a therapeutic alliance, tailored to the personality of the client (Horvath, Del Re, Fluckiger &

Symonds 2011). Moreover, in an exploration of the use of empathy as an agent of change in CBT it was noted that there are personality-driven differences in how empathy should be expressed in a therapeutic setting (Thwaites & Bennett-Levy, 2007).

Safran & Muran's (2000) work on ruptures within the therapy process also indicates that the strength of the alliance is not static over the course of therapy; rather, it fluctuates in response to the changing demands of the therapy process. In addition, they identified two types of rupture repair strategies. The confrontation rupture (complaints and attacks) was resolved by an acknowledgment by the client of a need for nurturance. This involved the therapist not reacting with hostility to the client but rather exploring unexpressed needs. The withdrawal rupture (denial, minimal response) was resolved by an exploration of the clients' difficulty expressing unmet needs for nurturing. This involved the client taking responsibility for interpersonal demands rather than expressing them indirectly. Blatt et al. (2010) postulated that a confrontation rupture is a characteristic introjective behaviour and resolution is achieved by addressing anaclitic issues: the need for interpersonal relatedness. In contrast, a withdrawal rupture is a characteristic anaclitic behaviour and is resolved by the introjective behaviour of self-assertion. The therapeutic response required to repair a rupture is congruent with the idea that sustained change is achieved if the normal developmental interactive processes are reactivated in such a way that clients experience themselves differently; thus, anaclitic clients develop their capacity to assert themselves and introjective clients become more emotionally engaged. It can be difficult for therapists to intervene in a manner that leads to resolution of ruptures (Binder & Strupp 1997; Coutinho, Ribeiro, Hill & Safran, 2011); however, the literature on personality-driven changes in therapy suggests that understanding of alliance patterns (Kivlighan & Shaughnessy, 2000; Dinger & Schauenburg, 2008), could be enhanced by integrating literature on the impact of personality on the therapy process. This

would assist in the dual challenge for clinicians and researchers of determining which client qualities to focus on and when to focus on a particular quality. Clearly, further exploration is required of an alliance-building approach that is based on an understanding of the client's characteristics that affect the therapy processes.

A Case Study Approach to Examining the Therapy Process

Randomised clinical trials are the 'gold standard' for exploring the effectiveness of psychotherapy; however, a case study approach is increasingly being utilised to discern the factors that contribute to treatment efficacy. The classic case study that relies on the therapist's record of a clinical session has been criticised for a lack of objectivity. In addition, lack of a control has meant meaningful comparisons were not possible (Lepper & Riding, 2006). The development of more rigorous assessment tools has addressed these criticisms. Research methodologists have proposed that the single case study is the appropriate methodology for exploring the psychotherapy process (Kiesler, 1981). A suitable process tool for examining behaviours that impact on therapeutic change is one that can be reliably assessed, that is, different raters can independently agree on the occurrence and relevance of a particular behaviour. In addition, the measurement tool should include a classification system that characterises the process in a manner that is amenable to quantitative analysis (Jones, 2000). The PQS (Jones, 2000) is a theoretically neutral tool that offers a standard language for illustrating psychotherapeutic processes. The PQS captures unique features of each session. The items describe the client's attitude and behaviour or experience, the therapist's actions and attitudes, and the nature of the interaction dyad, that is, the climate or atmosphere of the encounter. In a paper commenting on the utility of the PQS, Fonagy (2005) remarked on the

PQS's unique capacity to provide a stable and thorough assessment of a complete therapy session.

Currently, there is a shift in the approach to psychotherapy research, from examining what treatments work to how they work and with whom (Blatt & Zuroff, 2002; Blatt & Shahar, 2004). This represents a shift away from the emphasis on a manualised approach to treatment, which has been criticised for its inability to capture important variables that contribute to treatment change (Levy & Ablon, 2000).

The use of process tools to explore treatment is a shift away from an approach that has focused on discrete variables rather than the complex interaction of the client and the therapist (Levy & Ablon, 2000). This approach investigates how a treatment works rather than whether or not it works. In addition, it addresses some of the difficulties inherent in focusing on whether a treatment works. There is a loss of information pertaining to how a particular treatment works when data are averaged across groups of clients (Levy & Ablon, 2000). Levy & Ablon (2000) also pointed out that, although the use of manualised empirically validated treatments assumes that therapists will only use techniques prescribed within the manual, a review of brief psychotherapy indicated that both psychodynamic and cognitive behaviour therapists utilise techniques from one another's approach (Ablon & Jones, 1998). Although a focus on in-session behaviour of patients and therapists has considerable value, it is time consuming and expensive (Dinger & Schauenburg, 2009).

The importance of exploring the process is highlighted by reanalysis of the NIMH TDCRP study, which indicated that the outcome of both psychodynamic therapy and CBT was determined by its similarity to a psychodynamic prototype (Ablon & Jones, 2002). Examining

the treatment process facilitates understanding of what kinds of treatments are effective with particular types of clients (Blatt & Shahar, 2004; Blatt, Shahar & Zuroff, 2001).

The equivalence of the outcome between different treatment modalities in the TDCRP study propagated the notion that therapy is effective, although not because of a particular intervention; rather, it is due to nonspecific factors shared by different treatments. The use of the PQS (Jones, 2000) to explore therapy transcripts from the TDCRP study indicated that the outcome was predicted by the extent to which therapists adhered to psychodynamic principles. This is congruent with recent research indicating that psychodynamic treatment, with its focus on underlying vulnerabilities is associated with slower, but more sustainable changes (Knekt et al., 2008; Knekt et al., 2011).

A number of other studies have demonstrated the capacity of the PQS to describe the particular process variables that contribute to therapeutic change. Using the PQS, Jones et al. (1988) found that a good therapeutic response for individuals with mild post-traumatic stress and pathological grief occurred when treatment was characterised by the use of transference interpretations. A link was made between current experience and memories, and connections were drawn between the therapeutic relationship and other relationships. In contrast, a good outcome for individuals with high levels of stress was characterised by sessions in which the therapist was reassuring, had a more didactic approach and did not focus on stimulating insight.

Another study exploring the change process in brief psychotherapy with 30 clients (Jones, Parke & Pulos, 1992) noted significant clinical improvements when therapy followed a particular trajectory that involved moving from a focus on externalising difficulties to a focus

on self-reflection. Further examination of the NIMH study using factor analysis indicated that a factor labelled Collaborative Emotional Exploration was significantly related to a positive outcome (Coombs et al., 2002). Another factor, labelled Educative/Directive Process, did not predict an outcome, whereas a third factor, termed Patient Inhibition, was higher in interpersonal psychotherapy and resulted in a good outcome. Coombs et al. (2002) concluded that a poor outcome was associated with high levels of painful emotion.

Moreover, the use of modality-specific interventions was impeded by an increase in the client's experience of painful emotion. Other research has demonstrated that the PQS can discriminate between the Rational-Emotive and Gestalt Approach, and the Rational-Emotive and Client-Centred Therapy (Jones & Pulos, 1993). Thus, a divergent body of research with a range of clinical samples and treatment modalities indicates that the PQS is an effective instrument for delineating clinically meaningful aspects of the therapeutic relationship.

Descriptions for managing the therapy process with avoidant and anxious attachment styles are similar to descriptions for managing the therapy process with introjective and anaclitic personality styles (Blatt & Zuroff, 1992; Crittenden, 1997; Holmes, 2000; Harris, 2004). This is not surprising, given the attachment origins of introjective and anaclitic personalities; however, there are significant differences in how these constructs have been explored and in the tools used to assess them. Thus, it is important to explore them separately.

In order to further research the relationship between constructs, the co-occurrence of observable phenomena that represent the construct has to be established (Jones, 2000). Attachment styles and introjective and anaclitic personalities are based on the idea that an individual's view of self and others reflects how early childhood experiences were

internalised. The Depressive Experience Questionnaire (DEQ) assesses self-criticism and dependency, which are constructs that reflect an introjective or anaclitic personality. Research indicates that these are stable features, whereas it has been suggested that the attachment style is only activated when certain conditions are met (Slade, 2008). Although both attachment styles and introjective and anaclitic personalities have their origins in early attachment behaviour, the suggestion that the attachment style may not be activated during therapy is an area that requires further exploration. The putative attachment-based difference in an introjective personality may have little relevance if a therapy session does not provide the necessary conditions to activate a particular attachment style.

Although there are empirically validated tools for assessing the attachment style, self-criticism and dependency, examining the behaviours that characterise these constructs in a therapy session has been impeded by the lack of appropriate measurement instruments.

Aims of the Study

The aims of this study is to build on the previous work that has explored the impact of personality factors on the therapy process.

Study 1a will explore the relationship between the attachment style and introjective and anaclitic personalities in a sample of depressed clients. To date, research exploring the correlations between personality styles and attachment styles has focused on undergraduate samples (Permuy, Merino & Fernandez-Rey, 2010; Reis & Grenyer, 2002; Zuroff & Fitzpatrick, 1995).

The DEQ will be used to assess self-criticism (a construct that underpins introjective personality) and dependency (a construct that underpins anaclitic personality). The RQ will be used to assess the attachment style.

The research question is: What type of relationship exists between scores on the DEQ and scores on the RQ in a depressed sample?

Study 1b will explore the impact of these constructs on the working alliance, which has been identified as a stable predictor of outcome (Gaston, Marmar, Gallagher & Thompson, 1991; Horvath & Symonds, 1991; Diener, Hilsenroth & Weinberger, 2007).

The impact of personality factors on the alliance formation will also be explored (Blatt, Zuroff, Bondi, Sanislow & Pilkonis, 1998; Blatt, Quinlan, Pilkonis & Shea, 1995; Dolan, Arnkoff & Glass, 1993; Kivlighan, Patton & Foote, 1998; Mallinckrodt, Coble & Gantt, 1995; Goldman & Anderson, 2007). There is no consensus in the literature regarding the exact nature of this relationship.

The working alliance will be assessed with the Working Alliance Inventory (WAI), as it has been argued that measures of the working alliance do not capture the therapy process (Jones & Pulos, 1993).

Study 2 will assess the therapy process with the PQS, and the therapy transcripts of a sample of depressed clients who completed a 16-week course of dynamic psychotherapy will be rated with the PQS and the Inventory of Countertransference Behaviour (ICB). Study 3 will explore the impact of personality factors on the treatment response. The sample includes clients who had a rapid response to treatment and clients who had a more modest response.

This study aims to contribute to the general body of psychotherapy research by using an empirically validated process tool to focus on the impact of psychological constructs on the therapy process. A combination of strategies to research these issues will be used, including studies of moderate sized samples of clinical patients and single case studies, using observation and qualitative analysis.

Scope and Limitations of the Study

The constraints around completing a doctoral thesis with a focus on clinical applications affected the design of this study. Establishing the inter-rater reliability of the measures used to rate therapy transcripts is labour intensive. In view of the time-consuming nature of the scoring and the need to complete the study within a particular timeframe, a decision was made to focus attention on a small, rich data set. Although the sample used in study 2 and study 3 was matched to the original sample for age and gender, the small sample size results in findings that may not be generalisable to other samples. In order to limit the burden placed on clients, each construct under investigation was assessed using one measure. Cross-validation with other measures would have strengthened the findings, which would have helped to determine the extent to which the constructs supported the underlying theory.

It was assumed that participants honestly reported their feelings and internal beliefs when completing these questionnaires. It is assumed that the measures of personality and relationship style represent and measure ongoing constructs accurately, and are not subject to biases or due to proximal events or current mood that may distort the responses. Participants were informed that the information was being used for research purposes and would not be

made available to others. It was also assumed that transcripts of the psychotherapy sessions would provide a reasonably accurate account of the processes that occurred in the therapy. Validity was addressed by having two trained raters assess the transcripts. In summary, although attempts were made to ensure measurement precision, confidence in the findings is limited by the sample size and other practical constraints.

Chapter 2: Study 1: Exploration of the Similarities Between Personality and Attachment Styles in a Sample of Depressed Clients

In a paper that synthesised the research on anaclitic and introjective depression, Blatt (1992) postulated that an anxious attachment style would predispose an individual to an anaclitic depression, whereas an avoidant attachment style would predispose an individual to an introjective depression. Despite the conceptual similarities between personality styles and attachment styles, there has been little work exploring an association between these constructs. Past research that explored the correlations between personality styles and attachment styles has focused on university samples. Reis and Grenyer (2002) noted that anaclitic depression was predicted by a preoccupied attachment style and introjective depression was predicted by a fearful-avoidant attachment style. In another study conducted with university students, Zuroff and Fitzpatrick (1995) noted that self-criticism was characterised by a fearful attachment style.

More recently, Permuy et al., (2010) noted that individuals who had a negative view of self (preoccupied and fearful) had higher depression scores than individuals who had a positive view of self (dismissing and secure). The preoccupied attachment style depressive symptoms were mediated by sociotropy, whereas the fearful attachment style depressive symptoms were mediated by autonomy. Both theories were influenced by Bowlby's (1969) work on early parenting experiences and are in accord with his hypothesis that mediating the desire for attachment and for separation are fundamental processes that underpin psychopathology.

Psychopathology, according to this conceptualisation can be understood as overdevelopment of one process at the expense of the other. Thus, individuals with anaclitic or sociotropic depression are preoccupied with relationship issues and have difficulty with issues of trust and intimacy. In contrast, individuals with introjective or autonomous depression struggle with issues of identity self-concept and achievement.

Although studies exploring attachment and personality styles support Blatt's (1974) theory, there is no comparable research that uses a clinical population. The purpose of study 1a is to explore the possible associations between personality styles and attachment styles in a depressed sample. Study 1b was conducted to ascertain if personality differences had an impact on the working alliance, which is an important construct to consider in understanding the therapy process.

The Working Alliance

A number of meta-analyses have been conducted that suggest that regardless of the treatment modality, the working alliance is a stable predictor of outcome (Gaston et al., 1991; Horvath & Symonds, 1991). Typically, effect sizes range from .20 to .26 and, although the effect size is small, it has been argued that given the complex nature of psychotherapy, the consistency of the finding indicates that attending to the therapeutic alliance is an important aspect of the therapy process. Bordin (1979, 1994) viewed the alliance as the degree to which the therapist and client were engaged in collaborative goal-focused work. In his conceptualisation, technique is an activity, whereas alliance is a way of characterising activity. Bordin (1994) also pointed out that, although the relationship may affect the alliance, it is not equivalent to the alliance. In addition, although the client's experience can provide a reasonable estimate of

the alliance, the alliance is not merely the client's experience. Clearly, the working alliance is a dynamic and complex interaction, and a number of studies have demonstrated the impact of personality styles on the working alliance.

Impact of the Attachment Style on the Working Alliance

Lower alliance ratings were associated with an anxious attachment style in a sample of 76 individuals undergoing treatment in a community and university setting (Mallinckrodt et al., 1995). Attachment style was assessed with the AAS (Collins & Read, 1990). Likewise, in a sample of 40 individuals at a university counselling clinic, who were also assessed using the AAS, Kivlighan et al. (1998) found that comfort with intimacy and the ability to depend on others were characteristics of a secure attachment style that predicted a better working alliance. Satterfield and Lyddon (1995) noted a significant correlation between the ability to depend on others and the working alliance. Other research has demonstrated that a secure attachment style is associated with an agreement on tasks and goals whereas scores on the subscale of the WAI are lower for individuals with an avoidant attachment style (Dolan et al., 1993).

Dozier (1990) examined the in-treatment behaviour of 42 clients with mental health issues. Secure clients were more amenable to treatment than dismissing or preoccupied clients. Dismissing clients found self-disclosure difficult, and they were less likely to seek help and more likely to reject help when it was offered. Korfmacher, Adam, Ogawa and Egeland (1997) assessed 55 mothers and explored the way in which the women, identified as high risk for depression, engaged with a preventive intervention program. The findings were similar to the Dozier (1990) study, where individuals who were identified as securely attached were

more emotionally engaged with treatment and more accepting of help than dismissing or preoccupied clients. Dismissing clients rejected therapeutic interventions in favour of a more superficial approach. Preoccupied clients were more likely to require crisis intervention and, although they appeared to emotionally engage with the process, they were less compliant with treatment than securely attached individuals.

Beretta et al. (2005) noted that clients who had a low alliance rating reported that they wished 'not to feel bad and relax'. They also expressed a wish to 'be close to others and accept others'; however, they reported perceiving others as 'unhelpful'. Although Beretta et al. (2005) did not measure the attachment style, the client profile that had a low alliance rating was akin to the profile of a client who had a fearful attachment style. Whereas the TDCRP study pointed to the influence of the introjective personality on the working alliance and outcome, research exploring the impact of the attachment style on the working alliance indicates that there are other personality factors that can enhance our understanding of the therapy process.

Impact of the Introjective Personality Configuration on the Working Alliance

The negative impact of the introjective personality as measured by perfectionism on the working alliance was noted in the TDCRP study (Blatt, Zuroff, Quinlan & Pilkonis, 1996; Blatt et al., 1998). The detrimental impact of perfectionism, a core feature of a self-critical personality style, was mediated by two interpersonal processes: the contribution to the therapeutic relationship (Zuroff et al., 2000), and the ability to maintain close relationships outside therapy (Shahar, Blatt, Zuroff, Krupnick & Sotsky, 2004). Moreover, the impact of perfectionism on these two processes was not predicted by personality disorder (Shahar et al.,

2003). Further analysis of the TDCRP data indicated that a strong alliance predicted a change in vulnerability towards perfectionism. Moreover, the change in personality vulnerability predicted the change in depression (Hawley et al., 2006). The TDCRP study highlighted the importance of understanding the impact of personality factors on the working alliance.

Research aims: This study aims to explore the personality configuration in relation to the attachment style in depressed clients:

- Research question 1: Is there a relationship between the attachment style and the personality configuration?
- Research question 2: Is there a relationship between the personality style and the working alliance?

In research question 1, it was hypothesised that:

1. With increases in self-criticism, there will be increases in fearful and dismissing attachment.
2. With increases in dependency, there will be increases in preoccupied attachment.

Method

Data Source

Sixty-two participants in the sample completed 16 weeks of supportive-expressive dynamic therapy (Luborsky et al., 1995) at a community-referral university treatment centre. Participants had a depression diagnosis according to the Diagnostic and Statistical Manual IV (DSM-IV), and comorbid personality disorder, and gave written informed consent to participate in the study following institutional board approval. Potential participants were

assessed by an experienced clinical psychodiagnostician using the Structured Clinical Interview (SCID) of DSM-IV (SCID-1 and SCID-2; First, Spitzer, Gibbon & Williams, 1997). Exclusion criteria included current substance dependence, schizophrenia or other psychotic disorders, bipolar disorders, obsessive-compulsive disorders, eating disorders, organic brain disorders or serious medical conditions. The 62 studied were selected from a sample of 92 consecutively recruited; however, 30 participants were not included in this current study since 23 had missing data and seven began treatment with an intake Beck Depression Inventory (BDI) score of ≤ 15. This left a study sample of 62 participants. The selection process did not lead to significant differences between those included in the study and those excluded from the study regarding variables such as age, education and the degree of clinical impairment or severity of depression. Table 1 shows the demographics and clinical characteristics of the participants who were excluded from the study and those who were included.

Table 1: A Comparison of Excluded (n = 30) and Included (n = 62) Participants' Characteristics at Intake

Mean intake score	Excluded			Included					
	n	mean	sd	n	mean	sd	t	df	p
Age	30	45.20	13.17	62	44.90	12.07	.11	90	.91
Years education	29	14.24	4.18	62	13.31	2.88	1.24	89	.22
Intake BDI	30	25.60	11.09	62	26.76	6.86	–.62	90	.54
Intake HRSD	30	23.90	5.05	62	23.48	4.49	.40	90	.69
Intake GAF	30	49.43	10.21	62	51.60	7.90	–1.12	90	.27

	n	mean rank	sum rank	n	mean rank	sum rank	Z	p
Intake MDD	30	45.75	1,373	62	46.86	2,906	–1.93	.85
Number of personality disorders	17	36.18	615	59	39.17	1,474	–.52	.60
Number of hospitalisations	29	50.81	2,311	62	43.75	2,713	–1.50	.13

Note: BDI = Beck Depression Inventory; HRSD = Hamilton Rating Scale for Depression; GAF = Global Assessment of Functioning; MDD = Number of DSM-IV criteria met for a major depressive disorder diagnosis (American Psychiatric Association, 1994)

Wilcoxon rank sum tests were used, as raw data for these variables represented ranks, demonstrating a positively skewed distribution.

Measures

Depressive Experience Questionnaire

Participants' scores on the anaclitic and introjective dimensions were determined by their scores on the DEQ (Blatt, D'Afflitti & Quinlan, 1976).

The DEQ is a 64-item self-report measure that assesses dependency, self-criticism and efficacy. Dependency items were used to measure anaclitic depression, and self-criticism items were used to measure introjective depression. Items were rated on a 1–7 point Likert scale, where 1 = strongly agree and 7 = strongly disagree. Factor scores for dependency and

self-criticism were obtained using a computer program that calculated scores based on the norms derived from previous studies (Blatt et al., 1976). As efficacy does not contribute to Blatt's model of depression, data for this factor were not utilised. The DEQ had a high internal consistency (Cronbach alphas > .75) and a high test-retest reliability (r = .79) (Zuroff, Igreja & Mongrain, 1990). In addition, the DEQ had a high convergent, construct, and discriminate validity (Blatt & Zuroff, 1992).

The Relationship Questionnaire

Participants' attachment scores were determined by their scores on the RQ (Bartholomew & Horowitz, 1991), which is a self-report measure containing four brief paragraphs that describe four attachment styles (secure, fearful, preoccupied and dismissing):

1. 'It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me' (secure).
2. 'I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others (fearful).
3. 'I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable about being without close relationships, but I sometimes worry that others don't value me as much as I value them' (preoccupied).
4. 'I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me' (dismissing).

Participants rated the degree to which they identified with each attachment style on a scale of one ('not at all like me') to 100 ('very much like me'). Reliability estimates for the RQ classifications (kappas of around .35) and ratings (*r*s of around .50) are similar to the Hazan and Shaver (1987) three-category measure, from which the RQ originated (Scharfe & Bartholomew, 1994). The RQ has a good convergent validity with other attachment measures (Bartholomew & Horowitz, 1991; Reis & Grenyer, 2004).

The Working Alliance Inventory

The WAI was used to assess the quality of the working alliance. The WAI is a therapy process tool that is scored after session three of psychotherapy. The WAI describes a client's relationship with his or her therapist. The WAI was scored after session three of psychotherapy; at this point, personality features are expected to affect the way the clients views their relationship with their therapist.

The WAI (Horvath & Greenberg, 1989) is a 36-item self-report inventory based on Bordin's (1979) model of the therapeutic alliance. The WAI consists of three subscales (Bond Development, Goal Agreement and Task Agreement) and an overall alliance index. Horvath and Greenberg (1989) reported estimated Cronbach alphas ranging between .87 and .93. The meta-analyses of 24 studies (Horvath & Symonds, 1991) found a moderate reliable positive association between client-perceptions of the working alliance and the therapy outcome.

Statistical Analysis 1a

Pearson's *r* rank order correlation coefficient was used to summarise the strength and direction (negative or positive) of the relationship between the participant's DEQ and RQ scores. Statistical significance was set at .05, using the Statistical Package for the Social Sciences (SPSS) version 15.

Results 1a

Table 2: Correlations Between Self-criticism and Dependency (DEQ) and Attachment Styles (RQ)

	Secure	Fearful	Preoccupied	Dismissing
Self-criticism	–.123	.384**	.137	.462**
Dependency	–.025	.066	.032	–.346**

Note: ** p > .01

Statistical analyses using Pearson's *r* correlations revealed that self-criticism was positively correlated with the dismissing attachment style (r = .462; p < .000) and positively correlated with the fearful attachment style (r = .384; p = .002). Dependency was negatively correlated with the dismissing attachment style (r = –.346; p = .005). No other correlations were significant.

Impact of the Personality Style on the Working Alliance 1b

Statistical Analysis 1b

Participants' scores on self-criticism and dependency were determined by their DEQ scores (Blatt et al., 1976), and their attachment scores were determined by their RQ scores (Bartholomew & Horowitz, 1991).

Pearson's *r* rank order correlation coefficient was used to summarise the strength and direction (negative or positive) of the relationship between the participant's DEQ and WAI scores, and between their RQ and WAI scores. Statistical significance was set at .05, using SPSS version 15.

Results 1b

Statistical analysis using Pearson's *r* correlations revealed a negative correlation between dismissing attachment and the goal-agreement subscale of the WAI ($r = –.38$; $p = .032$). No other correlations were significant (see Table 3).

Table 3: The Correlation Between the Working Alliance Inventory and Depressive Experience Questionnaire/Relationship Questionnaire Scores

	DEQ		RQ			
WAI	Dependency	Self-critical	Secure	Fearful	Preoccupied	Dismissing
Task	–.048	–.055	.287	.100	.079	–.298
Bond	.131	.003	.130	.127	.228	–.266
Goal	–.159	–.077	.149	–.032	.127	–.380*

Note: p < .05

Discussion

In this clinical sample, depressed clients that scored higher on the fearful attachment style were higher on self-criticism. Clients with high scores for the dismissing attachment style had high scores on self-criticism and low scores on dependency. This is an interesting finding, which suggests that the experience of depression in self-critical clients may activate either a fearful or dismissing attachment style. The clinical significance of this will be explored by examining personality-driven differences in the therapy process. In study 2, personality-driven process differences will be assessed with the WAI. In study 3, personality-driven process differences will be assessed with the PQS.

There are significant clinical implications for the existence of two types of self-critical clients, as research on attachment-related differences in mental representations point to differences between individuals with fearful and dismissing attachment styles, which are likely to have an impact on the therapy process (Levy et al., 1998). Changes in mental representations have a significant impact on the therapy process, with a number of studies showing that symptom improvement is associated with changes in attachment-related representations (Blatt, Stayner, Auerbach & Behrends, 1996; Harpaz-Rotem & Blatt, 2005). In addition, it has been suggested that increased rigidity in mental representations is associated with increased depression (Gross et al., 2007).

Given the impact of changes in mental representation on symptom improvement, exploring in-session differences between self-critical clients who have a dismissing attachment style and self-critical clients who have a fearful attachment style is an important step in elucidating personality-driven differences in client behaviour.

In terms of alliance formation, this is likely to have a considerable impact on the therapy process, as it suggests that self-criticism may not always be associated with an approach-avoidance conflict. It also indicates that alliance-building strategies that incorporate a self-critical personality need to consider the attachment style.

The expected relationship between the preoccupied attachment style and the anaclitic personality configuration (high dependency) was not observed. In a study exploring correlations between RQ scores and dependency scores on the DEQ, a correlation was found between the preoccupied attachment style and dependency (Zuroff & Fitzpatrick, 1995). Insufficient power may be an alternative reason for the lack of correlation. In the Zuroff and Fitzpatrick (1995) study, the sample sizes were 160 and 149. However, the lack of correlation fits in with research that indicates that self-criticism is a better predictor of depression than dependency (Blatt, Quinlan, Chevron, McDonald & Zuroff, 1982; Nietzel & Harris, 1990; Priel & Shahar, 2000). This is thought to indicate that dependency has a maladaptive and an adaptive component, that is, dependency reflects a tendency to rely on others to meet security needs; however, it also reflects a capacity for intimacy (Blatt et al., 1995).

Impact of the Personality Style on the Working Alliance

The dismissing attachment style was negatively correlated with the goals subscale of the WAI, indicating that the higher a client's score on dismissing attachment, the more difficult it was for them to agree on a therapy goal. This is commensurate with theoretical descriptions of avoidant clients, which suggests that avoidant attached clients are likely to find it difficult to trust the therapist, and their desire for self-reliance may provoke a rejection of goals or

tasks suggested by the therapist (Mikulincer & Shaver, 2007). The correlation between the dismissing attachment style and the goal subscale was the only significant correlation observed. This suggests that the impact of the dismissing attachment style, at this point in therapy, is more powerful than the impact of other personality styles. It is possible that therapists adjusted their approach with dismissing clients, leading to a difference in the working alliance. Further exploration of this phenomenon will be conducted in study 2.

However, fearfully attached clients who are also considered avoidant did not reject therapy goals. In the TDCRP study, descriptions of self-criticism were analogous to a fearful attachment style. The TDCRP study suggested that the detrimental impact of self-criticism occurs in the second phase of therapy. It is possible that a desire to form a relationship, which is one aspect of a fearfully attached personality, was activated at this point in therapy, and that fearfully attached clients did not seek to withdraw from the therapy process or express autonomy by rejecting therapy goals.

The lack of significant correlations between alliance ratings for individuals who have a secure or preoccupied attachment style is in keeping with the Kivlighan and Shaughnessy (2000) study, which noted that alliance ratings were highest at the beginning of therapy for individuals with either a secure or preoccupied attachment style. Eames and Roth (2000) also noted that significant correlations were not observed between the fearful attachment style and the working alliance across all sessions.

The differences in how fearfully attached and avoidant attached clients engage with the working alliance supports the observation in study 1 regarding the differences in how these constructs correlate with the DAS. However, the WAI did not illustrate any differences in

how self-critical and dependent clients engage. Although the client-rater version of the WAI that was used in this study is a better predictor of outcome than the observer-rater version of the WAI (Horvath & Symonds, 1991), it is possible that at this point in the therapy, a desire of clients to engage with therapy led to high-alliance ratings. The working alliance construct has been criticised for not providing sufficient detail regarding the therapy process (Jones & Pulos, 1993). This problem will be addressed by exploring personality-driven process differences with the PQS in study 2.

The impact of the therapist's behaviour on the client-rated working alliance warrants some consideration. Dozier, Cue and Barnett (1994) noted that the therapist's attachment style had an impact on how therapists responded towards clients. Therapists who had an insecure attachment style matched the client's behaviour, whereas therapists who had a secure attachment style had a complementary stance. The impact of therapist style on therapy process is not always evident. In an investigation of alliance development in an inpatient psychotherapy setting it was concluded that therapist skill prevailed over the influence of their attachment style (Dinger, Strack, Sachsse & Schauenburg, 2009). Other research suggests that the essential therapist skills for alliance promotion are their capacity to convey, trust, appreciation and warmth (Ackerman & Hilsenroth 2003; Hilsenroth & Cromer, 2007). However, there may be personality-driven differences in how clients respond to trust, appreciation and warmth. Reanalysis of data from the TDCRP study suggests that effective therapists have the capacity to facilitate the use of core features of psychodynamic therapy (Shedler, 2010). Exploring the impact of therapist behaviour on client responses necessitates the assessment of therapist interventions that are conducive to development of a good working alliance and interventions that are likely to be detrimental to alliance development. The impact of the therapist's behaviour on the client's responses will be explored in study 2.

Chapter 3: Study 2: Process Research: What Impact Does a Client's Personality Style Have on the Therapy Process?

Findings from study 1b demonstrated that the goal-aspect of the working alliance was differentiated by personality style. However, the mechanism by which this occurred requires further explanation. Findings from study 1a demonstrated that, in the sample of clients being treated for depression, individuals who scored high on self-criticism were differentiated by their attachment style. The possible impact of this on the therapy process requires closer examination. Tailoring the treatment to the client's characteristics necessitates a more thorough understanding of how clients engage with the therapy process. Although there are descriptions in the literature on how various personality styles have an impact on the therapy process, to date this has not been examined in a systematic way, using a process tool. A further aim of this study is to explore the impact of the therapist's behaviour on the client's response.

Research Questions

1. What impact do personality characteristics have on the therapy process? PQS scores will be used to ascertain the impact of personality characteristics on the therapy process.
2. What impact does the therapist's response have on the client's behaviour? As the therapeutic process is a dynamic interaction, it is important to explore the impact of the therapist's response on the client's behaviour. Therapist behaviour will be explored in two ways: (a) The PQS will be utilised to identify the therapy process

that characterises all psychotherapy sessions. The extent to which therapists engage in a manner that promotes a good alliance will be assessed. The PQS has previously been used to explore the extent to which the therapist's responses are in keeping with their therapeutic orientation (Ablon & Jones, 1999). (b) The ICB will be used to explore the extent to which the therapist's responses impede the therapy process. The ICB was designed to assess reactions that originate from the therapist's unresolved conflicts and anxieties; thus, it provides a measure of the extent to which the therapist's responses were arising from their characteristics, as opposed to responses aligned with their therapeutic orientation. Countertransference feelings, if acknowledged and recognised by the therapist, can enhance therapy. However, if countertransference feelings are not addressed, the therapist's interventions are guided by his or her inner world, rather than by an understanding of the clients' needs (Mikulincer & Shaver, 2007). This manifests as countertransference behaviour, which impedes the therapy process. It has been suggested that the tendency of clients who have a negative view of self or others, or who find it difficult to respond to others, is likely to elicit a hostile response from others, thereby reinforcing their negative views (Aube & Whiffen, 1996; Blatt & Shahar, 2005; Zuroff & Duncan, 1999; Blatt & Luyten, 2009). Thus, exploring the impact of countertransference on the therapy process is important.

3. What impact do personality styles have on the outcome? TDCRP indicated that individuals with an introjective personality configuration had a poor outcome. Other research indicates that an insecure attachment style is associated with a poor outcome. The literature on the impact of the attachment style on the outcome is contentious, with a dismissing attachment style predicting a poor outcome (Dozier, Lomax, Tyrell & Lee, 2001) and a good outcome (Fonagy et al., 1998**).** It has been

suggested that contradictory reports could reflect a failure to tailor treatment to the attachment style (Harris, 2004). An additional criticism is that the attachment measures do not provide an accurate assessment of the degree of insecurity in attachment styles (Bifulco, Moran, Ball & Bernazzani 2002). Another possibility contributing to inconsistent results is the tendency to group dismissing and fearful clients together.

Method

Research question: What is the impact of the personality style on the therapy process? The impact of the personality style on the therapy process will be explored in two ways:

1. Therapy transcripts will be rated with the ICB, and the scores will be correlated with scores on the RQ and the DEQ to ascertain whether each personality style evokes specific countertransference behaviour.
2. Therapy transcripts will also be rated using the PQS. The impact of the personality style on the therapy process will be addressed by an exploratory examination of the ten most and ten least characteristic PQS items, rank ordered for each personality style.

Participants

Data were collected by rating transcribed audiotaped recordings of the third treatment session of 20 clients from study 1. The sample consisted of 10 women from 21 to 56 years of age (M = 35.3, *sd* = 9.60), and 10 males from 34 to 67 years of age (M = 50, *sd* = 11.2). Ten clients made rapid and large treatment gains and 10 clients made modest gains (five males and five

females per group; see Table 1). There were no differences between them on initial depression scores or on interpersonal mastery scores. The use of clients with different responses allowed an exploration of the impact of personality factors on the outcome. As a good response to treatment in the first three sessions has a strong association to outcome (Busch, Kanter, Landes & Kohlenberg 2006; Gaynor et al., 2003; Kelly Roberts & Ciesla, 2005), session three was used to explore the therapy process. Due to missing data, three clients were excluded (total n = 17).

Measures

The Depressive Experience Questionnaire and the Relationship Questionnaire (See Study 1)

The RQ provides a rating for the degree to which an individual identifies with each attachment style. There is an argument in the literature that the attachment style is not stable; rather, it reflects a number of mental representations that can be activated by particular situations. Although one attachment style may dominate emotional processing and interpersonal interactions, across the course of a therapy session, it is possible that the behaviour associated with one or more attachment styles may be activated.

Inventory of Countertransference Behaviour

The ICB (Friedman & Gelso, 2000) is a 32-item measure that assesses negative and positive countertransference. Negative countertransference items include therapist behaviours that are disapproving of clients, whereas positive countertransference items reflect therapist behaviours that are inappropriately familiar or overly supportive. Two studies using the ICB

have noted that negative countertransference is associated with a poorer working alliance and positive countertransference is associated with a weaker bond (Friedman & Gelso, 2000; Ligiero & Gelso, 2002).

Psychotherapy Process Q-Set

The PQS is a theoretically neutral, 100-item scale that comprises three types of items that:

1. describe the client's attitude and behaviour or experience
2. reflect the therapist's actions and attitudes
3. attempt to capture the nature of the interaction dyad, that is, the climate or atmosphere of the encounter.

The PQS has construct and discriminant validity (Ablon & Jones, 1999, 2002; Jones & Pulos, 1993; Jones et al., 1988; Jones, Hall & Parke, 1991). The inter-rater reliability across all PQS items ranges from .83 to .89 between rater pairs, whereas the reliability for individual items ranges from .50 to .95 (Jones & Pulos, 1993; Jones et al., 1988, 1991).

Scoring of the Psychotherapy Process Q-Set

Validity was addressed by having two trained raters (the author and another experienced doctoral-level clinical psychologist) read verbatim therapy transcripts of an entire therapy hour and then arrange the 100 items in the Q-Set on a continuum from the least characteristic to the most characteristic, according to the published manual (Jones, 2000). Placement in the least characteristic direction does not mean that the item was irrelevant to the session; rather, it suggests that the absence of the item is significant. For example, the placement of 'patient is

anxious and tense' as least characteristic suggests that the client was 'calm and relaxed', whereas placement of the item as most characteristic indicates that the client was 'anxious and tense'. Items follow a normal distribution and are scored from one to nine. A coding manual provides the Q-items and the operational criteria and descriptions, which allows the raters to assess the importance and intensity of all items (Jones, 2000). The raters scored each transcript separately, then compared ratings and reached a consensus rating.

Results

Impact of Countertransference on the Therapy Process

The impact of the personality process on countertransference was explored by examining the correlations between personality characteristics and ratings on the ICB.

Table 4: Correlations Between ICB and RQ/DEQ Scores

	Secure	Fearful	Preoccupied	Dismissing	Dependent	Self-critical
ICB-neg	–.087	.269	–.338	.457	–.072	–.136
ICB-pos	–.127	.011	–.184	.219	–.251	–.307

There were no significant correlations between scores for the ICB and the RQ, or for the ICB and the DEQ. This suggests that client characteristics did not trigger specific countertransference behaviour.

Part A: The Impact of Client Characteristics on the Therapy Process (2)

Data Analysis

Following the protocol developed by Jones and Pulos (1993), the 10 most and 10 least characteristic PQS items, were rank ordered for each personality style. A median split was utilised to determine individuals with high scores on each subscale of the RQ and the DEQ.

Results

The use of the RQ means that self-ratings for the extent to which each attachment style is endorsed allows for exploration of the possibility that more than one client attachment may be activated within the session. Individual ratings that are above the group median will be used to determine grouping. A median split was utilised and individuals with scores above the group median on a particular attachment style were classed as high scorers, and were grouped with that attachment style for qualitative analysis of the therapy process (see Table 1). The sample had reasonably even distribution of attachment styles, which gives confidence that it is less biased. On the RQ, nine clients had scores above the median on the dismissing scale, six had scores above the median on the preoccupied scale, eight had scores above the median on the fearful scale and nine had scores above the median on the secure scale. As rated by the RQ, fearful and preoccupied clients had a negative view of self; thus, it is not surprising that three clients had scores above the median on both of these attachment styles. Likewise, as clients who had a fearful and dismissing attachment style had a negative view of others, it is expected that three clients had scores above the median on these attachment styles. Two

clients had scores above the median on all domains, and four had scores above the median on one domain. Two clients did not have any scores above the median and two were missing data.

Table 5: Median RQ Scores for Each Attachment Style

Attachment style	Median	Range	Mean	sd
Secure attachment	42.5	0–88	40.5	25.4
Fearful attachment	50	0–100	57.3	29.1
Preoccupied attachment	50	0–100	47.2	29.64
Dismissing attachment	49	0–100	49.72	30.86

On the DEQ, eight individuals had scores above the median on the self-criticism scale and nine individuals had scores above the median on the dependency scale (see Table 6).

Table 6: Median Scores on the Dependency and Self-criticism Domains of the DEQ

DEQ domain	Median	Range	Mean	sd
Dependency	.47	–3.38–.81	–.50	0.9
Self-criticism	1.08	–.69–2.45	1.14	0.97

Most and Least Characteristic of Psychotherapy Process Q-Set Items

The most and least characteristic aspects of the therapeutic process were calculated using Q-item means. The mean score was calculated on each PQS item for each personality group. To highlight the most descriptive therapeutic processes and to identify the 10 most and 10 least characteristic items of the session, Q-items were rank ordered according to their means (e.g., Ablon, Levy & Katzenstein 2006; Jones & Pulos, 1993). Mean scores across 100 PQS items ranged from a high of 8.50 to a low of 2.33 for clients who scored high on the dismissing scale; 8.50 to 2.16 for clients who scored high on the preoccupied scale; 8.43 to 2.56 for clients who scored high on the fearful scale; and 8.50 to 2.22 for clients who scored high on the secure scale. Means ranged from a high of 8.44 to a low of 2.44 for clients who had high scores on the dependency scale, and from 6.72 to 3.11 for clients who had high scores on the self-criticism scale. A number of items were unique to each personality style (see Table 7), and a number of items occurred across all sessions (see Table 8).

Table 7: Q-items Unique to Each Personality Style

Item number	PQS items and number	M
	Unique items for high secure attachment	
13	P is animated or excited	6.61
78	P seeks T's approval, affection or sympathy	6.22
77	T is tactful	3.16
98	The therapy relationship is not a focus of discussion	2.88
	Unique items for high preoccupied attachment	
66	T is directly reassuring	6.75
73	P is committed to the work of therapy	6.66
25	P does not have difficulty beginning the hour	2.91
	Unique items for high fearful attachment	
33	P talks of feelings about being close to or needing someone	7.00
34	P blames others, or external forces, for difficulties	6.62
99	T does not challenge P's view	3.12
70	P does not struggle to control feelings or impulses	3.12
	Unique items for high dismissing attachment	
58	P resists examining thoughts, reactions, or motivations related to problems	7.00
79	P does not seek T's approval, affection, or sympathy	2.94
97	P is not introspective, does not readily explore inner thoughts and feeling	2.33
	Unique items for clients high on self-criticism	
4	P's treatment goals are discussed	6.72
28	T accurately perceives the therapeutic process	6.77
29	P did not talk of wanting to be separate or distant	2.77
	Unique items for clients high on dependency	
56	P discusses experiences as if distant from his/her feelings	2.88
12	Silences occur during the hour	2.88

Table 8: Q-items that Characterised Session 3 Across All 17 Psychotherapy Sessions

Item number	PQS items
63	P's interpersonal relationships are a major theme
69	P's current or recent life situation is emphasised in discussion
35	Self-image is a focus of discussion
18	T conveys a sense of non-judgemental acceptance
6	T is sensitive to P's feelings, attuned to P; empathic
14	P felt understood by T
82	P's behaviour during the hour is not reformulated by T in a way not explicitly recognised previously
100	T did not draw connections between the therapeutic relationship and other relationships

Results

Therapist Responses

Q-items that characterised session 3 with all 17 psychotherapy sessions (Table 8) indicated that the therapists utilised a number of skills that promoted a good alliance. An empathic, non-judgemental response that was sensitive to the client's feelings was evident in the PQS items across all 17 psychotherapies, wherein therapists responded in a manner that promoted a good alliance (Hilsenroth & Cromer, 2007).

Although there was no correlation between ICB scores and the personality style, the PQS scores highlighted countertransference responses. The PQS scores (see Table 4) indicated that, across all sessions, therapists exemplified the stance required to facilitate a good therapeutic relationship (Hilsenroth et al., 2002). They were empathic, non-judgemental and

sensitive to the client's feelings, and there is evidence that it was difficult for the therapists in this early therapy session to adhere to all the principles that guide dynamic therapy (Luborsky, 1986). For example, they did not draw connections between the therapeutic relationship and other relationships, and they did not reformulate their client's behaviour.

PQS items that explore clients who have a dismissing attachment style (Table 7) extend the finding from study 1 that clients who have a dismissing attachment style found it more difficult to engage with the goal aspect of the working alliance than clients with other personality styles. PQS items that were unique to clients who have a dismissing attachment style indicated that clients were difficult to engage in the therapy process. Clients found it difficult to reflect upon their thoughts and feelings, and they were resistant to examining the relationship between problems and their thoughts and motivations. In addition, a client's lack of interest in seeking the therapist's approval, affection or sympathy was unique to dismissing clients. This fits in with the idea that dismissing clients have no interest in engagement, and is an extension of the observation from study 1 that dismissing features have a negative correlation with DEQ dependency.

Unique PQS items for dependent clients also corroborated Blatt's (1974, 2004) descriptions of this personality style. There was a focus on somatic symptoms and the clients appeared overwhelmed by their emotional experience. This was in stark contrast to the self-critical clients, who were more goal directed. It has been suggested that somatic symptoms are a way of communicating and maintaining interaction (Shapiro 2003). Thus a focus on somatic symptoms and an expression of emotional distress during the therapy session is a form of reassurance seeking that is congruent with Blatt's (1974, 2004) description of anaclitic clients need to be taken care off.

Unique PQS items for preoccupied clients appeared to indicate that clients were keen to engage with the therapy process; they were committed to the work of therapy and had little difficulty beginning the session (Table 7). The therapist's stance of providing direct reassurance was also unique to preoccupied clients. The 'provision of direct reassurance' has been identified as a PQS item that characterises interpersonal psychotherapy (Jones & Pulos, 1993).

'Patient's treatment goals were discussed' was a PQS item that was unique to self-critical clients. This reflects the goal-focused orientation that Blatt (1974, 2004) suggested characterises this personality style. Unlike fearful clients, who openly talked about their ambivalent feelings about relationships, the self-critical client's need for space appeared to be an unspoken issue that permeated the therapy session.

Part B: Did Psychotherapy Process Q-Set Scores Demonstrate Differences Between Introjective Clients Who Were Differentiated by the Attachment Style?

Following on from study 1, which indicated that participants with high scores on the introjective dimension of the DEQ could be discriminated based on their attachment style, process differences of these clients were explored with the PQS from actual therapy session interactions

Method

A median split was used to classify high scores (above the median) and low scores (below the median) on self-criticism. From this list, three clients with an introjective/fearful configuration were identified. These clients had high scores on self-criticism and fearful attachment, and low scores on dismissing attachment. Two clients with an introjective/dismissing configuration were also identified. These clients had high scores on self-criticism and dismissing attachment and low scores on fearful attachment.

Results

Table 9: Demographics for Individuals Who Have an Introjective/Dismissing Configuration

Gender	Age	Relationship status	Years education	Employment status
Female	26	Defacto	17	Employed
Female	36	Separated	15	Employed
Male	48	Single	10	Unemployed

Table 10: Demographics for Individuals Who Have an Introjective/Fearful Configuration

Gender	Age	Relationship status	Years education	Employment status
Female	34	Defacto	16	Employed
Male	44	Divorced	13	Employed

Most and Least Characteristic of Psychotherapy Process Q-Set Items

The most and least characteristic aspects of the therapeutic process were calculated using Q-item means. To highlight the most descriptive therapeutic processes, and to identify the 10 most and 10 least characteristic items of the session, Q-items were rank ordered according to their means (e.g., Ablon et al., 2006; Jones & Pulos, 1993). As depicted in Table 11, means ranged from a high of 8.66 to a low of 1.66 for clients who scored high on self-criticism and fearful attachment and low on dismissing attachment. As depicted in Table 12, means ranged from 9.00 to 1.75 for clients who scored high on self-criticism and dismissing attachment and low on fearful attachment.

Twelve items were identical across all the sessions. Sessions were strongly characterised by a focus on interpersonal relationships (Q. 63), love or romantic relationships (Q. 64) and current or recent life situations (Q. 69). In addition, the client brought up significant issues (Q. 88) and the dialogue had a specific focus (Q. 23). Therapists did not patronise clients (Q. 51). Clients did not talk of wanting to be separate or distant (Q. 29), they had no difficulty understanding the therapists' comments (Q. 5), accepted the therapists' comments and observations (Q. 42), were trusting and secure (Q. 44), felt understood by therapists (Q. 14) and initiated topics (Q. 15).

Although several overlapping items described the therapeutic processes, certain differences were also evident. In sessions with clients who had an introjective/dismissing configuration, therapists adopted a supportive stance (Q. 45), were responsive and affectively involved (Q. 9), made interpretations referring to actual people in the client's life (Q. 40), identified a recurrent theme in the client's experience of conduct (Q. 62), and did not comment on changes in the client's mood (Q. 79). The client's treatment goals were discussed (Q. 4). In addition, the client expressed angry or aggressive feelings (Q. 84), was not introspective and did not readily explore inner thoughts and feelings (Q. 97).

Clients who had an introjective/fearful configuration understood the nature of therapy and what was expected (Q. 72). They were introspective and readily explored their inner thoughts and feelings (Q. 97). Clients were committed to the work of therapy (Q. 73), did not resist examining the thoughts, reactions or motivations related to problems (Q. 58), did not struggle to control feelings or impulses (Q. 70), were not controlling (Q. 87), and self-image was a focus of discussion (Q. 35). Therapists were sensitive to the client's feelings (Q. 6). Although introspection (Q. 97) was evident for both client groups, it was more characteristic of sessions with clients who had an introjective/fearful configuration than sessions with clients who had an introjective/dismissing configuration.

Table 11: Unique PQS Items for Individuals (n = 3) Who Have a High Score on Self-criticism and Fearful Attachment (Above the Median), and a Low Score on Dismissing Attachment (Below the Median)

Item number	PQS items and number	M
	Most characteristic items	
73	P is committed to work of therapy	8.33
35	Self-image is a focus of discussion	8.33
72	P understands the nature of therapy and what is expected	8.16
97	P is introspective, readily explores inner thoughts and feelings	8.00
06	T is sensitive to P's feelings, attuned to P; empathic	7.83
	Least characteristic items	
70	P struggles to control feelings or impulses	2.33
87	P is controlling	1.66
58	P resists examining thoughts, reactions or motivations related to problems	1.66

Table 12: Unique Items for Individuals (n = 2) with a High Score on Self-criticism and Dismissing Attachment (Above the Median) and a Low Score on Fearful Attachment (Below the Median)

Item number	PQS items and number	M
	Most characteristic items	
84	P expresses angry or aggressive feelings	8.5
45	T adopts supportive stance	7.5
40	T makes interpretations referring to actual people in P's life	7.5
62	T identifies a recurrent theme in P's experience or conduct	7.25
04	P's treatment goals are discussed	7.25
	Least characteristic items	
79	T comments on changes in P's mood or affect	2.5
97	P is introspective, readily explores inner thoughts and feelings	2.0
09	T is distant, aloof (v. responsive and affectively involved)	1.75

Although the sample size was small, there were significant differences in therapy sessions between individuals who had an introjective/fearful configuration and individuals who had an introjective/dismissing configuration. Therapy sessions with clients who had an introjective/dismissing configuration appeared to be more difficult than therapy sessions with clients who had introjective/fearful configuration. Of particular note was the difficulty that individuals with a dismissing attachment style had in being introspective compared with clients who had a fearful attachment style, who readily explored thoughts and feelings.

Discussion

Therapy Process Across All Sessions

In this study, the PQS items indicated that, across all sessions, although current concerns, self-image and interpersonal relationships were emphasised, the therapist did not make interpretations regarding possible connections between the various relationships. These items were rated as highly uncharacteristic of all sessions, indicating that the absence of these interventions was clinically significant. The PQS indicates that the client's attachment style was activated in this session, and it appears that the force of the personality influence made it difficult for the therapist to attend to this aspect of dynamic therapy. Dynamic therapy entails helping the client to explore connections between current concerns and interpersonal experiences in the therapeutic relationship, current relationships and past relationships.

Impact of Attachment Style, Self-criticism and Dependency on Therapy Process

The PQS scores indicated that each client personality style was uniquely represented within the therapy sessions. This is in contrast with the findings from the correlations of ICB scores with RQ and DEQ scores that did not differentiate attachment styles. The activation of attachment styles within the therapy interaction was particularly evident with fearfully attached clients, dismissingly attached clients and self-critical clients. This is not surprising given the difficulties reported in the literature in alliance building with these clients (Blatt & Felsen, 1993; Blatt & Maroudas, 1992; Harris, 2004). However, each style presented in a unique way. PQS items with fearfully attached clients indicated that they were responding with the approach-avoidance style, which is considered characteristic of this attachment style. While they expressed their desire to be close to somebody, they simultaneously blamed others

for their difficulties. The lack of effort to control feelings suggests that the conflicting desire for closeness with others and the feelings of anger with others was vehemently expressed.

PQS items that explored clients with a dismissing attachment style extend the finding from study 1 that clients with a dismissing attachment style found it more difficult to engage with the goal aspect of the working alliance than clients with other personality styles. PQS items that were unique to clients with a dismissing attachment style indicated that clients were difficult to engage in the therapy process (e.g., Table 7). Clients found it difficult to reflect upon their thoughts and feelings, and they were resistant to examining the relationship between problems and their thoughts and motivations. In addition, the client's lack of interest in seeking the therapist's approval, affection or sympathy was unique to dismissing clients. This fits in with the idea that dismissing clients have no interest in engagement, and is an extension of the observation from study 1 that dismissing clients have a negative correlation with dependency. This fits in with other research that indicates that dismissing clients find disclosure difficult and have a tendency to reject therapeutic interventions in favour of a more superficial approach (Dozier, 1990). It is also in contrast to the therapy process with fearful clients, whose therapy is defined by conflicts relating to relationships.

The unique items that characterised self-critical, dismissing and fearful clients could almost be considered a continuum of emotional availability to the therapy process. On one end of the continuum were individuals who had a dismissing attachment style and actively resisted discussions around salient problem-related issues. Fearful individuals were located on the opposite side of the continuum, where difficult issues were presented for discussion; however, the manner in which they were discussed indicated considerable ambivalence. Self-critical

individuals sat midway along the continuum, where difficult issues were evident but not discussed or actively resisted.

The Therapy Process with Self-critical Clients Differentiated by the Attachment Style

Blatt (1992); Blatt & Felsen (1993) et al.'s (1976; 1996; 1998) extensive research on the impact of self-criticism indicates that this characteristic is detrimental to the therapeutic process. Blatt (1974) theorised that self-criticism originated from an avoidant attachment style. In study 1, self-criticism correlated with a fearful attachment style and a dismissing attachment style. The differentiation of self-criticism based on the attachment style was apparent in the PQS ratings and in transcripts of therapy sessions.

Previous studies have demonstrated that hostility, fear of abandonment, defensiveness and perfectionism have a negative impact on the therapy process (Gaston et al., 1991; Kokotovic & Tracey, 1990; Kivilighan et al., 1998; Zuroff et al., 2000). This study demonstrated that hostility and defensiveness were characteristic features of self-critical, dismissing patients within their interactional patterns with the therapist in session. Research consistently shows that self-criticism, which correlates with maladaptive perfectionism, is associated with difficulties in the therapeutic relationship. In contrast to the defensiveness and hostility evident with clients who had a dismissing attachment style, therapy with clients who had a fearful attachment style was characterised by a willingness to explore thoughts and feelings. This is in keeping with Levy et al.'s (1998) postulation that fearful individuals have less polarised views of others than dismissing individuals. The data from the present study contributes to an active understanding of the working alliance, and is in keeping with Bordin's (1994) suggestion that attachment is integral to the therapeutic relationship,

particularly in the early phase of therapy. Further exploration in the later phase of therapy is required to ascertain if attachment-based differences in the therapy process are maintained.

The focus on interpersonal and romantic relationships and current life situations that characterised sessions is in keeping with the style of dynamic therapy. However, the PQS also identified a number of characteristics in self-critical clients, which differed if the client was fearful-avoidant compared with dismissing. Contrary to the expectations of an avoidant attachment style and a self-critical configuration, an ability to trust and feel understood by the therapist also characterised the therapy process. This is an intriguing contrast to the evidence of hostility and defensiveness that characterised sessions with self-critical clients who had a dismissing attachment style. However, it demonstrates the dynamic nature of the therapeutic process. In a micromoment, there is a shift in the nature of the process, particularly with individuals who have a dismissing attachment style. In this study, these clients clearly demonstrated their ambivalence by vacillating from a position of trust to a position of hostility.

The PQS items that were unique to clients who had an avoidant attachment style appeared to interfere with therapy. This will be explored by assessing the impact of the personality style on the outcome.

Chapter 4: Study 3: What Impact Did the Personality Style Have on the Outcome?

Exploration of the therapy process indicated that both clients with an avoidant attachment style (dismissing and fearful) and self-critical individuals were particularly resistant to the therapy process. The impact of this on the outcome is worthy of exploration, as research indicates self-critical clients have high levels of distress and a poor outcome (Blatt et al., 1995,1998; Enns, Cox & Inayatulla, 2003; Rector, Zuroff & Segal, 1999). However, the literature exploring measures of attachment style is more contentious. Given their capacity to engage more readily with the therapist (Daniel, 2006), it is not surprising that outcome studies indicate that individuals identified as securely attached have a better therapy response than insecurely attached clients (Meyer et al., 2001). However, the data regarding clients with an insecure attachment style is not conclusive.

In a study conducted with 82 inpatient clients, who were assessed using the AAI and who were receiving psychoanalytical treatment, clients identified as having a dismissing attachment style had a better response to treatment than secure and preoccupied clients (Fonagy et al., 1998). In contrast to this finding, a study with 36 clients engaged in brief dynamic psychotherapy found that a dismissing attachment style was associated with the poorest outcome (Horowitz, Rosenberg & Bartholomew, 1993). Research into the impact of the attachment style on outcome is confounded by the use of different measures to assess attachment; in addition, particular therapeutic modes may be more effective with a particular attachment style. Fonagy et al. (1998) suggested that, as dismissing individuals have avoided thinking about the impact of past relationships on current difficulties, they will benefit more

from psychoanalytical treatment, since this is a focus. This is in contrast to preoccupied individuals, who are thought to already have a clearly defined narrative regarding their past relationships. Blatt (2004) also argued that the poor response observed by self-critical clients in the TDCRP might reflect a failure to match the treatment to the personality style. He argued that the imposition of a termination date associated with the manualised treatment offered in the program is likely to have an impact on an introjective client's need for autonomy. In support of this assertion, Blatt (2004) argued that the deterioration in the alliance observed in the TDCRP with introjective clients was in the later phase of therapy. In addition, he noted that, in a study of individuals in long-term inpatient psychoanalysis, introjective clients had a better response to treatment than anaclitic clients (Blatt et al, 1994). Moreover, self-criticism as measured by the DEQ was associated with a poor response to cognitive therapy (Rector, Bagby, Segal, Joffe & Levitt, 2000). In view of the findings in the literature that self-criticism has a detrimental impact on therapy outcome, the impact of personality style on therapy response was explored by examining correlations between personality style and outcome using chi-square analysis.

Method

Identification of Rapid Responders

Clients who experienced a rapid response to treatment were those who achieved a 50 per cent reduction in their BDI score by session six. From the original data set, 37 per cent of clients (23 of 62) had a rapid response to treatment. The average size of the reduction in the BDI score was 18.61 (sd = 7.60). In contrast, the average size of the BDI score reduction for clients with a more gradual treatment response was 4.59.

Data Analysis

The impact of the personality style on the response to treatment will be addressed by examining correlations between responses to treatment and the personality style using chi-square analysis. The sample included 10 clients who had a rapid response to treatment and 10 who had a more modest response. Due to missing data, analysis was conducted with nine clients who had a rapid response and nine who had a more modest response. The chi-square test was conducted to ascertain whether there was an association between the response to treatment (group membership rapid v. modest), as defined above by the reduction in the BDI scores by session six) and client characteristics (personality style, measured by the RQ and DEQ). Standardised residual BDI outcome scores (that is, controlling for pre-treatment scores) were used to identify slow responders and rapid responders. All analyses were performed with a two-tailed alpha of .05.

Results

There was no relationship between the dependency and the response to treatment ($\chi^2 = .554$, df = 1, p = .457), or between the dismissing attachment and the response to treatment ($\chi^2 = .222$, df = 1, p = .637). There was no relationship between self-criticism and the treatment response ($\chi^2 = .052$, df = 1 p = .819); however, there was a significant relationship between fearful attachment and treatment response ($\chi^2 = 4.00$, df = 1 p = .046). There was no relationship between preoccupied attachment and treatment response ($\chi^2 = 1.00$, df = 1 p = .317). There was no relationship between secure attachment and treatment response ($\chi^2 = 2.951$, df = 1 p = .086).

Table 13: Poorer (Slower) Responding Clients were Almost All (8 of 9) Fearfully Attached

		High fearful	Low fearful
Rapid response	Count	4	5
	Expected count	6	3
Slow response	Count	8	1
	Expected count	6	3

Discussion

Personality Styles and Outcomes

The slow response of fearfully attached clients fits in with previous research on fearful attachment (Reis & Grenyer, 2004). As fearfully attached clients appeared to be actively engaged in the therapy process, their slower progress appears somewhat incongruous. One possible explanation for this is the impact of shame proneness on the therapy process. Individuals with a fearful attachment style are more shame prone than individuals with a dismissing attachment style (Lopez, Melendez, Sauer, Berger & Wyssmann, 1998). Moreover, a recent study using a university sample found that shame mediated the relationship between self-criticism and depression (Sandquist, Grenyer & Caputi, 2009). Although capacity to introspect might be viewed by a therapist as a strength, it is possible that the exploration of thoughts and feelings activated a negative view of self that created a sense of shame. A metaphor may illustrate this process.

Imagine an impressionist painting in an art gallery, being viewed by three people. The first person is so close to the painting that all the person can see is a series of blobs, which makes the person feel incredibly overwhelmed. The person cries, ‘Help me, help me, I can’t see

anything. It's just a blobby mess.' The role of the art curator in this situation is to lead the person away from the painting to a vantage point that allows an alternative perspective. The second person is standing 10 metres away from the painting, so this person receives a vague impression, but feels irritated after spending so long driving to the art gallery, only to find that there is nothing to see. The role of the curator is to move the person forward so that the painting can resonate emotionally with this person. The third person is moving back and forth across the room; the person moves up very close and feels overwhelmed by the painting, and then moves about 10 metres away. The third person moves back and forth between both vantage points. The job of the curator with this person depends on what point in the journey they meet. If they meet close to the painting, the curator needs to move the person back, and if they meet far away, the curator has to move the person forward. If the curator is unclear of the direction, the curator needs to stand back for a moment and try to figure it out. A conversation with the third person may demonstrate that, unlike the person standing too close and the person standing too far away, the third person is acutely aware of two perspectives, but not fully aligned with either.

This is the painful dilemma of the fearfully attached client. They appear to have considerable ability to reflect on their experiences; however, they also experience distress from the two emotional points they move between. That is, not only is their view of themselves negative, but so too is their view of others—including the therapist. This tragic set of two negative views combines to create a situation whereby fearful clients who need help are unable to trust getting help either from themselves or from others. The data reported here illustrates this, with the poorest progress in treatment occurring in those fearfully attached. This is in contrast to clients who have a preoccupied attachment style or an anaclitic personality, in that they are acutely aware of their distress yet are very keen to be rescued (since their appraisal of others

is likely positive). Thus, therapy and the special relationship it provides are appealing. Introjective clients who have a dismissing attachment style have a positive view of self that appears to protect them from experiencing distress. A vignette of a client who had a self-critical personality and a fearful attachment style will be used to explore this process.

Vignette of a Client Who Has a Self-critical Personality and a Fearful Attachment Style.

Tim is a 44-year-old divorced male. He has 13 years of education and is in full-time employment. During the initial assessment, Tim had a moderate level of depression and his relationships were characterised by high levels of distress. PQS items from the session indicated a low level of hostility but a willingness to be introspective:

T: How did that make you feel about yourself, when she started to pull away?

P: Oh well, you feel awful. You keep trying to—like, you think if I can change myself a bit, maybe she'll stay. Maybe she won't go away. So, you get into silly arguments.

T: I guess what I'm interested in is how that affects you? I think this is about your patterns.

P: If she didn't like it, she'd go. That's how she operates.

T: Okay, so that's her? What about you?

P: Oh, I wonder what the hell is going on.

T: What the hell's going on in terms of what's going on in your head?

P: Yeah, yeah.

T: What sort of things are going on?

> P: I … I don't trust my judgement like I used to. I'm not comfortable. I feel I've lost a little some, especially when it comes to relationship.

In response to the question regarding what things were going on in Tim's head, the ability to introspect is evidenced by his responses, in which he articulates the struggle with how he is feeling. He is able to acknowledge his thoughts ('I don't trust my judgement') and his feelings ('I feel I've lost a little'). Introspection is also evident in the next extract:

> T: [softly:] For some people but what would be scary for you about being on your own? What would you be afraid of?
>
> P: [slowly:] Ahem—Oh I think just loneliness, to be—I think just to—just not having anyone around. I think that would be scary for you.

In response to the therapist's question about being alone, Tim is able to respond by mentioning his loneliness. However, he is not completely comfortable with exploring this; Tim uses 'you' to describe his experience rather than referring to himself using 'I'.

The therapist brings the focus back to the client: 'I'm interested in how that affects you'. The therapist persisted with asking Tim about his experiences, rather than interpreting them herself, and she also used the client's own language style in her questioning. This had the effect of increasing Tim's capacity to describe his experience.

Although Tim is capable of introspection, a withdrawal from this process is evident in his attempt to focus on a description of his partner's behaviour, rather than on his emotional response to her behaviour. The therapist guides him back to exploring his emotional experience and attempts to encourage him to consider his patterns of behaviour. It is possible that Tim's use of the word 'you' when describing an experience indicates an attempt to distance himself from his emotions

Tim's focus on his partner's behaviour is a subtle withdrawal from introspection. This engagement with and withdrawal from the therapy process is consistent with the notion that a fearful attachment style is characterised by both a desire for and a fear of connection. When one considers the better outcome experienced by dismissing attachment style, despite sessions being characterised by hostility, it suggests that a level of defensiveness is 'protective'. This study also highlights the importance of being vigilant to changes in how a client with a fearful attachment style responds within a therapy session. Engagement with the therapy process is likely to be followed by withdrawal. The withdrawal is likely to reflect not a 'resistance' to therapy but rather a building up of important defences that protect from the distress associated with focusing on a negative self-view.

Empathy has been defined as the capacity to understand the cognitive capabilities and emotional reactivity of others (Davis, 1983). It is a higher-order mental process that involves having an awareness of how a particular individual constructs reality. Bachelor's (1988) work indicated that, depending on the characteristics of a client, a particular strategy would be experienced as empathic or unempathic. The importance of developing empathy strategies targeted to the personality is evident in a study by Burns and Nolen-Hoeksema (1992), who found that, in a sample of 185 individuals being treated with CBT, empathy was associated with a reduction in depression scores. In addition, low scores in empathy were reflected in difficulties in the therapeutic alliance. Empathising with a self-critical/avoidant client involves being aware that a defensive hostile response may reflect a need to protect a fragile sense of self.

Luborsky's (1976) work on the dynamic nature of the therapeutic alliance suggested that creating a safe, supportive environment early in therapy is crucial. This study supports the idea that a client's personality will determine what is considered supportive. Thus, with clients who have a preoccupied attachment style or an anaclitic personality, providing direct reassurance is likely to provoke a sense of safety. For clients with an introjective personality or an avoidant attachment style, appropriate support will entail focusing on goals or self-image rather than directly on emotional experience. The personality theory informs us of the source of distress, whereas Luborsky's (1976) work suggested that the source of distress should not be addressed until the client is socialised to the therapy process. This study also indicates that fearfully attached clients may need therapy for a longer period than other attachment styles.

General Discussion

This project explored the impact of personality factors on the therapy process. Study 1a examined the relationship between depressed clients' scores on attachment style and scores on self-criticism and dependency. These constructs have their origin in early developmental history, and are associated with a vulnerability to depression and a poor response to treatment (Blatt & Shahar, 2005; Cyranowski et al., 2002; Santor & Zuroff, 1997). Despite the conceptual similarities and the body of research demonstrating their impact on therapy, this is the first study to explore correlations between these constructs in a depressed sample. The significant findings were: 1. high scores on fearful and dismissing attachment style were associated with high scores on self-criticism and 2. high scores on dismissing attachment were associated with low scores on dependency. This suggests that self-critical individuals may operate from a fearful attachment style or a dismissive attachment style. The differential

impact of attachment style on therapy process was observed in study 1b. High scores on dismissing attachment style were associated with difficulty agreeing on therapy goals. A major criticism of Blatt's postulation that dependency and self-criticism create a vulnerability to two prototypes of depression is the high correlation between these two constructs (Coyne & Wiffen, 1995). In this study, dismissing attachment style was associated with high scores on self-criticism and low scores on dependency, whereas fearful attachment was not associated with low dependency scores. This suggests that the correlation observed in studies between self-criticism and dependency reflects inclusion of individuals with a fearful attachment style.

These findings indicated that further exploration of the impact of personality factors on therapy process was warranted. Study 2a extended these findings by exploring the impact of personality factors on countertransference behaviour. Personality factors did not have a differential impact on countertransference behaviour. However, an examination of therapy process using the PQS, an empirically validated process tool indicated that the therapy process was differentiated by personality characteristics. The unique features that characterised the therapy process with each personality were commensurate with theory and clinical descriptions. The observation in study 1 that self-critical clients had either a fearful or dismissing attachment style was extended in study 2b by examining the therapy process with self-critical clients differentiated by attachment style. The results indicated that self-critical clients with a dismissing attachment style were less introspective and more hostile than self-critical clients with a fearful attachment style.

Study 3 explored the impact of personality characteristics on therapy response. An intriguing finding was that individuals with a fearful attachment style had the slowest response to

therapy. This seems at odds with the observation that clients with a dismissing attachment style had difficulty agreeing on therapy goals. It also seems at odds with the capacity for introspection identified in therapy with self-critical clients with a fearful attachment style. The poorer response observed with fearfully attached clients is commensurate with research regarding this client group (Reis & Grenyer, 2004). This study highlights the inherent problem in developing treatments for depression that do not consider personality factors. The differential engagement with treatment and differential response to treatment observed in this study indicates the importance of tailoring depression treatment to the client's personality. Clients in this study were equivalent in terms of diagnosis and symptom severity; yet there were significant personality-driven differences in therapy response.

This study demonstrated that self-critical clients can be differentiated by the attachment style, and that this difference had a considerable impact on the therapy process. In addition, this study noted that individuals who had a fearful attachment style had a more modest response to therapy than other personality styles. The activation of each client's personality style occurred in a unique way, which was consistent with clinical descriptions of these personality styles. This indicated that the measures of personality that were used had good construct validity. This study has significant implications for the treatment of depression. Although all clients had the same diagnosis and similar socio-economic backgrounds, there were significant personality-driven differences in how they engaged with therapy. This study concurs with the postulation that tailoring an intervention to the needs of an individual client is more important than matching the treatment to a particular diagnosis (Roth & Fonagy 2005; Norcross & Wampold, 2011).

Limitations

Due to time constraints, the labour intensive nature of this study meant that the focus of the study was a small data set. Care was taken to match the sample used in study 2 and study 3 with the original sample on age and gender; however, the small sample size limits how generalisable the findings are to other populations. A self-report measure was used to assess attachment. Cross-validation with the AAI (Main et al., 1985), a more in-depth interview that allows the interviewer to explore the quality of childhood memories, would have strengthened the findings. Correlation of the DEQ with the Sociotropy–Autonomy Scale (Clark, Steer, Beck & Ross 1995), a conceptually similar measure would also have validated the findings. Despite the small sample size and use of one measure to assess each construct under investigation the findings are congruent with theory. Although only one measure of attachment style was used, the measure used provided a self-rating for the extent to which clients endorsed each attachment style. Thus the use of the relationship questionnaire (RQ) concurs with the suggestion in the literature of the need to consider dimensional as opposed to categorical ratings of attachment (Ross, McKim, and Di Tommaso 2006). In addition, the RQ has a good convergent validity with other attachment measures (Bartholomew & Horowitz, 1991; Reis & Grenyer, 2004). Transcripts of therapy sessions were used to rate the PQS. Video recording would have highlighted nonverbal communications. Although inter-rater reliability was established by the use of two raters, other raters may have had different scores.

Future Research

Differences in how dismissing attachment and fearful attachment individuals respond in therapy could be explored in future studies by adapting other related tools, such as the Differentiation-Relatedness measure (Diamond et al., 1991) to explore the relationship between scores on this measure, attachment style and self-criticism on therapy process. A previous study demonstrated that scores on this scale differentiated individuals with a fearful attachment style from individuals with a dismissing attachment style (Levy et al., 1998).

This study only looked at the early phase of therapy; it would be interesting to explore the therapy process later in therapy. This is particularly important in view of the difficulties reported with self-critical clients in the later phase.

The study participants had a diagnosis of depression; it would be interesting to explore what occurs with clients with a diagnosis of anxiety. There is a trend in the literature is to take a transdiagnostic approach to treatment (Nolen-Hoeksema & Watkins, 2011; Kertz, Bigda-Peyton, Rosmarin & Bjorgvinsson, 2012). Rather than developing a specific treatment for each disorder, this approach involves developing a treatment to address risk factors that are shared across disorders. This study indicates that a negative view of self and others has a detrimental impact on depression treatment. Exploring the impact of this on treatment for anxiety is worthy of consideration, particularly as the literature on attachment styles and self-critical and dependent clients suggests that these personality characteristics create a vulnerability to other psychopathologies.

Clinical Implications

This study demonstrated that the emergence of particular behaviours associated with a personality style could derail the therapy process. The literature indicates that the rupture and repair of the alliance is a normal part of the therapy process, and represents an ongoing renegotiation of the process (Safran & Muran, 2000). Knowledge of the client's personality can assist the therapist to work with, rather than against, this process. In clinical practice, it is not always possible to assess clients with an extensive array of measures. However, this study indicates that the constructs under examination have considerable use in predicting how a client may respond within therapy. An awareness of a client's personality configuration provides an insight into how a client will respond to particular techniques. It also highlights the importance of the judicious use of what Jones et al. (1998) described as well-defined intentional actions, that is, specific skills that consider the client's personality style. It also suggests that providing training for therapists around personality-guided engagement strategies is an appropriate strategy for bolstering the therapeutic alliance. This would provide a framework for navigating the ruptures and breaks that Safran & Muran (2000) described.

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