Relationship factors and outcome in brief group psychotherapy for depression

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Relationship Factors and Outcome
in Brief Group Psychotherapy for Depression

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by

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Declaration

I, Trevor Patrick Crowe, certify that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy (Psychology) in the Department of Psychology, University of Wollongong, does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person where due reference is not made in the text. The document has not been submitted for qualifications at any other academic institution.

Trevor Patrick Crowe

12th July 2005
Abstract

Relationship factors such as a psychotherapy group's cohesion and interpersonal climate have been touted as being analogous to the therapist-client alliance in individual psychotherapy, and as such should predict treatment outcome. However, predicting and explaining contributors to outcome in group psychotherapy remains unclear. This series of studies examined therapist-client alliance, group cohesion and climate, self-other differentiation processes (using a repertory grid method) and mastery of Core Conflictual Relationship Themes (CCRT) in brief dynamic group therapy for depression. These studies also integrated qualitative-phenomenological and clinical-quantitative research methodologies to examine in detail significant helpful and hindering psychotherapy events. It was found that therapeutic alliance is not analogous with group cohesion, but is associated with group member's engagement in therapeutic tasks. Perceived levels of conflict and group developmental processes helped explain the dimensions of cohesion. How group members defined themselves in relation to others meaningfully changed over therapy. Changes in perceived conflict in the group, and an individual's mastery of their CCRT patterns predicted outcome. In particular, through the experience of telling their stories, clients were able to change their responses to conflicts both within the group and in their wider interpersonal circle.
Acknowledgements

I would like to acknowledge, and express my gratitude to, my supervisor Associate Professor Brin Grenyer. I have gained considerably from Brin in relation to guidance in: conducting and understanding research projects; supervision of Clinical Psychologists; understanding Supportive Expressive Dynamic psychotherapy; understanding psychotherapy research; and general academic issues. I would also like to acknowledge the guidance and support of Mr Peter Caputi in relation to the statistical methodologies utilised in this thesis. In relation to the depression treatment project from which the data in this thesis was drawn, I would like to acknowledge the team of Clinical Psychologists who participated in the project and who provided the clinical interventions. Similarly, I would like to acknowledge the people struggling with depression who agreed to participate in this project and who allowed me the opportunity to try to understand better some of the issues related to the treatment of depression. Finally, I would like to acknowledge my family generally for their support during the period of completing this thesis and in particular my wife Helena, my son Jamie and my daughter Alexandra, who have endured my moodiness, preoccupation, and at times unavailability.
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Preface

My interest in exploring what makes psychotherapy work stems from both my history as a clinician and my curiosity regarding the relationship between interpersonal processes, being human within a collage of experiential and interpersonal worlds, and mental health and behavioural issues. I also have an interest in exploring the similarities and differences between different therapeutic approaches (including both individual and group therapy) and their theoretical and philosophical underpinnings. This led me to the desire to gain a better understanding of the so called ‘common factors’ of psychotherapy and how they might be better understood and enhanced within a range of clinical settings.

This thesis focuses on aspects of the interpersonal interactions within group therapy treatment for depression. More specifically, it examines the potential associations between relationship phenomena and therapy outcome and attempts to elaborate this in terms of how individual experiences of therapeutic relationships may be influenced by previously adopted interpersonal relationship patterns.

More recently I have become more familiar with ‘recovery literature’ which describes people’s experiences of recovery from mental illness. Although recovery stories have become a catalyst for change (or at least reflection) in terms of how services are delivered, research exploring the intricacies of therapeutic interactions and their relationship with individual recovery processes is in its infancy.

It is my intention in this thesis to straddle qualitative-phenomenological with clinical-quantitative methodologies to examine individual recovery processes within the context of the dynamics and developmental processes of group psychotherapy for depression.
Chapter 1

Thesis introduction
Depression

Depression is characterized by cognitive and vegetative symptoms and poses significant risk for relapse and often has a chronic course (Kender, Thornton & Gardner, 2001). Rowe (1978, 2003) described depression as the feeling of being pressed down by the world, which might be as much a defence or coping mechanism as an illness. Only hypertension is greater than depression in terms of the most frequently reported chronic health conditions in general medical practice settings (Wells, Golding, & Burnham, 1989; Wells, Sturm, Sherbourne, & Meredith, 1996). The Australian Bureau of Statistics (1998) reported that the lifetime prevalence of depression in Australian adults is one in five, and increasing. Lin, Kanton & Von Korff (1998) reported that around thirty per cent of first episode patients with depression relapsed within twelve months after terminating treatment. This expands to an over fifty percent relapse rate when considered over the lifetime of first episode depression patients (Kender, et al., 2001). In relation to fatalities, Robins and Kulbok (1988) reported that major depression was implicated in approximately fifty per cent of suicides. Furthermore, based on current growth trends, the World Health Organization estimates that depression might be one of the greatest sources of disability worldwide alongside infectious diseases by 2020 (Murray & Lopez, 1996). This represents significant economic and population burden (Lewis & Araya, 2001; Parker, Roy, Mitchell, Wilhelm, & Eyers, 2000; Klerman, 1989).

In a recent cross-cultural study independent risk factors for the development of new depressive episodes for primary care patients were found to include psychological/psychiatric problems, suicidal thoughts, previous depressive episodes, more than one chronic organic disease, and high psychological distress (Barkow, Maier,
This study however did not consider broader adverse life events (Lewis & Araya, 2001), interpersonal problems (Luborsky, Mark, Hole, Popp, Goldsmith, & Cacciola, 1995; Weissman, 1995; Blatt, Zuroff, Quinlan, & Pilkonis, 1996), perfectionism (Blatt, 1995; Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982) and perceived isolation from others (Klerman, Weissman, Rounsaville & Chevron, 1984; Rowe, 1978, 2003) which have also been associated with the onset and recovery from depression.

Large cross-national differences in prevalence and presentation of depression symptomatology have been found (Simon, Goldberg, Von Korff, & Uestuen, 2003). Although this might be a result of the limitations of existing classification methods, it might also be indicative of differences in relation to cultural and interpersonal tolerance and recognition of the expression or presentation of particular symptoms. Lewis & Araya (2001) suggested that more recently a trend has emerged to de-emphasise the somatic syndrome of depression (which has been used to classify depressive presentations as either biological/endogenous or environmental/neurotic) to perhaps more appropriately consider depression along a continuum of severity. They also suggested that adverse life events were as common before depression with somatic symptoms as before depression without somatic symptoms. Others have suggested that diverse psychological syndromes including depression can be linked in terms of an internalizing factor that similarly is consistent across different cultures (Krueger, Chentsova-Dutton, Markon, Goldberg, & Ormel, 2003). Therefore, interventions aimed at supporting the recovery processes of people with depression and/or other mental health disorders might be more effective if the experiences of the person and therapeutic interactions are targeted rather than simply
targeting symptoms specific to particular disorders (Deegan, 1988; 1996; Anthony, 1993; Barkham & Mellor-Clark 2003; Norcross, 2002).

The National Institute of Mental Health Treatment of Depression Collaborative Research Programme study (Elkin, Shea, Watkins, Imber, Sotsky, Collins, et al., 1989) examined the popular treatment approaches for depression under controlled trial conditions. One of the main findings of this study was that outcome based on treatment approach was relatively equivocal, with interpersonal factors such as the strength of the therapeutic alliance between client and therapist being the most reliable outcome predictors (Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins, & Pilonis, 1996; Krupnick, Elkin, Collins, Simmens, Sotsky, Pilonis, & Watkins, 1994). Two salient points might be drawn from this finding in relation to the current thesis. First, factors that influence the establishment and maintenance of effective therapeutic relationships should be considered in relation to supporting the recovery processes of people with depression (e.g. Horvath, 2000; Horvath, & Greenberg, 1994; Horvath, & Symonds, 1991). Second, regardless of chronicity, cognitive and vegetative symptoms of depression, the client’s interpersonal relationship issues might be important to consider in relation to the management of the therapeutic relationship (e.g. Wilfley, MacKenzie, Welch, Ayres, & Weissman, 2000; Weissman, 1995; Brewin, 1985; Weissman, Klerman, Paykel, Prusoff, & Hanson, 1974).
Effectiveness of psychotherapy

The effectiveness of psychotherapy to facilitate improvement in populations experiencing mental and/or emotional health problems has long been established (e.g. Lambert & Bergin, 1994). For example, Smith, Glass & Miller (1980) conducted a meta-analysis of more than 475 studies that reported psychotherapy outcome compared with control groups and found a large effect size of .85 for psychotherapy compared to .2 for people not engaging in psychotherapy. What has been more difficult to determine is what makes psychotherapy effective. Furthermore, different psychotherapy approaches have been found equivocal in terms of treatment outcome (Wampold, Mondin, Moody, Stich, Benson & Ahn, 1997; Luborsky, Singer & Luborsky, 1975; Elkin et al., 1989). This was termed the ‘dodo bird verdict’ (Rosenzweig, 1936; Duncan, 2002). The dodo bird verdict appears to denounce that specific therapeutic benefits related to specific theories and therapy techniques are discernable (Bohart, 2000). In contrast, Shadish and Sweeney (1991) suggested that one risk of using meta-analytic methodologies is that conclusions based on average treatment effects across various studies fail to adequately address the influence of mediator and moderator variables. The more specific challenge is to determine what works with who under which circumstances (Howard, Krause, Saunders, & Kopta, 1997; Orlinsky, Grawe, & Parks, 1994; Shadish & Sweeney, 1991; Crits-Christoph, 1997).

However, Bohart (2000) suggested that theorists and researchers would do better reconceptualising the notion of ‘treatment’ (which tends to treat the client as a ‘dependent variable’) rather than debating the merits or inadequacies of the dodo verdict. That is, he
argued that a relational model of therapy focused on consultation, collaboration, and dialogue is better than a treatment model. Furthermore, Bohart advocated for considering the client as the most important common factor and that it is clients’ self-healing capacities which make therapy work. Despite psychotherapy approach allegiances of researchers and theorists (Bergin & Garfield, 1994; Bohart, 2000), perhaps the most productive reaction to the dodo bird verdict is the increased attention to identifying and examining the common factors across different psychotherapies that account for a greater proportion of outcome variance than individual therapy techniques alone (Ahn & Wampold, 2001; Ogrodniczuk, Piper, McCallum, Joyce, & Rosie, 2002; Orlinsky, & Howard, 1986; Orlinsky, Grawe, & Parks, 1994; Martin, Garske, & Davis, 2000).

Attempts to make progress with these challenges are directed by how ‘outcome’ is defined (Bohart, 2000; Shadish & Sweeney, 1991). Some of the domains of ‘recovery’ from mental health problems are not measured if outcome measurement is restricted to the number and severity of symptoms. Although the reduction or removal of symptoms is a general aim of treatment, particularly from a ‘medical model’ perspective, the efficacy of treatment approaches may vary in relation to environmental, interpersonal, and personality factors, as well as the disorder itself. Therefore, when investigating the relationship between predictor variables and outcome it is important to consider and clarify how one is defining ‘recovery’ and whether the outcome measures adequately track and reflect this definition. Furthermore, the interpretation of process and outcome research findings should reflect the assumptions underpinning this definition of recovery from mental health problems.
Qualitative-phenomenological and clinical-quantitative research methodologies

Barkham and Mellor-Clark (2003) considered different types of evidence based research into psychological therapies. They suggested that client treatment preferences are usually not considered at all in efficacy studies involving random assignment to different treatment and control conditions. Consequently the majority of efficacy studies fail to consider a broad array of intrapersonal, interpersonal, motivational and readiness factors that might mediate or moderate the variable associations reported in efficacy studies. Barkham and Mellor-Clark (2003) go on to suggest that the view that a linear progression of attempting to generalise findings from efficacy studies to effectiveness studies in ‘real life’ clinical settings, although seemingly logical might be problematic. They suggest that methodologies that ‘drill down’ through the data to ascertain individual differences and variations in client subgroups might be used in tandem with efficacy and effectiveness studies potentially representing a more ‘cyclical’ progression model. That is, research findings could be explored phenomenologically with the potential of identifying other individual and systemic factors to help explain process and outcome relationships.

Nomothetic approaches have tended to be favoured over ideographic approaches in the study of human behaviour and applied clinical research (Sheldon, Williams & Joiner, 2003). This has perhaps been the result of the hegemony of the behaviouristic research framework which promotes the desirability of quantitative data and reductionism (Hayes, Strosahl, Wilson, 1999). Sheldon, Williams and Joiner (2003, p. 4) postulated that ‘a new science of self-actualization’ which addresses the ‘question of how best to
engage the “self” of the client’ within treatment settings is overdue. They suggested that humanistic theory (with its favouring of narrative approaches) and empiricism based on quantitative methodologies can be complementary. Similarly Hayes, Strosahl and Wilson (1999) posited the need for psychotherapy and research to be based on ‘functional contextualism’. That is, rather than an exclusive attempt to isolate, observe and explain specific behaviours, it is more productive to consider and attempt to understand the ‘whole event’ including the interactions of context, self and behaviour.

Watson and Welch-Ross (2000) highlighted the importance of exploring the ‘phenomenal accuracy’ of research into human experience. They suggested that quantitative data can benefit in terms of explanatory and accuracy value by being integrated with qualitative methodologies and vice versa. Specifically, they suggest that quantitative methods can be used to examine the validity of qualitative data ‘while maintaining, as a central concern, the importance of assuring that the researcher understands, as much as possible, the individual’s personal experience’ (p. 197).

The growing demand for research methodologies that consider interpersonal interactions and context is given further support by studies which examine therapist effects. The problem of assuming individual therapist effects as negligible was identified by Crits-Christoph and Mintz (1991) in a meta-analysis that reported inconsistent therapist effects across fifteen studies. Norcross (2002) also critiqued standard research methodologies and suggested that the ‘person’ of the therapist is ‘inextricably intertwined’ with therapy outcome. He suggests that this is true despite researchers’ efforts to partial out or control for individual therapist effects. Similarly, Okiishi, Lambert, Nielsen and Ogles (2003) found a significant amount of variation among
therapists in terms of their clients’ rates of improvement. In fact they found that the therapists whose clients showed the fastest rate of improvement had an average rate of change that was ten times greater than the mean of their sample. Furthermore, the clients of the less successful therapists showed an average increase in symptoms.

Some quantitative and qualitative methodologies reflect the principles of phenomenology and hermeneutics. Whereas the phenomenological approach aims to describe the essence of phenomena by attempting to set aside assumptions and giving the subjective and objective equal weighting, hermeneutical phenomenology suggests that human existence is interpretive (Owen, 1994). Phenomenological enquiry is a genuine interest in the individual’s experience, how they see the world and contribute to creating their own experiences and meanings (Resnick & Parlett, 1995). The phenomenological method requires the enquirer to ‘bracket out’ his/her usual ways of thinking (i.e. models of interpretation, a priori assumptions, theories, etc.) so that s/he can gain some insight into the degree to which the subject’s current experience is influenced by residue from the past. The phenomenological perspective suggests that neither the therapist nor the client has the inside track on ‘reality’ (Resnick & Parlett, 1995).

Yontef (1993) suggested that in therapy phenomenological experiences traverse four different time zones. First, the ‘here and now’, which includes wishes, fears, unfinished business and personal meanings, involves the immediate, concrete and observable person in the present environment,. Second, the ‘there and now’, the person’s life space, the whole of the person’s current existence (both within and outside of the therapy room) (the subject’s experience that may or may not be articulated). Third, the ‘here and then’, reflects the nuances of the therapeutic relationship including the
transference relationship (might be observed as enactments of transference themes). Fourth, the ‘there and then’, which reflects the person’s ‘life story’ including his/her developmental history, which represents the background from which personal meaning is drawn (the subject’s articulated story may reflect interpersonal relationship patterns). In effect the person’s life stories offer some insight into how she or he processes and integrates her or his experiences and cognitions from each of the other ‘time zones’. These interactive ‘time zones’ resonate with Hayes, Strosahl and Wilson’s (1999) notion of ‘functional contextualism’ in that they represent contexts or ‘relational worlds’ that might interact and influence meaning-making and behaviours in the present. Therefore, research methodologies that attempt to capture the immediate behaviours, the transference dynamics, the relational histories and the person’s meaning laden stories may go some way to describing the influences on behaviour.

To emphasis the importance of studying the ‘stories’ people tell, several authors (e.g. Rennie & Toukmanian, 1992; Rennie, 2000; Rennie, 1994) posit that narratives occurring in therapy sessions concretise personal meaning and identity. This seems important considering that both personal meaning and identity are fundamental components of the process of psychological recovery (Andresen, Oades, & Caputi, 2003; Anthony, Cohen, Farkas, & Cohen, 2000; Whitwell, 1999; Deegan, 1988; Anthony, 1993). Rennie (1994) suggested that people shape their sense of personal identity and explore similarities and differences with others by transforming their cognitive experiences into narratives. Along similar lines Rennie (2000) suggested that therapists’ attempts to clarify, categorise and ultimately interpret the client’s experiences from a ‘grounded theory’ perspective, often requires the selection of accurate metaphors which
operate as an ‘empathic lens’. That is, the ‘stories’ therapists tell in therapy, which often take the form of metaphors, carry the responsibility of demonstrating empathy and attempt to articulate the meaning-making structures of the client. Although it could be argued that the therapist’s metaphors in fact concretise the therapist’s meaning making structures, it might also be argued that finding mechanisms by which the client can articulate and integrate his/her own experiences is an essential function of psychotherapy (Rennie, 2000, 1994; Rennie & Toukmanian, 1992).

Merleau-Ponty (2002, 1982) posited that individuals do not experience a world consciously as a system of interactions that completely determine events, but rather the experience is more as an open totality. Building upon this notion Staemmler (2000) suggested that ‘mastery’ requires insight into how these systems influence each other and lock the subject into repetitive patterns. Staemmler goes on to describe the hermeneutic approach as an attempt to understand clients within their existential situations. He suggests that this involves the formulation of open questions regarding what and how the client perceives, experiences and structures his/her thinking. An open phenomenological-hermeneutic enquiry such as this rarely produces one definite meaning, but rather a multitude of possible meanings that continue to change with time.

After Heidegger and Gadamer, phenomenology moved conventional psychology further towards hermeneutics, the study of how things are interpreted to be what they are (Owen, 1994). Such an approach to personal consciousness requires an emphasis on qualitative methods which closely fit the nature of the lived experiences under observation. Consequently research methodologies would benefit by including explorations of how the person perceives or construes him/herself in relation to others
(e.g. shared or social identities, similarities, differences, expectations, etc.) (Hogg, 1992; Kelly, 1955), how she or he makes sense of her or his own experience, how she or he makes sense of the psychotherapy and recovery processes, and how she or he integrates her or his experiences. Such a methodology might reflect upon the person’s evolving or resilient sense of self through dialogue with others (Neimeyer, 2002; Luborsky & Crits-Christoph, 1998), the potential relationships between common and treatment specific effects during the therapy process (Beutler & Harwood, 2002), and the study of helpful and hindering events in relation to the person’s recovery process (Elliott & Shapiro, 1992; Lietaer, 1992).

Methodological considerations

This thesis intentionally incorporates nomothetic and ideographic examinations of human behaviour. Qualitative-phenomenological and clinical-quantitative research methodologies are adopted in an attempt to complement the limitations of each approach with the strengths of the other. Whereas the qualitative-phenomenological tradition gives precedence to the ‘individual voice’, thus increasing the potential of understanding individual recovery processes, the clinical-quantitative methodologies, utilised by contemporary psychodynamic researchers, attempt to capture patterns and similarities between ‘voices’, or between the same ‘voice’ in a range of situations and contexts.

Although these two traditions have significant epistemological differences related to perceptions of ‘truth’ (i.e. is there one observable or innate truth or is truth relative to the perceiver, or can truth be clarified via the recognition of patterns?), Maze (1983, p.96) argues that ‘my apprehension of others as knowers is presupposed by my learning of
More specifically, by examining the language one chooses, the conversion of experiences and beliefs in words, insights might be gained regarding motivations and subjective explanations of experiences and behaviour. That is, both qualitative-phenomenological and quantitative-clinical traditions refer to the narratives of therapy to explore/examine therapy processes and personal experiences. However, the accuracy of what might be inferred from the language of narratives might need to be measured against the ‘meaning’ context or ‘ground’ from and against which the specific words emerged. These meaning contexts or grounds should not be restricted to the immediate situation unless the immediate situation is taken to include previous frames of reference that may continue to exert an influence on the person’s immediate perceptual processes (Yontef, 1993).

Maze (1983) implies that the challenges that present to the researcher and therapist associated with attempting to know ‘the mental processes’ of another may similarly be a challenge for a person to know his/her own mental processes. Specifically, Maze (p. 97) states that:

‘A person could, in fact, be possessed of a given belief over a long period of time, during which some of his acts may have been explicable only by supposing him to have that belief, yet if it were debarred from the subroutine of becoming verbally encoded, then he could not have known by any sort of privileged access that he had it......we cannot have the awareness of other person’s minute motor performances that we can have of our own, but we can see what they do and hear what they say, and the knowing in proprioception is not of a different kind from knowing in visual and auditory perception; it is just knowing through a different
channel. The important point is that in seeing what people do and hearing what they say, we are not seeing mere movement and hearing mere sounds, which we must then try to relate speculatively to inner mental processes; we are seeing movements and hearing sounds as informed by their makers’ beliefs.’

The phenomenological tradition (particularly when coupled with existential principles) emphasises the ‘self’ as the motivator and potential creator of personal change. Although this theory can rightfully be criticised when a unitary conception of ‘self’ is proposed (i.e. to change one’s self immediately implies a splitting of self into subject and object, doer and done to, thus if I was to attempt to capture or become more aware of this ‘self’ I would have to step outside of this self, thus making it an object, and would be thrust into a position of perpetual regression if the search for self was to continue) (Maze, 1983), it highlights the point that the knower needs to become an external observer and objectify that which is under scrutiny or perceived to be known. In other words, although a person may be privy to aspects of his or her own experiences and mental processes in a way that external observers are not, he or she must become an external observer of him or herself too in order to describe this experience to her or himself or others. Furthermore, if Maze’s (p. 90) contention has merit that ‘Consciousness is not an intrinsic or one-place property that a belief or mental event may have or not have; it is a relationship in which one awareness is object of another within the same mental life’, then a person’s consciousness might be contributed to by the reflections of an external other that stimulate the person’s awareness into broader considerations. That is, the reflections of an observer (e.g. therapist) on patterns apparent
within a person’s mental and associated interpersonal life (clinical-quantitative tradition) may have comparable validity to the reflections that one has of oneself (qualitative-phenomenological tradition), particularly if the ‘wood cannot be seen for the trees’ if the self observer lacks adequate distance to recognise patterns within oneself.

Subjective experience, meaning and symptom change

Mental health research is increasingly recognising ‘recovery’ from mental illness (particularly for chronic and recurring disorders) as an individual subjective process that can occur despite the persistence or recurrence of symptoms associated with the disorder (e.g. Andresen, Oades, & Caputi, 2003; Anthony, Cohen, Farkas, & Cohen, 2000; Whitwell, 1999; Deegan, 1996; Anthony, 1993). Although improvements in well-being are often associated with reductions in the more biologically defined symptoms, the strength of that association may vary substantially. This gives rise to the need to reconsider the importance of subjective experience and the personal meaningfulness of events embedded within the recovery process (Curtis, 2000; Pettie, & Triolo, 1999; Duckworth, Nair, Patel, & Goldfinger, 1997; Deegan, 1988; Anthony, 1993).

A person’s experience of mastery, personal agency and meaningfulness are integral parts of ‘psychological recovery’ (Sheldon, Williams & Joiner, 2003; Grenyer, 2002; Anthony, Cohen, Farkas, & Cohen, 2000; Whitwell, 1999; Deegan, 1996). Therefore, the subjective experience of recovery might need to be considered equal in importance to more objective symptom or behaviour based measures when attempting to track this process. It may be then that only phenomenological research approaches that
It is possible that certain variables are better than others at predicting certain outcome variables. Furthermore, it raises the question about whether some accepted variables adopt mediator or moderator roles in different clinical contexts or in relation to the expectations or needs of the individual. For example, one individual may report advances in recovery from a mental health condition related to gains in mastery of interpersonal functioning or overcoming a sense of existential isolation despite persistent physical symptoms, whereas another person may restrict his/her experiences of improvement to changes in physical symptoms.

**Relationship factors**

As mentioned above, ‘psychological recovery’ is not simply the removal of problematic illness symptoms or a return to a prior level of functioning, it includes the person’s subjective experience, sense of meaningfulness and identity (e.g. Spinelli, 2002, Anthony, Cohen, Farkas, & Cohen, 2000; Anthony, 1993). Furthermore, recovery tends not to occur in isolation but within an interpersonal context. An examination of the process of recovery involving psychotherapy immediately implies an interpersonal context. Regardless of whether psychotherapy occurs within individual therapy, case-management or group therapy contexts, significant relationship factors may influence the recovery process, and ultimately mental health outcomes. There has been extensive
research related to different aspects of the therapeutic relationship(s) and how they appear to be associated with mental health outcomes.

It has been suggested that the success of psychotherapy is only partially the result of what the therapist provides (Gelso and Carter, 1985). The therapeutic or working alliance has been studied extensively and been found to be a robust predictor of therapy outcome (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; Martin, Garske, & Davis, 2000; Horvath & Luborsky, 1993, Horvath & Symonds, 1991). However, Gelso and Carter (1994) highlighted the importance of considering the working alliance within the context of two other major relational dimensions present within the overall therapeutic relationship (also see Kivlighan, Patton, & Foote, 1998). These two dimensions are the ‘transference relationship’ and the ‘real relationship’.

**The ‘real’ or ‘existential relationship’**

The ‘real relationship’ is referred to here as consisting of the genuineness and realistic perceptions between two human beings in the present situation or contact. In other words, it is the observable behaviours and present centred contact (immediacy) between two people that is for the most uncontaminated by transference material (see transference section below). Gelso (2002, p. 37) suggested that the ‘real relationship pertains to both the personalities of and the communications (nonverbal as well as verbal) between therapy participants’. He also highlighted the lack of research investigating this aspect of the therapeutic relationship.

Although the ‘real’ relationship is not a major focus of this thesis it is briefly mentioned here in recognition of the part it plays in the therapeutic relationship. The level
of importance attributed to the real relationship varies in relation to the therapeutic approach. For example the classic Psychodynamic and Psychoanalytic approaches may seek clarity within the real relationship by exploring and interpreting the ‘transference relationship’ (Freud, 1913/1958). In contrast, Dialogical, Existential, Gestalt and some Humanistic psychotherapy approaches insist that the real or existential relationship is central to the work of therapy suggesting that healing occurs through genuine contact between the persons of the therapist and client (Gelso, 2002; Spinelli, 2002; Hycner, 1993; Buber & Friedman, 1965; Friedman, 1991).

Spinelli (2002, p. 112) refers to Laing’s proposals that exploring the existential relationship typically addresses concerns around the client’s ‘essence (“that I am”), existence (“what I am”) and identity (“who I am”). These explorations of one’s experience of ‘self’, particularly in the immediate situation of the therapy session, in effect represent an opportunity to explore an expansive sense of self in contact with the person (the clear ‘other’) of the therapist. That is, the therapy situation offers a forum where the client can be assisted with discerning clear self-other relations in the present from refuse from the past. This resonates with Martin Buber’s (Hycner, 1993; Buber & Friedman, 1965; Friedman, 1991; Buber, 1957) ideas about the ‘elements of the interhuman’ and the difference between ‘seeming’ and ‘being’. Buber’s notion of ‘seeming’ in some respects reflects the dynamics of the ‘transference relationship’ (see below) where the ‘other’ is related to as an ‘it’, an object of projection. Whereas Buber’s notion of ‘being’ represents the moments of ‘clear contact’ between two people.

‘Whatever the meaning of the word “truth” may be in other realms, in the interhuman realm it means that men communicate themselves to one another as
what they are. It does not depend on one saying to the other everything that occurs to him, but only on his letting no seeming creep in between himself and the other. It does not depend on one letting himself go before another, but on his granting to the man to whom he communicates himself a share in his being. This is a question of the authenticity of the interhuman, and where this is not to be found, neither is the human element itself authentic.’ (Buber, 1957, p.107)

Similarly, Symington (1986) suggests that Psychoanalysis is a method of investigating ‘truth’ which via ‘insightful understanding’ attempts to ‘repair the capacity’ to arrive at truth. Symington (1986, pp. 17-19) states that:

‘truth’ does not exist ‘as some eternal idea, as Plato thought, but as a reality that exists in between: in between two persons seeking it…truth is grasped in dialogue with another or others: it emerges in between…The glimpse of truth demands that a preconception is abandoned in both, for both have come to the encounter with their own preconceptions’ (italics in original).

The therapeutic alliance

The alliance between therapist/worker and client was initially conceptualized within the psychodynamic framework by Freud (1913/1958), where a ‘positive transference’ was seen as a pre-requisite to developing a successful working relationship. However, Freud (1913/1958) endeavoured to keep the real relationship distinct from the transference relationship, yet viewed the therapeutic alliance as the ‘ego-syntonic’ part of the transference relationship with the therapist (Grenyer, 2002).
Rogers (1951) suggested that although the client was an active force in the change process, it was primarily the therapist’s skill that established and shaped the alliance. Bordin (1979) revised this contention and suggested that the alliance was shaped by a negotiation of relational, task and goal setting demands involving both the client and the therapist. Consequently, Bordin’s model further developed into the more broadly accepted model of ‘working alliance’ (Horvath and Greenberg, 1994). However, Bordin’s model intentionally avoids dealing with the ‘transference’ and ‘real’ relationship dimensions of the therapeutic relationship.

The strength of the working alliance is determined by the level of relational ‘bonds’, degree of agreement or mutuality regarding the therapy ‘goals’, and agreement about the perceived usefulness of therapy ‘tasks’ between therapist and client (Bordin, 1979; 1994). The ‘goals’ are the targets of the intervention, or what is wanted as a result of therapy. The ‘tasks’ of therapy refer to the activities that are undertaken or assigned within the therapy contacts (Bordin, 1994). The ‘bonds’ refers to the network of positive personal attachments between client and therapist that includes issues such as mutual trust, acceptance and confidence. There should be a connection between the goals and the tasks assigned as the tasks are the practical steps required to progress towards achieving the identified goals (Bordin, 1994). A good alliance is characterized by mutual respect, adequate attachment and both therapist and client holding the belief that the goals and tasks are relevant, worthwhile and efficacious in relation to therapy outcome (Bordin, 1994; Lustig, Strauser, Rice, & Rucker, 2002).

Bordin (1979) described the working alliance as a unitary construct within which an interdependent relationship could be noted between each of the three components.
More recently however, Andrusyna, Tang, DeRubeis and Luborsky (2001) found that the relationship (bonds) between therapist and client might be largely independent of the client’s agreement with, and confidence in, the therapist and his or her treatment strategies (tasks & goals). In other words, a two-factor structure of alliance consisting of a task/goal agreement factor and a relational bonds factor was found, as opposed to the previously considered single factor of alliance (comprised of three parts). This suggests that there may be merit in examining interpersonal relationship phenomena independent of task and goal agreement issues. Furthermore, this allows for the re-inclusion of transference, attachment, relationship style, and expectations and objectification of the ‘other’ in this interpersonal relationship (bond) factor.

**Alliance ruptures**

Strupp and Hadley (1979) suggested that the ‘negative changer’ (i.e. the client who appeared to deteriorate rather than improve) was characterised as more self-derogatory as well as less psychologically minded than the positive changer. Furthermore, with these cases the therapist was assessed to be colder, more insensitive, and more rigid compared to the therapist of the positive changer. Consequently, poor therapy outcome was more often marked by superficiality, therapists’ errors in goal setting, and failure to take responsibility for the session or correct negative therapeutic processes over time. The dynamics of these types of negative therapy events have been identified as ‘ruptures’ of the therapeutic alliance (Safran, Crocker, McMain, & Murray, 1990).

Alliance ‘ruptures’ consist of an impairment or negative fluctuation in the quality of the alliance between the therapist and the client. Safran and Muran (1996) suggested
that alliance ruptures are characteristically: common; interactional phenomenon; a function of both client and therapist contributions; variable in intensity, duration and frequency depending on the particular therapist – client dyad. Ruptures are typically identified as one of two categories: 1) confrontational – client may express negative thoughts and feelings toward the therapist, and/or terminate therapy prematurely; 2) withdrawal – client engages in avoidance behaviours (Safran, et al, 1990; 1996). These categories reflect seven subtle themes or markers: the overt expression of negative sentiments; indirect communication of negative sentiments or hostility (may be non-verbal or passive-aggressive); disagreement about the goals or tasks of therapy; uncharacteristic or sudden compliance; avoidance manoeuvres; self-esteem-enhancing operations; and non-responsiveness to interactions (Safran, et al, 1990).

**Resolving alliance ruptures**

Safran et al (1990) suggested six strategies to resolve alliance ruptures: One, resolving ruptures involves meta-communication (i.e. talking directly about what is currently happening in the therapeutic relationship). Two, attending to ruptures in the alliance, which requires an understanding of alliance rupture markers and frame of reference sensitive to relationship dynamic fluctuations. Three, awareness of one’s own feelings. Four, accepting responsibility. Five, empathising with the client’s experience. Six, maintaining the stance of the participant observer.

Safran et al (1990) suggested that early detection of alliance ruptures by the therapist is critical to successful therapy. They also suggest that the resolution of alliance ruptures can be potent change events (also see Watson & Greenberg, 2000). Furthermore, Foreman and Marmar (1985) found that if therapists dealt with clients’ problematic
feelings towards the therapist by linking these feelings to established defences used to protect against these feelings, psychotherapy outcome improved. That is, the problematic relationship dynamics were addressed directly and explored in terms of the patterns of interpersonal adaptations. They also found that in unimproved cases this link was not made or problematic feelings were avoided or ignored by therapist.

**Interpersonal style, alliance and repetitive relationship patterns**

Horvarth and Symonds (1991) conducted a meta-analysis of studies that associated alliance with outcome and found that symptom severity and diagnosis did not significantly differentiate between alliance and outcome. However, although the working alliance has been found to be a pan-theoretical factor that retains its robustness as an outcome predictor regardless of many pre-therapy factors, it is not completely free of the influence of other relationship variables (Horvath & Greenberg, 1994; Horvath & Symonds, 1991; Safran, & Muran, 1998; Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; Martin, Garske, & Davis, 2000; Horvath & Luborsky, 1993; Bachelor, 1995). As mentioned above, transference factors and interpersonal style may have more of an influence on the formation, maintenance and predictive ability of the alliance than factors such as: social class, intelligence, pre-morbid adjustment, baseline symptom discomfort, insight, optimism, and motivation to change (Frank & Gunderson, 1990).

Hersoug, Monsen, Havik, and Hoglend (2002) found that the quality of the working alliance was difficult to predict on the basis of time, diagnoses and intrapsychic variables, particularly from the clients’ perspective. However, they did find that early alliance was a better predictor than later in therapy ratings, and that the quality of both current and past relationships was associated with working alliance. Interesting,
intrapsychic variables (such as insight, tolerance for affects, problem solving capacity, self-attack, self-control and self-conflict) predicted the therapists’ ratings of alliance, but not the clients’ ratings. They concluded that the client’s relationship style or pattern impacts on the expectations regarding the therapeutic relationship, and consequently the strength of the working alliance, for both the client and therapist. The study highlights how therapists formulate their clinical approaches in reference to theoretical models. It also highlights the importance of considering the influence of transference or interpersonal relationship patterns on the therapeutic relationship.

Saunders (2001) found those clients with a tendency toward being overly detached and experiencing their therapists as not understanding them (i.e. lower empathic resonance) also displayed a poorer quality of ‘bond’. Similarly, Hardy, Cahill, Shapiro, Barkham, Rees and Macaskill (2001) found that clients’ interpersonal style, particularly an under-involved style (although mediated by the alliance), was predictive of treatment outcome. These findings add further weight to the suggestion that interpersonal problems or relationship patterns appear to hamper the development of an effective alliance (e.g. Kokotovic & Tracy, 1990; Klee, Abeles, & Muller, 1990).

The belief that the alliance is an independent component of the therapeutic relationship needs reconsidering. Fenton, Cecero, Nich, Frankforter, Carroll (2001) suggested that there appears to be ‘halo’ and ‘transference and counter-transference’ effects impacting on the more subjective outcome measures rated by people actively involved in the treatment. This suggests that ratings of working alliance might not be free of the influence of transference effects. Consequently alliance ratings might be inflated or deflated in relation to the positive or negative nature of the transference.
The counterargument was proposed by Frieswyk, Allen, Colson, Coyne, Gabbard, Horwitz, and Newson (1986). They argued that the alliance should be solely defined as the client’s collaboration in the tasks of psychotherapy. This definition distinguishes the alliance from various aspects of the client’s experience of the relationship (especially transference) and issues of technique. However somewhat ironically Frieswyk, et al (1986) reported that they found: a) the exploration of the negative transference with highly motivated patients fostered the alliance; b) the expression of negative transference in supportive processes with less well-motivated patients undermined the alliance; c) the maintenance of a consistently positive attitude in supportive work with poorly motivated patients facilitated the alliance and outcome; and d) the failure to express and explore the negative transference with highly motivated patients who maintained a consistently positive attitude also undermined the alliance and yielded poor treatment results.

Norcross (2002) suggested that much of the research on the effectiveness of psychotherapy processes and relationships needs to be qualified by considering closely the context within which intervention response behaviours are observed. That is, treatment setting aside, individual therapists may interact differently with different clients making it difficult to effectively examine specific relational ingredients of the psychotherapy process and their relationship with outcome. Consequently, it may be even more difficult to examine specific relational ingredients within a group therapy context considering the multitude differing levels of interactions present. Fuhriman and Burlingame (2000) suggested that among the agents of change in small groups, the member-to-member interactions are one of the most significant, particularly when the immediacy of the interactions is highlighted. However, Burlingame, Fuhriman and
Johnson (2002) qualify this suggestion by highlighting research that found that member-to-member interactions can be influenced by group leader modelling (Barlow, Hansen, Fuhriman, & Finley, 1982; Billow, 2003) which consequently increases the accuracy of member perceptions (Fromme, Dickey, & Schaefer, 1983).

The transference relationship

The ‘transference relationship’ is often referred to in terms of the perceived configuration of its unconscious relationship dynamics. Book (1998, p. 5) describes transference as the way ‘by which patients unconsciously respond and react to the therapist in the present in the manner in which they responded to a significant care giving figure from the past’. Or more specifically, ‘the client’s/patient’s actions, attitudes, and feelings toward, or perceptions of, the therapist that are distortions based on relations with significant others in the past’ (Gelso, Hill, Mohr, Rochlen, & Zack, 1999, p. 259). Grenyer (2002, p. 9) describes transference more broadly as ‘the regular characteristic personality style of the patient’ that represents the ‘overall patterns of relationships that patients have with all people in their life’. However, Grenyer (2002) also describes a more specific definition which purports that the therapist is the ‘object’ of transference while ‘subject’ consists of the early images and other childhood relationships.

A positive transference is when the client views the therapist in positive terms or develops positive attachments (e.g. the therapist might be related to as if s/he were a nurturing parent or partner). A negative transference is when the client views the therapist as a source of unpleasant emotions, which represent unresolved issues from the past (e.g. the therapist might be perceived as rejecting or critical in a similar fashion as a parent was).
Gelso, Kivlighan, Wine, Jones, and Friedman (1997) found that the interaction of transference and ‘emotional insight’ predicted to psychotherapy outcome. They found that in the more successful cases an increase in transference was noted in the earlier stages of treatment before declining in the later stages. Whereas they found that in less successful cases transference continued to increase over the course of treatment. Gelso, et al (1999, p. 264) further explored the relationship between transference and the more conscious activities of the therapeutic relationship (see the working or therapeutic alliance above) and found that ‘a sound working alliance and real relationship were necessary conditions for transference resolution’. This suggests that the client is more likely to be prepared to persist with working through difficult transference issues if she or he experiences the therapist as genuine, committed and in agreement with his or her therapy goals. This also suggests that the perceived safety of the therapeutic relationship might offset and help resolve the perceived conflict evoked by transference material activation. The activation of transference material has been associated with perceptions of conflict and ‘ruptures’ or fluctuations in the working alliance (Safran, 1993; Safran & Muran, 2000, 1996; Safran, Crocker, McMain, & Murray, 1990; Saunders, 2000; Gelso & Hayes, 1998)

The likelihood of successful working through of transference material is increased if therapists manage their own contribution to the transference configuration (Gelso & Hayes, 2002; Hayes, Riker & Ingram, 1997; Hillard, Henry, & Strupp, 2000). ‘Countertransference’ refers to the therapist’s transference to the client’s material, as well as aspects of the therapist’s own relational history that may intrude upon the present relationship. Book (1998, p. 13) stated that countertransference ‘refers to unconscious
attitudes and feelings toward the patient that interfere with the therapist’s understanding and responding to the patient’s clinical needs.’ Countertransference may stem from areas of unresolved conflict in the therapist related to previous relationship experiences and/or a reaction to the present client’s material or relationship style.

Rosenberger and Hayes (2002) suggested that when client material touches upon therapist’s unresolved issues, it may affect the therapist’s avoidance behaviour as well as the working alliance, session impact, and the therapist’s perceptions of his or her own social influence attributes. They also found that countertransference management plays a modest role in fostering the alliance, which in turn suggests that strong working alliances may be able to tolerate low levels of countertransference behaviour.

However, to presume that all positive or negative reactions within the therapeutic relationship were transference based might be overlooking present centred interpersonal contact between the two persons interacting in the therapy session (see ‘real relationship’ section above). This might be seen as a type of objectification of ‘self’ and ‘other’, a detachment from the genuine contact between person and person in the present (Hycner, 1993; Clarkson, 1989/1997; Freidman, 1991; Buber, & Friedman, 1965; Buber, 1957).

Gelso and Hayes (2002) reviewed the literature on countertransference and outlined three definitive views: the therapist’s unconscious relationship material (classical), all of the therapist’s emotional reactions to the client (totalistic), and the therapist’s complementarity to the client’s transference and relationship style (complementary). They also described an ‘integrative’ view of countertransference as being inclusive of all three but highlighted the challenges of such an inclusive view for researchers in terms of identifying the origin and course of the countertransference
dynamic. Despite the challenges of ambiguity, they stressed the importance of studying countertransference ‘as both a hindrance and a potential aid to treatment’ (p. 270).

Hayes, Gelso, Van Wagoner, and Diemer, (1991) suggested that five factors are required for the successful management of countertransference. First, ‘self-integration’ refers to the therapists’ recognition of boundaries between themselves and clients. Second, ‘self-insight’ refers to the therapists’ awareness of their own feelings and their understanding of the motivational forces behind those feelings. Third, ‘anxiety management’ refers to the extent to which therapists are able to effectively control or manage their own anxiety. Fourth, ‘conceptualising skills’ refers to the therapists’ ability to conceptualise both the client’s dynamics and the therapeutic relationship. Fifth, ‘empathy’ consists of both the ability to be attuned to the client’s emotions and an intellectual understanding of the client’s experience. Of these five factors, Hayes et al (1991) found that ‘self insight’ and ‘anxiety management’ were most important in the management of countertransference. However, Gelso, Latts, Gomez and Fassinger (2002) found that conceptualising skills and self-integration along with anxiety management predicted outcome better than the other countertransference management components. Supervision that focuses on the interpersonal relationship has also been identified as helpful in relation to identifying and managing countertransference reactions (Gelso, Latts, Gomez & Fassinger, 2002; Hayes & Gelso, 2001; Robbins & Jolkovski, 1987).

*The dynamics of repetitive relationship patterns*

The above studies in some ways represent the signalling of the return of the examination of working alliance within the context of repetitive relationship phenomena. This often ‘transference related’ phenomena as mentioned above may elicit a response
from the therapist that may in itself be classed as part of the transference configuration or
dynamic – countertransference. Klee, Abeles, and Muller (1990) suggested that difficult
client relational styles are more likely to elicit negative responses from the therapist thus
affecting the capacity for both to develop working relationships. Similarly the therapists’
relationship style and management of his/her own unconscious processes can elicit
positive or negative responses from the client (Hayes, Riker & Ingram, 1997).

Therapy expectancies also seem to impact on the course of therapy and may be
related to previous relationship experiences. Meyer, Pilkonis, Krupnick, Egan, Simmens,
and Sotsky (2002) found that the link between treatment expectancies and outcome is
mediated by the client’s contribution to the alliance. This suggests that clients who expect
treatment to be effective tend to engage more constructively in therapy and benefit from
greater symptom reduction. Therefore, what the client expects to experience in therapy,
and how they have adapted interpersonally to cope with their expectations, matched with
how the therapist responds to the client, seems to influence the development of a working
alliance. Furthermore, Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins, and Pilonis
(1996) found that the client’s rather than the therapist’s contribution to the alliance was
the significant factor in improved outcomes. Once again this implies that a client’s
readiness to engage in the therapy process is more related to what she or he brings to the
relationship than what the therapist might provide.

What is interesting is that these findings suggest that the alliance should be
identified as a co-created relationship phenomenon which requires an interpersonal,
interactive focus that considers all three relationship dimensions as variables.
Consequently, simply considering the agreement on the goals and tasks of therapy, with
vague reference to relational bonds, as adequately capturing the important ingredients of the therapy process seems overly simplistic.

**Core Conflictual Relationship Themes (CCRT)**

The transference relationship might be described as the central relationship patterns, scripts, or schemas that each person follows in conducting relationships (Luborsky & Crits-Christoph, 1998). Although other approaches have been used to examine different aspects of the transference configuration (e.g. Configurational Analysis (Horowitz, 1979, 1994); Frame Method (Teller & Dahl, 1981); Cyclical Maladaptive Pattern (Schacht, Binder, & Strupp, 1984; Levenson, 1995); Plan Formulation Method (Weiss, Sampson et al., 1986); Idiographic Conflict Formulation Method (Perry, Augusto & Cooper, 1989), the Core Conflictual Relationship Themes (CCRT) method (Luborsky & Crits-Christoph, 1998) is generally considered the benchmark from which others are compared (Luborsky, Popp, & Barber, 1994; Miller, Luborsky, Barber, & Docherty, 1993).

In a simple way the transference relationship might be seen as generalized expectations about self-other interactions or interpersonal schemata that are based on past experiences. When a therapist acts in a fashion that could be perceived as consistent with the client’s unhelpful interpersonal schema, this cognitive-interpersonal cycle is perpetuated. If the therapist is able to refrain from participating in the client’s cognitive-interpersonal cycle (i.e. don’t compliment or reinforce it), the client encounters an important experiential challenge to his/her unhelpful relational pattern. Weiss, et al (1986) suggested that clients unconsciously submit their therapists to transference tests in
an attempt to disconfirm their pathogenic beliefs. In other words, enactments of the transference pattern, or even perhaps simply the telling of stories of these repetitive patterns, might be seen as an attempt by the client to gain mastery over them (Grenyer, 2002).

Book (1998) explained the choice of terms that form the CCRT title. Firstly, the CCRT is dealing with ‘Core’ or what might be seen as the most significant repetitive relationship difficulties, the center of the person’s symptoms and interpersonal struggles. It is this centrality which makes these themes most likely to be repeated during therapy and thus indicative of the transference configuration. It is experienced as a ‘Confictual Relationship’ in that the person does not experience his or her wishes as being met by the ‘other’. ‘At other times, the term conflictual also reflects the tension between what the patient consciously wishes for in relationships with others and what he or she unconsciously seeks in those relationships’ (Book, 1998 p.17). The term ‘Theme’ suggests that the person is dealing with a ‘recurrent motif’ which although may have historical relationship origins is present in current relationships.

Research has shown that working directly on gaining insight into the transference relationship, mostly through the therapist’s use of transference interpretation and effective management of their own countertransference, is associated with clinical outcome (e.g. Crits-Christoph, Cooper, & Luborsky, 1988; Hayes, Riker & Ingram, 1997). However, the timing of transference interpretations is important. Interpretations that enter the therapeutic relationship before an adequate therapeutic alliance has been nurtured increase the risk for an alliance rupture. Therefore, at times it seems more
important to understand the function of the relational pattern than to expose it and attempt to change it directly (Book, 1998, Luborsky, 1984).

Luborsky and Crits-Christoph (1998) describe the CCRT method (Luborsky, 1977) as a ‘measure of personality’. However, the CCRT method is more widely recognized as a reliable way of exploring a client’s transference patterns and how these may be enacted in therapy (Luborsky & Barber, 1994; Luborsky & Crits-Christoph, 1998). A client’s CCRT patterns represent recognizable, unhelpful, repetitive interpersonal relationship patterns. Effectively, enactments of CCRT patterns reinforce old relationship dynamics that leave the individual with the perception of her or his wishes (often unconscious) being hampered or invalidated by others. Enactments of CCRT patterns that are not handled effectively may result in premature treatment termination and poor treatment outcome (Frieswyk, et al, 1986; Foreman & Marmar, 1985). Enactments of CCRT patterns may impede the establishment and maintenance of an adequate working alliance between the client and the worker. Research evidence suggests that better outcomes are associated with working alliances that have been strengthened by effective management of CCRT enactments (e.g. Crits-Christoph, Cooper, & Luborsky, 1988; Frieswyk, et al, 1986; Foreman & Marmar, 1985). Therefore, identifying and tracking CCRT patterns, as well as attempting to provide corrective relationship experiences that challenge these established patterns, may help retain clients in treatment long enough to improve treatment outcome.

The CCRT method attempts to analyze therapy transcripts to derive repetitive themes from content describing relationship episodes (Luborsky & Crits-Christoph, 1998; Book, 1998; Grenyer, 2002). In particular these narratives are assessed in terms of the
presence of the three components or elements that comprise the CCRT pattern formulation. The three elements are: (1) the major wishes, needs, intent or strivings of the client in the context of a relationship (W); (2) responses from others (actual or anticipated) to the client and his or her behaviour in the context of the wish (RO); and (3) responses of the self in reaction to the actions or expected actions of others (i.e. what the person actually does and feels in the context of the RO) (RS) (Luborsky & Crits-Christoph, 1998; Book, 1998; Grenyer, 2002). Research suggests that the element configurations of CCRT patterns represent the major attributes of transference phenomena, or the transference template (Luborsky, Barber, & Crits-Christoph, 1990; Luborsky & Crits-Christoph, 1998). Grenyer (2002, p. 44) states that ‘the CCRT captures the conflict between the instinctual needs (expressed as wishes) and the meeting of these wishes (in the response from others and the self)...The CCRT shows a unique and pervasive pattern for each patient, supporting the notion of a template that “repeats,” deriving specifically from each patient’s unique upbringing and inheritance’.

Luborsky and Crits-Christoph (1998, p. 12) outlined the criteria for measures to be considered appropriate for the study of central relationship patterns.

‘...the inclusion criteria for this class of measures:

1. The measure must be based on extraction of a pattern from a sample of self-other narratives about relationship interactions. Each one is part of either (a) a narrative about such interactions or (b) a direct observation of an enactment within transcripts of audio or video recordings.

2. The pattern extracted should be of a central relationship pattern, with central defined as the most pervasive across the self-other interactions.
3. The process of extraction of the pattern must be based in part on clinical-quantitative judgment, not only on responses to a questionnaire filled out by the patient or on unguided clinical judgment.

4. The measure must be at least partly capable of reliable application.’

In line with these criteria, Luborsky and Crits-Christoph (1998) stated that CCRT patterns are extracted from narratives specifically dealing with ‘relationship episodes’ (RE). They define a RE as “a part of a session that is a relatively discrete episode of explicit narration about relationships with others or with the self” (p. 19). They proceed to suggest that ten relationship episodes is the desirable lower limit from which a CCRT can be derived. The CCRT then is the most frequent W, RO and RS configuration evident across these ten RE.

Book (1998, p. 21) states that the CCRT is neither arbitrarily selected by the therapist nor necessarily overtly corresponds with the problem area identified on presentation by the client. Rather “generating the CCRT is an atheoretical, easily operationalized activity…(which) requires no psychodynamic knowledge”. Book (1998) suggests that generating a CCRT focus is a ‘simply deductive task’ aimed at deriving the person’s dynamic structure by exploring his or her developmental relationship history.

What is interesting about studying CCRT in a group therapy setting is the presence of a broader relational field, when compared with individual therapy. The interactions between an individual group member and a range of ‘others’ can be observed directly within this broader relational field. There are potentially a number of advantages of having a range of ‘others’ in the group setting when compared with individual therapy.
First, the pervasiveness of CCRT patterns with different people can be directly observed. Second, identification with other group members based on similar experiences (a potential source of social identity) could help clarify the structure of the CCRT (e.g. identifying with the W, RO and/or RS described by other group members’ descriptions of relationship episodes). Third, it may be possible to identify a common CCRT reflected by people with similar problems or disorders (e.g. a depressive CCRT). Fourth, different aspects or nuances of the individual’s transference configuration might be triggered by the presence of a broader range of personalities and relationship styles. Fifth, a greater variety of interactions within a group might increase the likelihood of enactments that either reinforce or disconfirm the relationship dynamics and expectancies predicted by the CCRT.

**Mastery of relationship conflicts**

‘Mastery’ refers to the client’s sense of movement from being overwhelmed by symptoms and life experiences to being able to manage them better. Mastery has been found to be associated with treatment outcome (Grenyer, 2002). Grenyer (2002) suggested that there are a number of key indicators demonstrating an individual’s level of mastery across three phases (see table 1 below). Phase one (low level mastery) is characterised by the individual experiencing a dominance of symptoms and defences. The client is likely to exhibit poor impulse control and the introjection and projection of negative affects. Phase two (medium level mastery) is characterised by a struggle to understand and control responses within an interpersonal context. Phase three (high level mastery) is characterised by the client exhibiting self-understanding and self-control.
Table 1. Mastery Phases and Associated Mastery Categories

<table>
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<tr>
<th>Phase of Mastery</th>
<th>Mastery Scale Categories</th>
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| **Level 1. Lack of impulse control** | 1A Expressions of being emotionally overwhelmed  
1B References of immediacy of impulses  
1C References to blocking defences  
1D References to ego boundary disorders |
| **Level 2. Introjection & projection of negative affects** | 2E Expressions of suffering from internal negative states  
2F Expressions indicative of negative projection onto others  
2G Expressions indicative of negative projection from others  
2H References to interpersonal withdrawal  
2I Expressions of helplessness |
| **Level 3. Difficulties in understanding & control** | 3J Expressions of cognitive confusion  
3K Expressions of cognitive ambivalence  
3L References to positive struggle with difficulties |
| **Level 4. Interpersonal awareness** | 4M References to questioning the reactions of others  
4N References to considering the other’s point of view  
4O References to questioning the reaction of the self  
4P Expressions of interpersonal self-assertion |
| **Level 5. Self-Understanding** | 5Q Expressions of insight into repeating personality patterns of self  
5R Making dynamic links between past & present relationships  
5S References to interpersonal union  
5T Expressions of insight into interpersonal relations |
| **Level 6. Self-control** | 6U Expressions of emotional self-control over conflicts  
6V Expressions of new changes in emotional responding  
6W References to self-analysis |

It has been suggested that if therapist interventions match the needs of the client at the varying levels of mastery (e.g. predominantly supportive techniques for those clients exhibiting low levels of mastery) then increased mastery can be facilitated (Grenyer, 2002; Book, 1998). Of course mastery facilitation is not simply a matter of giving clients what they appear to need, it is about unravelling habitually relationship responses and helping them practice more constructive or mastery laden responses. In some respects this requires the therapist not only to remain vigilant to the attempts (usually unconscious) by the client to lure them into repeating the conflictual relationship
dynamics predicted by the client’s repetitive relationship patterns, but also to model self-control and self and interpersonal awareness. That is, the therapist needs to model mastery at a level that the client could be encouraged to match without this being beyond his or her current resources.
**Group psychotherapy**

*Individual therapy and multi-dimension relationship matrices in group therapy*

Much psychotherapy occurs in group therapy formats (Fuhriman & Burlingame, 1990). A meta-analysis found equivocal outcomes between individual psychotherapy and group psychotherapy (McRoberts, Burlingame, & Hoag, 1998). More recently, Burlingame et al (2004) conducted a comprehensive review of empirical studies published between 1990 and 2001 involving clinical populations with random assignment or with control groups and found that individual therapy and group therapy outcomes were equivocal. However, the question of whether the relationship factors studied in individual therapy can be generalised to group therapy situations has not been answered convincingly. This has been mostly because the complexity of the relationship factors present in group therapy has made it difficult to isolate specific factors like alliance and transference. Burlingame, MacKenzie & Strauss (2004, p. 648) suggested that the “unidirectional transfer of formal change theories from the individual to group format explains why some have felt that group treatments have a ‘borrowed identity’”.

Fuhriman and Burlingame (1990) suggested that the group environment represents a social microcosm, in which external relationship dynamics intermingle with present interpersonal relationships, thus offering an opportunity to work through transference material. Burlingame, Fuhriman and Johnson (2002, p. 71) stated that ‘the group therapeutic relationship requires a systemic definition, one that captures a multiplicity of relationships and assorted contributing factors that all come together to form a dynamic and complex influence.’ Attempts to capture such a definition have
tended to focus on the construct of ‘group cohesion’. Unfortunately, this focus may have inadvertently compressed the complexity of group therapy into a single group therapeutic factor, which would do better to consider in relation to broader group therapy variables such as the group climate (Kivlighan & Lilly, 1997; Ogrodniczuk & Piper, 2003).

The long-standing study of ‘cohesion’ in groups as both a therapeutic factor and an outcome predictor variable has occurred within the context of a diverse array of theoretical models, conceptual definitions and operational measures (Evans, & Javis, 1980; Bednar & Kaul, 1994). This conceptual diversity has resulted in cohesion being described variously as: a multidimensional phenomenon; a type of working alliance; a type of attraction, belonging or affiliation with a particular group (Roark, & Sharah, 1989; Piper, Marrache, Lacroix, Richardson, & Jones, 1983); and a function of social identity (Hogg, 1992; Hogg, & Tindale, 2001), to name a few. Furthermore, this conceptual diversity has been matched by a diversity of methods for measuring cohesion (Mudrack, 1989). Further still, considering group cohesion as analogous to the working alliance in individual therapy (Yalom, 1995), particularly in relation to outcome prediction, may be too presumptuous, as the relationship between the therapist and individual group members is potentially influenced by the presence of other group members, as well as other variables specific to the group therapy context (Holmes & Kivlighan, 2000; Heron, 1993; MacKenzie, & Tschuschke, 1993). Burlingame, et al’s (2004, p. 671) review of group therapy outcome studies reported that “Group Cohesiveness and the individual member’s sense of Relatedness to the group predicts outcome. Working Alliance does not predict outcome. Moving through standard
theorized stages of group development is correlated with better treatment outcome for the group members.”

There have been attempts to define ‘group alliance’ as distinct from ‘group cohesion’ (Marziali, Munroe-Blum and McCleary, 1997). At present there is no generally accepted definition of group alliance. While some researchers have considered group alliance as analogous with the working alliance in individual therapy, thus focusing on the individual group member with therapist relationship, others considered it to capture the strength of the relationship between group members, particularly in relation to working together and commitment to meeting the goals of therapy (Budman, Soldz, Demby, Feldstein, Springer and Davis, 1989; Marziali, Munroe-Blum, & McCleary, 1999).

There remains a lack of clarity or consensus regarding the definition and function of group cohesion (e.g. Drescher, Burlingame, & Fuhriman, 1985; Roak & Sharah, 1989; Mudrack, 1989; Langfred, 1998; Hogg, 1992). Some see cohesion as a group-as-a-whole phenomenon, whilst others emphasise the relationship between the group leaders and individual group members. The ‘group-as-a-whole’ view emphasises how attracted, similar, affiliated, cooperative, and so on, the group members are with each other, or as a unified entity. In contrast, the ‘group leader-group member’ view incorporates the group-as-a-whole view but see this as something that can be influenced or facilitated by the behaviours or characteristics of the group leader, or perhaps the strength of the relationship (or working alliance) between individual group members and the group leader. Links between the therapeutic alliance, group-as-a-whole and group leader-group member perspectives are frequently unclear (Bednar & Kaul, 1994).
Marziali et al. (1997) contrasted the concepts of group cohesion (group-as-a-whole) and group alliance (therapist-client bonds) and reported data that suggested that group alliance was a better predictor of outcome, whilst cohesion attested to the therapist’s ability to build the group-as-a-whole. Marziali, et al (1997) found that although group alliance and group cohesion were significantly correlated, with each separately contributing to outcome, alliance accounted for more outcome variance than cohesion. Budman, et al (1989) found less evidence for a clear distinction between group alliance and group cohesion, however raters were instructed to ignore the contributions of the relationship with the therapist in rating group alliance. More recently, Van Andel, Erdman, Karsdorp, Appels, and Trijsburg (2003), studied the relationship between working alliance and group cohesion and concluded that these two types of relationship phenomena are related but distinct, with each contributing in different ways to treatment outcome. Furthermore, Gillaspy, Wright, Campbell, Stokes and Adinoff (2002) found that neither alliance nor cohesion were satisfactory predictors of outcome for adult males attending a 21 day intensive residential substance abuse treatment programme, with alliance alone predicting client ratings of reduced psychological distress, but not other outcome measures.

In an attempt to study alliance from a systems perspective, Pinsof (1986, 1994) advocated an alliance model that involved two dimensions. The first dimension, ‘content’, incorporated Bordin’s (1979, 1994) components of alliance – ‘goal agreement’, ‘task agreement’, and ‘relational bonds’ between client and therapist. The second dimension ‘interpersonal system’, considered ‘goals’, ‘tasks’ and ‘bond’ in terms of the ‘self-therapist’ relationship, the ‘other group members-therapist’ relationship, and the
‘group-as-a-whole with therapist’ relationship. Pinsof (1986, 1994) along with others that advocate for a variety of multi-dimensional approaches to studying group cohesion, recognised and attempted to account for the complexity of interpersonal factors operating within the group therapy system (Drescher et al, 1985; Fuhriman, Drescher, & Burlingame, 1984; Burlingame, Fuhriman, & Drescher, 1984; Carron & Brawley, 2000; Braaten, 1991; Dion, 2000; Cota, Evans, Dion, Kilik, & Longman, 1995). However, there are few studies exploring predictors of group therapy outcome on the basis of such relational process factors such as alliance and cohesion.

In line with general alliance findings, it is a general expectation for greater therapeutic gains in group therapy to be associated with higher levels of group cohesion (e.g. Budman et al., 1989; Marziali, et al., 1997). Burlingame et al (2004, p. 649) reported that “members who experience a greater sense of acceptance, belonging, and support from their group, regardless of formal change theory, typically report more post-treatment improvement.” However, simple alliance or cohesion associations with outcome can be misleading. For example, Kellerman (1981) suggested that in some circumstances a high level of cohesion could actually impede progress towards the expected outcomes resulting in ‘fixed’ states of ‘confluence’ or ‘groupthink’ (Janis, 1982; Langfred, 1998). Similarly, Kivlighan & Lilly (1997) suggested that cohesion can foster avoidance or resistance in group members to deal with personal or interpersonal problems. However, Bernthal and Insko (1993) reported that in work groups at least providing a task-oriented focus which balances social-emotional cohesion needs can protect the group from slipping into groupthink. Regardless of this, the measurement of cohesion as a group-as-a-whole phenomenon should be qualified by measures within the
broader contextual field of other relational and other intrinsic and extrinsic factors (e.g. difficult interpersonal relationship style, involuntary group membership, treatment setting, etc.) (MacNair-Semands, 2000).

Gillaspy et al (2002) suggested that their finding that group cohesion did not predict outcome within a residential substance abuse treatment setting, may have been the result of a variety other interpersonal and treatment component factors hampering the development or impact of group cohesion. Furthermore, Dies (1985, p. 429) suggested that: ‘Even highly cohesive groups may contain certain members, such as the group scapegoat, who have a tenuous attraction to the group. The therapeutic outcome for these members may relate more to their idiosyncratic perspective than to the overall level of group cohesion expressed by the members.’ Further still, Kivlighan, Marsh-Angelone and Angelone (1994) suggested that not only does a group member’s interpersonal style and problems influence how s/he perceives and experiences the events occurring in group therapy, but that associated projections onto the group leader in particular, impact upon the degree of affiliation experienced.

In an attempt to progress a standard group-as-a-whole cohesion definition of ‘attraction-to-the-group’, Budman et al. (1989, p. 341) describe cohesion as: ‘the connectedness of the group, demonstrated by working together towards a common therapeutic goal, constructive engagement around common themes, and an open, trusting attitude which allows members to share personal material’. Budman et al. (1989), diverged from Marziali et al’s (1997) portrayal of group alliance, by modifying the Penn Helping Alliance Rating Method (Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982) to measure ‘group therapy alliance’, which they defined as ‘the degree to
which the members are able to work together constructively to further therapeutic work’ (p. 343). The divergence was that raters using this scale were instructed to ignore the contributions and relationship with the therapist when making alliance ratings.

Some authors see group cohesion as a multi-dimensional phenomenon defined by dimensions of person, variable function, measurement strategy, and time (Drescher et al, 1985; Fuhriman, Drescher, & Burlingame, 1984; Burlingame, Fuhriman, & Drescher, 1984; Carron & Brawley, 2000; Braaten, 1991). Similarly, Piper, Marrache, Lacroix, Richardson and Jones (1983) suggested that the study of group cohesion requires consideration of a group member’s perception of (a) other group members, (b) the group leaders, and (c) the group-as-a-whole. Unfortunately, simply suggesting that cohesion is best considered from differing perspectives falls short in terms of describing distinct underlying dimensions of cohesion.

Dion (2000) and Cota, Evans, Dion, Kilik, and Longman (1995) proposed a ‘new heuristic for cohesion’, comprising a multi-dimensional theory for group cohesion that offers insight into the nature of the underlying dimensions. Dion (2000) suggested that the study of cohesion requires identifying primary dimensions of cohesion that are evident in most group situations, with secondary dimensions defined by their association with specific types of groups. He suggested the primary dimensions should include ‘social cohesion’, ‘belongingness’, ‘task cohesion’, and ‘vertical cohesion’.

‘Social cohesion’ reflects the interpersonal relationships between group members and has been linked with issues of personal and social identity (or collective identity), and self-categorisation theory (Hogg, 1992; Hogg & Tindale, 2001). It emphasises a link between issues of ‘bond’ and perceptions of ‘self’ in relation to other group members and
leaders, and to some extent being a part of, or ‘belonging’ to, the group-as-a-whole. It may also reflect the existential negotiation involved with balancing the need for an individual self-identity and the need to affiliate with a group. The notion of ‘Task cohesion’ is suggested to reflect the alignment of the group around the clarification and performance of the specific tasks or functions for which the group was formed. ‘Vertical cohesion’ is purported to reflect how group members perceive and relate to the group leader in terms of leadership competence and responsibility (Dion, 2000).

It has been suggested that the difficulty in obtaining consistent results when examining the relationship between process variables (particularly common therapeutic factors) and outcome in group psychotherapy might be explained by inadequately accounting for other group developmental process variables (Kivilghan & Lilly, 1997; MacNair-Semands, 2000; Llewelyn & Haslett, 1986). For example, it has been purported that the ability of therapeutic alliance or group cohesion measures to predict outcome might be mediated by group members’ perception of conflict or avoidance within the group (Kivlighan & Tarrant, 2001). Furthermore, Kivlighan and Tarrant (2001) reported evidence that the group climate was affected in different ways by the group leader’s intentions and behaviours. Specifically, group members tended to be more actively involved in the group the less the group leaders engaged in doing individual therapy within the group, offered a clearer structure in terms of treatment goals and norms, and maintained a warm and supportive environment. These authors also suggested ‘that an increasingly active and engaged group climate uniquely predicted member-rated benefit, whereas a climate decreasing in conflict and distance uniquely predicted members’ feelings about the leader’ (p. 231).
Holmes and Kivlighan (2000) analysed processes within group and individual psychotherapy and found that components of the ‘relationship-climate’ and ‘other versus self-focus’ were more salient in group psychotherapy when compared with individual psychotherapy. However, ‘emotional awareness-insight’ and ‘problem definition-change’ were more important to the process in individual than in group psychotherapy. Emotional awareness-insight involved strong affective experiences linked with gaining new awareness or insight. ‘Relationship-climate’ involved the formation and maintenance of therapeutic relationships with the therapist or with group members. Other versus self-focus reflected the client’s external focus (e.g. altruism), while maintaining a focus and disclosure regarding self. ‘Problem definition-change’ refers to the problem solving aspect of treatment. Burlingame et al (2004) reviewed the literature regarding interpretive group models (that focus on early relationships and unconscious processes) and supportive group models (that focus of common therapeutic factors such as universality and altruism) and reported that outcomes were equivocal for both groups, although there were more dropouts in the interpretive groups (Piper et al, 2001). These findings highlight the need to consider the impact of treatment modality when examining common therapeutic factors.

**Group cohesion, group climate and group developmental processes**

Burlingame, Fuhriman and Johnson (2002) reviewed the group cohesion literature finding evidence that a positive linear relationship exists between group cohesiveness and outcome. They also reported evidence that the ‘group-as-a-whole’ rather than individual group members or the group leaders influenced the development and maintenance of group cohesion (Fuhriman & Burlingame, 1994). Furthermore, they highlighted
MacKenzie and Tschuschke’s (1993) finding that clients who reported higher levels of relatedness (for example, feeling understood, protected, and comfortable with their group) also reported the most symptomatic improvement in longer-term group therapy. However, Burlingame, Fuhriman and Johnson (2002) caution that the group cohesion literature rarely reports data from which causal relationships can be defined.

Bernard and MacKenzie (1994) suggested that groups appear to follow a progressive developmental process which typically includes a phase consisting of significant interpersonal conflict. Therefore he suggests that a certain level of early group cohesion may be required to sustain group members as they negotiate this ‘conflict based’ stage of the group development. Kivlighan and Lilly (1997) tested MacKenzie’s theory and found that groups required an initial period of development free of conflict in order to establish cohesion, and that more conflict was necessary later in treatment, which subsequently needed to be resolved if positive treatment benefits were to be achieved. This is similar to earlier comments in this thesis about the necessity of an adequate working alliance between the therapist and the client to sustain the client (and perhaps indeed the therapist) through periods of conflict related to the activation and working through of transference material (e.g. Frieswyk, et al, 1986). In other words, it appears that both individual therapy and group therapy processes predict periods of conflict which require supportive relationships to negotiate resolutions.

Bunch, Lund and Wiggins (1983) reported data that suggested a negative linear relationship between perceived interpersonal distance between individual group members and the amount of personal detail present in self disclosure. However the direction of this relationship and whether this relationship extends equally to ‘here-and-now’ or ‘there-
and-then’ disclosures is unclear (Slavin, 1993, 1995). If the perception of ‘interpersonal distance’ and self-disclosure are representative of group cohesion then it stands to reason that methodologies that attempt to capture these factors are worth developing. The study of self-disclosure also provides the opportunity for hermeneutic and clinical-quantitative analyses of the relationship narratives within which the self-disclosures occur (e.g. see CCRT method described above).

Lorentzen, Sexton, and Hoglend (2004) explored the relationship between alliance, cohesion and outcome in long-term group psychotherapy. They found that alliance steadily increased over a two year period which seemed to differ from short-term therapy where alliance was established more quickly and remained relatively stable. They also found that although therapists’ early alliance ratings predicted improvements in symptomatology they did not predict interpersonal change. Furthermore, their finding that neither client ratings of early alliance nor group cohesion predicted change highlights the difficulty in predicting outcome in group psychotherapy. It also suggests that therapeutic relationships that predict outcome tend to take longer to form under group therapy conditions and may be moderated by other relationship variables.

Interpersonal events and group members’ perceptions of the group interpersonal environment may impact on the person’s readiness to engage in, and thus benefit from, treatment activities. Group Climate is described as the group’s psychological and interpersonal atmosphere in terms of resistance, cohesion and friction (McCallum, Piper, Ogrodniczuk, and Joyce, 2002). It reflects the degree to which members are actively involved in the group therapy process (MacKenzie & Tschuschke, 1993). MacKenzie (1983) posited that group climate consists of three components: ‘engaged’ - reflecting
alliance and cohesion, ‘avoiding’ – reflecting the resistance of group members to take responsibility for changing, and ‘conflict’ – reflecting interpersonal tension and mistrust.

Ogrodniczuk and Piper (2003, p. 68) described ‘engagement’ as a ‘multifaceted dimension that reflects a cohesive environment and willingness of members to participate in the group. It involves a sense of closeness, attempts to understand the meaning of behavior, the importance of the group for the members, a willingness to challenge one another, and self-disclosure’. Therefore, because engagement reflects similar constructs to therapeutic alliance and group cohesion it might be expected that group members ratings of engagement should predict treatment outcome in a similar fashion (MacKenzie, personal communication, 2002). Ogrodniczuk and Piper go on to describe ‘avoidance’ as ‘avoiding problems within the group, depending on the therapist for direction, and adhering to group expectations.’ MacKenzie (1983) suggested that the ‘avoiding’ scale captures the reluctance of group members to face and deal with personal or interpersonal problems. Ogrodniczuk and Piper (2003, p. 68) describe ‘conflict’ as involving perceived ‘anger within the group, distance between the members, distrust, and tension among the members. A high score indicates an atmosphere where patients confront one another in an aggressive manner, distrust each other, and withdraw from each other.’

Few studies have examined the relationship of group climate with treatment outcome (Kivlighan & Lilly, 1997; Braaten, 1989; McCallum, Piper, Ogrodniczuk, and Joyce, 2002). Treatment retention has been shown to be related to the level of engagement in the group process (Connelly, Piper, Decarufel, & Debbane, 1986). MacKenzie (1983) suggested that the group leader can influence the group climate and thus have an indirect effect on client outcome. Kivlighan and Tarrant (2001) found that
the group climate mediated the relationship between group leader activity and group member outcome.

Stockton, Rohde, and Haughey (1992) found a significant interaction effect between group leaders structuring group exercises and time for the variables of cohesion, engagement and avoidance. Although there was no interaction effect for conflict, the main effect for structured group exercises was significant only for conflict. The researchers interpreted their findings as suggesting that group members’ perceptions of conflict in the group are immediately impacted by structured exercises aimed at enhancing engagement but take some time to impact on group members’ perceptions of engagement and avoiding behaviours.

It has been suggested that fluctuations in the different components of group climate should correspond with different stages in progressive models of group development (Brossart, Patton, & Wood, 1998; Kivlghan & Lilly, 1997; MacKenzie, 1983; Stockton, Rohde, & Haughey, 1992). MacKenzie and Livesley (1983) proposed a model of group development that negotiated stages of engagement, differentiation and individuation, intimacy, and mutuality, with termination ending the process. In the initial ‘engagement’ stage group members focus on developing a group identity, the level of engagement is expected to increase, while conflict remains relatively low. The ‘differentiation’ stage is where group members recognise differences and may be confronted with difficult emotions. It is typified by increasing conflict. Engagement returns in the ‘individuation’ stage and conflict abates as the group starts to work together. The ‘intimacy’ stage is typified by low to moderate levels of avoidance while conflict and engagement remain relatively static. The ‘mutuality’ stage ushers in a
reduction of avoidance in preference for a deeper commitment from other group members. Finally, the ‘termination’ stage signifies the ending of the group.

Advocates of progressive linear models of group development (Cissna, 1984; Mennecke, Hoffer, Wynne, 1992; MacKenzie, 1983; Kivlighan, & Goldfine, 1991) emphasise the importance of conflict to protect the group from becoming too cohesive to the point of group-think and confluence (Janis, 1982; Lanfred, 1998). This is achieved by the presence of conflict transforming the interpersonal environment into one which is capable of challenging and deeper, more meaningful disclosure. In this regard, it might be suggested that conflict corresponds with the differentiation stage in MacKenzie’s (1983) model and the ‘storming’ stage in Tuckman and Jensenn’s (1977) model of progressive group development (Brossart, Patton, & Wood, 1998).

The consequences of conflict influence how conflict is handled (Kivlighan & Lilly, 1997; MacKenzie, 1983). This may also be related to how individuals have previously handled conflict or how they have observed others handle conflict (Grenyer, 2002). Consequently, perceptions of conflict and its expected outcomes within the ‘microcosm’ of the therapy group might be associated with, and perhaps influenced by, previous conflict experiences (Fuhriman & Burlingame, 1990).
Repertory grid methods

Rowe (1969) posited that therapists should be interested in how people with depression view themselves and the world around them. One of the limitations of most group therapy process measures is that the group tends to be treated as a whole. Consequently, individual relationships between group members and perceptions of self in relation to others are often not examined. The self has been described as a reflexive product of social interaction (Catina, Tschuschke, & Winter, 1989), and consequently should be considered as an important component of group process. Furthermore, Cox (1973, p. 469) stated that the group process represents a ‘series of mirrors whose many-faceted reflections help to establish and individual’s sense of his own identity by delineating his similarities and differences in relation to other members in the group’. The repertory grid methods offer the opportunity to explore the person’s perception of him or herself in relation to each other group member, the group-as-a-whole, her or his ‘ideal self’ and the group leaders (Winter, 1992a), and also to predict change (Emerson, 1982). Rowe (1969, p. 1199) stated that the repertory grid technique ‘offers a useful method of understanding a depressive patient’s illness in the framework of his own constructs and in forming an objective measure of change in the course of the illness’. Boeker, Hell, Budischewski, Eppel, Haertling, Rinnert, et al. (2000) highlighted the advantages of using as idiographic approach involving a repertory grid technique to explore depressed clients’ self-concept and object relations. Their results emphasised the importance of the interpersonal dimension of depression (Rowe, 1971).

There are a variety of applications used to study personal and interpersonal systems of meaning (Fransella & Bannister, 1977; Ryle, 1975). Repertory grid techniques
or methods stemmed from personal construct psychology (Kelly, 1955). The ‘role construct repertory test’ was designed as a means of assessing the content of an individual’s repertory of role constructs. That is, the person’s own construct system used to derive meaning, organize, interpret, and orient and define his or her self and others within the interpersonal world. Beail (1985, p. 1) stated that ‘our constructs are not a chaotic jumble, but are organised into a system. They are linked, related and integrated into a complex hierarchical structure or system containing many sub-systems’.

Brown and Chiesa (1990) suggested that everyone views and construes the world through a ‘personal template’. Repertory grid methods attempt to capture features of these personal templates. They go on to state (p.413) that the ‘grid is a ‘map’ of the ‘interlocking equivalence-difference patterns’: it cannot be easily expressed in speech but represents the individual’s framework for organising the world in a form which is timeless. It resembles the concept of a ‘field’ (Lewin, 1997). The repertory grid method used in this fashion (i.e. where the person generates his or her own constructs to rate against a range of specific elements) has the potential of combining idiographic assessment with nomothetic research (Fransella & Bannister, 1977).

A repertory ‘grid is obtained whenever an observer rates or compares a set of objects, the elements, in terms of a set of logically applicable notions, or constructs, using a consistent scoring procedure throughout’ (Watson, 1970b, p. 319). Watson (1970a) posited that it is perfectly legitimate to compare different grids as long as the elements, constructs, and scoring system are consistent across all grids. The ‘elements’ are the ‘area of construing to be investigated’ while the ‘constructs’ are the ‘ways that the person groups and differentiates between the elements’ (Beail, 1985, p. 2). Although constructs
are most frequently elicited from the person by asking her or him to describe in what ways the elements are similar or different through a series of steps, at times constructs can be provided to tighten or focus the area of investigation (Fransella & Bannister, 1977; Ryle, 1975; Winter, 1992 b; Catina & Tschuschke, 1993; Slater, 1977). Being able to provide elements and constructs in grids is important if the main area of investigation is how grids differ across people in relation to specific constructs. The cost of providing constructs is some loss of insight into the person’s unique construing system, thus the investigation looses some phenomenological quality (Fransella & Bannister, 1977; Winter, 1992 a; Viney, 1996).

Repertory grids that consist of aspects of the self, group members and group leaders as the elements, while supplying specific bi-polar constructs that describe interpersonal relationship phenomena have been successfully used to explore the complex relationship matrices present in group therapy situations (e.g. Catina & Tschuschke, 1993). This type of grid method offers the possibility of producing what has been previously described as a ‘consensus grid’ (Slater, 1977). That is, an average of the grids completed by all the group members can be examined in relation to other group phenomena (Catina & Tschuschke, 1993).

Winter (1992 b) suggested that particular points of interest can be explored using repertory grid methods. For example, ‘element distances’ have been a point of interest in examining the degree of dissimilarity between self and ideal self, and between self and other group members, and the group leaders in group therapy situations. He also reported that changes in self-other differentiation tends to be an outcome of therapy as it appears to be a relatively stable measure in people not involved in therapy. Furthermore, Winter
reported that an increase in construing similarity between self and others has been more noticeable in group therapy than in individual therapy. Similarly, Hewstone, Hooper and Miller (1981) found that people with depression display a tendency to see themselves as being dissimilar to others. These authors suggested that by perceiving themselves as dissimilar to others they reduce anxieties related to uncertainties about social interactions and potential rejection. Unfortunately, the resultant self-isolation further adds to depression (Adams-Webber, 1973; Rowe, 1978, 2003). Research using repertory grid measures that demonstrates that group therapy, probably associated with Yalom’s (1995) group therapy curative factor of ‘universality’, leads to a reduction in self-other distance (Hewstone, et al., 1981; Winter, 1989, 1992 b; Neimeyer, Harter, & Alexander, 1991; Watson, 1970). In other words, it appears that the pattern of self-isolation through the tendency to perceive the self as dissimilar to others is eroded by identifying with other people with depression in group therapy situations.

Ashworth, Blackburn and McPherson (1985) found that repertory grids completed by depressed and manic patients reflected their clinical status rather than more permanent aspects of their thinking. Specifically, after at least four months into recovery from initial assessment, the grid distance between ‘self’ and ‘ideal self’ was no longer different from a non-psychiatric control group, when previously it had been a significantly greater distance. They also found that ‘integration of self and others’ which previously had been significantly different between the depressed and manic groups, and between the both of these groups and the non-psychiatric control groups, disappeared within the first four months of recovery.
Winter (1989) reported that both cognitive and analytic group therapies are capable of facilitating positive changes in how people with depression construe themselves and their world. However, only the analytic groups reduced the person’s sense of isolation - perhaps due to a greater opportunity to develop trust and sharing. He also suggested that certain people with depression may respond differently to different approaches due to the ‘degree of constriction of the client’s construct system’ (p. 46). Constriction of constructs for people with depression is thought to be a strategy to reduce anxiety by excluding confusing and inconsistent events from one’s perceptual field. In relation to grid measures Winter suggested that it is typical for people with depression to display constriction by operating ‘with only a limited, undifferentiated range of construct dimensions’, finding ‘many of their constructs inapplicable to other people,’ and are ‘unable to tolerate inconsistency in their construing’(p. 41).

As well as encouraging a dispersion of dependencies for depressed group members, Winter (1989) suggested that group therapy offers opportunity to overcome construct constriction (i.e. dilation) by providing a new range of people and experiences to expand the boundaries of his or her world. Furthermore, feedback from other group members during group therapy for people with depression may help invalidate problematic construing which includes seeing one’s self in polarised, negative terms, and highly dissimilar to others (Catina, Tschuschke, & Winter, 1989).

Catina & Tschuschke (1993) used repertory grids to examine process and outcome in analytic group therapy. They found that clients who responded well to treatment construed the actual self and social self as dissimilar at the beginning of treatment, and perhaps in consequence were more open to the integration of group
feedback into their self-construal. They also found that only clients who elaborated this reconstruing process to other self-other relationships outside of the group were likely to terminate the therapy successfully. In contrast, Winter (1984) outlined the benefits of the repertory grid technique for tracking reconstruing of people with depression within the context of different group therapy approaches. He found that different people responded differently to different therapeutic approaches. He suggested that although there are some therapeutic benefits for individuals identifying with other group members in relation to depressive experiences, experiences of interpersonal safety and trusting others with stories associated with some personal shame have greater therapeutic benefits.

Catina, Tschuschke, & Winter (1989) found that feedback from group members that invalidated the person’s self image could trigger reconstruing in a manner that reflects movement towards recovery from depression. However this is only effective if group climate was perceived as sufficiently supportive. If the individual did not perceive the environment as supportive, feedback received that was inconsistent with the person’s self-construction would likely be rejected and perhaps used as evidence to confirm the existing construct system. Greenway & Greenway (1985) used a repertory grid technique to examine an interpersonal ‘accepting-rejecting’ dimension in group members. They found that sensitivity to rejection and dependency fluctuated in a manner that reflected different group development stages. If the findings of these two studies are considered together it seems to imply that group members’ readiness to benefit from feedback that challenges their existing construal system, particularly that pertaining to self, might be associated with how rejecting or supportive they perceive the group to be.
**Significant events and mastery**

Significant Events are those events that occur during the course of psychotherapy that represent important markers in relation to the client’s progress (Elliott, 1991). Significant Events represent those occurrences where rapid or significant therapeutic gains can be observed, or in which clients experience a ‘meaningful degree of help or change’ (Elliott & Shapiro, 1992). For example, the event may have precipitated the client appearing to gain an important insight in relation to his or her current problems, or experimenting with healthier behaviours. Alternatively, an event may be deemed significant because it represented an important obstacle or setback in relation to the client’s progress. For example, the therapist may have reinforced the client’s unhelpful relationship dynamics, which in turn may have resulted in a rupture of the therapeutic alliance between the client and the therapist (Safran & Muran, 1996).

Elliott (1989) developed a methodology to study in detail those psychotherapy events that might be considered significantly helpful or hindering during the course of the individual counselling sessions. This methodology is known as Comprehensive Process Analysis.

**Comprehensive Process Analysis**

Comprehensive Process Analysis (CPA) (Elliott, 1983; 1989) is a systematic qualitative methodology developed for the purpose of analysing significant events. The overriding aim of CPA is to ‘understand: (a) the context out of which significant events arise, (b) the important features of the event itself, and (c) the impacts of the event’
(Elliott & Shapiro, 1992, p 164). These authors also suggest that it is possible to analyse the salient themes across collections of significant events using this methodology.

A significant, and perhaps ambitious, claim of CPA is that it offers measurement substance to the relativistic view advocated by phenomenological and hermeneutic schools, which challenges the epistemological hegemony of realism. As mentioned earlier in this thesis, realism assumes the existence of innate truths or facts external to the observer can be uncovered. In contrast, the phenomenological perspective insists that personal experience and behaviour is related to personal perception and meaning structures, not external ‘realities’. In other words, by studying significant events using the CPA methodology, the researcher is not simply noting specific behavioural phenomena and attributing to it a specific meaning that can be generalised across cases (realism or positivism). The researcher is also trying to understand the specific meaning of behavioural phenomena within the individual context of that person in that particular situation. In other words, there is the possibility of a juxtaposition of theory driven interpretations of observed behaviour and meaning laden descriptions of the subjective experience (Sheldon, Williams & Joiner, 2003; Hayes, Strosahl, & Wilson, 1999).

The phenomenological-hermeneutic perspective is grounded in the belief that people construct their own meaning, their own experienced realities, influenced significantly by their relational histories, expectations, and previous adaptations to the world and life events. Furthermore, personal meaning and realities can be created through current interactions as they can activate aspects of the background or history that each individual brings to the contact. In consequence, from this perspective it would be considered inadequate to rely solely on externally attributed interpretations of specific
observed behaviours. A more complete picture might be gained by complementing these theory driven interpretations with insights into the meaning making structures that people bring to the contact or specific events. Insight into how personal meaning is being constructed may be derived from considering the description of subjective experiences of specific events against the background of the person’s relationship history and previous experiences.

Bugas and Silberschatz (2000) argued that clients coach their therapists in how they want to be helped. This might at times be overt in terms of goal and task setting discussions, but might just as often be more covert in terms of dynamic relational ‘tests’. It is important then to expand the interpretive ‘field’ or context to try to capture the ideographic elements of the person’s experience, so that we may come closer to understanding the meaning of these observations (Hayes, Strosahl, & Wilson, 1999). The challenge is to conduct this type of expansive research in a way that minimises the impact of imposition and consequential influence on the psychotherapy process.

Although some behavioural researchers might posit that meaning is irrelevant to scientific explorations and that the aim of research is to report observations, this is simply deferring the meaning making processes to the reader, the observer of the reported ‘observations’. The implicit assumption is that human behaviour can be reduced to automaton explanations rather than interactional explanations with potentials of self-determinism. As stated earlier, the ‘recovery movement’ in mental health has emphasised the importance of personal meaning and the uniqueness of personal experience as fundamental to the recovery process (e.g. Anthony, 1994; 2000). Therefore, it is suggested that the methodologies that explore the machinations of subjective experience
and consider it as an essential mental health outcome are at least as important as positivistic methodologies for the progress of human science.

In an attempt to refine and realise the aims of CPA in order to collect data that could not be obtained adequately through simple observation, Elliott (1986) and Elliott and Shapiro (1988) developed a research method, named ‘Brief Structured Recall’ (BSR) which builds upon the ‘Interpersonal Process Recall’ method (Kagan, 1975). In effect the BSR method attempts to understand the individual phenomenologies of the participants directly involved in the therapy. This has the potential of offering insight into how they structure, interpret and derive meaning from their experiences, and plan behavioural responses. That is, the BSR method potentially allows access to what the person was thinking and feeling about particular therapy events and/or the other(s) present during these events. This information might not otherwise have been disclosed during the therapy session, or perhaps not even consciously processed by the person, yet possibly still influenced reactions and interpretations of subsequent events.

Elliott and Shapiro (1992) reported that significant correspondence occurred in CPA when comparing client, therapist and observer elaborations of significant events. That is, although some discrepancies existed between the three perspectives, the themes remained consistent, with differences being mostly in terms of language and frames of reference used to explain the themes (also see Kivlighan & Arthur, 2000). In contrast, Shefler and Tishby (1998) reported that therapists’ formulations of the central issues for their clients differed from the formulations of independent judges making these formulations on the basis of therapy transcripts. However, they go on to suggest that the therapists, being part of the therapy interactions with their clients, are privy to the internal
therapy context with access to the subtle non-verbal and dynamic signposts not explicit on therapy transcripts. This resonates with Zander et al (1995) report that inter-rater reliability for coding Core Conflictual Relationship Themes (Luborsky & Crits-Christoph, 1998) (see CCRT section above) increased with increased access to the nuances of the therapy session by having videos to rate. Therefore, the closer to the therapy action the researcher can get without influencing the client’s recovery process, the more likely she or he is to obtain a sense of the personal meaning created in the therapeutic interactions. Gaining access to the therapist’s perspective of the interactions and client background should go some way towards achieving this goal.

Helpful and hindering events in psychotherapy

Lietaer (1992) reported findings from a content analysis study of client and therapist post-session perceptions of helpful and hindering processes in Client-Centred/Experiential Psychotherapy. Overall evaluations of these sessions indicated that the therapy sessions were perceived as positive, particularly in the view of the clients. The ‘helpful’ processes identified fell into three categories: 1) aspects of the relational climate – whereby the participants referred to the basic attitudes of the therapist and to general characteristics of their mutual contact (e.g. empathy, respect, validation, authenticity); 2) specific therapist interventions (e.g. offering specific procedures, confrontation, interpretation); and 3) process aspects concerning the client (e.g. insight into situations or self, taking risks and exploring personal experiences). They found that clients were twice as likely as therapists to report the relational climate as helpful (21% of the client responses, 10% of the therapist responses). In relation to the helpful therapist interventions category (20% of the client responses, 23% of the therapist responses), the
therapist interventions most frequently reported as helpful by all participants were ‘confrontation and here-and-now feedback’ and ‘stimulation and deepening of self-exploration’. However the client process category contained the highest number of response segments of the total helpful responses (59% of all the client responses, 67% of all the therapist responses). Therefore, this study suggests that client processes such as the preparedness of clients to engage in, and gain insights from psychotherapy, is at least three times more likely to be reported as a helpful, when compared with specific therapist interventions or the relational climate. Although overall reporting trends were similar between clients and therapists, noticeable differences were that clients placed greater emphasis on the relational context of the session and more immediate outcomes, whereas therapists placed greater emphasis on involvement in deeper self-explorations.

Lietaer (1992) suggested that hindering processes in psychotherapy were more difficult to identify. In fact, the study reported that when asked about hindering processes no response was given 60% of the time by therapists and 75% of the time by clients. This contrasted with blank responses related to inquiry regarding helpful processes (23% for therapists, 14% for clients). The study suggested that generally clients experienced the sessions as less negative than did the therapists. However, Rennie (1990, cited Lietaer, 1992) reported some reticence on the part of clients to be critical of their therapist. Lietaer (1992) reported that both therapists and clients more likely to attribute negative experiences to themselves. Specifically, 76% of hindering responses identified by therapists were related to their own interventions (30% of which were related to their own lack of empathy, perhaps related to transference configuration issues), while 61% of client identified hindering responses involved their own lack of involvement or progress.
Common therapeutic factors

Lambert and Barley (2002, p. 17), suggested ‘that the advocacy of specific forms of treatment for specific disorders can lead to an overemphasis on the curative aspects of the therapeutic endeavor’. Instead they emphasise the relatively consistent evidence that the dynamics of the therapeutic relationship itself contribute to client progress in psychotherapy. They also highlight evidence that many people with mental and/or emotional disorders improve without formal therapy, and suggest that outcome is ‘highly influenced by individual patient characteristics and circumstances outside of therapy’ (p. 19). In fact they suggested that approximately forty percent of client change might be accounted for by ‘extratherapeutic factors’ (i.e. events occurring outside of therapy). They suggested that much of the improvement might still be linked to the effects of ‘supportive relationships’ that the person may be exposed to in their natural environment or other non-professional self care mechanisms.

Murphy, Cramer, and Little (1984) (cited in Lambert and Barley, 2002) asked out-patients, who had successfully completed a course of Cognitive Behavioural Therapy, what they believed were curative factors and found that they most endorsed ‘advice’ (79%), ‘talking with someone interested in my problems’ (75%), ‘encouragement and reassurance’ (67%), ‘talking with someone who understands’ (58%), and ‘instillation of hope’ (58%). Along similar lines Beutler and Harwood (2002) suggested that client factors, therapy specific factors, and relationship factors ‘selectively’ contributed to the variance predicted in psychotherapy outcome studies. Therefore, research methodologies that attempt to capture aspects of each of these factors might be considered favourable in relation to describing individual recovery processes.
Chapter 2

An outline and rationale for the studies in this thesis
Summary of the introductory literature review

Depression is a growing problem and has a significant interpersonal dimension. Psychotherapy has been shown to help with recovery from depression for many people. Large scale meta-analytic studies indicate that therapeutic factors that might be considered common across most forms of psychotherapy for depression account for more treatment outcome variance than treatment effects that might be considered directly related to the specific techniques of particular treatment approaches. There is little surprise then that substantial psychotherapy research has focused on identifying and attempting to understand the common factors that exist across different therapeutic approaches.

Relationship phenomena can be considered as both a primary therapeutic factor and predictor of therapy outcome. Perceptions of relationship phenomena such as the therapeutic alliance, group cohesion, group climate, and self-other differentiation processes have been found to fluctuate over the course of treatment. The extent to which the strength of the therapeutic alliance between the therapist and the client is associated with treatment outcome in group therapy remains unclear. Self-other differentiation has been previously examined using repertory grid methods. Examining self-other differentiation processes using repertory grid methods in relation to group developmental processes and fluctuations in other therapeutic relationship phenomena represents a relatively new area of investigation.

Perceptions of the interpersonal therapeutic environment may be influenced by the transference relationship. That is, repetitive relationship interaction patterns and expectations that have developed from previous significant relationship experiences may
influence how people perceive the climate of group, the strength of the working relationships, and how similar or different they perceive themselves to be in relation to others in therapy groups.

Mastery of repetitive conflictual relationship themes (i.e. those themes central to the transference relationship) can be tracked throughout the therapy process. The level of mastery of relationship conflicts has been found to be associated with treatment outcome. The examination of significant helpful and hindering events during the course of treatment might be seen as windows through which individual interpersonal recovery stories might be heard, and examined in relation to mastery of repetitive conflictual relationship themes.

Summary of research gaps identified in the introduction

There are a number of gaps and issues lacking clarity in the research outlined in the introduction of this thesis that the three studies and associated case studies attempt to address in this thesis.

First, a lack of clarity remains regarding how the therapeutic or working alliance is defined and operates within group therapy situations, and how this is related to group cohesion. Despite efforts to clarify this (e.g. Budman, et al, 1989; Gillaspy, et al., 2002; Marziali, et al, 1997; Van Andel, et al, 2003) some researchers have attempted to isolate the therapist-client relationship while others have treated it as part of the group-as-a-whole phenomenon, thus perpetuating inconsistencies in construct definitions. Further non-consensus persists regarding the elements and underlying dimensions of group cohesion. Study one of this thesis directly examines the relationship between alliance and
cohesion and further explores both of these constructs in relation to theoretical dimensions of cohesion and group developmental processes.

Second, there is little research examining the relationship between group climate and treatment outcome (Kivlighan & Lilly, 1997; Connelly, et al., 1986; Braaten, 1989; McCallum, et al., 2002). In fact the majority of these studies have focused on the mediator effects of group climate on other variables (e.g. leadership style) rather than examining specific relationships between the components of group climate and treatment outcome. Only two studies were found that directly examined the relationship between perceptions of conflict within the group climate and treatment outcome (McCallum, et al., 2002; Ogrodniczuk & Piper, 2003) with neither finding a significant relationship. Perception of conflict within the group climate is a particular interest for this thesis because of the interest in the impact of repetitive conflictual relationship themes on more immediate interpersonal dynamics.

Third, there is little research examining self-other differentiation processes within the context of group therapy for depression, and within the specific context of group developmental processes. Although repertory grid methods have been used to examine aspects of self-other differentiation in group therapy no studies have been identified that examine these differentiation process within Supportive Expressive group therapy for depression. There have also been no studies identified that use constructs closely associated with alliance and group cohesion as self-other differentiation parameters.

Four, there is little research examining CCRT patterns in relation to specific group therapy events. That is, by examining in detail the interpersonal dynamics of those specific events identified by clients and therapists as significantly helpful or hindering of
individual recovery processes, this thesis attempts to advance the research into the influence of group therapy on mastery of repetitive conflictual relationship patterns. To date, there are no known CCRT or mastery studies of group therapy.
The Current Study

The aims of this thesis

The overall aims of this thesis are:

1. To advance research in:
   a. The clarification of the relationship between therapeutic alliance, group cohesion and group climate,
   b. Dimensions of group cohesion in relation to group developmental processes,
   c. The relationship between group climate, and in particular perceptions of conflict in the group, and treatment outcome,
   d. Self-other differentiation processes during group therapy for depression,
   e. The mastery of CCRT patterns in group therapy,
   f. Significant events in group therapy.

2. To investigate the potential of integrating qualitative-phenomenological and clinical-quantitative research methodologies to:
   a. Conduct a preliminary investigation of relationship phenomena within the context of group developmental processes,
   b. Track individual recovery processes through single case study methods, and
   c. Examine the interaction of transference material with perceptions of the interpersonal environment of the therapy group.
**Major research questions**

1. Do measures of working alliance, group cohesion, group climate, and self-other dissimilarity change over the course of brief group therapy for depression?

2. What is the relationship between working alliance, group cohesion, group climate, and self-other differentiation within brief group therapy for depression?

3. Can the use of a repertory grid method help explore and clarify the dimensions of group cohesion?

4. Is participation in brief supportive-expressive therapy for depression associated with improvements in depression?

5. Do measures of working alliance, group cohesion, group climate, and self-other differentiation separately predict outcome in brief group therapy for depression?

6. Are characteristics of client primary CCRT patterns associated with the perception of ‘conflict’ within the group and the ‘working capacity’ of the group members?

7. Are significant events significant because they represent considerable progress or setbacks in relation to the mastery of CCRT patterns?

8. Can individual recovery processes be tracked through the examination of the significant therapy events.
9. Can meaning be added to individual client ratings of alliance, cohesion, climate and self-other differentiation measures as well as outcome by examining the person’s CCRT patterns.

Outline of specific studies

Each of the research questions will be addressed across a series of four studies.

Study One

Addresses research questions 1-3 above.

The aims of study one

1. To examine the relationship between working alliance, group cohesion, group climate, and self-other differentiations,
2. To conduct a preliminary dimensional analysis of group process,
3. To examine group members’ perceptions of specific relationships within the group therapy context using a repertory grid method.

Hypotheses addressed in study one

1. Scores on measures of working alliance, group cohesion and the engaged component of group climate will increase, and there will be changes in the avoiding and conflict components of group climate and self-other dissimilarity over the course of brief group therapy for depression.
2. There will be a positive association between components of working alliance and group cohesion as measured by the CALPAS-G.

3. There will be a positive association between components of working alliance and the engaged component of group climate and a negative association with the conflict and avoidance components of group climate.

4. There will be a negative association between components of working alliance and self-other dissimilarity.

5. There will be negative associations between measures of self-other dissimilarity and measures of group climate and cohesion.

6. The associations between measures of self-other dissimilarity and measures of group climate and cohesion will change over the course of therapy.

Study Two

Addresses research questions 4 and 5 above.

The aim of study two

The aim of study two is to examine the differential ability of alliance, group cohesion, group climate, and self-other differentiations measures (measured early in treatment) to predict outcome in a sixteen-session group therapy treatment for adults with major depressive disorder.

Hypotheses addressed in study two

7. There will be a negative association between the degree of dissimilarity on self-other differentiation indices and group therapy outcome.
8. There will be a positive association between components of working alliance and group therapy outcome.

9. There will be a positive association between the ‘engaged’ component of group climate and a negative association with the ‘conflict’ and ‘avoidance’ components of group climate and group therapy outcome.

10. There will be a positive association between components of group cohesion and group therapy outcome.

Study Three
Addresses research questions 6 and 7 above.

The aims of study three
1. To explore the transference dimension of the therapeutic relationships with particular emphasis on CCRT patterns and progress towards mastery of interpersonal conflict,

2. To examine the association between the group therapy outcome predictors of ‘perceived conflict’ and ‘patient working capacity’ and CCRT patterns,

3. To examine the helpfulness of specific therapy events and whether these events have utility as markers of the pervasiveness and resilience of the client’s CCRT patterns, and

4. To examine the relationship between CCRT patterns and progress towards mastery of interpersonal conflict during significant therapy events.
**Hypotheses addressed in study three**

11. The identified significant events will be concordant with CCRT patterns.

12. The level of significant events – CCRT concordance will be associated with outcome.

13. The level of significance and the helpfulness-hindrance ratings of significant events will be associated with alliance ratings of the significant events.

14. The helpfulness-hindrance ratings of significant events will differ when rated within the context of the entire treatment when compared with ratings at the time of the events themselves.

15. The pervasiveness of the client’s CCRT patterns and how much control s/he exhibits of his/her CCRT patterns will be associated with treatment outcome and other outcome predictors.

16. The level of mastery of CCRT patterns will be positively associated with outcome.

17. The level of mastery of CCRT patterns and significant events-CCRT concordance ratings will be positively associated with ‘Patient Working Capacity’ and their perception of ‘conflict’ in the group.

**Study Four (Case Studies)**

Addresses research questions 8 and 9 above.

**The aims of study four**

1. To examine the significant events in relation to the individual recovery processes for each case.
2. To investigate whether the ratings of alliance, cohesion, climate and self-other differentiation measures by each of the two cases with apparently different outcomes appear meaningful within the context of each person’s CCRT.

Limitations and strengths

The current study has a major limitation related to the size of the sample and the variety of measures collected and analysed from this sample. Although the data is drawn from six distinct small therapy groups, the total number of client participants is thirty. Consequently, the number of analyses required to cover the scope of this thesis represents a risk of Type I error occurring. Strategies to reduce the risk of Type I error have been used to direct the analysis of the results in each study. The strategies include setting the significance criterion a priori at $p < .01$ and limiting the number of analyses conducted to those of primary interest. The $p < .01$ significance criterion was thought to be adequate because the nature of most of the studies is exploratory and an even more stringent significance criterion might unduly increase the risk of Type II error. In other words, the limitations posed by a sample size of thirty in relation to the scope of this study have been recognised and the results amended accordingly.

However, it is also believed that the exploratory nature of the studies in this thesis and the integration of different research methodologies represent a significant strength of this thesis. That is, as mentioned above, the integration of qualitative-phenomenological and clinical-quantitative research methodologies means that the conservative nature of the results in relation to the sample size is strengthened by the inclusion of intensive case studies.
Chapter 3

Study One

Relationships between self-other differentiation, the group climate, and dimensions of cohesion and alliance in brief group psychotherapy
Study one explores the potential overlap between some of the common factors of group psychotherapy. More specifically study one examines the associations between the relationship phenomena of therapeutic alliance and group cohesion, and how they may be related to the interpersonal group climate. These relationships are further extended in terms of associations with self-other differentiation between group members within group psychotherapy situations.

The following sections are a recap of the pertinent points from the relevant literature reviewed in the introduction chapter of this thesis.

**Alliance and cohesion**

Although the construct of cohesion in group psychotherapy has been suggested to be the therapeutic equivalent therapeutic alliance in individual psychotherapy (e.g. Budman, et al., 1989), there are some important differences. Therapeutic or working alliance refers to the relationship between the therapist and the client (Horvath & Greenberg, 1994), whereas group cohesion, despite the lack of definitional consensus, tends to be primarily concerned with the relationships between the group members, or the group-as-a-whole (e.g. Drescher, et al., 1985; Roak & Sharah, 1989). Links between the therapeutic alliance, group-as-a-whole and group leader-group member perspectives of cohesion are frequently unclear (Bednar & Kaul, 1994).

‘Social cohesion’ is thought to reflect the interpersonal relationships between group members and might be linked with issues of personal and social identity (or collective identity), and self-categorisation theory (Hogg, 1992; Hogg & Tindale, 2001). It might be further suggested that social cohesion involves issues of ‘bond’ and perceptions of ‘self’ in relation to other group members and leaders, and to some extent being a part of, or ‘belonging’ to, the group-as-a-whole. Furthermore, this dimension of group cohesion might also reflect the negotiation of existential themes involved with balancing the need for an individual self-identity and the need to affiliate with a group, or as a differentiation process between self and others (e.g. Winter, 1992 b). Other researchers have explored this interpersonal process as the negotiation of the need for autonomy with the need for relatedness (Deci, Eghrari, Patrick, Leone, 1994; Ryan, 1995; Ryan, Deci, Grolnick & Wendy, 1995; Sheldon & Elliot, 1999).

The notion of ‘Task cohesion’ is suggested to reflect the alignment of the group around the clarification and performance of the specific tasks or functions for which the group was formed. Therefore, this dimension appears to resonate with the ‘task’ and perhaps ‘goal’ agreement components of the working alliance (Bordin, 1979). ‘Vertical cohesion’ is purported to reflect how group members perceive and relate to the group leader in terms of leadership competence and responsibility (Dion, 2000).

A more comprehensive overview of the issues involved with attempting to understand the common therapeutic factors and interpersonal complexity present in group psychotherapy can be found in the Group Psychotherapy and Linking Process to Outcome sections of the introduction of this thesis.
**Repertory Grids**

Most group therapy process measures tend to only consider the group-as-a-whole. Therefore, individual relationships between group members and perceptions of self in relation to others are often not examined. The repertory grid methods offer the opportunity to explore the person’s perception of him/herself in relation to each other group member, the group-as-a-whole, her/his ‘ideal self’ and the group leaders (Winter, 1992 a). Repertory grid ‘constructs’ can be provided, rather than elicited from individual clients, to focus the area of investigation (Fransella & Bannister, 1977; Ryle, 1975; Winter, 1992 b; Catina & Tschuschke, 1993; Slater, 1977). Being able to provide elements and constructs in grids is important if the main area of investigation is how grids differ across people in relation to specific constructs.

Repertory grids that consist of aspects of the self, group members and group leaders as the ‘elements’, while supplying specific bi-polar constructs that describe interpersonal relationship phenomena have been successfully used to explore the complex relationship matrices present in group therapy situations (e.g. Catina & Tschuschke, 1993). This type of grid method offers the possibility of producing a ‘consensus grid’ (Slater, 1977). That is, an average of the grids completed by all the group members can be examined in relation to other group phenomena (Catina & Tschuschke, 1993), such as the alliance, cohesion and group climate. Therefore, it may be possible to explore and clarify some of dimensions of group cohesion by providing bi-polar constructs for a grid that reflect the key descriptors of cohesion in the literature.

Hewstone, Hooper and Miller (1981) found that people with depression display a tendency to see themselves as being dissimilar to others. ‘Distance’ measures, or the degree of perceived dissimilarity between the elements (e.g. the self
and other group members, or the self and the group leaders) might be a useful indicator for changes in self-other differentiation trends over the life of the group. Research using repertory grid measures that demonstrates that group therapy, probably associated with Yalom’s (1995) group therapy curative factor of ‘universality’, leads to a reduction in self-other distance (Neimeyer, Harter, & Alexander, 1991; Winter, 1989, 1992 b; Hewstone, et al., 1981; Watson,1970a). That is, the tendency to perceive the self as dissimilar to others is eroded by identifying with other people with depression in group therapy situations, thus challenging the depressive pattern of self-isolation (Rowe, 2003). Furthermore, feedback from group members that invalidated the person’s self image has been shown to trigger reconstruing in a manner that reflects movement towards recovery from depression (Caine, 1981; Watson,1970a). However, Catina, et al. (1989) also suggested that this is only effective if the group climate was perceived as sufficiently supportive.

Leach, Freshwater, Aldridge, and Sunderland (2001) described the strengths and weaknesses of several different methods of analysing grid data. They found that by analysing grids completed at different stages of therapy, useful qualitative and quantitative data (e.g. self-ideal self discrepancy as a measure of self esteem, and self-other differentiation) can be used to track progress. They also described how the use of ‘element distance’ measures with ‘multidimensional scaling’ can be used for analysing repeated measures fixed construct and element grids. This study highlights how multidimensional scaling can illustrate dimensional relationships between variables over time that may be more difficult to detect by relying on analyses based of correlations.

Multidimensional scaling is a set of data analysis techniques that depict the structure of distance data (i.e. degree of similarity or dissimilarity) that approximate
the distances between pairs of the objects as a geometrical picture within a multidimensional space. The points are located within this space in terms of the strength of the relationships between pairs of points (i.e., two similar objects are represented by two points that are close together, and two dissimilar objects are represented by two points that are far apart) (Young & Hamer, 1994; Borg & Lingoes, 1987; Schiffman, Reynolds, & Young, 1981).

**Group Climate**

Interpersonal events and group members’ perceptions of the group interpersonal environment may impact on the person’s readiness to engage in, and thus benefit from, treatment activities. Measurement of the group climate is thought to capture these events and perceptions (MacKenzie, 1983). The group climate is described as the group’s psychological and interpersonal atmosphere in terms of resistance, cohesion and friction. (McCallum, Piper, Ogrodniczuk, and Joyce, 2002). It reflects the degree to which members are actively involved in the group therapy process (MacKenzie & Tschuschke, 1993). MacKenzie (1983) posited that group climate consists of three components: ‘engaged’ - reflecting alliance and cohesion, ‘avoiding’ – reflecting the resistance of group members to take responsibility for changing, and ‘conflict’ – reflecting interpersonal tension and mistrust. It has been suggested that fluctuations in the different components of group climate should correspond with different stages in progressive models of group development (Brossart, Patton, & Wood, 1998; Kivlighan & Lilly, 1997; MacKenzie, 1983; Stockton, Rohde, & Haughey, 1992).

A more comprehensive overview of the group climate literature can be found in ‘the group climate and group development’ section of the introduction of this thesis.
The aims of study one

1. To examine the relationship between working alliance, group cohesion, group climate, and self-other differentiations,
2. To conduct a preliminary dimensional analysis of group process,
3. To examine group members’ perceptions of specific relationships within the group therapy context using a repertory grid method.

Research questions addressed in study one

1. Do measures of working alliance, group cohesion, group climate, and self-other dissimilarity change over the course of brief group therapy for depression?
2. What is the relationship between working alliance, group cohesion, group climate, and self-other dissimilarity within brief group therapy for depression situations?
3. Can the use of a repertory grid method help explore and clarify the dimensions of group cohesion?

Hypotheses addressed in study one

1. Measures of working alliance, group cohesion, group climate, and self-other dissimilarity will change over the course of brief group therapy for depression.
2. There will be a positive association between components of working alliance and group cohesion as measured by the CALPAS-G.
3. There will be a positive association between components of working alliance and the engaged component of group climate and a negative association with the conflict and avoidance components of group climate.
4. There will be a negative association between components of working alliance and self-other dissimilarity.

5. There will be negative associations between measures of self-other dissimilarity and measures of group climate and cohesion.

6. The associations between measures of self-other dissimilarity and measures of group climate and cohesion will change over the course of therapy.
Method

Therapists

Seven psychotherapists (6 female, 1 male, mean age 34.43 years, range 28-46 years) trained in SE dynamic therapy served as the group facilitators. Therapists had a median of 13 years clinical experience and were currently providing clinical services in the Northfields Clinic associated with post-registration advanced doctoral-level clinical psychology training. Therapists received weekly group and individual supervision by an experienced senior SE therapist and group sessions were videotaped for the purpose of monitoring fidelity to the treatment approach.

Client participants

Participants came to the clinic from a number of sources, including self-referral, referral from physicians, community and counselling services. Primary diagnosis of major depression was confirmed by the Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon & Williams, 1997) and severity of depression determined by interviewer ratings on the Hamilton Rating Scale for Depression-17 (HRSD) (Hamilton, 1960). Participants were considered suitable if their met the diagnostic criteria for major depressive disorder and scored more than 17 on the HRSD. Exclusion criteria included the presence of any of the following co-existing psychiatric disorders: alcohol or drug abuse or dependence, schizophrenia or other psychotic disorder, bipolar disorder, obsessive-compulsive disorder, eating disorder, or serious medical conditions (e.g. cancer, serious cardiac conditions).
Psychotherapy

Treatment comprised of 16 weeks of supportive-expressive (SE) psychodynamic group therapy (Grenyer and Crowe, 2001) based on the individual SE manual for depression (Luborsky, Mark, Hole, Popp, Goldsmith, and Cacciola, 1995), the general SE treatment manual (Luborsky, 1984) and interpersonal SE mastery studies (Grenyer, 2002). Within this model, problems associated with depression are examined in the context of an understanding of the person's interpersonal and intrapsychic functioning as formulated in terms of the Core Confictual Relationship Theme (CCRT) (Luborsky & Crits-Christoph, 1998). Some people with specific, persistent interpersonal relationship patterns have been found to be vulnerable to depression. Specifically, pervasive internalisation of anger with others has been linked to helplessness, avoidance of interpersonal situations where conflict is anticipated (Luborsky, et al., 1995; Grenyer, 2002).

SE is a staged set of interventions, moving from more supportive techniques initially to more expressive techniques as appropriate. Rather than aiming to change behaviour, supportive techniques attempt to bolster the therapeutic alliance and the client’s self support systems and esteem. Examples of supportive techniques include: basic counselling micro-skills (e.g. active listening, empathy, immediacy, etc.); defining and maintaining the therapeutic frame; identifying and supporting the client’s vital defences; maintaining appropriate self-object transferences; setting limits appropriately; identifying and reinforcing gains; and genuine interest and respect being demonstrated by the clinician. Once the alliance and therapeutic frame have been established, expressive techniques are gradually introduced to help the client better understand and attempt to change problematic behaviour. Expressive
techniques include: clarification; confrontation; and interpretation (often involving the exploration and elaboration of CCRT patterns) (Book, 1998).

Working with a CCRT focus requires the clinician to identify current maintaining factors in psychopathology with a particular emphasis on repetitive, conflictual relationship themes. This involves looking for repetitive themes within the client’s interpersonal history and observing current relationship dynamics and helping the client to mastery them. Specifically, the clinician helps clients clarify: a) their underlying ‘wishes’ or desired outcomes from interactions, b) their expected or anticipated responses of others to these wishes, and c) their typical responses or reactions to the responses of others. The therapy provides insight through interpretation and potentially corrective emotional/interactional experiences for clients with the aim to modify and master maladaptive internal representations of relationships. An example of a CCRT based interpretation might be, “so when you try to get close to people you care about you become very afraid the other person will reject you, and you get angry, depressed and tend to withdraw.”

Groups were facilitated by two therapists, and were 1.5 hours in duration per week. The initial and termination sessions were conducted on an individual basis with one of the group therapists to: (a) orient the client to the group and set goals in the initial session, and (b) to review the progress with the therapy goals and debrief from the group process at the termination session. A group therapy orientation package was worked through in session one with the individual clients adapted from Wilfley, MacKenzie, Welch, Ayers, & Weissman, (2000). Group leader tasks included: making sure each group member had enough time to explore his or her issues; ensuring that group was not dominated by certain group members; help clarify individual CCRT structures; ensure appropriate group therapy behaviours occurred
(e.g. no intimidation of group members, no intoxication with substances of abuse, adhering to the allotted therapy group therapy time frame, etc.); facilitating the development of supportive relationships between group members; and providing supportive and expressive techniques.

Group leaders also staged different interventions to match the stages of group development (see chapter one section ‘the group climate and group development’). For example, initially more supportive techniques were used during the earlier stages of group development (i.e. the ‘engagement’ stage in MacKenzie and Livesley (1983) model, or the ‘forming’ stage in Tuckman and Jenseenn’s (1977) model), while a combination of supportive and expressive techniques are typically used to negotiate the more emotionally charged stages of group development (i.e. the ‘differentiation and individuation’ stages of MacKenzie and Livesley (1983) model, or the ‘conflict’ stage in Tuckman and Jenseenn’s (1977) model). Typically it is expected that the middle stages of group development is where the individual group members’ CCRT patterns become more activated. If group leaders and other group members are able to refrain from engaging in behaviours that reinforce the individual group members’ CCRT patterns, the group is more likely to progress to the more advanced stages of group development (i.e. ‘intimacy and mutuality’ stages of MacKenzie and Livesley (1983) model, or the ‘norming and performing’ stages in Tuckman and Jenseenn’s (1977) model) where corrective relationship experiences might occur and CCRT mastery becomes more evident.
**Procedure**

Data for this study were derived from participants receiving group therapy in the Northfields Clinic Depression Treatment Program for adults with current Major Depressive Disorder. The key steps in the procedure were as follows:

1. Initial screening for eligibility of potential treatment participants was completed by a brief telephone interview.

2. Potential participants completed an assessment interview which included a diagnostic interview using the SCID I and the HDRS-17. Other baseline measures collected from those identified as suitable to participate in the study based on the diagnostic interview were the Global Assessment of Functioning (GAF) scale (DSM-IV, American Psychiatric Association, 1994) and the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) (see method section in study 2 for description of these measures).

3. Session one of treatment was an individual therapy session of 60 minutes with one of the group leaders. This session was used to orient the client to the group therapy process and to elicit individual treatment goals.

4. Sessions 2-15 were group therapy sessions of 90 minutes each. At the end of session 4 the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) (see below for description) was completed by each of the group members and the group leaders.

5. At the end of session 6 the California Psychotherapy Alliance Scale – Group (CALPAS – G) (Gaston and Marmar, 1993, 1994), the Group Climate Questionnaire (GCQ-S) (MacKenzie, 1983), and the Group Cohesion Grid (GCG) (Crowe, 2000) (see below for descriptions), were completed by each of the group members. This measurement timeframe reflects recommendations to
allow adequate time for group members to formulate a sense of the relational climate of the group (e.g. Silbergeld, Koining, Manderscheid, Meeker & Hornung, 1975; Piper, et al, 1983; Marziali, et al, 1997). Participants were also asked to rate outcome at week six on two scales of zero to ten on the basis of perceived satisfaction/ therapy success (see study 2 method section for detailed description).

6. Session 16 of treatment was an individual therapy session of 60 minutes with one of the group leaders. This session was used to review progress with the treatment goals, debrief the client after the group therapy process, and to ensure any residual treatment termination issues were addressed. WAI, CALPAS-G, GCQ, and GCG measures of group relationship factors were also collected at the end of this session.

7. Post treatment assessment interview was conducted with the same with the same assessment interviewer that collected the pre treatment measures within 7 days of treatment completion. GAF, HAM-17, BDI and perceived satisfaction/ therapy success outcome measures were collected along with Client perceptions of significant therapy events were also collected during this interview (see method section of study 3 for a description of the Significant Events Scale).

8. Within 14 days of treatment group termination the group leaders completed the therapist’s version of the Significant Events Scale and a questionnaire assessing the characteristics of each of the group members CCRT patterns (see study 3 method section for description of this questionnaire).
**Measures**

*The Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989).*

The WAI is a 36 item self-report scale designed to reflect Bordin’s (1979) pan-theoretical therapeutic alliance model. This instrument was designed for assessing the client-therapist relationship in individual therapy. It is therefore unknown whether it assesses the therapeutic alliance in group therapy in the same manner (Marziali et al., 1997). The WAI self-report version (Horvath, 1982) comprises an overall measure and three subscales (task agreement, goal agreement, and bond development) consisting of 12 items each. Horvath and Greenberg (1989) reported an estimated alpha of .93 for the client version as an adequate measure of reliability. They also reported correlations with other measures concerned with similar therapeutic relationship components. Furthermore, they questioned the distinctness of the three alliance components because of the high correlations between these scales (.85 - .88).

*California Psychotherapy Alliance Scale – Group (CALPAS – G) (Gaston and Marmar, 1989, 1994).*

The CALPAS-G (short version), is a twelve item scale, and is a close variation of the CALPAS-P which is widely used in a variety of individual therapy settings (Gaston, & Marmar, 1994; 1993; Gaston, & Schneider, 1992). It contains four subscales. The Patient Working Capacity scale (PWC) reflects the patient’s ability to work actively and purposefully in treatment. The Patient Commitment scale (PC) reflects the patient's attitude towards therapy, including affectionate trusting feelings and a commitment to go through the complete process of therapy. The Working Strategy Consensus scale (WSC) reflects the degree of agreement, between group members and therapist about how therapy should proceed. The Member
Understanding and Involvement scale (MUI) reflects components of group members’ involvement in therapy, including empathic understanding and active participation in therapy for the sake of the individual group member (Gaston, & Marmar, 1993). No published reliability data is available for this version of the CALPAS-G. However, reliability analyses conducted on the data from the current study (n= 30) returned alphas ranging from 0.75 (when measured at six weeks) and 0.86 (at sixteen weeks) for the entire scale. Cronbach alphas were also calculated for the four subscales separately returning ranges of: 0.31 to 0.89 for PWC; 0.74 to 0.70 for WSC; 0.20 to 0.65 for PC; and 0.72 to 0.72 for MUI, when measured at six and sixteen weeks respectively.

*Group Climate Questionnaire (GCQ-S) (MacKenzie, 1983).*

The Group Climate Questionnaire (MacKenzie, 1983) is based on the assumption that the ‘climate’ or psychological atmosphere of the group can be elicited from group members’ perceptions across a number of constructs. The GCQ-S is a self-report measure consisting of 12 items rated on a 7 point Likert scale. Factor analysis has identified three subscales described as Engaged (5 items), Conflict (4 items), and Avoiding (3 items), with internal consistency of the GCQ–S subscales reported as being high, with alpha coefficients ranging from .88 to .94 (Kivlighan & Goldfine, 1991).

Ogrodniczuk and Piper (2003, p. 68) describe the engaged subscale as ‘a multifaceted dimension that reflects a cohesive environment and willingness of members to participate in the group’. Higher scores on the engaged subscale suggests a positive working atmosphere where members are involved in the group and able to interact well. The ‘avoiding’ subscale attempts to capture the reluctance or resistance
of group members to take responsibility for dealing with problems within the group and directing their own recovery processes via the group process. The ‘conflict’ subscale indicates the group members’ perception of interpersonal friction within the group. It may include the perception of distrust and unresolved anger within the group, perhaps manifested as distance between group members.

The validity of the GCQ–S has also been established in a number of studies. The GCQ–S ratings have been found to be related to therapeutic gain (Kivlighan & Lilly, 1997) and have also proven to be able to discriminate between different clinical samples (Daroff, 1996). It has been suggested that fluctuations in the different components of group climate should correspond with different stages in progressive models of group development (Brossart, Patton, & Wood, 1998; Kivlighan & Lilly, 1997; MacKenzie, 1983).

*Group Cohesion Grid (GCG) (Crowe, 2000).*

The GCG is a fixed construct repertory grid technique (Kelly, 1955; Beail, 1985; Brown, & Chiesa, 1990; Leach, Freshwater, Aldridge, & Sunderland, 2001) that was utilised in order to further explore the individual group members’ experience of every other group member, the therapists, and general experiences of the group-as-a-whole. By setting the elements on the group cohesion grid (GCG) as the individual group members and group leaders, as well as a ‘self’ element, ‘psychological space’ was explored as a distance measure between self and other group members and self and group leaders. Distance measures are derived from Euclidean distance analyses which calculate dissimilarity between specific group members on the basis of the given attributes. Distance measures indicate how similar or dissimilar the individual group members perceive themselves to be in relation to other group members and the
group leaders, in terms of the provided constructs, or bipolar attributes, that attempt to capture a variety of group cohesion components identified in the research literature. Subsequently, the assumption is that the group’s level of cohesiveness is equated to the average perceived distance between people in the group. That is, the lower the averaged dissimilarity score, the more cohesive the group may be considered.

Subscales from the GCG data used in the analyses in this study were: 1. a mean ‘overall cohesion’ score – derived from an average across all 30 grids of the mean perceived dissimilarity between all group members, 2. the self–group leader(s) relationship - derived from an average across all 30 grids of the mean perceived dissimilarity between self and group leaders, and 3. the self – all other group members relationship - derived from an average across all 30 grids of the mean perceived dissimilarity between self and other group members. Of particular interest is the self–group leaders distance measure as it may prove to be a helpful comparison to the working alliance in individual therapy, from a group therapy perspective.

Some licence was taken when deciding on the final eleven bipolar attributes, as the breadth, weight in terms of importance, and exact meaning of those attributes identified in the literature as components of group cohesion are not always clear. For example, ‘expressed care’ (Budman et al., 1989) was expected to be a point of consideration when participants came to rate the ‘unsupportive – supportive’ bipolar attribute on the GCG. Similarly, ‘personal compatibility’ (Piper et al., 1983) was likened to the ‘is not like me – is like me’ attribute, and ‘attraction’ (Drescher et al., 1985, Evans & Javis, 1980; Yalom, 1995) was likened to the ‘I don’t like – I like’ construct, and so on.

The eleven provided bipolar attributes were: ‘not committed to group – committed to group’; ‘doesn’t contribute to group – contributes to group’;
‘untrustworthy – trustworthy’; ‘unsupportive – supportive’; ‘submissive – dominating’; ‘disagrees with the group goals – agrees with the group goals’; ‘doesn’t understand me – understands me’; ‘I don’t like – I like’; ‘doesn’t help the group to solve problems and keep working – helps the group to solve problems and keep working’; ‘is not like me – is like me’; ‘is isolated in the group – fits into the group well’.

Participants were provided with a grid, the vertical axis comprised the names of the therapists, group members, self, and ideal self, and the horizontal axis comprised the 11 bipolar attributes. Participants were asked to rate each of the people listed in the X axis on each of the bipolar constructs in the Y axis, on a scale of one to ten. Ratings closer to ‘one’ align with the left hand side of the bipolar attributes, whilst ratings closer to ‘ten’ align more with the right hand side. For example, a rating of ‘two’ on the ‘untrustworthy – trustworthy’ attribute suggests that the rater considered that particular group member to be highly untrustworthy, while a rating of ‘six’ would suggest that the person was perceived to be somewhat more trustworthy than not.

**Analyses**

Changes in early in therapy measures (WAI session 4 and session 6 for CALPAS-G, GCQ, and GCG) compared with end of treatment measures (same measures collected at session 16) were examined using repeated measures $t$-tests.

The relationships between the measures of alliance, cohesion, group climate and self-other differentiation were examined by both correlational analyses and multi-dimensional scaling.
Results

Description of sample recruited

Thirty client participants (17 females, 13 males; mean age 47.77 years, range 24-65 years) contributed to one of 6 depression psychotherapy groups and provided informed consent to participate in the research following institutional ethics review board approval. Initial group membership at intake was 7-9 members, but early drop-outs resulted in an average group size of 5 participants completing the study. In terms of chronicity of depressive symptomatology, only seven participants reported their current episode of major depression as their first, with most reporting lengthy histories of depression.

The results are described in relation to complete data available for the thirty clients who participated in one of six distinct therapy groups that consisted of sixteen therapy sessions. Of the 46 participants recruited in the study 16 dropped out (5 attended no therapy sessions, 11 attended a mean of 1.95 sessions (range 1-5)). Those that dropped out did so before ratings of alliance were collected, and consequently were not included in this analysis. Early treatment dropouts did not differ from those remaining in therapy in terms of clinical ratings or demographics (see Table 2). Although more females dropped out of treatment than males, Chi square regarding gender and drop-out was non-significant ($\chi^2 = 2.78, p = .10$).
Table 2. Group treatment sample compared with early dropouts.

<table>
<thead>
<tr>
<th></th>
<th>Included in treatment</th>
<th>Early dropouts</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>30</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Age</td>
<td>47.80 years</td>
<td>41.32 years</td>
<td>3.52</td>
<td>.07</td>
</tr>
<tr>
<td></td>
<td>Range 24 – 65 yrs</td>
<td>Range 23 – 64 yrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Intake BDI scores</td>
<td>25.07 (s.d. 8.07)</td>
<td>27.50 (s.d. 9.30)</td>
<td>.85</td>
<td>.36</td>
</tr>
<tr>
<td>Mean Intake HDRS scores</td>
<td>23.80 (s.d. 4.70)</td>
<td>24.13 (s.d. 4.83)</td>
<td>.05</td>
<td>.83</td>
</tr>
<tr>
<td>Mean Intake GAF</td>
<td>51.37 (s.d. 8.52)</td>
<td>48.25 (s.d. 7.76)</td>
<td>1.48</td>
<td>.23</td>
</tr>
</tbody>
</table>

Changes in Group Cohesion, Working Alliance and Group Climate over time

Hypothesis One stated that measures of working alliance, group cohesion, group climate, and self-other dissimilarity will change over the course of brief group therapy for depression.

Before any conclusions can be drawn regarding the relevance of working alliance under group therapy conditions, it is important to consider the question of whether working alliance becomes more relevant as the group develops over time. Table 3 displays results of repeated measures t-tests conducted on the WAI and group cohesion scales between early in therapy (WAI session 4, session 6 for CGC, GCQ, CALPAS-G) and end of therapy (after session 16 for all measures) time points.

As noted in Table 3, when the criterion for significance is set at .01 (2-tailed) only the WAI subscales and the MUI subscale of the CALPAS-G show improvement
over time. Although non-significant, the mean scores on the WSC subscale of the CALPAS-G, the ‘engaged’ subscale of the GCQ, and the ‘self-leader’ distance subscale of the GCG were in the expected direction. It is worth noting that a lower mean distance between self and group leader (i.e. the ‘self-leader’ subscale of the GCG), although not significant, indicates that the group members perceive themselves as more similar to the group leaders than higher mean distance scores.
### Table 3. Mean (SD) alliance and cohesion scores from early in treatment (Time 1) and end of treatment (Time 2)

<table>
<thead>
<tr>
<th>Measure (means)</th>
<th>Time 1</th>
<th>Time 2</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAI Total</td>
<td>190.91 (25.46)</td>
<td>207.59 (24.91)</td>
<td>-3.56 *</td>
</tr>
<tr>
<td>Tasks</td>
<td>60.50 (11.61)</td>
<td>66.82 (10.13)</td>
<td>-3.62 *</td>
</tr>
<tr>
<td>Bond</td>
<td>68.40 (8.47)</td>
<td>72.78 (8.46)</td>
<td>-2.54</td>
</tr>
<tr>
<td>Goals</td>
<td>62.01 (8.68)</td>
<td>68.00 (8.45)</td>
<td>-3.44 *</td>
</tr>
<tr>
<td>Calpas-G Total</td>
<td>19.55 (3.26)</td>
<td>21.23 (3.70)</td>
<td>-2.81 *</td>
</tr>
<tr>
<td>Patient working capacity (PWC)</td>
<td>4.57 (1.16)</td>
<td>4.91 (1.51)</td>
<td>-1.21</td>
</tr>
<tr>
<td>Working strategy consensus (WSC)</td>
<td>4.68 (1.32)</td>
<td>5.27 (.96)</td>
<td>-2.39</td>
</tr>
<tr>
<td>Patient commitment (PC)</td>
<td>5.80 (1.01)</td>
<td>5.89 (1.22)</td>
<td>-.475</td>
</tr>
<tr>
<td>Member understanding &amp; involvement (MUI)</td>
<td>4.50 (1.06)</td>
<td>5.16 (1.07)</td>
<td>-3.76 *</td>
</tr>
<tr>
<td>GCQ Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>3.79 (.92)</td>
<td>4.15 (.69)</td>
<td>-2.23</td>
</tr>
<tr>
<td>Conflict</td>
<td>1.07 (.84)</td>
<td>1.17 (.78)</td>
<td>-.527</td>
</tr>
<tr>
<td>Avoiding</td>
<td>2.92 (1.14)</td>
<td>3.01 (.87)</td>
<td>-.414</td>
</tr>
<tr>
<td>GCG Overall cohesion score</td>
<td>7.14 (2.22)</td>
<td>7.45 (2.60)</td>
<td>-.809</td>
</tr>
<tr>
<td>Self-leader distance</td>
<td>8.98 (3.02)</td>
<td>7.91 (2.87)</td>
<td>2.23</td>
</tr>
<tr>
<td>Mean Distance Self-all other group members</td>
<td>8.60 (2.56)</td>
<td>8.91 (3.20)</td>
<td>-.652</td>
</tr>
</tbody>
</table>

Note - * p < .01 (2-tailed)

Early in therapy = WAI measured after session four; all group measures after session six.
Late in therapy = All measures collected after session sixteen.
Specific variable associations - early in therapy and end of therapy associations

The following sections address the remaining four hypotheses. Each of these hypotheses examines associations between specific relationship phenomena variables of interest, and how the associations between these variables may vary between early in therapy (i.e. after session 4 for WAI measures and after session 6 for all other group measures) and at the end of treatment (i.e. after session 16 for all measures).

Working alliance (WAI) compared with group cohesion (CALPAS-G)

Hypothesis Two: There will be a positive association between components of working alliance and group cohesion.

Table 4 indicates first of all that there is a strong association between the WAI and CALPAS-G scales, summarised in the correlations between the total scale scores. That is, WAI total measured at session 4 correlated with CALPAS-G total measured at session 6 (r = .44). The WAI total correlation with CALPAS-G total at session 16 was even higher (r = .75). The most notable associations between alliance and cohesion early in therapy were between the ‘task’ and ‘goal’ subscales of the WAI and the ‘working strategy consensus’ (WSC) and ‘member understanding and involvement’ (MUI) subscales of the CALPAS-G. The ‘patient commitment’ (PC) subscale of the CALPAS-G was also significantly correlated with the WAI ‘task’ subscale. MUI was the only CALPAS-G subscale associated with the ‘bond’ subscale of the WAI.

By therapy termination (after session 16) it can be noted in Table 4 that the WAI and CALPAS-G subscales show a more comprehensive relationship when compared with their correlations measured earlier in therapy. The most significant
change occurred with the ‘bond’ subscale of the WAI, where a new association with PWC, WSC, and PC replaced the earlier association with MUI. Consequently, these results indicate an increasing association between alliance and cohesion over the life of the group, particularly in terms of the relational bonds factor.

Table 4. Pearson correlation coefficients of Working Alliance with Group Cohesion Scales – Early and Late in Treatment.

<table>
<thead>
<tr>
<th></th>
<th>Task</th>
<th>Bond</th>
<th>Goals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working Alliance Inventory (WAI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calpas-G Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>.52 *</td>
<td>.19</td>
<td>.42 *</td>
<td>.44 *</td>
</tr>
<tr>
<td>Late</td>
<td>.73 *</td>
<td>.66 *</td>
<td>.69 *</td>
<td>.75 *</td>
</tr>
<tr>
<td>Patient working capacity (PWC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>.06</td>
<td>-.04</td>
<td>-.09</td>
<td>-.02</td>
</tr>
<tr>
<td>Late</td>
<td>.48 *</td>
<td>.69 *</td>
<td>.51 *</td>
<td>.60 *</td>
</tr>
<tr>
<td>Working strategy consensus (WSC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>.50 *</td>
<td>.15</td>
<td>.44 *</td>
<td>.43 *</td>
</tr>
<tr>
<td>Late</td>
<td>.71 *</td>
<td>.54 *</td>
<td>.66 *</td>
<td>.69 *</td>
</tr>
<tr>
<td>Patient commitment (PC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>.42 *</td>
<td>.01</td>
<td>.31</td>
<td>.30</td>
</tr>
<tr>
<td>Late</td>
<td>.70 *</td>
<td>.43 *</td>
<td>.56 *</td>
<td>.62 *</td>
</tr>
<tr>
<td>Member understanding &amp; involvement (MUI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>.52 *</td>
<td>.43 *</td>
<td>.56 *</td>
<td>.57 *</td>
</tr>
<tr>
<td>Late</td>
<td>.39</td>
<td>.31</td>
<td>.41 *</td>
<td>.40 *</td>
</tr>
</tbody>
</table>

Note: * p < .01 (1 – tailed)
Early in therapy = WAI measured after session four; all group measures after session six.
Late in therapy = All measures collected after session sixteen.

Working alliance (WAI) compared with group climate (GCQ)

Hypothesis Three: There will be a positive association between components of working alliance and the engaged component of group climate and a negative association with the conflict and avoidance components of group climate.

The only GCQ subscale associated with the WAI early in therapy was the ‘engaged’ subscale (Table 5). The ‘task’ agreement subscale of the WAI appears to have accounted for most of the association between the engaged subscale and the
WAI early in therapy. By therapy termination, no GCQ subscales were associated with the WAI subscales. This suggests that group members being ‘engaged’ in the therapy process early in therapy resonates with the ‘task’ agreement notion of alliance. No significant negative associations between the ‘conflict’ and ‘avoiding’ subscales from the GCQ and the WAI scales were found.

**Table 5. Pearson correlation coefficients of Working Alliance with Group Climate Scales – Early and Late in Treatment.**

<table>
<thead>
<tr>
<th>Working Alliance Inventory (WAI)</th>
<th>Task</th>
<th>Bond</th>
<th>Goals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GCQ</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>Early</td>
<td>.43 *</td>
<td>.29</td>
<td>.35</td>
</tr>
<tr>
<td></td>
<td>Late</td>
<td>.35</td>
<td>.29</td>
<td>.27</td>
</tr>
<tr>
<td>Conflict</td>
<td>Early</td>
<td>-.13</td>
<td>.13</td>
<td>.05</td>
</tr>
<tr>
<td></td>
<td>Late</td>
<td>.17</td>
<td>.07</td>
<td>.05</td>
</tr>
<tr>
<td>Avoiding</td>
<td>Early</td>
<td>.16</td>
<td>-.02</td>
<td>.30</td>
</tr>
<tr>
<td></td>
<td>Late</td>
<td>-.07</td>
<td>-.26</td>
<td>-.22</td>
</tr>
</tbody>
</table>

Note: * p < .01 (1-tailed)
Early in therapy = WAI measured after session four; all group measures after session six.
Late in therapy = All measures collected after session sixteen.

**Working alliance (WAI) compared with group cohesion (GCG)**

**Hypothesis Four:** There will be a negative association between components of working alliance and self-other dissimilarity.

Early in therapy the WAI subscales did not show an association with the ‘self-leader’ subscale of the GCG (Table 6). However, the ‘bond’ subscale of the WAI was associated with the ‘self-other group members distance’ subscale of the GCG. Although non-significant, as hypothesised at therapy termination the ‘self-leader distance’ scale of the GCG showed a negative trend with the ‘task’ and ‘bond’ subscale of the WAI. Therefore, it might be suggested that early in therapy, alliance seems to be associated with the relationships between group members rather than the
relationship between individual group members and the group leader, at least in terms of relational bond issues. Furthermore, although non-significant, there appears to be a trend that suggests that the perception of self-leader dissimilarity becomes increasingly associated with WAI ratings by treatment end. The ‘bond’ component of the WAI showed the greatest trend of association with self-others differentiation measures. The available data fails to show any significant changes or trends over time between alliance and self-other differentiation.

Table 6. Pearson correlation coefficients of Working Alliance with Group Cohesion Grid Distance Scales – Early and Late in Treatment.

<table>
<thead>
<tr>
<th></th>
<th>Working Alliance Inventory (WAI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Task</td>
</tr>
<tr>
<td>GCG Overall cohesion score</td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>-.04</td>
</tr>
<tr>
<td>Late</td>
<td>-.05</td>
</tr>
<tr>
<td>Self-leader distance</td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>.03</td>
</tr>
<tr>
<td>Late</td>
<td>-.36</td>
</tr>
<tr>
<td>Mean Distance Self-all other group members</td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>.01</td>
</tr>
<tr>
<td>Late</td>
<td>-.16</td>
</tr>
</tbody>
</table>

Note: * p < .01 (1–tailed)
Early in therapy = WAI measured after session four; all group measures after session six.
Late in therapy = All measures collected after session sixteen.

Group climate (GCO) compared with the Group Cohesion Grid (GCG)

Hypothesis Five: There will be negative associations between measures of self-other dissimilarity and measures of group climate and cohesion.

Hypothesis Six: The associations between measures of self-other dissimilarity and measures of group climate and cohesion will change over the course of therapy.

It can be seen in Table 7 that in the earlier stages of group development the mean ‘self – leader’ distance measure was negatively associated with the ‘engaged’
and ‘conflict’ subscales of the GCQ. This suggests that the more group members perceive themselves as being dissimilar to the group leaders across the range of constructs (e.g. commitment to group, trustworthiness, fitting in, etc), the less likely they were to perceive the group as experiencing conflict, or being engaged in the group. Or from the opposite perspective, the less dissimilar to group leaders the group members perceived themselves to be, the more engaged the group was perceived to be, and the greater the level of perceived conflict.

When comparing variations in association between the GCQ and GCG subscales between early in therapy and therapy termination time points, Table 7 indicates that the ‘engaged’ subscale from the GCQ expanded on its early association with the ‘self-leader’ subscale to become more significantly associated with all the GCG distance subscales. This suggests that as the group reached termination the individual group members perceived the other group members to be more engaged the less they seemed dissimilar to themselves.

Table 7. Pearson correlation coefficients of the Group Cohesion Grid with the Group Climate Questionnaire (early and late in treatment).

<table>
<thead>
<tr>
<th>GCQ</th>
<th>Overall score</th>
<th>Group Cohesion Grid (GCG)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Self-leader distance</td>
<td>Self-all other group members</td>
</tr>
<tr>
<td>Engaged</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>-.28</td>
<td>-.49 *</td>
<td>-.35</td>
</tr>
<tr>
<td>Late</td>
<td>-.51*</td>
<td>-.38 *</td>
<td>-.57 *</td>
</tr>
<tr>
<td>Conflict</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>-.19</td>
<td>-.48 *</td>
<td>-.28</td>
</tr>
<tr>
<td>Late</td>
<td>.12</td>
<td>-.07</td>
<td>.03</td>
</tr>
<tr>
<td>Avoiding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>-.17</td>
<td>-.25</td>
<td>-.06</td>
</tr>
<tr>
<td>Late</td>
<td>-.09</td>
<td>.09</td>
<td>-.07</td>
</tr>
</tbody>
</table>

Note: * p < .01 (1-tailed)
Early in therapy = All measures after session six.
Late in therapy = All measures collected after session sixteen.
Table 8 indicates an association early in therapy between the ‘overall cohesion score’ from the GCG and the ‘patient working capacity’ and ‘member understanding and involvement’ subscales from the CALPAS-G. This suggests that the lesser the distance perceived between those present in the group, the higher the perception of the group members’ capacity and tendency to be involved in exploring their issues in the group. Similarly, the association between the ‘self and all other group members’ dissimilarity subscale and ‘member understanding and involvement’ suggests that the less dissimilar to ‘self’ the other group members were perceived to be, the more likely they were perceived to participate in deeper personal involvement in the group.

When comparing variations in association between the CALPAS-G and GCG subscales between early and therapy termination time points, Table 8 indicates significant associations between the mean ‘self-leader’ dissimilarity ratings from the GCG and the CALPAS-G total and subscales of PWC, WSC, and PC at therapy termination, which were not significant earlier in therapy. However, the association between the ‘overall group cohesion’ subscale from the GCG and the MUI subscale from the CALPAS-G remained consistent over time.
Table 8. Pearson correlation coefficients of the Group Cohesion Grid with the CALPAS-G (early and late in treatment).

<table>
<thead>
<tr>
<th></th>
<th>Overall cohesion score</th>
<th>Group Cohesion Grid (GCG)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Self-leader distance</td>
<td>Self-all other group members</td>
</tr>
<tr>
<td>CALPAS-G Total</td>
<td>Early - .29</td>
<td>- .36</td>
<td>- .20</td>
</tr>
<tr>
<td></td>
<td>Late - .23</td>
<td>- .51 *</td>
<td>- .27</td>
</tr>
<tr>
<td>Patient working capacity</td>
<td>Early - .41 *</td>
<td>- .35</td>
<td>- .33</td>
</tr>
<tr>
<td>(PWC)</td>
<td>Late - .12</td>
<td>- .45 *</td>
<td>- .18</td>
</tr>
<tr>
<td>Working strategy consensus</td>
<td>Early - .08</td>
<td>- .32</td>
<td>- .05</td>
</tr>
<tr>
<td>(WSC)</td>
<td>Late - .23</td>
<td>- .46 *</td>
<td>- .23</td>
</tr>
<tr>
<td>Patient commitment (PC)</td>
<td>Early .11</td>
<td>.02</td>
<td>.24</td>
</tr>
<tr>
<td></td>
<td>Late - .02</td>
<td>- .40 *</td>
<td>- .13</td>
</tr>
<tr>
<td>Member understanding &amp;</td>
<td>Early - .46 *</td>
<td>- .34</td>
<td>- .41 *</td>
</tr>
<tr>
<td>involvement (MUI)</td>
<td>Late - .39 *</td>
<td>- .26</td>
<td>- .31</td>
</tr>
</tbody>
</table>

Note: * p < .01 (1-tailed)
Early in therapy = All measures after session six.
Late in therapy = All measures collected after session sixteen.

**Multidimensional Scaling Analyses**

The relationship between the WAI subscales and those of the GCG, GCQ, and CALPAS-G, were further analysed using a multidimensional scaling method (MDS), which generated plots displayed in Figures 1a-1c (measured early in treatment) and 2a-2c (measured at treatment termination) below. An advantage of the MDS method is that it caters for the examination of the Euclidian distance relationships between all of the subscales of the GCG, the GCQ, the WAI, and the CALPAS-G simultaneously. Effectively, each component subscale is a stimulus point for every other component subscale, and is thus plotted in relation to every other component subscale. Consequently, it is possible to identify differences or similarities in terms of distance measures between the individual component subscales in relation to underlying dimensions (Young & Hamer, 1994; Schiffman, Reynolds, & Young, 1981; Borg & Lingoes, 1987).
Early in therapy plots

Figures 1a to 1c represent a single three-dimensional derived stimulus configuration that has been rotated three times to highlight how the indices spread about specific dimensions. These plots compare the means of the subscales of the WAI measured at session four with the means of the CALPAS-G, GCQ, and GCG subscales all measured at session six.

The results of this analysis yielded a good fit to the data, Stress = .03, RSQ = .99. Stress indicates the degree to which the display of dimensions can explain the pattern of data in the similarity/distance matrix. Lower stress values indicate more complete explanation of variance. The three dimensional model was chosen as it better captures the distinctions and associations between the different measures than the two dimensional model, whilst improving goodness of fit without unduly complicating the model by increasing dimensional divisions further (Schiffman, Reynolds, & Young, 1981; Young & Hamer, 1994; Borg & Lingoes, 1987). The three dimensions described below were defined and interpreted in terms of those subscale components located closest to each of the dimensions’ zero lines when contrasted with those subscale components located furthest from the zero lines.

Dimension one (Figure 1a and 1c) was defined early in therapy by: the WAI component subscales (goal4, task4, bond4), all the CALPAS-G component subscales (pwc6, wsc6, pc6, and mui6), and the ‘engaged’ component subscale of the GCQ (engag6). The specific self-other differentiation relationships (as defined by the GCG subscales) most closely associated with dimension one was the mean overall cohesion score (gcgtl6) which considers the group-as-a-whole. Dimension one was further defined by contrasting those indices mentioned above with the indices located at the
greatest distance from them. At week six the specific dissimilarity relationships of ‘self-leader’ and ‘self-other group member’ distance subscales of the GCG (‘sflead6’ and ‘selfogm6’) and the GCQ subscales ‘conflict’ and to a lesser extent ‘avoiding’, were located furthest from the zero line, which indicates that they were not the direct concern of dimension one. Therefore, based on early in therapy data alone the emerging description of dimension one was that similar to the notion of ‘group alliance’ (Marziali et al, 1997). That is, the defining cluster of indices on this dimension were concerned with the level of alignment of the group-as-a-whole around ‘task’ and ‘goal’ setting functions and a general sense of the level of commitment, working capacity and engagement of the group members.

Dimension two (Figure 1a and 1b) was defined early in therapy by the GCQ component subscales ‘conflict’ (confl6), ‘avoiding’ (avoid6) and ‘engaged’ (engag6), with the ‘group alliance’ cluster of component subscales (discussed in dimension one above) also located reasonably central on this dimension. Apart from the centrality of ‘conflict’ and ‘avoiding’ component subscales distinguishing dimension one from dimension two, the location of the ‘self-other group member’ (selfogm6) dissimilarity index on dimension two has become more central when compared with dimension one (note that closeness to zero line relative to small Y axis indices for dimension 2 when compared with the X axis indices of dimension 1). It is also worth noting that the defining cluster of component subscales for dimension two was contrasted with the ‘self-leader’ (sflead6) and ‘overall cohesion’ (gcgtl6) dissimilarity indices, which were located most distant from the dimension two zero line. Once again the location of the ‘conflict’ and ‘avoiding’ component indices are worth noting in relation to dimension two. ‘Conflict’ and ‘avoiding’, as well as the other component indices of
the central cluster, were more closely linked with the ‘self-other group member’
dissimilarity index.

Dimension three (Figures 1b and 1c) was defined early in therapy more by
those component indices outside the central cluster than those within. That is, once
again the central cluster at week six reflected the majority of those component indices
implicated in the general ‘group alliance’ factor described in dimension one, with the
exception of the CALPAS-G component subscales of ‘patient working capacity’
(pwc6) and ‘working strategy consensus’ (wsc6). Therefore, there appeared to be an
association between ‘patient working capacity’, ‘working strategy consensus’, on the
positive side of the dimension three zero line, and ‘conflict’, ‘avoidance’ and the ‘self-
leader’ dissimilarity indices on the negative side of the line, in that they were distinct
from the general group alliance cluster. In terms of specific dissimilarity relationships,
the group-as-a-whole index ‘overall cohesion’ (gegtl6) and the ‘self-other group
member’ (selfogm6) dissimilarity index held the central defining position.

MDS plots at therapy termination

Figures 2a to 2c represent a single three-dimensional derived stimulus
configuration that has been rotated three times to highlight how the indices spread
about specific dimensions at therapy termination. The results of this analysis of all
four sets of indices yielded a good fit to the data, Stress = .03, RSQ = .99.

As can be observed in Figures 2a and 2c, the configuration of indices
remained fairly stable over time (when compared with Figure 1a) in terms of
dimension one, with the exception of the ‘self-leader’ (sflead16) dissimilarity index.
By week sixteen of treatment the ‘self-leader’ index became located more centrally
(i.e. less distinct) on dimension one. This suggests that the ‘self-leader’ relationship
may have no longer been perceived as separate from group alliance issues as it appeared at session six.

Dimension two, as depicted in Figures 2a and 2b, can be seen to have changed substantially over time. One notable change was in relation to the ‘conflict’ index (confl16). Whereas ‘conflict’ was a centrally defining index at week six of treatment, by week sixteen it was located most distant from the dimension two zero line. The other significant shift over time was in relation to the relocation of the ‘self-leader’ index (sflead16) from being the most distant index from the dimension two zero line, to being closer to the central points. These changes indicate that the distinction between ‘self-leader’ and ‘self-other group members’ (selogm16) and generally with the group-as-a-whole (i.e. gcgt16) is less discriminating over time. This might be considered as suggesting that progressively not only were the group members noticing more similarities than differences between themselves and the group leaders, but that group leaders were perceived as less distinct from other group members than earlier in treatment.

Dimension three, as depicted in Figures 2b and 2c, indicates that there was a shift over the course of therapy. The most significant shift was in relation to the centralisation of the ‘conflict’ (confl16) and ‘avoiding’ (avoid16) indices at week sixteen. This effectively left the ‘self-leader’ index alone outside the centralised dimension three cluster of indices. Consequently, dimension three was progressively associated with ‘conflict’ in relation to ‘self-other group members’ (selogm16) and to a lesser extent the ‘group-as-a-whole’ (gcgt16).
Figure 1a. Rotated Multidimensional Scaling Plot highlighting indices distinctions (alliance, group cohesion, group climate and self-other differentiation measures) on the basis of dimensions one and two early in therapy.

Figure 2a. Rotated Multidimensional Scaling Plot highlighting indices distinctions (alliance, group cohesion, group climate and self-other differentiation measures) on the basis of dimensions one and two at therapy termination.
Figure 1b. Rotated Multidimensional Scaling Plot highlighting indices distinctions (alliance, group cohesion, group climate and self-other differentiation measures) on the basis of dimensions two and three early in therapy

Figure 2b. Rotated Multidimensional Scaling Plot highlighting indices distinctions (alliance, group cohesion, group climate and self-other differentiation measures) on the basis of dimensions two and three at therapy termination
Figure 1c. Rotated Multidimensional Scaling Plot highlighting indices distinctions (alliance, group cohesion, group climate and self-other differentiation measures) on the basis of dimensions one and three early in therapy.

Figure 2c. Rotated Multidimensional Scaling Plot highlighting indices distinctions (alliance, group cohesion, group climate and self-other differentiation measures) on the basis of dimensions one and three at therapy termination.
Discussion

Considering the limitations associated with the sample size available for analysis in this study, the results need to be considered in terms of their exploratory value rather than their conclusiveness. Furthermore, that fact that there were only two measurement points (early in therapy and treatment termination after sixteen sessions) limits the capacity of the significant results and noted trends to represent a reliable analogue of progressive group development processes. However, the findings are interesting enough to encourage further research of this type, particularly the use of repertory grid methods for examining self-other differentiation in group therapy and multidimensional scaling analysis methods with larger samples and more frequent measurement.

The first research question of this study was *do measures of working alliance, group cohesion, group climate, and self-other dissimilarity change over the course of brief group therapy for depression?* Based on the data available from this sample this might be answered two ways. Firstly, considering significant changes in means over the life of the group some variables do change and others appear not to. Secondly, in relation to how different variables relate to each other again the answer is some variable relationships do change and others do not.

Repeat measures *t*-tests revealed that in general only the measures of the therapeutic alliance between individual group members and the group leaders appears to become stronger. This might mean that it takes longer to build a stronger alliance in group therapy situations than in individual therapy situations related to direct interpersonal contact dispersion (in terms of direct time with the therapist at least), or it could simply represent an artefact of collection time points. That is, the alliance is
expected to fluctuate throughout the course of treatment (Safran & Muran, 1996, 2000; Safran, Crocker, McMain, & Murray, 1990; Horvath & Greenberg, 1994). However, it may have been the case that perceptions of alliance a session or two either side of the collection points may have been different. This is one of the reasons that more frequent measurement and consideration of average ratings across a number of sessions would perhaps be a more reliable indicator of progressive changes in alliance and other process variables over time (e.g. Brossart, Patton, & Wood, 1998; Kivlighan & Goldfine, 1991; Kivlighan & Lilly, 1997). More specific discussion regarding the potential interaction of dimensions of group cohesion over the life of the group with this sample, and how this might reflect progressive models of group development, will be discussed later.

Therefore in relation to hypothesis one, ‘measures of working alliance, group cohesion, group climate, and self-other dissimilarity will change over the course of brief group therapy for depression’, this hypothesis was only partially supported. That is, only working alliance and the ‘member understanding and involvement’ subscale of the CALPAS-G significantly changed over time. It is worth noting though that although changes in the mean ratings of each of the variables were not all significant they were in general changing in the expected directions. Furthermore, some of the relationships between the different variables did change over time, which is elaborated below.

The second and third research questions concerned exploring the relationship between working alliance, group cohesion, group climate, and self-other dissimilarity within brief group therapy for depression situations and the usefulness of a repertory grid method for exploring and clarifying the dimensions of group cohesion. These questions
were addressed in terms of key correlational analyses and subsequent multidimensional scaling analyses.

The major findings of this study, and indeed its strength in terms of incorporating self-other dissimilarity repertory grid data, appear to offer at least preliminary support for some of Dion’s (2000) proposal for primary dimensions of cohesion model. The nature of the associations between the variables and how they varied over the life of the group also offers some insights, although tentative at this stage, for the debate regarding alliance and cohesion in group therapy (e.g. Bednar & Kaul, 1994; Marziali, et al., 1997), and progressive models of group development (e.g. Cissna, 1984; Mennecke, Hoffer, Wynne, 1992; MacKenzie, 1983; Kivlighan & Goldfine, 1991; Kivlighan & Lilly, 1997).

The first contention arising from this study is that dimensions of group cohesion might best be considered progressively over the life of the group. Secondly, that data derived from brief Supportive-Expressive group therapy with depressed populations suggests that group cohesion might consists of three main underlying dimensions. Thirdly, that perceived levels of conflict, and where the conflict lies in relation to self-other differentiation indices, appears to represent an influence in terms of defining the primary dimensions of cohesion.

The preliminary correlation analyses produced some interesting findings. Firstly, the early in therapy association between the ‘task’ and ‘goal’ agreement subscales of the WAI and the ‘working strategy consensus’ (WSC) and ‘member understanding and involvement’ (MUI) subscales of the CALPAS-G suggests that group members’ understanding and involvement in tasks such as problem solving might be seen as an extension of, or specific example of, the general perception of task/goal agreement with
the group leaders. This might be a comment on the groups going through a ‘forming’ and
‘norming’ stages of group development in the Tuckman and Jensen (1977) model, or the
‘engagement’ stage in MacKenzie’s (1983) model of group development. These early
stages of group development involve discerning ‘what’ to work on and ‘how’ to achieve
these goals. Group developmental processes will be elaborated further shortly.

By therapy termination the WAI and CALPAS-G subscales showed a more
comprehensive relationship when compared with their correlations measured earlier in
therapy. Most notably the ‘bond’ subscale of the WAI displayed new associations with
PWC, WSC, and PC where previously the only association was with MUI. This might
suggest that as the groups progressed over time the relational bonds with the group
leaders, and indeed alliance in general, is associated with the level of cohesion perceived
within the group. Therefore these findings appear to support hypothesis two in that ‘a
positive association between components of working alliance and group cohesion as
measured by the CALPAS-G’ was noted which appeared to become more comprehensive
over the life of the group.

Secondly, the only Group Climate (GCQ) subscale associated with the WAI early
in therapy was the ‘engaged’ subscale with ‘task’, which diminished by therapy
termination. This finding represents only partial support for hypothesis three that ‘there
will be a positive association between components of working alliance and the engaged
component of group climate and a negative association with the conflict and avoidance
components of group climate’. This also somewhat supports MacKenzie’s (personal
communication, 2002) contention that the ‘engaged’ construct in the group climate may
resonate with the alliance construct.
Thirdly, the mean ‘self-other group members’ differentiation subscale of the Group Cohesion Grid (GCG) was associated with the ‘bond’ subscale of the WAI early in therapy. This suggests that the less dissimilar (i.e. more similar) to other group members individuals perceived themselves to be, the higher the perception of relational bonds with the group leaders. Described from the opposite direction, early in therapy there appears to be a relationship between how well individual group members bond with the group leaders and how similar or dissimilar to other group members they perceive themselves to be in terms of contributing to aspects of group cohesion. Therefore, it might be suggested that the initial process of engagement between group members appears to be influenced by the initial bonding with the group leaders. However, by therapy termination this association diminished. This represents only partial minor support for hypothesis four that ‘there will be a negative association between components of working alliance and self-other dissimilarity’.

Therefore, based on correlations between the subscales measured in the early stages of therapy, it seems that the ‘bond’ subscale of the WAI is connected with group members’ perception of self differentiation from other group members, whilst the ‘task’ and ‘goal’ agreement subscales of the WAI are connected with similar constructs as measured by the CALPAS-G and the ‘engaged’ subscale of the GCQ. Consequently, based on correlation results alone, it might be speculated that there appears to be a distinction between ‘task’ functions and ‘social’ or relational issues.

Furthermore, in the earlier stages of group development the ‘self – leader’ dissimilarity measure was negatively associated with the ‘engaged’ and ‘conflict’ subscales of the GCQ. This suggests that early in the group process the more group
members viewed themselves as dissimilar in relation to the group leaders, the less engaged and less conflictual the group was perceived. By therapy termination the ‘engaged’ subscale from the GCQ expanded on its early association with the ‘self-leader’ subscale to become significantly associated with the ‘overall cohesion score’ and the ‘self-other group members’ distance subscales. Perceived ‘conflict’ was no longer associated with any of the self-other differentiation indices at treatment termination. These finding suggest that the group members’ perception of group climate, in terms of engagement at least, is initially restricted to associations with group members’ views on how similar or dissimilar they are in relation to the group leaders, and later in the life of the group in relation to similarity or dissimilarity in relation to everyone present in the group. Therefore, it might be speculated that this shift over the life of the group from a narrower self-leader relational focus to one that includes all group members and the group leaders might reflect the group development process linked to the shift from dependency on the group leaders (at least in terms of responsibility for engagement and conflict management) to one where the group members become more differentiated from each other and thus may take more responsibility for the group climate.

Whereas the above interpretation describes shifts in responsibility for the group climate of the life of the group, an alternative interpretation regarding the shift in self-other differentiation focus and associations with engagement might reflect on the progressive developments in negotiating a ‘group’ or ‘social identity’ with one’s own personal identity. In other words, when the group is defined by how different the group members are from the group leaders, which seems to resonate with ‘self-categorisation theory’ (outlined further below) (Hogg, 1992; Hogg & Tindale, 2001) and the formation
of a ‘group’ or ‘social identity’ this seems to reflect the ‘engagement’ stage of the group developmental process (MacKenzie and Livesley, 1983). However, when the group is defined by how different the group members are from each other this seems to reflect at a minimum the ‘differentiation’ stage but more likely the ‘intimacy’ or ‘mutuality’ stages by treatment end. As mentioned earlier the ‘differentiation’ or ‘individuation’ stages is where group members recognise differences between each other and may be confronted with difficult emotions and perceive the climate as conflictual. The ‘intimacy’ stage is typified by low to moderate levels of avoidance while conflict and engagement remain relatively static. The ‘mutuality’ stage is typified by a reduction of avoidance in preference for a deeper commitment from other group members (MacKenzie and Livesley, 1983).

The fact that this study found an association between ‘conflict’ and ‘self-leader’ dissimilarity early in therapy and not at therapy termination also appears to reflect the notion that by six weeks the groups were negotiating a stage that in terms of ‘self-leader’ differentiation that was less conflictual by therapy end. What is interesting though is that the conflict had not yet become more associated with the ‘self-other group members’ differentiation process by week six. If the ‘conflict’ and ‘engagement’ associations within self-other differentiation measures are considered together it seems to suggest that at six weeks the individual groups on average were still forming a ‘social identity’ (Hogg, 1992; Hogg & Tindale, 2001) by considering what they as group members had in common and how they were different from the group leaders. The finding that conflict had not yet become significantly associated with ‘self-other group member’ differentiation could be taken to imply that the groups had not fully entered the
‘differentiation – individuation’ stage (where conflict would be expected) by week six. Furthermore, the lack of significant association between ‘conflict’ and any ‘self-other’ differentiation index by treatment end seems to further imply that the group had successfully negotiated the differentiation – individuation stage and was most likely in the intimacy or mutuality stages (MacKenzie, 1997).

In relation to associations between self-other differentiation indices (GCG) and the components of cohesion as measured by the CALPAS-G subscales, early in therapy the ‘overall cohesion score’ and the ‘self-other group member’ dissimilarity indices from the group cohesion grid were negatively associated with the ‘member understanding and involvement’ (MUI) from the CALPAS-G. This suggests that early in therapy the more group members perceived themselves as dissimilar to others in the group the less they perceived the group members as understanding and involved in the group process. The ‘overall cohesion score’ was also negatively associated with the ‘patient working capacity’ (PWC) CALPAS-G subscale. Similarly this suggests that early in therapy the more group members were perceived as dissimilar the lower their capacity to work actively and purposefully in treatment was perceived to be. This association was no longer significant by the end of treatment.

By treatment end the ‘self-leader’ dissimilarity index became negatively associated with PWC, ‘working strategy consensus’ (WSC), and ‘patient commitment’ (PC) (which reflects the group member’s attitude towards therapy, including affectionate trusting feelings and a commitment to go through the complete process of therapy) (Gaston, & Marmar, 1993), while MUI maintained its association with the ‘overall cohesion score’. These findings seem to imply that the more individual group members
perceived themselves as dissimilarity to the group leaders the less likely the group was perceived to be able to work together, to reach agreement about how therapy should proceed, and to be committed to the therapy process. In other words, on average the less individual group members viewed themselves as different from the group leaders and each other the more cohesion the group was perceived to be. These findings offer support for hypothesis five that ‘there will be negative associations between measures of self-other dissimilarity and measures of group climate and cohesion’.

Again a trend of shifting in association between self-other differentiation indices and group measures can be noted here. This seems to imply that earlier in the group process group cohesion is more defined by processes of differentiation between group members, whereas by the end of treatment self-group leader differentiation seems to be more central to group cohesion issues. This appears to be a shift in the opposite direction to that noted in relation to group climate.

Although it would have been better in relation to tracking group development stage processes if these measures were collected more frequently over the life of the group (although client burden issues also had to be considered), these climate and cohesion with self-differentiation index association findings still appear to represent an indicator of a progressive movements between self-leader differentiation and broader self-other differentiation processes. This offers support for the final hypothesis that ‘the associations between measures of self-other dissimilarity and measures of group climate and cohesion will change over the course of therapy’.

Although purely speculative at this stage these self-other differentiation processes may be linked to Dion’s (2000) notion of ‘vertical cohesion’ in that there appears to be a
progressive shifting of responsibilities for the climate of the group over time from leader focus to all of group including leaders focus. However, in relation to cohesion the shift seems to be from processing similarity between group members to focusing on similarities with the group leaders. These shifts in self-other differentiation alignments also seem to reflect the notion of ‘social cohesion’ (Dion (2000).

The speculative correspondence between these emerging trends and Dion’s (2000) proposal of ‘task’, ‘social’ and ‘vertical’ primary dimensions of cohesion, was further explored by the multidimensional scaling (MDS) analyses performed on the early in therapy and therapy termination data. MDS converts each of the WAI, CALPAS-G, GCQ subscales and the self-differentiation measures into indices plotted in terms of distance measures. That is, the MDS plots depict the structure of distance data (i.e. degree of similarity or dissimilarity) that approximate the distances between the indices as a geometrical configuration within a multidimensional space. The points are located within this space in terms of the strength of the relationships between all of the different indices at once (Young & Hamer, 1994; Borg & Lingoes, 1987; Schiffman, Reynolds, & Young, 1981). An advantage of complementing correlational results with MDS analysis plots is that it offers a visual analogue of a ‘best fit’ model across different underlying dimensions that captures in one rotatable plot where each index is located in relation to each of the other indices, rather than being restricted to comparisons of individual associations.

The first dimension produced by the MDS plots is closest to the general conception of working alliance (or group alliance as defined by Marziali et al, 1997). It relates issues of task and goal agreement with components of group cohesion, a general
sense of the level of commitment, working capacity, engagement and alignment of the group-as-a-whole. It is specifically concerned with the clarification and application of the therapy agenda and, similar to the concept of working alliance (regardless of fluctuations) this dimension remains reasonably stable over time. Subsequently, dimension one appears to resonate with the notion of ‘task cohesion’, and suggests that issues of task agreement remain important throughout the life of the group.

The early in therapy link between issues of ‘bond’ and perceptions of self in relation to other group members found in the correlational data is less obvious on the MDS plots. However, there is a notable distinction between ‘self-other group members’ and ‘self-leader’ indices early in therapy on the basis of dimension two on the MDS plot. The ‘self-other group members’ index more centrally defines dimension two than the other self-other differentiation indices. The ‘group alliance’ cluster defined in dimension one is still fairly central to dimension two, however ‘conflict’ and ‘avoiding’ are most central in terms of defining this dimension and most distantly contrasted by the ‘self-leader’ differentiation index and to a lesser extent the ‘overall group cohesion’ index (which considers the average perceived distance between all present in the group). By the end of therapy dimension two was centrally defined by the ‘engaged’ group climate and the ‘self-other group members’ differentiation indices and most distantly contrasted with the ‘conflict’ index. Consequently, the theme that appears to be emerging from dimension two is concerned with conflict and avoidance issues between self and other group members. This dimension also appears to reflect a shifting in emphasis between ‘self-leader’ and ‘self-other group member’ dynamics. In functional terms, this dimension
appears to be concerned with the often conflict featured negotiation involved in balancing the need for an individual self-identity and the need to affiliate with a group.

There was an early in therapy trend for group members to perceive themselves as dissimilar to the group leaders. This could be considered as a reflection of the more existential features of ‘social identity theory’, or more specifically ‘self-categorisation theory’ mentioned above (Hogg, 1992; Hogg & Tindale, 2001). Self-categorisation theory predicts that individual group members at some stage perceive the group as an almost faceless entity linked by some common identifier, contrasted against other groups that lack this common theme. This involves the establishment of a ‘social identity’ (group membership of the in-group), with resultant feelings of belonging and enhancement of self-esteem, and secondly, the establishment of the distinct ‘other’ (or out-group). The perceived out-group could take a couple of different forms here. Firstly, as Aviran and Rosenfeld (2002) suggested, if the in-group is defined by the presence of a common problem (e.g. depressive disorder, or some stigmatisation), the out-group could be defined as people in society not identifying with the same problem. Secondly, for similar reasons, the out-group might consist of a subgroup within the group that are perceived as different, such as the group leaders. Consequently, it could be expected that a bond is likely to form between group members earlier in the life of the group because, under some circumstances, the leaders might be perceived as the ‘other’ or out-group, and because part of the role of the leader is to facilitate recognition of similarity between group members. This did occur in the present study, as defined by all three dimensions but particularly dimension two, and the early correlation between the ‘bond’ and ‘self-other group members’ dissimilarity indices.
Therefore, it might be suggested that the second dimension seems to merge both the ‘social cohesion’ and the ‘belonging’ primary dimensions of Dion’s (2000) primary dimensions of cohesion model.

The third dimension derived from the MDS plots effectively mapped the process of group members gradually softening the intensity of the contrast between being a group member and needing the group leaders to be perceived as different from the group. At six weeks the initial MDS configuration trend suggests that dimension three appears to deal with a ‘group-as-a-whole’ phenomenon that was perceived by the group members as distinct from issues of perceived ‘conflict’, ‘patient working capacity’, ‘working strategy consensus’ and the ‘self-leader’ relationship. It might be suggested on the basis of dimension three that in the early stages of group psychotherapy a significant role for group members is to get to know each other, form connections and to allow themselves to be supported, not necessarily seeing it as their own responsibility, or perhaps capability to set and perform the task and maintenance roles of the group (e.g. Yalom, 1995; Wilfley, et al., 2000). Consequently, locating ‘conflict’, ‘patient working capacity’, ‘working strategy consensus’ with the ‘self-leader’ dissimilarity indices outside the dimension three cluster might be indicative of the group members’ tendency to be more concerned with forming an alliance around tasks and developing a sense of social cohesion and belongingness at this early stage of group development, rather than being ready to explore their relationships with the therapists, their ability to agree and work together, or their conflict with each other.

Although this seemed to be somewhat dealt with on dimension two, dimension three further appears to be dealing with the distinction between the group members and
the group leaders in terms of role responsibilities, rather than social and personal identity issues. That is, this dimension seems more involved with discerning who is responsible for what (e.g. setting and maintaining the group climate), and just how prepared group members were to invest or commit themselves to taking responsibility for the group. The results show that group members tended to identify more (i.e. are perceived as less dissimilar) with the group leaders, perhaps mimicking previously leader modelled behaviours, and perceive themselves as more responsible for the group climate (e.g. being engaged in the group and dealing with conflict), as the group developed over time. More specifically, the progressive centralisation of ‘conflict’, ‘avoiding’ ‘patient working capacity’ and ‘working strategy consensus’ as defining indices of dimension three further suggests that this dimension deals with the gradual integration of these indices with the alliance cluster. That is, it appears that the ‘group-as-a-whole’ gradually starts to identify with having responsibility for these group climate issues, or at least associated them with perceptions of group member ‘commitment’, ‘understanding’, ‘engagement’ and so on rather than continuing to defer to the group leaders to take responsibility for them. It might also be suggested that this process may reflect the working through of transference issues with the group leaders (Kivlghan, et al, 1994).

Finally, it is worth noting that the ‘conflict’ index from the GCQ and the self-other differentiation indices from GCG seemed to be the most influential stimulus points when considering dimensional changes in group alliance and cohesion over time. In fact the only other indices that were occasionally located outside the central alliance cluster only on the basis of dimension three was the PWC and WSC indices. That is, group alliance seemed to be generally defined by the cluster of CALPAS-G and WAI
component subscales and the ‘engaged’ subscale from the GCQ. However, the ‘conflict’ and to a lesser extent the ‘avoiding’ component subscales of the GCQ seemed to stimulate the discernment of the dimensions of group cohesion in relation to group developmental processes and differing aspects of the therapeutic relationship as defined by the self-other differentiation indices.

In summary, working alliance appears to operate differently within a group setting than is expected in individual therapy. The relationship between individual group members and the group leaders appears to be influenced by a number of coexisting relational demands which might be examined in terms of three related dimensions. The first of these dimensions, ‘task cohesion’ mirrors some of the components of working or group alliance (i.e. ‘task’ and ‘goal’ agreement, engagement, etc.). The ‘bonding-with-group-leaders’ component tends to be more associated with ‘self-other group members’ differentiation and engagement processes earlier in treatment. The more specific relational issues seemed to be more broadly and likely associated with the second dimension, ‘social cohesion’ and the third dimension. Whereas the second dimension appeared to primarily reflect processes of individuation and belonging to the group, the third dimension, seemed to be more specifically reflecting processes of taking responsibility for the direction of the group. In this regard it might be speculated that the third dimension reflects the notion of ‘vertical cohesion’. Therefore a conclusion of this study is that working alliance is not analogous with group cohesion, but is intimately involved with it when considered in the context of the dimensionality of functional and relational phenomena involved in the development of a group.
Chapter 4

Study Two

Alliance and cohesion predictors of outcome in brief group psychotherapy for depression
Study one explored the associations and overlap between alliance, cohesion, climate and self-other differentiation processes early in the group therapy process and at therapy end. Study one offered some preliminary support for theories that describe group cohesion as a multidimensional construct that might be viewed as an analogue for group developmental processes over the life of the group. Although these findings need to be considered as tentative due to study limitations, they highlight the potential importance of investigating self-other differentiation processes and group members’ perceptions of conflict within the group alongside more traditional outcome predictors such as alliance and cohesion. Study two extends on the initial exploration in study one by examining the same variables in relation to group therapy outcome prediction.

The following sections are a recap of the pertinent points from the relevant literature reviewed in the introduction chapter of this thesis. For a more comprehensive review of this research see the sections entitled ‘Group Psychotherapy’ and ‘Linking Process to Outcome’.

**Predicting outcome in group therapy**

Various studies have found that the quality of the working alliance is positively related to treatment outcome (Alexander & Luborsky, 1986; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Marmar, et al., 1986; Truant, 1999; Saunders, 2000). Furthermore it has been suggested that the predictive ability of the working alliance can be determined as early in the therapy as the third session (Hersoug, Monsen, Havik, & Hoglend, 2002; Truant, 1999; Saunders, 2000). However the ability of alliance measures to predict outcome, as well as the best time to measure alliance, in group therapy is less known.
There have been attempts to define ‘group alliance’ as distinct from ‘group cohesion’. Some research findings support this distinction when it comes to predicting group therapy outcome. Marziali, et al (1997) found that although group alliance and group cohesion were significantly correlated, with each separately contributing to outcome, alliance accounted for more outcome variance than cohesion. However, at present there is no generally accepted definition of group alliance. Whilst some researchers have considered group alliance as analogous with the working alliance in individual therapy, thus focusing on the individual group member to therapist relationship, others considered it to capture the strength of the relationship between group members, particularly in relation to working together and commitment to meeting the goals of therapy. Budman, et al (1989) found less evidence for a clear distinction between group alliance and group cohesion, however raters were instructed to ignore the contributions of the relationship with the therapist in rating group alliance. Gillaspy, Wright, Campbell, Stokes and Adinoff (2002) found that neither alliance nor cohesion were satisfactory predictors of outcome within an intensive residential substance abuse treatment programme, with alliance alone predicting client ratings of reduced psychological distress, but not other outcome measures.

Although study one of this thesis found a significant association between alliance and group cohesion, on the basis of the study sample it appears that the strength of this association may require some time to develop over the life of the group. Therefore, considering group cohesion as analogous to the working alliance in individual therapy, particularly in relation to outcome prediction, may be presumptuous, as the relationship between the therapist and individual group members appears to be influenced by a range
of group developmental processes (Heron, 1993; MacKenzie, & Tschuschke, 1993). For example, Holmes and Kivlighan (2000) analysed processes within group and individual psychotherapy and found that components of the ‘relationship-climate’ and ‘other versus self-focus’ were more salient in group when compared with individual psychotherapy.

Kivlighan and Tarrant (2001) found that therapy specific behaviours offered by therapists in group therapy situations that were not aligned with client readiness had a negative relationship with client engagement which in turn was related to client outcome. It might further be suggested that the readiness for engagement in specific therapeutic tasks might be mediated by individual clients’ relational and existential characteristics and/or the strength of the therapeutic alliance.

Few studies have examined the relationship of group climate with treatment outcome (Kivlighan & Lilly, 1997; Braaten, 1989; McCallum, et al., 2002). However, treatment retention has been shown to be related to the level of engagement in the group process (Connelly, et al., 1986). Furthermore, MacKenzie (1983) suggested that the group leader can influence the group climate and thus have an indirect effect on client outcome. Kivlighan and Tarrant (2001) found that the group climate mediated the relationship between group leader activity and group member outcome. The findings of study one of this thesis offer some preliminary support for these contentions.

Andrusyna, et al. (2001) suggested that the generally held belief that the three alliance components of task agreement, goal agreement and therapeutic relationship bonds, based on Bordin’s (1979, 1994) conception, should no longer be accepted as independent components holding equal weight in relation to predictive ability. More specifically, they suggested that the relationship (bonds) between therapist and client
might be largely independent of the client’s agreement with, and confidence in, the therapist and the treatment strategies, consequently requiring these two factors to be measured independently.

Within the group therapy field, and in line with general alliance findings, it is a general expectation for greater therapeutic gains to be associated with a group displaying higher levels of cohesion. Simply measuring cohesion as a group-as-a-whole phenomenon without adequately qualifying measures within the broader contextual field of other relational, client specific and group developmental process factors (e.g. difficult interpersonal relationship style, group membership motivation, self-other differentiation processes, etc.) might confound research results. Dies (1985) suggested that individual group members may be attracted to the group for different reasons and perform different roles within the complex interpersonal relationship matrices of groups. Furthermore, Kivlighan, et al. (1994) suggested group members’ interpersonal style, problems and transference dynamics particularly those related to the group leaders might influence the degree of affiliation individual group members experience within the group. Therefore treatment outcomes for different group members might reflect their idiosyncratic perspectives more than objective indicators of the overall level of group cohesion.

In summary, confusion and definitional diversity in terms of group cohesion and alliance in group therapy conditions adds to the difficulty of predicting treatment outcome. Although the therapeutic or working alliance has generally been found to be a robust predictor of outcome in individual psychotherapy conditions, the extent to which this can be relied upon for predicting outcome in group therapy conditions is relatively unknown. At a minimum it seems reasonable to presume that the principles of alliance in
group therapy need to be considered in the context of the influence of the relationships between group members as well as with the therapists. However, the extent to which alliance is discernable from group cohesion is currently a point of contention, at least in terms of definition. Furthermore, there has been little research completed that examines the relationship between group climate and outcome, and self-differentiation processes and outcome.

**The aims of study two**

The aim of study two was to examine the differential ability of alliance, group cohesion, group climate, and self-other differentiation measures (measured early in treatment) to predict outcome in a sixteen-session group therapy treatment for adults with major depressive disorder.

**Research question addressed in study two**

4. Is participation in brief supportive-expressive group therapy for depression associated with improvements in depression?

5. Do measures of working alliance, group cohesion, group climate, and self-other differentiation separately predict outcome in brief group therapy for depression?

**Hypotheses addressed in study two**

7. There will be a negative association between the degree of dissimilarity on self-other differentiation indices and group therapy outcome.

8. There will be a positive association between components of working alliance and group therapy outcome.
9. There will be a positive association between the ‘engaged’ component of group climate and a negative association with the ‘conflict’ and ‘avoidance’ components of group climate and group therapy outcome.

10. There will be a positive association between components of group cohesion and group therapy outcome.

**Method**

The process measures data (i.e. the GCG, CALPAS-G, GCQ, WAI) and sample (N = 30, representing 6 psychotherapy groups) used in this study were the same as that used in study one.

*Outcome Measures*

The following measures were collected at intake and treatment termination after 16 sessions of group therapy. Some measures were collected by a trained diagnostician and others were self report measures. Standardised residual gain scores were determined using regression analyses, with the dependant variable comprising the termination scores, and the independent variables the intake scores. These standardised residual gain scores were used as the outcome measure, thereby controlling for differences in intake severity.

*Observer ratings*

*Depression Severity*

Depression severity was determined by interviewer ratings on the *Hamilton Rating Scale for Depression- 17 (HRSD)* (Hamilton, 1960). The 17 items are rated on a
scale of 0-4. The HRSD-17 is a well validated measure that has been referred to as the ‘gold standard’ measure for rating depression severity (Rabkin & Klein, 1987), and has proven to be significantly better at detecting change than self-report depression rating scales (Lambert, Hatch, Kingston, and Edwards, 1986). The HDRS-17 has also been shown to correlate well with global ratings of depression by psychiatrists (Knesevich, Biggs, Clayton, & Ziegler, 1977). Lemke, Puhl, & Broderick (1999), reported an adequate interrater reliability for the HDRS of .82. In general the HDRS total score has been found to have adequate reliability (Endicott, Cohen, Nee, Fleiss, & Sarantakos, 1981), with Kobak, Reynolds, Rosenfeld, & Greist (1990) reporting a coefficient alpha of .90 for internal consistency.

**Global Functioning**

The Global Assessment of Functioning (GAF) scale (DSM-IV, American Psychiatric Association, 1994) was used to track clinical progress of individuals in global terms. The Global Assessment of Functioning scale (GAF) is one of the most widely used measures of impairment and functioning in clinical and research settings (Basco, Krebaum, & Rush, 1997). The GAF scale scores range from 0–100. Higher scores reflect better functioning in terms of psychological, social, and occupational functioning. The scale includes 10 sets of anchor descriptions spaced at 10-point intervals. Anchors allow clinicians to consider both symptom severity and social/occupational functioning in making their ratings (Bacon, Collins, & Plake, 2002). The GAF is reliable when assessors have be adequately trained in its use (Bates, Lyons, & Shaw, 2002), and is a valid measure (Startup, Jackson, & Bendix, 2002) of a client’s general adaptive
functioning/impairment frequently used in mental health settings. Bacon, et al. (2002) reported interrater reliability kappa coefficients ranging from .65 - .70, indicating substantial agreement among judges.

**Participant depression severity ratings**

Depression symptom severity was rated by participants using the *Beck Depression Inventory* (BDI) (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). The BDI has become one of the most widely used instruments to assess depression. It was initially based upon clinical observations and descriptions of symptoms frequently experienced by depressed patients. The BDI is a 21 item self-report measure rated from 0 – 3 on each item. Therefore total scores can range from 0 – 63 an the full inventory, which can be categorised in terms of depression severity (≤ 9 considered ‘normal’, 10-18 being mild-moderately depressed, 19-29 being moderate-severe, and ≥ 30 indicating severe depression). The BDI assesses 21 symptoms and attitudes including pessimism, sense of failure, self-dissatisfaction, guilt, self dislike, suicidal ideas, social withdrawal, indecisiveness, body image change, insomnia, fatigability, weight loss, somatic preoccupation, and loss of libido in the week preceding administration. Alpha reliability coefficients range from .76 to .95 in psychiatric samples and from .73 to .92 in non-psychiatric samples indicating that the BDI has good internal consistency (Beck, Steer and Garbin, 1988).

**Participant ratings of treatment satisfaction and success**

Participants were also asked to rate outcome at week six and following termination on a two scales of zero to ten on the basis of perceived *satisfaction/ therapy*
success. On these Likert scales (0-10) scores between 0 and 4 indicated a negative outcome, while a score of 5 indicated no change, and scores between 6 and 10 indicated a positive outcome. The mean of these the ratings of the two scales was calculated to produce single perceived satisfaction/therapy success score for each client participant. These satisfaction and success Likert ratings have a long history in psychotherapy research, and are first described by Rogers and Dymond (1954).

**Statistical Analyses**

Repeated measures *t*-tests were conducted using each of the outcome measures to examine changes in depression symptoms over the course of treatment and changes in client ratings of satisfaction and therapy success between sessions six and sixteen of treatment. Pearson’s correlation analyses were used to determine associations between the measures of alliance, cohesion, climate and self-other differentiation collected early in treatment (alliance at session 4 and all other measures at session six) and standardised residual change scores for each of the outcome measures. Correlations are only considered significant if they meet the significance criterion of *p* < .01 one tailed.

**Results**

**Treatment outcome**

Means and standard deviations of pre and post-treatment ratings of depression symptomatology and overall functioning from both the perspective of the client (BDI, Satisfaction/Success) and the assessment interviewer (HRSD & GAF) are listed in Table 9 below. Repeated measures *t* – test results can also be seen in Table 9. The significance
of the ‘t’ values indicates that there was a significant reduction in depressive symptomatology and improvement in overall functioning over the course of treatment as indicated by both client self report ratings (BDI: \( t = 4.80 \)) and interviewer ratings (HRSD: \( t = 10.70 \); GAF: \( t = -6.93 \)). However, ratings of satisfaction/therapy success did not significantly increase beyond the initial gains over the final ten weeks of treatment (\( t = -2.39 \)) to the minimum significance criterion of .01.

Table 9. Mean depression severity ratings pre and post-treatment.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-treatment mean (SD)</th>
<th>Post-treatment mean (SD)</th>
<th>( t )-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRSD</td>
<td>23.77 (4.61) intake</td>
<td>12.10 (6.15)</td>
<td>10.70*</td>
</tr>
<tr>
<td>GAF</td>
<td>51.37 (8.52) intake</td>
<td>65.23 (11.70)</td>
<td>-6.93*</td>
</tr>
<tr>
<td>BDI</td>
<td>24.87 (8.65) intake</td>
<td>15.00 (10.80)</td>
<td>4.80*</td>
</tr>
<tr>
<td>Satisfaction/success</td>
<td>7.04 (1.64) six weeks</td>
<td>7.72 (1.65)</td>
<td>-2.39</td>
</tr>
</tbody>
</table>

Note: * significant at \( p < .01 \)

Outcome Prediction

Hypothesis seven - There will be a negative association between the degree of dissimilarity on self-other differentiation indices and group therapy outcome.

Neither the ‘self-group leaders’ nor the ‘self-other group members’ differentiation indices from the GCG, which dealt with specific perceived interpersonal relationships within the group setting, displayed a significant relationship with the range of outcome measures (see Table 10).
Table 10. Pearson correlation coefficients between alliance/cohesion instrument subscales and outcome measures

<table>
<thead>
<tr>
<th></th>
<th>GAF Residuals</th>
<th>HRSD Residuals</th>
<th>BDI Residuals</th>
<th>Satisfaction/Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calpas-G</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PWC</td>
<td>.27</td>
<td>-.41 *</td>
<td>-.45 *</td>
<td>.15</td>
</tr>
<tr>
<td>WSC</td>
<td>.38</td>
<td>-.25</td>
<td>-.29</td>
<td>.48 *</td>
</tr>
<tr>
<td>PC</td>
<td>.17</td>
<td>.02</td>
<td>-.03</td>
<td>.43 *</td>
</tr>
<tr>
<td>MUI</td>
<td>.10</td>
<td>-.14</td>
<td>-.19</td>
<td>.41 *</td>
</tr>
<tr>
<td>WAI-client</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>.06</td>
<td>-.06</td>
<td>-.19</td>
<td>.35</td>
</tr>
<tr>
<td>Bond</td>
<td>-.07</td>
<td>.25</td>
<td>-.15</td>
<td>.21</td>
</tr>
<tr>
<td>Goal</td>
<td>-.06</td>
<td>.10</td>
<td>-.05</td>
<td>.20</td>
</tr>
<tr>
<td>GCQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>.07</td>
<td>.03</td>
<td>-.03</td>
<td>.39</td>
</tr>
<tr>
<td>Conflict</td>
<td>-.30</td>
<td>.29</td>
<td>.43 *</td>
<td>.06</td>
</tr>
<tr>
<td>Avoiding</td>
<td>-.24</td>
<td>.10</td>
<td>.25</td>
<td>.26</td>
</tr>
<tr>
<td>GCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Leaders</td>
<td>-.13</td>
<td>-.03</td>
<td>-.01</td>
<td>-.29</td>
</tr>
<tr>
<td>Self-O.G.M.</td>
<td>.07</td>
<td>-.08</td>
<td>.03</td>
<td>-.05</td>
</tr>
</tbody>
</table>

Note – * p < 0.01 level (1-tailed).


WAI = Working Alliance Inventory (at session 4), with subscales being: task agreement, goal agreement, and bond or relationship connection between client and therapist.

WAI-C: client rating of WAI. WAI-T: therapist rating of WAI.

GCQ subscales (at session 6): Engaged; Avoiding; Conflict

CALPAS-G subscales (at session 6): PWC – patient working capacity; WSC – working strategy consensus; PC – patient commitment; MUI – member understanding and involvement.

Outcome measures: Satisfaction/therapy success– client ratings of satisfaction with treatment success at week 16; BDI residuals – standardized residualised gain in client ratings on the Beck Depression Inventory (intake to week 16); HRSD residuals – standardized residualised gain in interviewer ratings on the Hamilton rating scale for depression (intake to week 16). GAF residuals standardized residualised change scores in interviewer ratings on the Global Assessment of Functioning scale (intake to week 16).
Hypothesis eight - There will be a positive association between components of working alliance and group therapy outcome.

As can be seen in Table 10, client ratings of working alliance (WAI-C) at session four of treatment did not predict scores on any of the outcome measures. Only the ‘task’ agreement subscale approached significance as a predictor of client ratings of satisfaction/therapy success.

Hypothesis nine - There will be a positive association between the ‘engaged’ component of group climate and a negative association with the ‘conflict’ and ‘avoidance’ components of group climate and group therapy outcome.

Of the group climate (GCQ) subscales only the ‘conflict’ subscale was associated with outcome as rated by the clients on the basis of BDI residuals. Therefore greater treatment gains in terms of reduced levels of depression symptomatology as perceived by clients are associated with perceptions of lower levels of conflict within the group. A trend was noted that as group members were more satisfied with treatment the more they perceived the group members to be engaged in the treatment process.

Hypothesis ten - There will be a positive association between components of group cohesion and group therapy outcome.

All four of the CALPAS-G subscales were associated with one or more outcome indicators. The Patient Working Capacity (PWC) subscale was related to residual treatment gains as determined by client ratings on the BDI (r = -.45) and the HRSD (r = -
.41). The Working Strategy Consensus subscale (WSC) was related to client ratings of ‘satisfaction/therapy success’ (r = .48). Patient Commitment (PC) was related to client ratings of ‘satisfaction/therapy success’ (r = .43). Member Understanding and Involvement (MUI) also was related to client ratings of ‘satisfaction/therapy success’ (r = .41).
Discussion

The first research question addressed in this study was - *is participation in brief supportive-expressive therapy for depression associated with improvements in depression?* The findings suggest that on average for this sample there did appear to be an improvement in depression symptomatology over the course of treatment as indicated by both client and assessment interviewer ratings. Client ratings of satisfaction/therapy success did not change significantly in the final ten weeks of treatment when compared with the first six weeks of treatment. This appears to suggest that at least in terms of satisfaction and perceptions of therapy success most of the treatment gains occurred during the first third of treatment for this sample. However, it might equally indicate that satisfaction/therapy success measured in this way is subject to ceiling effects.

The second research question addressed in this study was - *do measures of working alliance, group cohesion, group climate, and self-other differentiation separately predict outcome in brief group therapy for depression?* Only the subscales of the CALPAS-G measuring aspects of group cohesion and perceptions of conflict in the group climate were associated with treatment outcome. Neither ‘alliance’ nor ‘self-group leaders’ differentiation ratings, which both focussed on the relationship between individual group members and the therapists from the client’s perspective, were related to outcome. That is, client ratings of the subscales of the WAI failed to predict outcome. This suggests that, although the setting and mutual agreement about the appropriateness of treatment strategies (tasks) between therapists and clients seems important early in group therapy, client rated working alliance measured early in therapy might be less
reliable than might be expected as an outcome predictor (e.g. Horvath & Symonds, 1991) under group therapy conditions. This might mean that the alliance under group therapy conditions takes longer to form or follows a different path, perhaps influenced by the presence of the relational demands of other group members, when compared with the alliance under individual counselling conditions. This finding that alliance as determined by scores on the WAI was a poor predictor of group therapy outcome appears to be contrary to recent findings (McCallum et al., 2002; Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004). However, the McCallum et al (2002) and Abouguendia et al (2004) studies used a different measure of alliance that may have been capturing different aspects of the therapeutic relationship than the WAI. Furthermore, both of these studies used aggregated alliance scores across 12 group therapy sessions, whereas the current study relied on alliance scores collected after session four of treatment alone. The predictive ability of alliance measured earlier in the group therapy process may have been enhanced by including later alliance scores in the aggregated alliance score of the McCallum et al and Abouguendia et al studies.

Although the ‘self-group leaders’ dissimilarity ratings did not meet the significance criterion a trend was noted that suggests that clients in this sample were more likely to indicate higher levels of satisfaction and perceived therapy success the less dissimilar to the group leaders they perceived themselves to be. The ‘self-other group members’ differentiation scores were not associated with any of the outcome measures. This suggests that at week six in the sixteen week treatment, individual group members’ perceptions of dissimilarity to other group members in terms of a range of factors
believed to contribute to the group’s cohesiveness was not associated with eventual treatment gains.

The remaining discussion, which addresses this study’s significant outcome predictor findings, is organised in terms of the different perspectives of outcome from the client and the assessment interviewer (observer).

*Client ratings*

A number of the process variable subscales were predictors of the client ratings of ‘satisfaction/therapy success’. These were the WSC, PC and MUI subscales of the CALPAS-G. This suggests that what might be considered as the more subjective measure of outcome is more readily associated with the more overt functions of group therapy. That is, the ‘task’ and ‘social’ aspects of group work that may be more obviously associated with the experience of being a member of a group, and which have tended to be linked conceptually with alliance and cohesion (Dion, 2000). In other words, some group members may have experienced some relief or satisfaction as a result of being around others who were experiencing similar difficulties, in line with Yalom’s (1995) ‘universality of problem’ group based therapeutic factor. In turn this may influence perceptions of the group as being cohesive, or meeting social identity needs (Aviram & Rosenfeld, 2002; Perrone, & Sedlacek, 2000). Hogg, 1992; Hogg & Tindale, 2001), or being conducted within a productive, nurturing climate (MacKenzie, 1983).

Interestingly, fewer process measures were able to predict outcome based on improvements in depressive symptomatology in terms of the client ratings on the BDI. In fact, the only subscales that were significantly related to outcome based on the BDI were ‘Conflict’ from the GCQ and ‘Patient Working Capacity’ (PWC) from the CALPAS-G.
Both of these findings might be explained in terms of both general alliance and cohesion principles and characteristics of depressed populations.

The finding that client perceived ‘conflict’ was related to outcome suggests that greater reductions in depressive symptomatology were associated with client perceived lower levels of conflict in the group. Therefore, it might be speculated that the conflictual relationships perceived in the social environment are perhaps distorted or exaggerated by the projected internal conflicts of those with higher levels of depression. This possibility reflects Freud’s notion that much of depression might be internalised anger (Freud, 1957), and that lower levels of mastery of the associated persistent conflictual relationship patterns (Luborsky & Crits-Christoph, 1998) are typified by a dominance of symptoms and defences including projections of negative affects onto others (Grenyer, 2002). Alternatively, higher levels of depression might be related to withdrawing from perceived (or perhaps anticipated) environmental conflict, of which people with depression may be acutely sensitive.

The finding that client perceived ‘Patient Working Capacity’ predicts outcome suggests that the higher the level of depressive symptomatology, the less likely group members were to perceive themselves and the other group members as being able to work successfully together towards therapeutic gains. The association between client-perceived conflict in the group and PWC is highlighted by Gaston and Marmar’s (1993) description of what comprises a ‘patient’s working capacity’. They suggested that PWC is comprised of: the group members’ ability or preparedness to self-disclosure and self-reflect on salient therapy themes; to explore their contribution to problems; to experience strong
emotions in a modulated fashion; to actively use therapist's comments; to deepen exploration of salient themes; and to purposefully work towards solving problems.

Gaston and Marmar (1993, p. 5) reported that in earlier versions of the CALPAS they identified a similar, but perhaps more ‘transference’ based relational phenomena, which they termed ‘Patient Hostile Resistance’. This was thought to consist of the client: “being hostile and mistrustful towards the therapist; engaging in a power struggle; defying therapist's efforts to promote self-understanding; keeping the therapist at arm's length with words or emotions; and expecting an easy and quick cure”. They went on to suggest that “for a good working alliance to be achieved, meaning has to emerge from the material provided by the patient, and emotions need to be sufficiently contained and congruent with the material. Otherwise, such a display can be more reflective of a defensive disorganization rather than of therapeutic work”, or alternatively result in avoidant compliance. This type of avoidant compliance with the group therapy setting resonates with Kellerman’s (1981) comments on ‘group-think’ or ‘confluence’ mentioned earlier.

Observer outcome ratings

The outcome measures provided by an assessment interviewer were standardized residual gain scores on the HDRS and the GAF. This represents an observer rating of changes in depressive symptomatology and overall functioning. The only relationship process variables that were related to these outcome measures were PWC for HDRS. The WSC subscale scores approached displaying a significant association with the GAF residual change scores. Therefore, as mentioned above, in terms of client perceived
‘Patient Working Capacity’, the less likely group members were to perceive themselves and the other group members as being able to work successfully together towards therapeutic gains, the poorer the outcome in terms of residual gains on the HDRS. In terms of ‘Working Strategy Consensus’ - the degree of agreement between group members and therapists about how therapy should proceed, WSC ratings displayed a trend which associated higher WSC scores with greater improvements in level of functioning.

In summary and conclusion, outcome in group therapy for depression can be considered from two differing but related perspectives. Group members appear to be able to identify improvement and treatment success independent of changes in depressive symptomatology. Group cohesion (as measured by the CALPAS-G) was the most comprehensive predictor of outcome. Working alliance (as measured by the WAI) was a poor predictor of outcome, with client ratings early in treatment found to be unrelated to outcome. ‘Self-other’ differentiation scores did not predict outcome. Client perceived levels of ‘conflict’ in the group and perceptions of the group members’ ability to work actively and purposefully in treatment (Patient Working Capacity), emerged as being significant predictors of outcome in group psychotherapy for depression with this sample. Consequently, it might be suggested that the efficacy of alliance or group cohesion measures in terms of predicting group therapy outcome might benefit by having a closer focus on issues of perceptions of conflict within the group. That is, measurement methods that attempt to highlight both interpersonal and intra-personal conflictual relationship themes, might hold some potential in terms of tracking these key relational phenomena,
and examining their impact on the development of therapeutic alliance and group cohesion.

Limitations

As mentioned in chapter two of this thesis there are some significant limitations in regards drawing any firm conclusions from this study. The limitations are mostly related to the same size and the continued risk of type I error despite attempts to minimise this risk without unduly inflating the risk of type II error. The other significant limitation of this study is the single time point measurement of the predictor variables. That is, different groups might take different lengths of time to negotiate the different developmental stages of the group. Consequently, some groups may have been well into stages such as the ‘storming’ stage in Tuckman and Jensen (1977) group development model or the ‘differentiation’ or ‘individuation’ stages of MacKenzie and Livesley (1983) model of group development, when the measures were collected. Therefore, ratings of ‘conflict’ and PWC may have been quite different from groups that were still in earlier stages of group development.
Chapter 5

Study Three

The impact of interpersonal relationship patterns on alliance and group cohesion: a study of significant events
As mentioned in chapter one, the overriding aims of this thesis are to explore the therapeutic relationships that exist within the group therapy context and to examine the explanatory value of process and outcome prediction methods. The previous two studies of this thesis focused on examining the common and specific characteristics, as well as the outcome prediction utility, of the therapeutic alliance and group cohesion within group therapy. Study three attempts to represent a closer exploration of personal recovery processes and the interior of the psychotherapy processes within the context of the transference dimension of the relationships present in group psychotherapy. To reiterate earlier descriptions of transference, Book (1998, p. 5) describes transference as the way “by which patients unconsciously respond and react to the therapist in the present in the manner in which they responded to a significant caregiving figure from the past”. Or more specifically, “the client’s/patient’s actions, attitudes, and feelings toward, or perceptions of, the therapist that are distortions based on relations with significant others in the past” (Gelso, Hill, Mohr, Rochlen, & Zack, 1999, p. 259). The study of transference is a sensible strategy given that the psychodynamic therapy administered gave prominence to understanding and controlling these problematic relationship patterns.

This study draws on the principles of hermeneutic phenomenology by asking clients and therapists to identify and describe the most significant events of the therapy process. In turn these significant psychotherapy events will be examined in relation to all 30 clients’ Core Conflictual Relationship Themes (CCRT) and their progress towards mastery of these repetitive, interpersonal relationship patterns. Finally, two case studies will be explored in the next chapter in terms of these points of interest to detail the ideographic nature of an individual’s recovery process.
The aims of study three are:

1. To explore the transference dimension of the therapeutic relationships with particular emphasis on CCRT patterns and progress towards mastery of interpersonal conflict,

2. To examine the association between the group therapy outcome predictors of ‘perceived conflict’ and ‘patient working capacity’ and CCRT patterns,

3. To examine the helpfulness of specific therapy events and whether these events have utility as markers of the pervasiveness and resilience of the client’s CCRT patterns, and

4. To examine the relationship between CCRT patterns and progress towards mastery of interpersonal conflict during significant therapy events.
Transference and the therapeutic alliance

There is evidence that suggests that the transference relationship can have a significant impact on the formation and maintenance of the therapeutic alliance in individual therapy (Safran & Muran, 2000, 1996; Saunders, 2000; Gelso & Hayes, 1998; Hayes, Riker & Ingram, 1997; Frieswyk et al, 1986). It might be expected that the broader relational field present in group therapy similarly activates transference material, or repetitive, conflictual relationship themes for individual group members and therapists. The CCRT method (Luborsky & Crits-Christoph, 1998, Luborsky, 1977) might prove to be a useful organising framework to further examine individual clients’ efforts towards the mastery of interpersonal relationship conflicts within the group therapy setting.

The examination of CCRT patterns of group members might also provide a meaningful explanatory context to interpret the earlier finding (study two) that the ‘conflict-based’ subscales of group cohesion and climate measures were related to treatment outcome. To recap these findings, greater reductions in depressive symptomatology were associated with clients perceiving lower levels of ‘conflict’ in the group. Similarly greater reductions in depressive symptomatology were associated with clients perceiving themselves and the other group therapy participants as being able to work successfully together towards therapeutic gains. It is possible that the conflictual relationships perceived in the social environment are perhaps distorted or exaggerated by the projected internal conflicts (i.e. an aspect of transference) of those with higher levels of depression. Alternatively, higher levels of depression might be related to withdrawing from perceived (or perhaps anticipated) environmental conflict, of which people with depression may be acutely sensitive. Furthermore, clients may be more reluctant to self-disclosure, self-reflect on salient therapy themes,
and explore their contribution to problems, if they believe that others in the group do not possess the capacity to respond to them in a helpful or beneficial manner.

The CCRT method specifically examines that aspect of the transference template concerned with client perceived/anticipated conflict stemming from previous interpersonal relationship experiences. This is a useful line of enquiry as it is possible that the perception of ‘conflict’ and ‘working capacity’ within the group is influenced by previous interpersonal relationship experiences. To this end, an examination of the transference based dynamics with a particular focus on the clients’ expected or anticipated ‘responses of others’ may offer explanatory options in relation to individual group members’ perceptions of conflict within the group and anticipated working capacity deficits of the group-as-a-whole as ‘other’.

The study of significant events

To recap the ‘significant events and mastery’ section in chapter one, Significant Events are those events that occur during the course of psychotherapy that represent important markers in relation to the client’s recovery progress. Although most of the research in this area has concentrated on those events that occurred within the therapy sessions, events that occur outside the therapy sessions are often significant in terms of therapy progress and may be associated with the ‘within therapy’ events. Significant events represent those occurrences where rapid or significant therapeutic gains could be observed, or in which clients experienced a ‘meaningful degree of help or change’ (Elliott & Shapiro, 1992). They may also represent significant impedances to progress. That is, specific psychotherapy events might be deemed significant because they appear to be helpful or hindering in relation to therapy gains for the client (Elliott, 1985) (see the ‘Significant Events and Mastery’ section...
section in chapter one). For example, a ‘helpful’ event may have precipitated the client appearing to gain an important insight in relation to his/her current problems, or experimenting with new or more fulfilling behaviours. An ‘unhelpful’ event may be deemed significant because it represented an important obstacle or setback in relation to the client’s progress. For example, the therapist may have reinforced the client’s unhelpful relationship dynamics, which in turn may have resulted in a ‘rupture’ of the therapeutic alliance between the client and the therapist (Safran & Muran, 1996).

Elliott et al (1994) suggested that significant psychotherapy events are often associated with the client gaining important insights into interpersonal or intrapersonal functioning. They also suggested that ‘insight’ may consist of four elements: a) metaphorical vision, b) connection, c) suddenness, and d) newness. In other words, insight involves the discovery of some new information or experience (or noumena) about oneself and the weaving of this into the stories and images that structure one’s sense of self and meaning construction (also see Resnick & Parlett, 1995).

Elliott (1989) advanced the work known as Comprehensive Process Analysis (detailed in chapter one) to study in detail helpful or hindering psychotherapy events that occurred during individual counselling sessions. More specifically, Elliott (1986) and Elliott and Shapiro (1988) developed a research method named ‘Brief Structured Recall’. This method built upon Kagan and colleagues’ (1975, 1997) ‘Interpersonal Process Recall’ method which attempted to understand the individual phenomenologies of the participants directly involved in the therapy. Effectively these methodologies explored what the therapy participants were thinking and feeling about particular therapy events and/or each other during these events. This information might not otherwise have been disclosed during the therapy session, or perhaps not
even consciously processed by the person, yet possibly still influenced reactions and interpretations of subsequent events.

Unfortunately a dilemma exists in using structured process recall research methodologies during the course of psychotherapy. When used directly with therapy participants such methodologies unavoidably represent a type of therapy intervention in and of itself. That is, use of these research techniques encourages meta-cognition and a deeper processing of the events of therapy that may not have otherwise occurred naturally. In other words, because these methodologies explore significant events by having the client elaborate on what s/he might have been thinking and feeling at the time of these events, they represent potential processing and insight building techniques. Insight building is a key therapeutic aim of many psychotherapy approaches. Therefore, using these methodologies results in an unavoidable ‘Hawthorne Effect’ where the researcher or the research process impacts on and thus contaminates the phenomena being studied (O’Sullivan, Orbell, Rakow, & Parker, 2004; Adair, 1984). Consequently, the research method is an intervention, and not an objective, detached observation of behaviours and events.

The CCRT method could be considered a way of understanding what makes significant events significant if a notable concordance could be found between the details of the events and the clients’ CCRT patterns. Furthermore, the occurrences within these significant events could be examined in terms of reinforcement or disconfirmation of relationship patterns predicted/anticipated by the clients CCRT.

**Mastery of conflictual interpersonal relationship themes**

To paraphrase the section on ‘Mastery’ in chapter one, mastery refers to the client’s sense of movement from being overwhelmed by symptoms and life
experiences to being able to manage them better. Grenyer (2002) reports on how changes in mastery of problematic, interpersonal relationship themes can be measured by examining segments of therapy transcripts against a set of key mastery indicators. These markers treat mastery as a continuum that might be divided into three phases. Phase one (low level mastery) is characterised by the individual experiencing a dominance of symptoms and defences. The client is likely to exhibit poor impulse control and the introjection and projection of negative affects. Phase two (medium level mastery) is characterised by a struggle to understand and control responses within an interpersonal context. Phase three (high level mastery) is characterised by the client exhibiting self-understanding and self-control.

Study three examines the relationship between significant therapy events and the clients’ Core Conflictual Relationship Theme patterns (Luborsky & Crits-Christoph, 1998) as a way of exploring conflict as a predictor of outcome for group therapy for depression. It is anticipated that indicators of mastery of the clients’ CCRT patterns during significant therapy events might be associated with the perception of conflict in group therapy. This will be further explored in the next chapter by providing and comparing the case studies of a good therapy outcome client with a poor therapy outcome client.
**Research Questions**

6. Are characteristics of client primary CCRT patterns associated with the perception of ‘conflict’ within the group and the ‘working capacity’ of the group members?

7. Are significant events significant because they represent considerable progress or setbacks in relation to the mastery of CCRT patterns?

**Hypotheses**

11. The identified significant events will be concordant with CCRT patterns.

12. The level of significant events – CCRT concordance will be associated with outcome.

13. The level of significance and the helpfulness-hindrance ratings of significant events will be associated with alliance ratings of the significant events.

14. The helpfulness-hindrance ratings of significant events will differ when rated within the context of the entire treatment when compared with ratings at the time of the events themselves.

15. The pervasiveness of the client’s CCRT patterns and how much control s/he exhibits of his/her CCRT patterns will be associated with treatment outcome and other outcome predictors.
16. The level of mastery of CCRT patterns will be positively associated with outcome.

17. The level of mastery of CCRT patterns and significant events-CCRT concordance ratings will be positively associated with ‘Patient Working Capacity’ and their perception of ‘conflict’ in the group.
Method

The Measurement of Significant Events

In this study it was decided to record and rate significant events at the completion of treatment for a number of reasons:

1. As mentioned earlier, asking therapy participants during their therapy what they found ‘helpful’ and ‘hindering’ and why, or exploring their reactions to these events in terms of thoughts, feelings or interpretations, would in itself represent an intervention. Thus inquiring about and processing significant events during the course of therapy would introduce a factor that may not have occurred naturally in the therapy process.

2. It provided an opportunity to compare the perceived impact of particular events at the time of the event itself and in the context of the entire treatment. Therefore, it was possible for events that were initially perceived as ‘hindering’ (or perhaps only slightly helpful) at the time of the event, might later be seen as more ‘helpful’ once considered in the context of subsequent events and/or how the therapist or other group members responded to these events.

3. It might be possible that the specific events of therapy sessions might be seen as less important in terms of the overall therapy experience and/or outcome. For example, clients might consider the relationship with the therapist as very helpful because it meant they had someone to talk to, but didn’t really associate this with any particular thing the therapist said or did. In other words, a particular client might feel better without being clear about what in particular helped. Therefore, in the context of the entire therapy process, clients would have the opportunity to nominate treatment specific features/techniques in the
form of therapy events (e.g. insight into one’s CCRT patterns) and/or what might be considered common therapy features (e.g. the alliance).

4. It might offer insight into when significant events tend to occur in the course of treatment.

Consequently, it was decided to adapt Elliott’s Interpersonal Process Recall method (e.g. Elliott, et al, 1994; Elliott, 1986; Elliott, et al 1985), which was designed to be used at the end of individual therapy sessions, by waiting until the end of treatment (i.e. after 16 therapy sessions) before identifying significant events. More specifically, the ‘Helpful Aspects of Therapy’ form (HAT) (Llewelyn, Elliot, Shapiro, Firth, Hardy, 1988) was modified to be completed retrospectively at the end of treatment, by asking participants to recall and rate how helpful/hindering the event was at the time of the event and then in the context of the entire treatment. This process occurred with both the individual group members and the group leaders separately. Clients were interviewed by the assessment interviewer after treatment was completed following the structure of the ‘Significant Events Scale – Client (see Appendix 1). The following description of how significant events were elicited and rated by the therapists/group leaders was the same protocol conducted with the clients. The eventual data explored in detail for this study was the group leaders’ elaborations of significant events for reasons that are explained below.
How significant events were identified

After the sixteen sessions of group therapy had been completed for individual groups, therapists were asked to identify, describe and rate the most significant events of each client’s treatment.

The following prompt was developed by the researcher and used to assist therapists identify the significant events:

“Of the events that occurred during your counselling treatment with ______________, please list the 5 most significant or important psychotherapy events for your client? (By "event" we mean something that happened at some point during the treatment. It might be something you said or did, or something your client said or did. For example, significant events could be: you the therapist saying something that seemed to give your client a new way of looking at a problem, or, you may have responded to your client in a way that made your client feel really understood, supported, positively challenged, etc., or a particular event may have left you feeling that your client was relating to you in a way that was significantly different from other relationships your client has had, or, you may have been surprised by something your client said or did, etc. Significant events could also include those events that seemed to have a negative or hindering effect on the client or the counselling process. That is, hindering events are those that made your client doubt that this treatment or you as his/her therapist were going to be able to help him/her move forward in dealing with his/her problems. For example, you may have said or did something that appeared to make your client feel misunderstood, disrespected, judged harshly, unsupported, or patronised, etc., or an event may have left your client feeling unsafe, untrusting, disconnected, like avoiding, or isolated, etc. Alternatively, you might consider certain client behaviours or characteristics, or external or systemic issues, as hindering.)”

The therapists were then asked to describe the significant events along different dimensions which represent an adaptation of the ‘Helpful Aspects of Therapy’ form (HAT) (Llewelyn, Elliot, Shapiro, Firth, Hardy, 1988). Whereas the HAT was designed as explore in detail the events of the previous therapy session, the Significant Events Scale was designed to be used at the end of the entire treatment. Consequently, the Significant Events Scale uses less specific prompts than the HAT with the intention of eliciting only those aspects of the significant events that
remained salient for the therapists when reviewing the client’s entire treatment. Furthermore, the Significant Events Scale differs from the HAT in that it encourages the therapists to describe why they thought the selected events were significant without any specific theory driven prompts as the HAT does (see Appendix 1 for a copy of the Significant Events Scale). The dimensions along which the therapists were asked to describe the significant events were:

a. Descriptions of the event (e.g. What did you do? What did the client do? Etc.)
b. Why the event was viewed as significant in the context of the whole treatment.
c. When the event occurred (i.e. which treatment session)
d. How significant/important the event was in relation to its impact on the overall treatment process. (scale of 1 = no impact to 9 = very strong impact)
e. How helpful or hindering the event was at both the time of occurrence and in the context of the entire therapy. Hindrance – helpfulness rating on scale -4 (extremely hindering) to +4 (extremely helpful)

The therapists were also asked to recall and record their thoughts, feelings and what they were trying to do at the time of the particular events.

Therapists were then asked to estimate the strength of the working alliance at the time of these events. This was done by completing a brief alliance scale consisting of six items extracted from the 36 item Working Alliance Inventory (Horvath and Greenberg, 1989). Two items for each of the three components of the alliance (goal agreement, task agreement, and relational bonds) were used in line with the brief alliance scale used by Safran, Muran and Wallner Samtag (1994) and Safran and Wallner (1991).
The derivation of Core Conflictual Relationship Theme (CCRT) patterns

A combination of methods was used to identify and refine the individual group members’ CCRT patterns. First, some details of the client’s relationship histories were recorded upon assessment for inclusion in the group therapy programme. At times this information was useful when looking for repetitive relationship patterns. Second, the therapists were asked to formulate primary and secondary and potentially tertiary CCRT patterns for each client, which were discussed and refined in terms of accuracy and treatment planning and progress during weekly clinical group and individual supervision sessions. To assist this process, transcripts and audiotape and videotape material were consulted. Third, individual group members’ CCRT patterns were discussed by the two group leaders immediately after each group session and referenced in client file notes. Fourth, as therapy progressed the CCRT formulations were posed as hypotheses to these clients and discussed in terms of accuracy and the implications for treatment. Finally, at the end of therapy therapists were asked to complete a CCRT questionnaire describing their views of the client’s primary, secondary and tertiary CCRT patterns where applicable. This questionnaire (see appendix 3) required the therapists to provide two specific transcribed examples of these CCRT patterns in each client’s functioning as reported by the client or observed directly by the individual therapists. The therapists were also asked to rate the CCRT patterns in terms of: treatment pervasiveness; client’s insight into CCRT patterns; ratings of the client’s ability to control the CCRT pattern; and similar ratings of the client’s insight and control of the CCRT pattern components of Response of Others and Response of Self. In summary, the therapists chose up to three CCRT patterns
from a collection of patterns derived during the course of therapy as documented at the end of each therapy session and presented during clinical supervision.

These methods are in line with Luborsky’s standard method of deriving CCRT patterns from descriptions of relationship episodes during therapy sessions or interviews (Luborsky & Crits-Christoph, 1998). That is, CCRT patterns can be derived by considering several stories or relationship episodes (Luborsky and Crits-Christoph suggests a minimum of ten relationship episodes) within which there is evidence of repeated patterns of the client’s underlying wishes (W), expected or repeated responses from others related to these wishes (RO), and typical responses of self to the RO patterns (RS). In this study though, it was not a requirement for therapy sessions or assessment interviews to be transcribed and rated using Luborsky and Crits-Christoph’s (1998) method. Rather it was believed the therapists’ documentation of the relationship material discussed or observed directly during the therapy sessions and case notes were appropriately accurate to formulate and refine CCRT patterns (Book, 1998).

The different methods for deriving CCRT patterns often reflect the purpose for which the CCRT will be used. Whereas Luborsky and Crits-Christoph’s retrospective transcribed research tool method is used to study the characteristics of CCRT structures and processes, the clinical-qualitative method (e.g. Book, 1998) has case formulation and clinical functions. The former method is often restricted to the verbalisations occurring in selected therapy segments, whereas the latter draws on the same data more generally but also includes input from the supervision process and the case formulation.
Comparison of primary CCRT patterns and Significant Events

The level of correspondence between the therapist-identified significant events and the individual client’s primary CCRT pattern was determined by reviewing therapists’ ratings on the ‘Significant Events Ratings Scale’ (see below). On this scale therapists were asked first to rate the level of concordance between each identified significant event and the primary CCRT pattern from zero (no concordance) to 10 (highly concordant). Therapists were then asked to rate how much they thought the significant event corresponded with the specific components of the primary CCRT pattern (W, RO, RS) on a scale of zero (e.g. the significant event is not an example of the patient’s expressing of a wish or attempting to elicit a response from the other that reflects the CCRT pattern) to six (e.g. the significant event is an excellent, clear-cut example of the patient’s expressing of a wish or attempting to elicit a response from the other that reflects the CCRT pattern). This concordance scale was adapted from ‘Patient Scale of Key Unconscious Wishes’ (Weiss et al, 1986).

Weiss et al (1986, p 275), used this method to compare competing theories about how a patient might react when his/her analyst responded neutrally to the ‘patient’s transference demands’. The competing theories were based on ‘automatic functioning’ (which predicted patient ‘frustration’ and elicitation of infantile responses) and ‘higher mental functioning’ (which predicted the patient would feel ‘reassured’ and thus more confident and able to work progressively in the therapy) concepts. The aim of these studies was to see how well different theories predicted patient responses to therapy interactions. They found more support for the ‘higher mental functioning’ hypothesis than the ‘automatic functioning’ hypothesis, but suggested that this method had the potential to access theories that possessed both ‘frustration’ and ‘reassurance’ potentials. By considering the group members’ CCRT
patterns within specific therapy segments (significant events), the current study does possess the potential of both ‘frustration’ and ‘reassurance’ reactions to not only the therapists’ behaviour but also to the behaviours of the other group members.

The researcher also independently used the ‘Significant Events Ratings Scale’ to assess the level of correspondence between the significant events and the clients’ CCRT patterns by viewing video recordings of the therapy sessions containing the significant events. Inter-rater reliability was then determined by examining the correlation between the therapists’ and researcher’s concordance ratings.
# SIGNIFICANT EVENTS RATING SCALE

## LEVEL OF CONCORDANCE BETWEEN SIGNIFICANT EVENTS AND PRIMARY CCRT PATTERN

<table>
<thead>
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<th>No Concordance</th>
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<th>3</th>
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<th>6</th>
<th>7</th>
<th>8</th>
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<th>10</th>
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<tr>
<td>Highly Concordant</td>
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### i. Correspondence with Wish

<table>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>SE is not an example of the patient’s expressing of a wish or attempting to elicit a response from the other that reflects the CCRT pattern</td>
<td>SE is a rather poor example of the patient’s expressing of a wish or attempting to elicit a response from the other that reflects the CCRT pattern</td>
<td>SE is a weak example of the patient’s expressing of a wish or attempting to elicit a response from the other that reflects the CCRT pattern</td>
<td>SE is a moderate example of the patient’s expressing of a wish or attempting to elicit a response from the other that reflects the CCRT pattern</td>
<td>SE is a good but somewhat weak example of the patient’s expressing of a wish or attempting to elicit a response from the other that reflects the CCRT pattern</td>
<td>SE is a good example of the patient’s expressing of a wish or attempting to elicit a response from the other that reflects the CCRT pattern</td>
<td>SE is an excellent, clear-cut example of the patient’s expressing of a wish or attempting to elicit a response from the other that reflects the CCRT pattern</td>
</tr>
</tbody>
</table>

### ii. Correspondence with Response of Other

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>SE is not an example of the other responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a rather poor example of the other responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a weak example of the other responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a moderate example of the other responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a good but somewhat weak example of the other responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a good example of the other responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is an excellent, clear-cut example of the other responding in a manner that is predicted by the CCRT pattern</td>
</tr>
</tbody>
</table>

### iii. Correspondence with Response of Self

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>SE is not an example of the patient responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a rather poor example of the patient responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a weak example of the patient responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a moderate example of the patient responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a good but somewhat weak example of the patient responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is a good example of the patient responding in a manner that is predicted by the CCRT pattern</td>
<td>SE is an excellent, clear-cut example of the patient responding in a manner that is predicted by the CCRT pattern</td>
</tr>
</tbody>
</table>
The reconfiguration of the significant events into CCRT components

Although the CCRT method was designed to be used to identify a repetitive relationship pattern across a collection of relationship episodes (Luborsky and Crits-Christoph, 1998) it is also useful clinically for describing the interpersonal relationship dynamics of specific events (Book, 1998). That is, interactions within therapy sessions can be considered as relationship episodes.

In the current study the significant events were reconfigured, or broken down, into the component structure of CCRT patterns as described below. This was done for two main reasons. First, although the concordance between the significant events and the clients’ CCRT patterns was rated on the basis of the intact significant events (i.e. before they were reconfigured), having the significant events reconfigured to highlight the interpersonal interactions components of interest meant a more direct comparison of CCRT components could be observed. That is, this method allowed a succinct explanation of the CCRT – significant events concordance ratings for ‘Wish’, ‘Response of Others’ and ‘Response of Self’ (see Table 12 below for an example of the reconfiguration of significant events for one client’s data in the column entitled ‘Relationship pattern displayed in each event’.

The second reason for significant event reconfiguration into CCRT components was that each individual component of the interactions that occurred during these events could be given mastery ratings (see ‘Mastery Ratings section below for description of this method and Table 12 for example of individual interaction components mastery ratings for one client – columns entitled ‘Mastery Ratings’). In other words, this allows the possibility of examining the client’s demonstration of mastery of his/her repetitive interpersonal relationship themes at a
micro level. That is, in terms of specific interaction components rather than being restricted to a general mastery rating of his/her overall CCRT pattern.

**Step One**

The researcher highlighted (i.e. underlined) the key concepts presented in the significant event descriptions before transposing and recording them as interpersonal relationship themes (i.e. into the column entitled ‘relationship pattern displayed in each event’). That is, the interaction dynamics of the significant event were considered to represent a ‘relationship episode’ and were subsequently reconfigured and recorded in terms the CCRT structure of ‘implicit or expressed wish’ (W), ‘response of other’ (observed RO) and the ‘response of self’ (observed RS). By recording the components of the ‘actual or observed’ interactions that occurred during the significant events in an adjacent column to where the client’s primary CCRT pattern was recorded direct comparisons could be made between the actual behaviours that occurred and those predicted by the client’s primary CCRT pattern.

There are two main advantages of this. One, it offers the possibility of examining whether certain components of the clients’ CCRT patterns are more resistive to change than others for different clients. This is consistent with the Weiss et al (1986) studies that examined client responses to analyst interventions (see ‘Comparison of primary CCRT patterns and Significant Events’ section above). For example, the client’s actual responses (observed RS) to the interactions with others during the significant events may remain consistent (and thus highly concordant) with the RS identified as part of his/her CCRT pattern (predicted RS), despite others (observed RO) in the group interacting with the client in a manner that is inconsistent (and thus attracting a low concordance rating) with the RO predicted or expected by
the client’s CCRT pattern (predicted RO). In other words, in this case this client’s response fails to support the theory of ‘higher mental functioning’ but rather supports the ‘automatic functioning’ hypothesis.

Reason two, builds upon point one, certain components of the CCRT structure may represent more sensitive markers of the client’s recovery process and/or mastery of interpersonal relationship conflicts than other components. For example, the actual interpersonal reactions observed during the significant events might not demonstrate explicitly or accurately the extent of the client’s mental processing of his/her recovery processes. That is, if this study was to replicate the findings of Weiss et al (1986) then the client’s ‘automatic functioning’ (typified by CCRT predicted RS behaviours) would be a poorer indicator of the client’s progress with recovery, and related mastery of interpersonal conflict patterns, than the component of the significant events that reflects ‘higher mental functioning’ like perhaps the stories the client articulates (the presenting themes). Consequently, if observable behaviours specific to the interactions that occurred during the significant events prove to represent only crude indicators of mastery and progress with his/her recovery process, then a second step may be required to attempt to capture the client’s ‘higher mental functioning’.

Step Two

There exists a possibility that the interactions that occur during therapy sessions have a delayed effect (Mallinckrodt, 1994; Beck & Hollon, 1993; Mahrer & Nadler, 1986; Elliott & Wexler, 1994) in terms of the client adopting alternate behavioural responses to those that are typical and thus predicted by his/her CCRT patterns. Therefore, although the ‘actual’ or ‘observed’ responses of others in the therapy group (observed RO) may be different from those responses predicted by a
repetition of the client’s CCRT pattern, the client’s response to these interactions (observed RS) may not change overtly immediately. Furthermore, interactions with others (particularly those significant others who have previously been engaged in the client’s CCRT patterns) outside of the therapy group may also impact on the clients progress with mastery of his/her CCRT patterns. Therefore, it is important to identify an aspect of the client’s presentation during the significant events that might represent a clearer indicator of his her progress with his/her recovery process and mastery of his/her CCRT patterns.

The researcher decided to isolate the ‘presenting themes’ of the significant events from the ‘observed RO’ and ‘observed RS’. The ‘presenting themes’ represent a type of ‘storytelling’ that is gathering evidence as being integral to the therapy process itself (Rennie, 1994). There is evidence that apart from considering the meaningfulness of the specific words people choose in the forming written or spoken stories, storytelling serves an important function in terms of organising complex emotional experiences (Pennebaker & Seagal, 1999; Pennebaker & Graybeal, 2001; Groom & Pennebaker, 2002). The client’s processing of the interpersonal markers in his/her recovery process via the ‘presenting theme’ may represent ‘higher mental functioning’ processes when compared with the specific observable interaction dynamics of the significant events. The examination of the presenting themes allows the inclusion of interactions that may have occurred in previous therapy sessions or from events outside of the therapy group. The assumption being made here is that what the client talks about in during the significant events may be as important as the actual interactions that occur during the significant events, and may represent a clearer marker of mastery and recovery processes than the interactions themselves.
For example, a significant event may have been a client discussing how she experimented with assertiveness with her partner and how she was better able to respond to his criticism. Here the ‘described response of other’ was criticism. However, if the ‘observed RO’ during the event of this story being told was that the group members and the facilitators were reassuring and supportive, then the ‘observed RO’ and that RO described in the story were quite different. Second, the ‘actual’ or ‘observed’ dynamics of the event can similarly be reconfigured and recorded in terms of the CCRT method structure. This allows the opportunity to allocate ‘mastery’ ratings (see below) in relation the interactions occurring and immediate impacts of these interactions during the significant events. That is, mastery ratings could be allocated firstly for, the ‘presenting theme’ (i.e. the initial substance of the event expressed as the client’s wish or in behaviour in story form), secondly, the ‘response by the therapist or other group member’ to the client’s presenting material (observed RO), and finally ‘how the client responded’ to the interaction within the group setting (observed RS) (see example in Table 12 below).

Mastery Ratings

The Mastery Scale (Grenyer, 1994, 2003) (see Table 11 below) was used by the researcher to rate the material presented in each of the significant events in terms of progress towards mastery of interpersonal relationship conflicts. Although the Mastery Scale was designed to rate the person’s progress in relation to his/her overall CCRT patterns it has been used in the current study to rate the specific interaction components of the CCRT. Specifically, the underlying theme of the event, the intervention during the group session (observed RO), and the client’s response to the intervention (observed RS) were each given a rating from the mastery scale. That is,
first the ‘presenting theme’ was rated in terms of the level of mastery being exhibited by the client’s behaviour or in the features of the content of the client’s story being told. Secondly, the response by the therapist or other group members (observed RO) to the client’s presenting material was rated in terms of ‘encouraged’ or ‘modelled’ or ‘exhibited’ level of mastery for, or toward, the client in question. In other words, the response of other, or the interaction itself was given a mastery rating. Thirdly, how the client responded to the interaction within the group setting (observed RS) was given a mastery rating.

Giving the CCRT reconfigured components of the significant events individual mastery ratings provided the opportunity to examine the client’s immediate response (RS) to the actual ‘Response of Other’ (RO from therapists and/or other group members). Furthermore, this provided an opportunity to examine the interactions during the significant event in terms of similarity and difference in relation to the anticipated or predicted RO and RS based on the individual’s CCRT pattern. That is, if the actual or ‘observed RO’ during the significant event was different from the ‘response of other’ that would have been typical of the client’s reported relationship history, this may represent a concrete and experiential challenge to the reliability of the client’s primary CCRT pattern to predict interpersonal interactions. Consequently, an immediate observable marker of the impact of this experiential challenge would be the client’s reaction to the actual or observed RO, which is recorded as the observed response of self (observed RS). Furthermore, delayed responses to the interactions of the interpersonal interactions that occurred during a particular group therapy session might be examined in terms of changes in the level of mastery observed in subsequent sessions or specific significant events (e.g. presenting themes).
### Table 11. The Mastery Scale (Grenyer, 1994, 2002) - Mastery Phases, Associated Mastery Categories and Category Examples

<table>
<thead>
<tr>
<th>Phase of Mastery</th>
<th>Mastery Scale Categories</th>
<th>Category Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase One – Low Dominance of symptoms and defences</strong></td>
<td><strong>Level 1. Lack of impulse control</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1A Expressions of being emotionally overwhelmed</td>
<td>Being globally emotionally overwhelmed and distressed. The state described is extreme, it dominates the person’s state of mind, and it includes regressive features</td>
</tr>
<tr>
<td></td>
<td>1B References of immediacy of impulses</td>
<td>Extreme loss of control in mind and actions, an overwhelming urgency to gratify needs, and an overwhelming urgency to escape.</td>
</tr>
<tr>
<td></td>
<td>1C References to blocking defences</td>
<td>Blockages in thinking and feeling, repression of affects; and denial, forgetting, numbness, and avoidance.</td>
</tr>
<tr>
<td></td>
<td>1D References to ego boundary disorders</td>
<td>Serious disorders of ego functioning – fragmentations, ego boundary ruptures, and regression of the ego. Also included are dependency, submission, and masochistic passivity-aggression; identity instability; and omnipotent narcissism.</td>
</tr>
<tr>
<td></td>
<td><strong>Level 2. Projection &amp; projection of negative affects</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2E Expressions of suffering from internal negative states</td>
<td>References to the self suffering – anxieties, melancholia, mania, guilt, shame, and jealousies</td>
</tr>
<tr>
<td></td>
<td>2F Expressions indicative of negative projection onto others</td>
<td>Negative internal states directed toward others – anger and blame, cynicism and repressed rage, resentments and defiance, vengeful and sadistic feelings, and domination and manipulation of others. Patients’ negative emotions are intended to upset the others’ feelings.</td>
</tr>
<tr>
<td></td>
<td>2G Expressions indicative of negative projection from others</td>
<td>The other is perceived to be punishing and rejecting self. Also includes paranoid ideation about others’ motives, no compassion or understanding of the other’s point of view, and feeling laden down and the victim of the other.</td>
</tr>
<tr>
<td></td>
<td>2H References to interpersonal withdrawal</td>
<td>Avoiding, withdrawing, and isolating of self from others. Also involves interpersonal difficulties, timidity in approaching others, and moving away from others.</td>
</tr>
<tr>
<td></td>
<td>2I Expressions of helplessness</td>
<td>Giving up. Assertion problems, apathy, amotivation, and external locus of control. Also includes having no perceived choice and lacking self-value.</td>
</tr>
<tr>
<td>Phase Two – Medium</td>
<td>Level 3. Difficulties in understanding &amp; control</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3J Expressions of cognitive confusion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The inability to predict or understand, things being left unresolved, and feeling uncertain, confused.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3K Expressions of cognitive ambivalence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Struggling to understand, partial awareness and hypothesizing, and difficulties communicating or putting things into words.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3L References to positive struggle with difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expressions of struggling with difficulties and seeking change and control, in addition to effort, hope, and engagement in struggles to get better and improve.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 4. Interpersonal awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>4M References to questioning the reactions of others</td>
</tr>
<tr>
<td>Probing, assessing, and challenging others’ reactions rather than blindly accepting them.</td>
</tr>
<tr>
<td>4N References to considering the other’s point of view</td>
</tr>
<tr>
<td>Clear consideration of alternative perspectives, compassion and understanding toward another person, consideration of how the other may be viewing the self, and listing qualities of the other.</td>
</tr>
<tr>
<td>4O References to questioning the reaction of the self</td>
</tr>
<tr>
<td>Awareness of role of the self – one’s own contribution to conflict or situation</td>
</tr>
<tr>
<td>4P Expressions of interpersonal self-assertion</td>
</tr>
<tr>
<td>Standing up for self with confidence, acting independently and stating views with ease, the free expression of ideas previously difficult to discuss, and pro-social attempt to get needs and wishes met displaying emotional modulation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase Three – High</th>
<th>Level 5. Self-Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-understanding and self-control</td>
<td></td>
</tr>
<tr>
<td>5Q Expressions of insight into repeating personality patterns of self</td>
<td></td>
</tr>
<tr>
<td>Making a self-observation about one’s own personality – insight into transference pattern. Also includes awareness of maladaptive interpersonal patterns of relating to others.</td>
<td></td>
</tr>
<tr>
<td>5R Making dynamic links between past &amp; present relationships</td>
<td></td>
</tr>
<tr>
<td>Observations about similarities and differences in the patterns of relating between present situations and past relationships.</td>
<td></td>
</tr>
<tr>
<td>5S References to interpersonal union</td>
<td></td>
</tr>
<tr>
<td>Interpersonal support, closeness, and communication. Includes approaching others, intimacy between people including physical, offering and giving help to others or seeking and receiving help from others, and benefaction to the self from positive patterns of interpersonal relating.</td>
<td></td>
</tr>
<tr>
<td>5T Expressions of insight into interpersonal relations</td>
<td></td>
</tr>
<tr>
<td>Insight into other people and the dynamics of their relationships with the self.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 6. Self-control</th>
</tr>
</thead>
<tbody>
<tr>
<td>6U Expressions of emotional self-control over conflicts</td>
</tr>
<tr>
<td>Adequate freedom from mental conflict. Includes self-control, positivity, self-esteem, modulation of feelings, adaptive solutions, responding rather than reacting, constructive emotional distancing from conflict (not avoidance), and internal locus of control.</td>
</tr>
<tr>
<td>6V Expressions of new changes in emotional responding</td>
</tr>
<tr>
<td>Changes in emotional reactions that are nontrivial; adaptability and flexibility in responses, and overcoming maladaptive repetitive patterns of reacting to problems and relationships.</td>
</tr>
<tr>
<td>6W References to self-analysis</td>
</tr>
<tr>
<td>References to introspection, self-monitoring, internal dialogue with the self, and carrying out psychotherapy of the self.</td>
</tr>
</tbody>
</table>
Table 12. Examples of major presenting theme selection from significant event descriptions and configuration into CCRT terms and allocated mastery scores.

<table>
<thead>
<tr>
<th>Significant event description</th>
<th>Mastery ratings</th>
<th>Relationship pattern displayed in each event</th>
<th>Primary CCRT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Individual session with male group leader as client was only group member that to show for that session. Explored transference issues as theme of client feeling disconnected from significant male figures in his life (father, doctor, brother, etc.) Why Sig.: Feeling disconnected and let down left client with a sense of meaninglessness and isolation – he experienced this in some of the earlier sessions of group, with the male group leader (father substitute) being experienced as 'aloof'. Insight into this theme allowed client to strengthen his resolve to take responsibility for making meaning in his life and reaching out for his desired connections with people.</td>
<td>Presenting Theme</td>
<td>Observed RO</td>
<td>Observed RS</td>
</tr>
<tr>
<td>2G</td>
<td>5R</td>
<td>4O</td>
<td>W – connection - support - direction</td>
</tr>
<tr>
<td>2G</td>
<td>4M</td>
<td>3L</td>
<td>W – to be directed RO – no answers, focus elsewhere RS – depressed, disillusioned</td>
</tr>
<tr>
<td><strong>2.</strong> Redirection of responsibility by therapist to client. Clarification of roles and relationship dynamics (e.g. clients responsible for finding own answers to problems whilst also being a part of research – negatively reacting to being asked to complete a brief process assessment). Client stating desire for greater solution focus rather than focussing on current feelings of group members. Why Sig.: Exploration of client’s feelings of frustration and disillusionment – which when reframed redefined impressions of role responsibility.</td>
<td>1D</td>
<td>3L</td>
<td>2H</td>
</tr>
<tr>
<td><strong>3.</strong> Client was a bit ‘off the air’ and obviously depressed. He shared more from present experiences rather than conceptually. He was directly challenging of the therapists. Why Sig.: An example of genuineness or clear contact between client and therapists as opposed to talking about things.</td>
<td>4P</td>
<td>4P</td>
<td>4P</td>
</tr>
<tr>
<td><strong>4.</strong> Client more active in facilitating the group (the start of future more direct involvement with others) Why Sig.: Active engagement of major theme of being productive versus stagnant, again wanting to be directed versus taking responsibility for own progress.</td>
<td>4P</td>
<td>5T</td>
<td>5S</td>
</tr>
</tbody>
</table>
Outcome Measures

The outcome measures were those outlined in chapter four.

Case-study selection

After the initial analyses were completed on the data for the entire 30 participant sample and their 150 significant events (i.e. 5 significant events per client), two cases were selected for a more detailed exploration of individual recovery processes. These cases were selected to explore in more detail the relationship between the significant events, the CCRT patterns, fluctuations in the alliance and eventual treatment outcomes. A case study method was chosen to provide an ideographic description of processes towards mastery and symptom based outcomes that may not be adequately explained by periodic alliance and group cohesion measurement. The cases chosen were a female that responded well to treatment and a male who responded poorly to treatment. Background data such as diagnostic was also included. These cases are outlined in Chapter Six.
Figure 3. Method steps for study three.
Results

The results are described in relation to complete data available for the thirty clients who participated in one of six distinct therapy groups that consisted of sixteen therapy sessions.

*The client’s perspective of significant events*

The clients/group members responded in a generally non-specific manner to the enquiry about what they believed were the significant therapy events. That is, there was a response trend that suggested that the majority of clients in this study identified only general or common therapeutic factors such as ‘being in a group with others who were going through or had had similar experiences’ as being ‘significantly helpful events’. This was the most common response and reflects Yalom’s (1995) ‘universality of problems’ therapeutic factor of group psychotherapy. More specific ‘significant events’ were less forthcoming from clients (see Table 13 below). Since specific therapy events were not readily available from the clients, all subsequent analyses were conducted on therapist-identified significant events.
**Table 13 Client Identified Significant Events Summary**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients interviewed</td>
<td>30</td>
</tr>
<tr>
<td>Number of events identified</td>
<td>111</td>
</tr>
<tr>
<td>Number of helpful events</td>
<td>85</td>
</tr>
<tr>
<td>Main themes:</td>
<td></td>
</tr>
<tr>
<td>- Identifying with others, common struggles, not feeling so alone</td>
<td>22</td>
</tr>
<tr>
<td>- Feeling supported, understood, respected, safe, heard</td>
<td>19</td>
</tr>
<tr>
<td>- Learning from others, coping strategies, having a routine/structure</td>
<td>18</td>
</tr>
<tr>
<td>- Expressing self, talking to others, getting things out</td>
<td>13</td>
</tr>
<tr>
<td>- Gaining insight, clarifications, working through issues</td>
<td>10</td>
</tr>
<tr>
<td>- Being helpful to others</td>
<td>3</td>
</tr>
<tr>
<td>Number of hindering events</td>
<td>26</td>
</tr>
<tr>
<td>Main themes:</td>
<td></td>
</tr>
<tr>
<td>- Needed more personal attention, would have preferred individual counselling over group therapy</td>
<td>8</td>
</tr>
<tr>
<td>- Some of the discussions were irrelevant to me, too repetitive at times</td>
<td>6</td>
</tr>
<tr>
<td>- Feeling confronted, uncomfortable, intimidated</td>
<td>4</td>
</tr>
<tr>
<td>- Poor motivation, commitment or negativity of others in group</td>
<td>4</td>
</tr>
<tr>
<td>- Unclear about psychotherapy process, goals</td>
<td>3</td>
</tr>
<tr>
<td>- Would have preferred single sex group</td>
<td>1</td>
</tr>
</tbody>
</table>

*The therapists’ perspective of significant events*

The therapists, however, were more able or willing to identify significant events. Perhaps this trend simply indicates that the therapists were more concerned with tracking the therapy process by watching for potential opportunities to enhance the therapy process and potential obstacles to be negotiated. Furthermore, as the therapy model used in this study had an interpersonal focus, therapists were trained to be vigilant regarding changes in the types of contact that occurred between group members and the therapists, and between the group members themselves. In addition, therapists had detailed process notes of each therapy session to review, which often detailed significant events.
The researcher decided to explore the therapist identified significant events in more detail. The restriction of the focused exploration to the therapist identified significant events alone brings with it a number of potential advantages and some limitations which are outlined in the discussion section below.

**Significant Events Descriptives**

A minimum of five significant events were recorded for each client. Although there was an average of 7.8 significant events per client collected, only the first five events (i.e. the events rated most significant) were included in subsequent analyses. This was done so that each case contributed the same amount of data to the analyses.

150 significant events were identified and rated (5 for each of the 30 clients). The mean significance rating (from 1 = no impact on the treatment process to 9 = very strong impact on the treatment process) as well as standard deviations and ranges for the significant events are recorded in Table 14 below. As the focus of this study is on the significant therapy events themselves rather than the clients participating in the study, the subsequent analyses are based on 150 events. If the events were averaged for each client this would distort the phenomena under investigation. That is, the study is not concerned with client specific event trends but rather the nature of the events themselves and how they relate to process and outcome variables.

**Table 14. Mean significance ratings for the five significant events**

<table>
<thead>
<tr>
<th>Overall mean across 150 events</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event one</td>
<td>7.72</td>
<td>0.80</td>
<td>6.0-9.0</td>
</tr>
<tr>
<td>Event two</td>
<td>7.53</td>
<td>0.89</td>
<td>5.5-9.0</td>
</tr>
<tr>
<td>Event three</td>
<td>7.48</td>
<td>1.13</td>
<td>5.0-9.0</td>
</tr>
<tr>
<td>Event four</td>
<td>7.15</td>
<td>1.01</td>
<td>5.0-9.0</td>
</tr>
<tr>
<td>Event five</td>
<td>6.95</td>
<td>1.23</td>
<td>4.5-9.0</td>
</tr>
</tbody>
</table>
As indicated in Table 14, on average all 5 events were considered highly significant in terms of relative impact on the treatment process for the 30 participants.

*When the significant events occurred*

The middle quartiles of the sixteen group therapy sessions were where the majority of the significant events were nominated. That is, both the 2nd (sessions 5 to 8) and 3rd (sessions 9 to 12) quartiles had 46 significant events each identified in them. Together these two quartiles contained 61.4% of the total significant events. Quartile one recorded 36 significant events (24%), while the final quartile only 22 significant events (14.7%). This implies that the mid therapy quartiles were where the most significant therapy gains or efforts toward mastery of interpersonal conflicts were perceived by the therapists as occurring within this sample.
**Types of significant events reported**

Table 15 describes the different types of significant events identified by the group therapists. As can be seen on Table 15, approximately 44% of the significant events involved the client telling or processing different aspects of his/her life story. The remaining 56% of the significant events involved specific interactions that occurred during group sessions.

**Table 15. Types of significant events reported**

<table>
<thead>
<tr>
<th>Event Type</th>
<th>% of total significant events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client reporting events that occurred outside of the group sessions</td>
<td>25.33%</td>
</tr>
<tr>
<td>Reports of external or historical events which were elaborated in relation to how the client functioned within the group</td>
<td>18.67%</td>
</tr>
<tr>
<td>Events/interactions that occurred during the group sessions</td>
<td>56%</td>
</tr>
</tbody>
</table>

**Concordance between Significant Events and CCRT patterns**

**Inter-rater reliability of concordance ratings**

Inter-rater reliability was determined by conducting a correlational analysis of the ratings of the therapist with the ratings of the researcher regarding the level of concordance between the individual group members’ primary CCRT patterns and the components of the significant events. The significant events – CCRT concordance ratings were not available from the main group therapist for one of the six small therapy groups and were therefore not used in the analysis of inter-rater reliability. Consequently inter-rater reliability was determined on the basis of 135 significant events – CCRT concordance ratings each from the main group therapists and the researcher. An overall correlation of .86 (p = .00) was found across all 135 ratings comparisons. This indicates that there was a very high level of agreement between the raters in relation to their
perceptions of the degree to which the significant events corresponded with the individual group members’ primary CCRT patterns.

On an individual therapy group basis the correlations between raters were: group 1 (number of events = 25), .82 (p= .00); group 2 (number of events =25), .88. (p= .00); group 3 (number of events =30), .85 (p= .00); group 4 (number of events =30), .91 (p= .00); and group 5 (number of events =25), .73 (p= .00) respectively. Group 6 only had the researcher’s concordance ratings available and consequently an inter-rater correlation could not be calculated.

_Hypothesis eleven - The identified significant events will be concordant with CCRT patterns._

Table 16 displays the descriptive statistics for the mean concordance ratings between the significant events and the clients’ CCRT patterns. The concordance ratings reported are an average of both the therapist and the researcher ratings. The conversion of the mean concordance ratings on the Likert scale into percentages was simply achieved by dividing the mean by the maximum achievable rating on the individual scales and multiplying by 100 (e.g. 6.87/10 = .687; .687 x 100 = 68.70%).

**Table 16. Concordance ratings of significant events and CCRT patterns**

<table>
<thead>
<tr>
<th>Mean concordance ratings</th>
<th>Scale</th>
<th>Min.</th>
<th>Max.</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Concordance as %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant event with primary CCRT</td>
<td>(0-10)</td>
<td>2.75</td>
<td>9.60</td>
<td>6.87</td>
<td>1.55</td>
<td>68.70%</td>
</tr>
<tr>
<td>Significant event with ‘Wish’ (0-6)</td>
<td>(0-6)</td>
<td>2.50</td>
<td>6.00</td>
<td>4.51</td>
<td>.76</td>
<td>75.17%</td>
</tr>
<tr>
<td>Significant event with ‘Response of Other’</td>
<td>(0-6)</td>
<td>.55</td>
<td>4.15</td>
<td>2.42</td>
<td>1.15</td>
<td>40.33%</td>
</tr>
<tr>
<td>Significant event with ‘Response of Self’</td>
<td>(0-6)</td>
<td>1.60</td>
<td>5.00</td>
<td>2.92</td>
<td>.87</td>
<td>48.67%</td>
</tr>
</tbody>
</table>
As can be seen in Table 16 above, the significant events generally appeared to reflect the clients’ CCRT patterns with a mean concordance rating of 68.70% (rated on a 0 to 10 Likert scale) (see method section above ‘Comparison of primary CCRT patterns and Significant Events’ for copy of significant events – CCRT concordance rating scale). However there is considerably less concordance reported when the individual ‘response’ components of the CCRT structure are considered separately (i.e. ‘response of other’ (RO) = 40.33%, and ‘response of self’ (RS) = 48.67%). These were rated on a scale of 0 to 6. For example, a rating of 0 for correspondence with RO has a descriptor of ‘significant event is not an example of the other responding in a manner that is predicted by the CCRT pattern’. A rating of 6 has a descriptor of ‘significant event is an excellent, clear cut example of the other responding in a manner that is predicted by the CCRT pattern’. Ratings of 2 to 3 indicate the significant event is a weak to moderate example of that particular CCRT component being represented by that particular significant event. Only the ‘wish’ component (W) of the CCRT was rated in a manner that indicated a reasonable concordance or representation in the significant events (mean = 4.51 or 75.17%).

Consequently, it appears that the actual or observer RO and RS displayed during the significant events did not resonate with those predicted by the CCRT pattern as well as the W component did. In other words, the therapists and other group members generally did not respond to the individual group member and his/her wishes in a manner that s/he was accustomed (CCRT predicted RO). Similarly, the individual group members did not generally respond to the therapists’ and other group members’ interventions in a manner typically predicted by their CCRT patterns (RS).

*Hypothesis twelve: The level of significant events – CCRT patterns concordance will be associated with outcome.*
The significant events – CCRT concordance ratings (based on 150 events, 5 events per client) were compared with outcome measure ratings. This was done to examine whether outcome could be predicted by how well the specific occurrences of the significant events reflected the clients’ CCRT patterns. More specifically, these analyses may prove useful in relation to examining the representativeness of the individual components of the CCRT patterns (W, RO & RS) in the significant events as predictors of outcome. Table 17 displays these Pearson correlations.

As can be seen in Table 17, only the concordance rating between the observed RS and the RS predicted by the CCRT pattern was associated with outcome (significant correlation with GAF residuals and therapy satisfaction/success, with HAM 17 residuals approaching significance). That is, the more the observed RS (i.e. the actual response of self that occurred during the significant events) differed from the predicted RS (i.e. the RS predicted by the person’s CCRT pattern) the better the outcome recorded. In other words, the more that group members responded to the interactions of the significant events in a manner that was not typical of their CCRT patterns, the better their treatment outcomes tended to be, and vice versa.

Table 17. Pearson Correlations between significant events and CCRT patterns concordance ratings and outcome ratings

<table>
<thead>
<tr>
<th>Mean Concordance</th>
<th>GAF residuals</th>
<th>HAM residuals</th>
<th>17BDI residuals</th>
<th>therapy satisfaction/success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratings with CCRT</td>
<td>Predictions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant event overall</td>
<td>.06</td>
<td>-.02</td>
<td>-.28</td>
<td>-.08</td>
</tr>
<tr>
<td>Wish</td>
<td>-.06</td>
<td>-.14</td>
<td>-.23</td>
<td>-.12</td>
</tr>
<tr>
<td>Observed RO</td>
<td>-.18</td>
<td>.22</td>
<td>.16</td>
<td>-.08</td>
</tr>
<tr>
<td>Observed RS</td>
<td>-.46*</td>
<td>.36</td>
<td>.27</td>
<td>-.49*</td>
</tr>
</tbody>
</table>

* Correlation is significant p < .01 (1-tailed).
Hypothesis thirteen: The level of significance and the helpfulness-hindrance ratings of significant events will be associated with alliance ratings of the significant events.

The significant events were rated in terms of helpfulness or hindrance by the therapists in relation to the client’s recovery process. Therapists were asked to rate each of the events (from hindered = -4 to helpful = +4) at the time of each event and then in the context of the entire treatment. Of the entire 150 ratings at the time of the events only 25 (16%) were rated as ‘hindering’. Furthermore, when rated a second time in relation to the context of entire treatment only 21 (14%) retained a hindrance rating. Considering all ratings the mean helpfulness rating was 1.71 at the time of the event, and 1.89 in the context on the entire treatment. Therefore, on average the significant events were considered slightly to moderately helpful (see Significant Events Scale in Appendix 1).

Table 18 displays the therapist brief working alliance ratings describing the working alliance relationship between the therapists and the individual group member at the time of each of the significant events. The brief alliance ratings are based on two items for each of the working alliance components of goals, tasks, and bond from the working alliance inventory (see method section ‘How significant events identified’ for description). As can be seen in Table 18 on average alliance ratings were high (i.e. all means > 5.00 on a 7 point scale) based on retrospective ratings of the significant events.

Table 18. Therapist’s Working alliance ratings during each of the 150 significant events

<table>
<thead>
<tr>
<th>Brief Working Alliance Total</th>
<th>Min.</th>
<th>Max.</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bond</td>
<td>3.50</td>
<td>6.33</td>
<td>5.31</td>
<td>.55</td>
</tr>
<tr>
<td>Tasks</td>
<td>3.00</td>
<td>7.00</td>
<td>5.68</td>
<td>.63</td>
</tr>
<tr>
<td>Goals</td>
<td>2.00</td>
<td>7.00</td>
<td>5.00</td>
<td>.84</td>
</tr>
</tbody>
</table>
Table 19 shows the correlations between the therapists’ brief alliance ratings and the ratings of the significant events in terms of level of impact on the overall treatment process (significance) and level of hindrance-helpfulness displayed during the events and in the context of the entire treatment.

**Table 19 Pearson correlations between significance and helpfulness/hindrance ratings and working alliance during the significant events**

<table>
<thead>
<tr>
<th></th>
<th>Alliance total</th>
<th>Bond</th>
<th>Task</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significance rating</td>
<td>.44 *</td>
<td>.35 *</td>
<td>.09</td>
<td>.34 *</td>
</tr>
<tr>
<td>Helpfulness/hindrance at the time of event</td>
<td>.36 *</td>
<td>.10</td>
<td>.00</td>
<td>.42 *</td>
</tr>
<tr>
<td>Helpfulness/hindrance in the context of the whole treatment</td>
<td>.38 *</td>
<td>.16</td>
<td>.05</td>
<td>.39 *</td>
</tr>
</tbody>
</table>

* Correlation is significant p < .01 (1-tailed).

As can be seen in Table 19 the significance ratings for the events were reflected in the alliance ratings. That is, the greater the perceived impact of the events on the treatment process the greater the perceived alliance between therapist and client. Similarly, alliance ratings were also reflected in helpfulness ratings both at the time of the event and in the context of the whole treatment.

The goal agreement component of the working alliance was the component most responsible for the positive relationship with significance and helpfulness ratings. The quality of the affective relationship also featured to a lesser degree (i.e. ‘bond’ was associated with the significance ratings and approached a significant correlation with the helpfulness/hindrance ratings in the context of the entire treatment). The level of ‘therapy task agreement’ between the therapists and the client was neither related to the significance ratings of the events nor the helpfulness/hindrance ratings.
Hypothesis fourteen: The helpfulness-hindrance ratings of significant events will differ when rated within the context of the entire treatment when compared with ratings at the time of the events themselves.

A paired t-test was used to compare hindrance-helpfulness ratings at the time of the event (150 ratings: mean = 1.71, std. dev. = 2.08) with hindrance-helpfulness ratings of the same event in the context of the entire treatment (150 ratings: mean = 1.89, std. dev. = 1.83). This analysis was done to examine whether considering significant events in the context of the entire treatment (i.e. with the reference of subsequent and perhaps what might be perceived as consequently events) would affect hindrance-helpfulness ratings. It was found that hindrance-helpfulness ratings changed when considered in the context of the entire treatment (t = -2.29, p < .01). That is, the significant events were considered generally more helpful in the context of the entire treatment than they were at the time of the event alone.

Hypothesis fifteen: The pervasiveness of the client’s CCRT patterns and how much control s/he exhibits of his/her CCRT patterns will be associated with treatment outcome and other outcome predictors.

Table 20 displays therapists’ ratings of characteristics of the clients’ CCRT patterns and their relationships to outcome. The relationships between these CCRT characteristics and the group cohesion subscales identified as the best predictors of outcome in study two of this thesis (‘Patient Working Capacity from the CALPAS-G and the ‘Conflict’ scale from the Group Climate Questionnaire), are also displayed in Table 20.
As can be seen in Table 20 the characteristics of the CCRT that were associated with outcome measures were ‘post-treatment pervasiveness’ and ‘post-treatment control’ of the CCRT patterns. The post-treatment control of the RS component of the CCRT further supports the finding that the client’s ability to refrain from responding to others in a manner predicted by the CCRT patterns, predicts outcome.

Identifying associations between characteristics of the CCRT patterns and PWC and Conflict subscale outcome predictors proved less convincing. Only post-treatment control of the CCRT pattern (r=.48) was associated with PWC ratings. Furthermore, it was only the post-treatment control of the RS (r=.43) that seemed to follow the trend of the CCRT pattern control associations with PWC ratings.

**Table 20. Pearson correlation coefficients between primary CCRT characteristics ratings and outcome measures and predictors**

<table>
<thead>
<tr>
<th>Primary CCRT</th>
<th>HAM residuals</th>
<th>17Patient Working Capacity</th>
<th>Conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCRT post-treatment pervasiveness</td>
<td>.50*</td>
<td>-.29</td>
<td>.13</td>
</tr>
<tr>
<td>CCRT control post-treatment</td>
<td>-.45*</td>
<td>.48*</td>
<td>-.29</td>
</tr>
<tr>
<td>RO control post-treatment</td>
<td>-.26</td>
<td>.31</td>
<td>-.28</td>
</tr>
<tr>
<td>RS control post-treatment</td>
<td>-.53*</td>
<td>.43*</td>
<td>-.29</td>
</tr>
</tbody>
</table>

* Correlation is significant at p < .01 (1-tailed).

**Hypothesis sixteen: The level of mastery of CCRT patterns will be positively associated with outcome.**

**Mastery Ratings during the significant events**

The level of mastery demonstrated during the significant events was rated using the mastery scale (Grenyer, 2002, 1994) (see method section above). Mastery ratings
were recorded in relation to the themes being presented during the significant events (presenting theme), the responses or interventions from the therapists and other group members that occurred during the significant events (observed RO), and how the client responded to the interactions that occurred during the significant events (observed RS).

Table 21 displays the mean mastery ratings of the significant event components (i.e. reconfigured into CCRT component structure) across all 150 significant events. As can be seen in Table 21 the ‘presenting themes’ on average were rated as displaying Phase one - low level of mastery on the Mastery Scale (i.e. mean = 2.04 represents Phase one – level 2: Introjection and projection of negative affects). The ‘observed RO’ (i.e. the actual responses of others in the group that occurred during the significant events) on average were rated as displaying a Phase Two – medium level of mastery (i.e. mean = 4.34 represents Phase Two – Level 4: Interpersonal Awareness). The ‘observed RS’ (i.e. the actual response of self in relation to the observed RO) on average were rated as displaying a Phase Two medium level of mastery (i.e. mean = 3.41 represents a Phase Two – Level 3: Difficulties in understanding and control).

Table 21. Descriptives of mastery ratings of CCRT reconfigured components of the significant events across 150 events.

<table>
<thead>
<tr>
<th>Component</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting theme</td>
<td>2.04</td>
<td>1.01</td>
</tr>
<tr>
<td>Intervention (actual/observed RO during group)</td>
<td>4.34</td>
<td>.75</td>
</tr>
<tr>
<td>Outcome (observed RS during group)</td>
<td>3.41</td>
<td>1.03</td>
</tr>
</tbody>
</table>

Figure 5 below displays the frequency rates at which the different mastery categories forming the Mastery Scale (see method section above for descriptions of these categories) were rated for the ‘presenting themes’, the ‘observed RO’ and the ‘observed RS’ noted as present during the significant events. As can be seen in Figure 5 the ‘observed RO’
clusters relatively tightly between 3K and 5S, whereas the dispersion of frequency scores for the ‘presenting themes’ and the ‘observed RS’ spreads across the entire range of categories.

![Mastery Categories](image)

**Figure 5. Frequencies of mastery category ratings during significant events**

Note:
- ‘presenting theme’ refers to the initial substance of the event expressed as the client’s wish or in behaviour in story form,
- ‘observed RO’ refers to the response by the therapist or other group member to the client’s presenting material during the group session,
- ‘observed RS’ refers to how the client responded to the interaction within the group setting.

*Mastery ratings over time*

An analysis of when significant events occurred and the level of mastery displayed produced correlation coefficients of $r=.17$ (p=.04) and $r=.14$ (p=.09) for the ‘presenting themes’ and the ‘observed RS’ respectively. This suggests that as the groups
developed over time group members presented material that indicated a trend (although not meeting the significance criterion for this thesis) towards higher levels of mastery. Furthermore, group members’ responses to the interactions that occurred during the significant events also approached being significance in terms of increased mastery as the group developed over time.

Mastery as a predictor of outcome

The level of mastery displayed during the significant events was compared with outcome measures. Table 22 shows that the level of mastery displayed in the ‘presenting themes’ of the significant events, and to a lesser extent the ‘observed RS’ to the interactions during the significant events, were associated with outcome ratings. That is, the more the ‘presenting themes’ reflected higher mastery the better the outcome. Similarly, the more the ‘observed RS’ reflected higher levels of mastery the better the outcome. The level of mastery displayed in the interventions offered (observed RO) was not associated with outcome.

Table 22. Pearson correlations of mean mastery ratings and outcome measures

<table>
<thead>
<tr>
<th>Mean mastery ratings during significant events</th>
<th>GAF residuals</th>
<th>HAM residuals</th>
<th>17BDI residuals</th>
<th>therapy satisfaction/success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting theme</td>
<td>.41*</td>
<td>-.55*</td>
<td>-.60*</td>
<td>.12</td>
</tr>
<tr>
<td>Observed RO</td>
<td>.14</td>
<td>-.34</td>
<td>-.22</td>
<td>.35</td>
</tr>
<tr>
<td>Observed RS</td>
<td>.28</td>
<td>-.33</td>
<td>-.42*</td>
<td>.52*</td>
</tr>
</tbody>
</table>

* Correlation is significant at p < .01 (1-tailed).

Hypothesis seventeen: The level of mastery of CCRT patterns and significant events-CCRT concordance ratings will be positively associated with ‘Patient Working Capacity’ and their perception of ‘conflict’ in the group.
Exploring the process measures in terms of mastery and CCRT concordance ratings

Table 23 displays the correlation coefficients comparing the group process measures subscales of ‘Patient Working Capacity’ (from the CALPAS-G) and ‘Conflict’ (from the Group Climate Questionnaire) with mastery ratings and CCRT concordance ratings based on observations of the significant events. Mean concordance and mastery ratings are based on 150 significant events (5 events for each of the 30 clients). It was anticipated that these analyses might help identify the aspects of the group members’ ‘transference based’ relationship themes associated with scoring patterns of outcome predictors.

Table 23. Pearson correlation coefficients between alliance and group cohesion outcome predictors and significant events mastery and concordance ratings

<table>
<thead>
<tr>
<th></th>
<th>Mean Mastery Ratings</th>
<th>Mean Significant events - CCRT categories concordance ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Presenting theme</td>
<td>Observed RO</td>
</tr>
<tr>
<td>CALPAS-G (session 6)</td>
<td>Patient Working Capacity</td>
<td>.32</td>
</tr>
<tr>
<td>GCQ (session 6)</td>
<td>Conflict</td>
<td>-.30</td>
</tr>
</tbody>
</table>

* Correlation is significant at p < .01 (1-tailed).

As can be noted in Table 23 although the ‘Patient Working Capacity’ scale approached a significant correlation with each of the mean mastery ratings of the interaction components observed during the significant events (except the significant events – CCRT concordance related to the observed RO), it only met the p < .01 significance criterion with the mastery rating of the observed RS (r = .44). Therefore, this suggests that group members were more likely to rate the group as a whole as having a
higher degree of working capacity if they were also displaying a higher rate of mastery within their interactions during the significant events, particularly in relation to RS.

In terms of the associations between PWC and the mean CCRT-significant events components, Table 23 shows that only the CCRT-observed RS ratings have a negative association with the PWC ratings (r=-.42). This suggests that group members were more likely to rate the group-as-a-whole as having a higher degree of working capacity if their own responses to the interactions that occurred during the significant events were divergent from the RS predicted by their CCRT patterns. Interestingly, there was no association between PWC and the CCRT-observed RO concordance ratings.

Perceived level of ‘conflict’ in the group did not quite meet the significance criterion (p < .01) to be significantly associated with the level of concordance between the RO predicted by the CCRT patterns and those observed during the significant events (r=.37). However, this is a noteworthy trend. This suggests that the more the other group members responded to the client in a manner predicted by his/her CCRT pattern the more conflict s/he perceived to exist within the group climate. Interestingly, the perceived level of ‘conflict’ in the group was not associated with mastery ratings.
Discussion

The aims of study three were:

1. To explore the transference dimension of the therapeutic relationships with particular emphasis on CCRT patterns and progress towards mastery of interpersonal conflict,

2. To examine the association between the group therapy outcome predictors of ‘perceived conflict’ and ‘patient working capacity’ and CCRT patterns,

3. To examine the helpfulness of specific therapy events and whether these events have utility as markers of the pervasiveness and resilience of the client’s CCRT patterns, and

4. To examine the relationship between CCRT patterns and progress towards mastery of interpersonal conflict during significant therapy events.

Before discussing the results it is important to comment of the reliability and validity of the methods utilised in this study.

Firstly, to the knowledge of the researcher, the use of the Mastery Scale (Grenyer, 1994, 2003) to assess progress with CCRT patterns on the basis of specific therapy events within group therapy situations has not be done before. Although the Pearlin Mastery Scale has been used in one group therapy study (Bowen, South, Fischer & Terah, 1994), Grenyer’s Mastery Scale has not. Furthermore, the researcher could only find one study that applied the CCRT method to examine the interactions between the group members’ structure of conflicts and group therapy outcomes (Strass, Dauert, Gladewitz, Kaak, et al., 1995). Consequently, the dearth of research in these areas both highlights the significance of the current study and cautiousness required in interpreting the results.
Secondly, to the knowledge of the researcher, the reconfiguration of the interactions that occurred during the significant events into a CCRT component structure has also not been done before. To recap the rationale for this reconfiguration outlined in the method section of this study, there were two main reasons for this innovation. One, breaking the observable interactions into CCRT defined components allows for a finer grained or more specific and direct comparison between the actual interactions that occurred during the significant events (observed behaviours) and the components of the person’s CCRT patterns (transference template). Two, it meant that each component of the interaction could be rated in terms of mastery, thus providing the opportunity to examine whether different components of behaviour change at different rates. Once again this innovation highlights the significance of the current study and the prudence with which the results should be approached.

A third general limitation of the current study is the sample size. That is, although one hundred and fifty significant events were examined across six distinct small therapy groups, this represents the data of thirty group members alone. Consequently, although it is believed that the size of the sample was adequate to produce the results it did, the reliability and generalisability of these results would be improved with a repeat of the study’s method with a larger sample.

The fourth major limitation of the current study is related to the decision to restrict the analysis of the data related to the study’s hypotheses to the significant events identified by the therapists only. The decision was primarily the result of clients responding in a generally non-specific way to the enquiry at the end of the treatment proper about what they believed were the significant events. This particular client sample was four times more likely to identify helpful therapy characteristics than helpful or hindering therapy experiences. In other words, client responses involved identifying
general or common helpful therapeutic factors (e.g. being in a group with others who were going through or had had similar experiences) rather than specific therapy events per se.

There are a number of possible ways to interpret this trend towards non-specificity from the clients’ perspectives:

1. Clients may have found it difficult to recall specific events or interventions.
2. They may have been uninterested in processing the therapy any further after it had been completed.
3. They may have experienced some improvement without being concerned with linking this to specific events or therapy specific techniques.
4. They may not have thought that specific events contributed separately to the overall progression of therapy. That is, specific events might not have been considered significant enough to warrant being identified as ‘significant events’, but were preferred to be viewed as events that just occurred along the way.

The other response trend from clients was the tendency not to nominate specific ‘hindering events’. The ‘hindering events’ identified generally referred to the challenges of being in a group as opposed to individual therapy. This trend may have occurred for some of the same reasons Lietaer (1992) mentioned (see introduction section ‘helpful and hindering events in psychotherapy’) with a few possible additional explanations:

1. They didn’t want to appear critical of the attempts made to help them.
2. They may have had a tendency to hold themselves responsible for any ‘hindrances’ rather than particular events involving others.
3. There may have been a persistently positive transference with the therapists which filtered the objective observation of hindering on negative therapist interventions or other behaviours.

Consequently, the decision to adapt the principle of ‘Comprehensive Process Analysis’ rather than the method (Elliott, 1989) out of concern for contamination of the natural flow of therapy, meant that the client identified significant events could not be used to answer the research questions of the current study. The limitations of restricting the focus on significant events to those identified by the therapists include:

1. The loss of detailed insight into the clients’ unshared experience of the nuances of the therapy process.

2. As a result of the first point, inferences made regarding the meaning of client ratings of alliance and cohesion may lack the confirmation of further client meta-cognitive information.

However, the advantages of restricting the focus on significant events to those identified by the therapists include:

1. The specificity of the therapist identified significant events offered the opportunity to examine specific therapy interactions in relation to the clients’ CCRT patterns. That is, the general non-specific themes identified by clients would have been more difficult to examine in relation to CCRT patterns. Consequently if it was attempted to include the client data in this analysis the association between the significant events and the CCRT patterns may have proven more difficult to isolate.
2. The therapist identified significant events provided an opportunity to explore patterns of when significant events occurred.

3. There were fewer burdens placed on the clients after the therapy has completed. That is, clients did not have to commit to further engagement in the therapy research without specific therapeutic input or intention. This was so even though as mentioned in the method section above, the exploration of significant events can in and of itself represent a facilitation of meta-cognition regarding the therapy process. There may have been ethical issues related to a deeper processing of therapy events with clients, with potential further cognitive and affective engagement, without then providing further therapy, as the previous therapy groups had terminated.

The discussion will be structured in terms of the study’s hypotheses.

*Hypothesis eleven: The identified significant events will be concordant with CCRT patterns.*

The questions of how much and in what ways the themes and interactions during the significant events corresponded with the relationship dynamics predicted by the CCRT patterns produced some interesting results. First, the clients’ ‘wishes’ component of their CCRT patterns was found to be concordant with the dynamics and themes present in the significant events (75.17% concordance rating by therapists and researcher). This suggests that clients were still attempting to have these longer term wishes met within the therapy groups. This supports the notion that group members’ efforts towards mastery of relationship conflicts can be identified within the narratives present in therapy sessions.
Furthermore, in relation to stories about negative interactions in particular, ‘the remembering and telling probably is in the service of trying to master the conflictual relationships’ (Luborsky, Barber, & Diguer, 1992, p. 284). That is, the fact that the ‘wishes’ remained present in the themes or stories presented in the significant event sessions is consistent with CCRT research. For example, Grenyer (2002, p. 47) reported that ‘the wishes, which correspond to instinctual needs, did not alter in pervasiveness (66.3% early in therapy versus 62.9% late in therapy), which indicates that these are relatively stable within the personality’.

Secondly, the responses from other group members and the therapists (observed RO) to the individual client’s ‘presenting themes’ during the significant events was on average rated as only a weak to moderate correspondence to the RO predicted by his/her primary CCRT pattern (40.33% concordance). That is, in general the therapists and other group members did not respond to the individual group member and his/her wishes in the conflictual manner that s/he was accustomed. In terms of the CCRT pattern structures, the patterns were generally disconfirmed by the actual ‘other’ present during the significant events of the therapy groups. This is supported by the finding that only 16% of the 150 significant events were rated as hindering the client’s recovery process at the time of the event, which reduced to only 14% when considered in the context of the entire treatment (see hypothesis 13 below).

Thirdly, during the significant events the individual group members did not generally respond (observed RS) to the therapists’ and other group members’ interventions (observed RO) in a manner typically predicted by their CCRT patterns. Once again the mean concordance ratings for observed RS, when compared with CCRT pattern predicted RS, was weak to moderate (48.67% concordance).
Therefore, although the CCRT patterns of the group members were obviously present during the 150 significant events (i.e. 5 events for each of the 30 clients) (overall mean concordance of 68.7%), the overt behaviours of the therapy participants during these significant events also demonstrated efforts towards mastery of these underlying conflicts.

_Hypothesis twelve:_ The level of significant events – CCRT concordance will be associated with outcome.

The question of whether significant events-CCRT concordance ratings could predict outcome was assisted by the decision to reconfigure the significant events in terms of CCRT components. Only the concordance between the ‘observed RS’ (i.e. how the clients actually responded to the interactions that occurred during the significant events) and the RS consistent with the clients’ CCRT patterns was associated with outcome. This finding suggests that the more group members responded to the interactions of the significant events in a manner that was not typical of their CCRT patterns, the better their treatment outcomes tended to be, and vice versa.

_Hypothesis thirteen:_ The level of significance and the helpfulness-hindrance ratings of significant events will be associated with alliance ratings of the significant events.

The significant events were rated in terms of how significant and how helpful or hindering the events were in relation to the client’s recovery process by the therapists. Therefore, these ratings were in relation to the impact the events had on the individual’s efforts towards mastery of interpersonal conflicts. The significant events were on average deemed to fall within the ‘slightly’ to ‘moderately’ helpful segment of the continuum,
with only 16% of the events being rated on the ‘hindering’ polarity of the scale at the
time of the event.

The significance ratings for the events were reflected in the alliance ratings. That is, the
greater the perceived impact of the events on the treatment process the greater the
perceived alliance between therapist and client from the therapists’ perspective. It was
also found that the degree of helpfulness was related to fluctuations in the working
alliance. Of particular note is that it was the goal agreement component of the alliance
that most reflected the helpfulness ratings. This suggests that the more helpful events
were perceived to be the stronger the alliance was perceived to be and vice versa.
Furthermore, events were perceived to have more impact and to be more helpful the more
they reflected alignment with mutually agreed upon treatment goals and vice versa. These
findings highlight the importance of engaging clients in a process of goal monitoring,
with a particular emphasis on goal agreement.

_Hypothesis fourteen: The helpfulness-hindrance ratings of significant events will differ
when rated within the context of the entire treatment when compared with ratings at the
time of the events themselves._

Two hindrance-helpfulness ratings were generated. One was based on the time
when the event occurred, while the second was based on how hindering or helpful the
event was within the context of the entire treatment. As mentioned above, only 16% of
the significant events were rated as ‘hindering’ at the time of the event. However, this
was reduced to 14% when rated within the context of the entire treatment. Therefore, the
interactions during the significant events were considered to be significantly more helpful
in the context of the entire treatment than they were at the time of the event alone.
There are a couple of ways of interpreting this finding. Firstly, having an expanded frame of reference that includes events and experiences that occurred subsequent to the significant event in question, may have afforded the therapists the opportunity to note positive delayed effects of the events. That is, the extended impact of specific therapy events may have become clearer when subsequent behaviours or cognitive processing could be noted in later therapy sessions. Secondly, the group members’ mastery plans may have become clearer when placed within the broader context of the entire treatment. In other words, it might be suggested that the levels of mastery demonstrated during specific significant events are probably influenced as much by the interactions during earlier sessions (and events outside of the therapy groups) as they are by the interactions occurring during the specific significant events themselves.

Hypothesis fifteen: The pervasiveness of the client’s CCRT patterns and how much control s/he exhibits of his/her CCRT patterns will be associated with treatment outcome and other outcome predictors.

At the end of therapy the therapists were asked to rate the degree to which they perceived clients had control over their CCRT patterns and how pervasive they thought the clients’ CCRT patterns were. Post-treatment pervasiveness and control of CCRT patterns were found to predicted treatment outcome. In particular post-treatment control of CCRT predicted RS patterns were associated with objective and subjective outcome measure scores. This suggests that the clients’ ability to refrain from eliciting responses from others (or the perception of these responses) and in particular responding to others in a manner predicted by the CCRT patterns, predicts outcome.

When therapists’ ratings of clients’ post-treatment control of CCRT response interactions were correlated with the group cohesion and climate subscales of ‘Patient
Working Capacity’ and ‘Conflict’ the only significant association was found between the post-treatment control of RS and PWC. Therefore, once again the person’s ability to control his/her reactions to others by the end of treatment was associated with how they viewed the others present in the group as being able to help them (PWC). None of the ratings of CCRT characteristics were associated with the ‘Conflict’ subscale ratings. That is, the clients’ perception of the level of conflict within the group was not associated with the level of pervasiveness or control of the CCRT pattern as rated by the therapists.

It could be argued that post-treatment control of CCRT patterns is in itself an outcome of treatment, as this is an obvious aim of clients trying to improve their mastery of interpersonal conflicts. However, the association between post-treatment control of CCRT patterns and symptom reduction should not be minimised. This association clearly identifies the importance of recognising and addressing the interpersonal features of depressive disorders as an appropriate strategy for recovery facilitation.

Hypothesis sixteen: The level of mastery of CCRT patterns will be positively associated with outcome.

The association between mastery of CCRT patterns and symptom severity has previously and comprehensively been demonstrated with a range of clinical populations (e.g. Grenyer, 2002; Luborsky & Crits-Christoph, 1998; Book, 1998, Luborsky, 1984). Consequently this finding was expected to be confirmed in this study.

The level of mastery demonstrated during the significant events was rated using the mastery scale (Grenyer, 2002, 1994). Mastery ratings were recorded in relation to the themes being presented during the significant events (presenting theme), the responses or interventions from the therapists and other group members that occurred during the
significant events (observed RO), and how the client responded to the interactions that occurred during the significant events (observed RS).

The presenting themes were rated on average as displaying a low level of mastery while the ‘observed RO’ and the ‘observed RS’ displayed a medium level of mastery on average. However, a closer examination of the distribution of the mastery ratings suggests that the ‘presenting themes’ ratings were distributed across the entire range of mastery categories, while the ‘observed RO’ ratings clustered tightly between the medium to high mastery. The ‘observed RS’ mastery ratings were also relatively broadly distributed across most mastery categories. This suggests firstly that the themes that clients presented during the significant events leaned more towards higher levels of mastery than were indicated by the mean and standard deviation of the mastery scores. Secondly, the responses of the others in the group to the client’s presenting themes tended to be consistently and at least moderately divergent from the client’s CCRT patterns. Thirdly, the clients’ ‘observed RS’ was fairly consistently divergent from their own CCRT patterns.

Although the mean mastery level allocated to the clients’ ‘presenting themes’ represented a low level of mastery, indicating a dominance of symptoms and defenses, the mastery ratings of these themes or stories had a significant association with treatment outcome. That is, the more the ‘presenting themes’ reflected higher mastery the better the outcome.

Interestingly, although the mean mastery level of the observed responses of the clients to the interactions that occurred during the significant events (observed RS) had a higher mean level of mastery than the presenting themes, their association with treatment outcome was limited. Perhaps even more surprising is the finding that the interventions or responses from the therapists and other group members (observed RO) were not directly
related to outcome. However, this latter finding might be explained by the tightness of the distribution of the scores about the mean, indicating that the ‘observed RO’ was consistently displaying a medium level of mastery (i.e. had little variance when related with outcome measures).

These findings suggest that levels of mastery apparent in the ‘presenting themes’ of the significant events seem to operate independently of the immediate response interactions occurring during the significant events. This might suggest that the themes or stories presented during the significant events reflected a level of processing that is relatively independent of immediate contact with others or interactive behaviours. In other words, the ‘presenting themes’ may represent a type of meta-cognitive processing that is involved with the organization, clarification and articulation of the person’s recovery story, while the ‘observed RS’ may be more directly tied to the control or choice of certain interaction response behaviours.

_Hypothesis seventeen: The level of mastery of CCRT patterns and significant events-CCRT concordance ratings will be positively associated with ‘Patient Working Capacity’ and their perception of ‘conflict’ in the group._

Of particular interest to this final study were the associations between measures of interpersonal relationship conflict phenomena and the outcome predictors of the ‘Patient Working Capacity’ subscale of the CALPAS-G and the ‘Conflict’ subscale of the Group Climate Questionnaire.

PWC was significantly correlated with ‘observed RS’ ratings. More specifically, PWC was positively associated with the level of mastery displayed in the ‘observed RS’, and was negatively associated with the significant events-CCRT concordance ratings related to the ‘response of self’. That is, the level of divergence from the CCRT pattern
the ‘observed RS’ displayed during the significant events seemed to be consistent with mastery ratings attributed to the ‘observed RS’ in relation to the PWC ratings. PWC also approached significance with both the mastery ratings of the ‘presenting themes’ and the ‘observed RO’. This suggests that mastery of core interpersonal conflict patterns is associated with the perception of the other group members’: ability or preparedness to self-disclosure and self-reflect on salient therapy themes; to explore their contribution to problems; to experience strong emotions in a modulated fashion; to actively use therapist's comments; to deepen exploration of salient themes; and to purposefully work towards solving problems (Gaston & Marmar, 1993).

Whereas the initial part of this description of the PWC construct reflects the ‘presenting themes’ component of the significant events (e.g. ‘ability to self-disclose and self-reflect on salient themes’), the latter part seems to be describing the ‘response of self’ operations (e.g. ‘experience strong emotions in a modulated fashion’). Therefore, considering this in relation to the abovementioned findings it might be concluded that the way clients perceive the PWC of the group is directly associated with their own working capacity, or preparedness to engage in interpersonal recovery enhancing activities. In other words, one’s own efforts towards mastery, and in particular one’s efforts to control CCRT consistent RS, are associated with how one views the mastery capacity and efforts of others in the therapy group. Group members’ perceptions of the working capacity of the group as a whole appears to be associated with their management of their own transference patterns, in particular their own responses to the interactions that occur during group therapy session.

Gaston and Marmar (1993, p 5) described progress in therapy occurring when ‘meaning emerges from the material provided by the patient, and emotions being sufficiently contained and congruent with the material’. Therefore, group members’
efforts towards mastery of conflictual relationship themes within a group therapy context might be facilitated by the observation of the efforts towards mastery of other group members. Alternatively, the projection of one’s own working capacity onto others might determine the degree to which the individual is prepared to engage in treatment and adjust his/her CCRT consistent RS.

**General discussion**

*The mastery of conflictual relationship themes over time*

The majority of the significant events occurred during the second and third quartiles of treatment. Therefore, it might be suggested that greater advancement in the mastery of the interpersonal dimension of recovery from depression is moderated mostly by the events that occurred during the middle sessions of therapy. This also seems to indicate that by sessions 5 to 8 an adequate alliance and group cohesion had formed to accommodate the more challenging tasks of therapy. These tasks required a higher level of involvement and application of the group members. This is in alignment with progressive models of group development (e.g. Cissna, 1984; Mennecke, Hoffer, Wynne, 1992). The finding that the level of mastery (particularly in terms of the ‘presenting themes’ and ‘observed RS’) increased over the course of treatment also offers support for progressive models of group development.

Progressive models of group development suggest that the earlier group sessions are involved with dealing with safety and inclusion issues (e.g. ‘forming’ stage in Tuckman & Jensen’s model, 1977; ‘engagement’ stage in MacKenzie and Livesley model, 1983) whereas the middle sessions are where the group starts to challenge each
other and the group leadership to move beyond safety concerns (e.g. the ‘storming’ stage in Tuckman & Jensen’s model; ‘differentiation’ or ‘individuation’ stage in MacKenzie and Livesley model) into activities representative of the client’s efforts towards mastery of interpersonal conflict patterns (‘performing’ stage in Tuckman & Jensen’s model; ‘intimacy, and mutuality’ stages in the MacKenzie and Livesley model). In other words, the CCRT patterns of the group members become more overtly activated, and potentially worked through, during the middle stages of therapy. This adds some context to the earlier finding of this thesis that perceived ‘conflict’ in the group and the perception of the ‘working capacity’ of the group members were predictive of outcome by session six of therapy (second treatment quartile). Furthermore, this suggests that the ‘storming’ stage of group development (Tuckman & Jensen, 1977) may be where the transference dimension (or social and vertical cohesion dimensions of the group therapeutic relationships system) of the therapeutic relationship overrides the role assignment and therapy structuring processes of the working alliance (or task cohesion dimension of the group therapeutic relationships system).

It is worth noting though that approximately 44% of the significant events involved the client telling different aspects of his/her life story (either historical or from his/her current life) that occurred outside of the group. This is important because one of the features of the significant events given a mastery rating in this study was the client’s ‘presenting themes’, which most often involved the telling of part of his/her story. With this in mind, it is worth mentioning that mastery gains are perhaps only partially influenced by the interactions occurring during the specified significant events. That is, although how the group responds to the client’s material may be important as a facilitator of mastery gains, what seems equally important is what the client presents in the first instance.
What these findings suggest is that the themes and stories presented were better indicators of mastery in terms of predicting outcome than the specific interactions that occurred subsequently. This might be interpreted in line with the point mentioned above, that the level of mastery demonstrated in the presenting themes was related to the interactions from previous sessions and external events. That is, some of the events identified as significant may have been nominated on the basis of overt signals of therapy progress, whereas the interactions that were more mastery enhancing were less obvious or had a more delayed or gradual impact. For example, it may have been that generalizing the relational experiences of the therapy groups to real-life situations is where the major gains were obtained, as with homework research (e.g. Kazantzis, Deane, & Ronan, 2000). Or it may have been that the extent of the immediate impact of the group interactions was dampened by the group members’ active defense mechanisms (e.g. RS) during the group sessions, only to engage in more direct processing later in the relative safety of their own homes. Alternatively, it may have been the case that the immediate gains observed during the significant events were short-lived and did not always generalize outside the therapy group enough to impact substantively on symptoms. What these findings do seem to indicate though is that the unfolding of one’s story during therapy might be a better gauge of treatment progress than direct impacts of specific events. In other words, it is how people make sense of these events and weave them into their life stories over time that is important.

A number of inferences could be drawn from this story/theme versus immediate contact finding. Firstly, it implies that the telling and validation of one’s story can in and of itself be a corrective relationship experience (Pennebaker & Graybeal, 2001; Pennebaker, & Seagal, 1999; Groom, & Pennebaker, 2002; Rennie, 1994). That is, a story cannot be told unless there is someone there to hear it. Often in therapy situations
(and particularly in group) there is some personal risk involved in disclosing personal or interpersonal material. Therefore, when an individual chooses to trust the group enough to disclose, s/he is engaging in an interpersonal interaction which could result in a ‘response of others’ that either reinforces or disconfirms his/her CCRT pattern. In other words, simply telling one’s story can at times be seen as an attempt to work through transference material. Secondly, attempts at articulating the different processes (e.g. psychological, emotional, behavioural) are indicative of a higher level of mastery. That is, increases in self-awareness or insight can often be the result of engaging in the meta-cognitive processing required to describe one’s personal experiences related to interpersonal events.

Thirdly, considering the previous two points, the telling of one’s story is an expression of one’s self. Consequently, having an interaction with an ‘other’ or ‘others’ in relation to one’s story can have the impact of shaping, reshaping, or consolidating one’s beliefs about self (Rennie, 1994). Therefore, the initial impact of the interaction (the ‘observed RS’), is a glimpse into the pervasiveness and utility of the CCRT pattern. In other words, the degree of difference between the observed RS and the CCRT consistent RS is a correlate of the pervasiveness of the CCRT pattern. Furthermore, the resilience of the CCRT consistent RS may be a marker of the degree to which the RS has become a personality trait or identified with the person’s existential self. Where such self-CCRT entanglement occurs, longer-term psychotherapy would be required to facilitate a recalibration and expansion of response options.
Conclusion

If these points are considered collectively, a number of general conclusions can be tentatively drawn from this study. Firstly, mastery is a process that may increase over the life of the group. Secondly, the two aspects of the therapy where efforts towards mastery of core interpersonal conflict patterns were most notable, and most predictive of treatment outcome with this sample, were in the ‘presenting themes’ and in how the client adjusted the way s/he responded to others (observed RS). More specifically, mastery and ultimately treatment outcome appeared to be reflected in how well clients controlled old unhelpful interpersonal response patterns, and how they integrated their experiences through the telling of their stories. Thirdly, the processing required formulating and telling one’s story appears to be relatively distinct from controlling one’s response patterns. That is, immediate response behaviours may assist with the telling and hearing of stories, however, the telling of the story itself seems therapeutic. Fourthly, mastery of conflictual relationship themes is related to symptom reduction and well being. Fifthly, the therapeutic benefit of participating in the group was related to one’s perception of the group-as-a-whole in terms of level of conflict and working capacity for this sample. This perception might be related to the transference of conflictual relationship theme expectancies onto the group. In particular, those who benefit more from group therapy take more responsibility for mastery of conflictual relationship patterns, especially how they themselves contribute to maintaining these patterns. Therefore, how one perceives the group may be congruent with the actual events that occur during therapy sessions or may be congruent with what one expects may happen based on one’s transference template (CCRT configuration).
It is still unclear what determines the persistence or pervasiveness of CCRT patterns, but if others present in the group respond to the client in manner predicted by the CCRT pattern, the client appears to be more likely to perceive the group as conflictual and have a poorer treatment outcome. It might be suggested that if client’s find evidence in the response behaviours of others in the group to support their CCRT patterns, the pattern may be more likely to be maintained. It is also unclear why some clients have more persistent response patterns than others. However, this may be related to the chronicity of both their depressive condition and/or the CCRT pattern itself.

Future research with larger samples may help clarify these issues and recommend strategies to identify appropriate interventions to address the needs of individual cases. However, based on the findings of this current study it can be concluded that consideration of transference dynamics is important for understanding and maintaining effective therapeutic relationships within group therapy situations. The next chapter examines some of these issues in detail for two people attending two different groups in the current sample.
Chapter 6

Case studies
**Case-study selection**

In study three the initial analyses were completed on the data for the entire 30 participant sample and their 150 significant events (i.e. 5 significant events per client). Study four attempts to provide an ideographic examination of the individual recovery processes of two cases. These cases were selected to explore in more detail the relationship between the significant events, the CCRT patterns, fluctuations in the alliance and eventual treatment outcomes.

Furthermore, a case study method was chosen to provide an ideographic description of processes towards mastery and symptom based outcomes that may not be adequately explained by periodic alliance and group cohesion measurement. The group cohesion repertory grids completed by these two cases are also discussed here to again investigate whether a fixed construct grid method illuminates the ideographic nature of individual recovery processes for these two group members.

Finally, a case study method is a logical way to complete this thesis because of the exploratory nature of the findings in the previous studies (due to limitation of the sample size) might be appropriately grounded within the context of individual experiences by elaborating the principles of the earlier findings via intensive case studies. That is, as stated in chapter one, because this thesis stretches between the qualitative-phenomenological and the clinical-quantitative traditions the overriding aim has been to emphasise the individual experience within the context of others participating in group therapy. In other words, although the previous studies have found some evidence of associations between dimensions of relationship phenomena, group development processes and therapy outcome in terms of the combined measures competed by this sample of thirty people with depression, an understanding of individual recovery processes requires an attempt to hear the ‘individual voice’.
The cases chosen were a female that responded well to treatment (described under the pseudonym Jill) and a male who responded poorly to treatment, or at least did not register any significant gains on most of the outcome measures (described under the pseudonym Jack). Background data such as diagnostic history is also included. Jack and Jill were selected for the case studies to illustrate the differences in interpersonal recovery processes of someone who experienced significant change and someone who experienced little change over the treatment period. That is, Jack and Jill were representative of differential outcomes. Jack and Jill were members of different therapy groups.

To summarise, the aims in elaborating these two cases were:

1. To examine the significant events in relation to the individual recovery processes for each case.

2. To investigate whether the ratings of alliance, cohesion, climate and self-other differentiation measures by each of the two cases with apparently different outcomes appear meaningful within the context of each person’s CCRT.
Case One: Jill

Jill is a 44 year old female. Her assessment revealed no comorbidity or dysthymia. She was experiencing her second episode of Major Depression which was severe for four weeks prior to her inclusion in the study. She reported her first depressive episode lasting approximately three months when she was 21 years of age. The details of this client’s significant events and CCRT patterns can be viewed in Table 24 below.

The Primary CCRT pattern for Jill:

W – I wish for approval, acceptance, independence

RO – I experience the other person as critical, demanding, mock me, keeping me dependent & submissive

RS – I respond by feeling guilty, worthless, depressed, responsible, driven to fix things, I comply but resist doing so

Jill recorded pre and post measures of depressive symptomatology on the Beck Depression Inventory of 38 and 2 respectively, and the Hamilton Rating Scale for Depression of 28 and 5 respectively. This suggests that Jill improved substantially over the sixteen sessions of group therapy from being severely depressed to displaying virtually no symptoms of depression.

The overall significant events - CCRT concordance mean across all five significant events for Jill was 7.4 (max 10). The mean concordance between the observed ‘wish’ during the significant events and the ‘wish’ identified in Jill’s CCRT pattern was 4.75 (max 6). The mean concordance at the RO level was .80 (max 6) and at the RS level was 1.65 (max 6).
Table 24. Description of significant events for Jill (Client number 11)

<table>
<thead>
<tr>
<th>Significant event description</th>
<th>Presenting Theme</th>
<th>Observed RO</th>
<th>Observed RS</th>
<th>Relationship pattern displayed in each event</th>
<th>Overall Concordance</th>
<th>Help 1</th>
<th>Help 2</th>
<th>BWA</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. First real contribution/participation in group, therefore overcoming feelings of being judged or different from others. Why Sig.: Redress of feelings/experiences in work group, and generally as country girl now in bigger city.</td>
<td>2E</td>
<td>3L</td>
<td>3K</td>
<td>W – to be connected, to fit in RO – support, validation RS - satisfaction</td>
<td>9.5</td>
<td>2</td>
<td>2</td>
<td>5.33</td>
<td>5</td>
</tr>
<tr>
<td>2. Selling of old family home – signifying end of marriage and further connection with new home. Why Sig.: End of being split between 2 homes and making a final decision regarding complete separation from partner.</td>
<td>5T</td>
<td>6U</td>
<td>6U</td>
<td>W – to feel settled and supported RO – support, validation RS - satisfaction</td>
<td>6.5</td>
<td>3</td>
<td>3</td>
<td>5.50</td>
<td>12</td>
</tr>
<tr>
<td>3. Confronting friend/confidant at work, therefore empowering self in a meaningful and significant relationship Why Sig.: Redress of pattern of idealising others at cost of own self worth.</td>
<td>3J</td>
<td>4P</td>
<td>4P</td>
<td>W – to be heard, to have boundaries respected RO – supported, validated RS - satisfaction</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>5.33</td>
<td>12</td>
</tr>
<tr>
<td>4. Having an incontinence accident at work and dealing with the embarrassment and remaining at work. Why Sig.: No longer intimidated by work colleagues.</td>
<td>3L</td>
<td>4P</td>
<td>4P</td>
<td>W – support RO – support RS - satisfaction</td>
<td>6.5</td>
<td>2</td>
<td>2</td>
<td>5.33</td>
<td>13</td>
</tr>
<tr>
<td>5. Enforcing boundaries of personal responsibility with daughter. Why Sig.: Overcoming caretaking role driven by guilt</td>
<td>6V</td>
<td>6V</td>
<td>6V</td>
<td>W – to have boundaries respected RO – support RS - satisfaction</td>
<td>8.5</td>
<td>2</td>
<td>2</td>
<td>5.33</td>
<td>14</td>
</tr>
</tbody>
</table>

Help 1 = helpfulness – hindrance rating by the therapist in terms of how helpful/hindering the event was seen at the time of the event (-4 extremely hindering to + 4 extremely helpful)
Help 2 = helpfulness – hindrance rating by the therapist in terms of how helpful/hindering the event was seen in the context of the entire treatment
BWA = brief alliance rating as an estimate by the therapists of the strength of the alliance at the time of the event (max 7)
Session = therapy session number in which the event occurred.
These ratings suggest that Jill’s primary CCRT pattern was easily recognisable and highly represented in the material and behaviours she brought the group therapy significant event sessions. Furthermore, Jill’s primary interpersonal ‘wish’ was also highly represented during the significant events. It might be suggested then that the observation that Jill was attempting to have her ‘wish’ (for approval, acceptance, and independence) met within the significant event therapy sessions, in fact accounts for most of the high overall significant events – CCRT concordance rating.

However, there was a very low level of concordance between the RO displayed by the therapists and other group members (i.e. offering support and validation) and the RO predicted by Jill’s CCRT (i.e. RO – critical, demanding, mock her, keep her dependent & submissive). Similarly Jill did not respond to the others present in the significant event therapy sessions in a manner that was typical of her CCRT pattern (i.e. feel guilty, worthless, depressed, responsible, driven to fix things, passive-aggressive compliance). Rather, her responses displayed a level of mastery of her interpersonal conflicts ranging from 3K – expressions of cognitive ambivalence to 6V – expressions of new changes in emotional responding (as rated on the Mastery Scale – Grenyer, 2002). Together these results suggest that the interactions that occurred during the significant events represented disconfirmations of Jill’s CCRT patterns and behavioural examples of practicing new response options.

The mastery ratings of the five presenting themes of each significant event for case one are:

1. 2E (expressions of suffering from internal negative states) (therapy session 5).
2. 5T (expressions of insight into interpersonal relations) (therapy session 12),
3. 3J (expressions of cognitive confusion) (therapy session 12),
4. 3L (references to positive struggle with difficulties) (therapy session 13),
5. 6V (expressions of new changes in emotional responding) (therapy session 14),

This indicates that only one (20%) of Jill’s significant events represented the client being dominated by symptoms and defences (low level of mastery). Therefore, 80% of Jill’s significant events indicated she was attempting to, and in some events succeeding to, understand and control responses within an interpersonal context (medium to high level of mastery).

During significant event five (which was the earliest significant event in her treatment) Jill displayed her lowest level of mastery in her presenting theme (2E - expressions of suffering from internal negative states) and was met with a response from the group that recognised and validated her struggle to participate and overcome her difficulties (3L). Although she appeared ambivalent about engaging herself even further in the group as a result of this interaction (3K), there was a high level of alliance reported from the perspective of the therapists (mean 5.33, max 7). This suggests that she appeared engaged even though she seemed ambivalent. This might also add some support for the previously mentioned notion (chapter five) that the narratives or stories people tell during therapy session may reflect a meta-cognitive level of functioning that may be independent of, yet related to, the therapy interactions and related components of the working alliance.

Jill seemed to be viewing her depressive experience and symptoms within an interpersonal context. Making changes in her interpersonal functioning seemed to be reflected in her reduction in symptoms and overall sense of well being. All the significant events that occurred in the last five sessions of the group (sessions 12 – 16) were rated as demonstrating medium to high level of mastery. This seems to indicate
Jill gradually used the group over time to gain insight and explore issues related to interpersonal recovery from depression. Jill initially displayed severe symptoms of depression including suicidal ideation. Furthermore, she took five sessions to disclose personal experiences in the group. However, she was able to overcome her sense of being dominated by these symptoms relatively quickly subsequent to her engagement and self disclosure during session five.

It might be suggested that in Jill’s case the relatively recent accumulation of life events associated with the onset of this recent episode of depression were clear (e.g. marriage breakdown, sense of isolation after moving to another city, feeling pressured at work, feeling used by her daughter, etc.), and that making progress with these events might result in improvements in symptoms and well being. However, in identifying her CCRT it was established that she had a long history of having her wish (W) for approval, acceptance and independence, impeded by others (RO) in her life being critical, demanding, mocking her and attempting to keep her dependent and submissive. Her typical responses to this pattern of interpersonal conflict (RS) was to feel guilty, worthless, depressed, responsible, driven to fix things, and to display passive-aggressive compliance. In other words, even though she had long-term depressive tendencies, she also had a tendency to take responsibility to overcome problems. Consequently, it might be speculated that some of the adaptations (responsibility, driven to fix things, passive aggression) she had developed to cope with interpersonal conflict may have been useful mechanisms to counter the other more depressive responses (guilt, worthlessness, depression).

It might therefore be suggested that the more constructive adaptations may have been generally protective against the onset of depression except for those times when a number of significant life events could not be contained by them. By having
her CCRT disconfirmed by the support of the group (interventions within the group were rated as being quite helpful at each significant event) she appeared to be able to reactivate her constructive adaptations as well as make some changes to the RO predicted by her CCRT and exhibited by unhelpful others in her current life situations.

Although many of these change events occurred outside the group, it seemed important that Jill was able to receive contact from others within the group that supported her interpersonal wished (W). In other words, she seemed to gain strength from the support, acceptance and validation of the group to make the changes in her life outside the group. It also seemed important that she was able to return to the group to tell her story about her interpersonal struggles and successes, and to be heard and validated by others. This might be further evidenced by the struggle Jill identified in the early stages of the group (i.e. up to session five where she first engaged herself into the group via meaningful self-disclosure).

A closer review of the significant events might suggest that Jill had a significant need to feel connected with and supported by people in her life. This appears to be an underlying theme that was present in each of the situations mentioned across the five significant events. That is, she had a desire for a sense of belonging, approval, support and acceptance within her work team, within her new community, within her significant relationships, and within her family. However, this was not to be at the cost of her wish for independence. This wish, and Jill’s anticipation of rejection (based on her CCRT pattern), was activated within the therapy group by Jill identifying ways in which she differed from the other group members. In consequence, she felt that she did not belong and therefore did not allow herself to be supported by the group. Again this behaviour within the first five sessions of the group strongly reflected Jill’s persistent ‘wish’ to be ‘approved of and
accepted’ whilst maintaining her ‘independence’. This resonates with the ‘social cohesion’ dimension of group cohesion outlined in chapter three of this thesis.

In summary, Jill displayed significant improvement over the sixteen weeks of treatment in terms of reductions in depressive symptomatology and increases in well-being and interpersonal functioning. Although she was initially quite overwhelmed and dominated by her symptoms, she responded well to group therapy which focussed on issues related to interpersonal recovery (medium to high level of mastery). The fact that Jill responded well to this type of treatment may have been related to the structure of her CCRT. That is, she was able and willing to have her wish for approval, acceptance and independence met within the group which helped facilitate the reactivation of some of her more constructive coping mechanisms. These coping mechanisms included Jill taking responsibility for making changes in her interpersonal life that challenged the dominance of her CCRT.
Case Two: Jack

Jack is a 59 year old male. His assessment revealed the presence of Dysthymia for the past twenty years with sporadic Major Depressive Episodes. As well as current Major Depressive Disorder he also met the diagnostic criteria for Social Phobia. His Social Phobia may have played a significant role in Jack finding it difficult to engage in the group process. The details of Jack’s significant events and CCRT patterns can be viewed in Table 25 below.

Jack recorded pre and post measures of depressive symptomatology on the Beck Depression Inventory of 25 and 25 respectively, and the Hamilton Rating Scale for Depression of 27 and 14 respectively. This suggests that Jack reported little to modest change in depressive symptomatology as a result of undertaking this treatment. However, the assessment interviewer suggested that there was more improvement than Jack acknowledged in the self report measures. This in itself might indicate that Jack was reluctant to recognise improvement.

The overall significant events - CCRT concordance mean across all five significant events for Jack was 7.5 (max 10). The mean concordance between the observed ‘wish’ during the significant events and the ‘wish’ identified in Jack’s CCRT pattern was 4.45 (max 6). The mean concordance at the RO level was 3.10 (max 6) and at the RS level was 5.00 (max 6). This suggests that Jack’s primary CCRT pattern was easily recognisable and highly represented in the material and behaviours he brought the group therapy significant event sessions. Furthermore, Jack’s primary interpersonal ‘wish’ was also highly represented during the significant events. As with Jill, it might be suggested then that the observation that Jack was attempting to have this ‘wish’ (i.e. to be understood, experience empathy) met within
the significant event therapy sessions, in fact accounts for most of the high overall significant events – CCRT concordance rating.

However, Jack noticeably differs from Jill in regards the concordance ratings for the RO and RS components of the interactions observed during the significant events. The observation that the RO predicted by Jack’s CCRT pattern (i.e. displaying a lack of understanding, criticism or frustration) demonstrated a ‘moderate’ to ‘good but somewhat weak’ level of concordance (3.10, max 6) with the RO displayed by the therapists and other group members (i.e. at times ‘trying to help, listen and give choices’, at other times ‘rejecting his helplessness’). This suggests that at times the therapists and/or other group members were engaged in partially enacting Jack’s CCRT pattern.

Again unlike Jill, Jack on average responded to the others present in the significant event therapy sessions in a manner that was highly typical of his CCRT pattern (RS concordance of 5.00, max 6), (i.e. he responded with ‘bitterness and frustration’). This response patterns was judged as displaying a level of mastery of his interpersonal conflicts ranging from 1C – ‘references to blocking defences’ to 3K – expressions of cognitive ambivalence (as rated on the Mastery Scale – Grenyer, 2002). This suggests that Jack responded to the interactions within the significant events in a manner that indicated low to low medium levels of mastery of interpersonal conflict. Together these results suggest although the interactions that occurred during the significant events generally represented disconfirmations of Jack’s CCRT patterns by others he persisted in responding in a CCRT typical fashion. In other words Jack did not appear ready to explore alternate response options.
The mastery ratings of the five presenting themes of each significant event for Jack were:

1. 2G (Expressions indicative of negative projection from others) (therapy session 3),
2. 2F (Expressions indicative of negative projection onto others) (therapy session 9),
3. 1A (Expressions of being emotionally overwhelmed) (therapy session 10),
4. 2I (Expressions of helplessness) (therapy session 13),
5. 2G (Expressions indicative of negative projection from others) (therapy session 14).

Again these mastery ratings suggest that the narratives or stories Jack told during the significant events indicate a low level of mastery suggesting he remained dominated by symptoms and defences. This pattern did not seem to change over the course of therapy as evidenced by the persistence of a low level of mastery spanning session 3 to 14. Furthermore, despite Jack’s apparent lack of effective engagement in the treatment the therapists still rated the alliance with this client as consistently high (mean 5.20, max 7) across all five significant events. This suggests that efforts were made to keep this client engaged in the setting treatment goals and engaging in treatment tasks whilst attempting to remain respectful and supportive throughout the significant events.
Table 25. Description of significant events for Jack (Client number 18)

<table>
<thead>
<tr>
<th>Significant event description</th>
<th>Presenting Theme</th>
<th>Observed RO</th>
<th>Observed RS</th>
<th>Relationship pattern displayed in each event</th>
<th>Overall Concordance</th>
<th>Help 1</th>
<th>Help 2</th>
<th>BWA</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Theme of powerlessness – trapped by circumstances. Why Sig.: Persistent theme through group treatment for this client.</td>
<td>2G</td>
<td>40</td>
<td>2I</td>
<td>W – to be understood</td>
<td>6.25</td>
<td>-2</td>
<td>-2</td>
<td>4.50</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RO – reject his helplessness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RS – retreat, ruminate, disown choices/responsibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Angry outburst at group leader in response to suggestion that he had a choice about whether he might benefit from participating in simple awareness/self-monitoring exercises or not. Why Sig.: Challenged his insistence on helplessness. Positive in terms of more genuine/clearer contact with the group leader (i.e. emotion matched content) – especially in terms of expression of self powerfully in a social context (i.e. not contained by his social phobia)</td>
<td>2F</td>
<td>4N</td>
<td>2I</td>
<td>W – to be helped, understood, given answers</td>
<td>9.75</td>
<td>3</td>
<td>3</td>
<td>5.50</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- to be recognised as helpless</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RO – try to help, listen, give choices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RS – get angry, ruminate</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3. Processing of angry outburst with group leader the previous week. Particularly the client’s changing of words used at the time when asked what he wanted from the group leader (i.e. initially the client said ‘answers’ one week later he said what he really wanted was ‘empathy’) Why Sig.: Realisation that he had exposed a flaw in interpersonal orientation (i.e. he wanted answers). He had been obsessing on the outburst for the past week. He had been shown empathy but appeared to have been resisting taking personal responsibility (i.e. wanting others to give him the ‘answers’ – which he could then pull apart and reject – as he did the previous week). He had returned to deal with this however, which he reported was quite different from how he would have normally dealt with things (i.e. avoid them). He seemed to resist owning that he tended to be unclear with people about what he wanted.</td>
<td>1A</td>
<td>4O</td>
<td>2F</td>
<td>W – to be helped, understood, given answers</td>
<td>9.5</td>
<td>1</td>
<td>1</td>
<td>5.33</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- to be recognised as helpless</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RO – try to help, listen, give choices</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>RS – get angry, ruminate, disown choices/responsibility</td>
<td></td>
<td></td>
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</tbody>
</table>
4. A previous perceived alliance with another group member though similar feelings of being ripped off by employers etc., was now resisted by the other group member in question. Why Sig.: No longer a clear ally in the notion of ‘helplessness’ and ‘victimhood’ (i.e. lack of agency). That is, the accuracy or currency of these beliefs was being challenged through lack of support.

| 2I | 4M | 1C | W – to understood - to be recognised/ supported as helpless RO – reject his helplessness RS – retreat, ruminate, disown choices/responsibility | 7.75 | 1 | 1 | 5.33 | 13 |

5. Connecting lack of dog’s obedience at shows (client is a show dog trainer) to client’s own decrease in authoritativeness in public arenas (i.e. client seems to be disempowered by social anxiety). Why Sig.: Insight into how he contributes to his perceived lack of response (or indifference) of others (i.e. his dog in this instance).

| 2G | 4O | 3K | W – to be respected, powerful RO – try to help, listen, give choices RS – deflect | 4.25 | 3 | 3 | 5.33 | 14 |

Help 1 = helpfulness – hindrance rating by the therapist in terms of how helpful/hindering the event was seen at the time of the event (-4 extremely hindering to +4 extremely helpful)
Help 2 = helpfulness – hindrance rating by the therapist in terms of how helpful/hindering the event was seen in the context of the entire treatment
BWA = brief alliance rating as an estimate by the therapists of the strength of the alliance at the time of the event (max 7)
Session = therapy session number in which the event occurred.

The Primary CCRT pattern for Jack:

W – I wish to be understood and receive empathy

RO – I experience others as lacking understanding, being critical of me, frustrated with me

RS – I feel bitterness, frustration
Although some improvements seemed to be apparent during some of these events, the overall impact of treatment seemed to be minimal. Some of his apparent treatment resistance may have been related to Jack becoming locked into an unhelpful mode of interpersonal responding through habit over a long period of time. In other words, his RS might have become part of his self identity as being a bitter victim of life events beyond his control. Some evidence of this might be that despite the majority of the interventions of the therapists and other group members being rated reasonably helpful at the time of the events, Jack’s RS remained steadfast and consistent with his CCRT pattern. Alternatively, it could be argued that his interpersonal relationship style, existential outlook, and personality features may have left him with a predisposition of vulnerability to depression. Consequently, recovery from depression would also require a significant adjustment of his personality, which might once again require longer term psychotherapy.

A closer inspection of Jack’s CCRT pattern and the interactions that occurred during the significant events warrants further discussion in terms of treatment impact. This case could be seen as a good example of how the significant events themselves might at times help clarify and elaborate the initial CCRT pattern formulation rather than simply analysing the dynamics of the events in terms of the previously formulated CCRT patterns. In other words, CCRT pattern formulations should be seen as hypotheses that can be adjusted in the light of new observations, rather than given factual status or characterising permanence. For example, a therapist or researcher remaining open to new CCRT formulations might discover that there is more than one ‘wish’ evidenced by the client’s dialogue and behaviour. It might also be discovered that there are primary,
secondary and tertiary CCRT patterns in operation at different times, and at some moments might be occurring simultaneously and in conflict with one another.

In Jack’s case, significant events 1, 3 and 4 were rated as only slightly helpful (events 3 and 4) or hindering (event 1) his efforts towards mastery. These events also exhibited a set of ‘wishes’ that occurred simultaneously and that appeared at some levels in conflict with one another. For example, to have a wish to be helped (which was verbalised) seems to be at odds with a wish to be recognised as being helpless (which was implied by his reaction to interventions which could be seen as attempts to be helpful). A confrontation of Jack’s negation of his ability to engage in behaviours that might help him help himself could then be translated by his CCRT pattern as yet another example of the ‘other’ being critical of him, being frustrated with him, and not understanding him. Paradoxically, attempts by others to meet his ‘wishes’ (to be helped) were converted into a failure to meet another of his ‘wishes’ (to be understood, to experience empathy). Consequently, the CCRT patterns persist because they are multi-faceted and mutually reinforcing. In might be speculated that Jack was either not ready to take responsibility to make change happen for himself, or that he had more to gain (or perhaps felt safer) by remaining angry and bitter with the world and the people in his life than progressing with his recovery.

In summary, Jack did not appear to respond to the interpersonal interventions offered during the significant events. In fact, Jack’s persistence in responding to the therapists and other group members in a manner typical of his CCRT pattern at times appeared to entice the others into enacting and thus reinforcing his CCRT pattern through CCRT concordant response patterns. This phenomena of individual processes provoking
interactions within the group system also finds some support in Personal Construct Theory (Kelly, 1955) where anger/hostility may reflect a reaction to experiencing (or at least construing) invalidation of one’s personal construct system (Cummings, 2003; Kalekin-Fishman, 1993; Beck, 1988).

An exploration of the two cases’ alliance, group cohesion, group climate and self-other differentiation ratings – early in therapy and at therapy termination.

Table 26 displays the mean ratings of alliance, group cohesion, group climate and self-other differentiation early in therapy (i.e. session 4 for alliance ratings and session 6 for cohesion, climate and self-other differentiation ratings) for both Jack and Jill. Table 26 also displays the mean ratings of alliance, group cohesion and group climate for the entire 30 cases (i.e. all six groups data combined) as well as the mean ratings for the separate small therapy groups (n = 6 for each group) that Jack and Jill had membership. Table 27 contains the same measures rated at the end of treatment (i.e. after session 16). As can be seen in Tables 27 & 28 Jack and Jill have rated these relationship phenomena quite differently.

Jill’s group process variable ratings.

Jill rated all the alliance and group cohesion scales within one standard deviation of the mean produced by the entire sample of thirty cases. This suggests that she is quite representative of the sample as a whole in terms of alliance and group cohesion measures.
Jill’s ratings of group climate did vary from the mean of the entire sample of thirty cases apart from the ‘engaged’ subscale score. Jill’s ratings of group climate also varied from the mean subscale scores of her own therapy group on all three group climate subscale scores (i.e. engaged, conflict and avoiding). This suggests that early in therapy Jill perceived the group as a whole on average as displaying less conflict and avoiding behaviour than did other members of her therapy group and the entire treatment sample in general. She also perceived the group members as being less engaged in the therapy than others in her group did in general. Although she did view the group as typically engaged in the therapy in line with the entire group mean.

Considering these results together it might be suggested that Jill viewed her therapy group as highly cohesive and operating in a non-conflictual, non-avoiding interpersonal atmosphere. Interestingly these measures were collected from Jill at the same time as the significant event that occurred earliest in her treatment. As mentioned above this event involved Jill articulating her feelings of not fitting in with the therapy group, which seemed to be concordant with her interpersonal theme regarding her desire for a sense of belonging, approval, support whilst establishing and maintaining independence.

It might be speculated that Jill may have been perceiving conflict and avoidance as characteristic of herself rather than part of the broader relationship climate of the group. That is, she might have been over-identifying with and internalising the conflictual and avoiding behaviours of others. The fact that she saw the group as less ‘engaged’ than others in her group might also be seen as an indication of her own feelings of only minimal connection with others. This could be seen as reflecting the struggle of the
establishment of the notion of ‘social cohesion’ mentioned earlier (chapters 1 & 3), the
struggle to form a social identity without losing one’s personal identity. Furthermore, this
possibility resonates with her primary CCRT pattern in that she had a pattern of being
overly responsible for the behaviour of others and that if there was a conflict it must have
been the result of her failing in some way. This would add credence to her belief that she
did not belong and was not acceptable.
Table 26. Mean ratings of alliance, group cohesion, group climate and self-other differentiation early in therapy for both Jill, Jack, their individual groups and the entire 30 case sample.

<table>
<thead>
<tr>
<th></th>
<th>Jill</th>
<th>Jill’s therapy group (n = 6)</th>
<th>Jack</th>
<th>Jack’s Therapy Group (n = 6)</th>
<th>Combined data from all 6 groups (n = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Early in treatment (mean)</td>
<td>Early in treatment (mean) (std. dev)</td>
<td>Early in treatment (mean)</td>
<td>Early in treatment (mean) (std. dev)</td>
<td>Earlier in treatment (mean) (std. dev)</td>
</tr>
<tr>
<td>WAI (max 21)</td>
<td>16.08</td>
<td>17.30 (.13)</td>
<td>11.42**</td>
<td>14.90 (1.84)</td>
<td>15.91 (2.12)</td>
</tr>
<tr>
<td>Goal (max 7)</td>
<td>5.33</td>
<td>5.61 (.30)</td>
<td>4.42**</td>
<td>5.01 (.55)</td>
<td>5.17 (.72)</td>
</tr>
<tr>
<td>Task (max 7)</td>
<td>5.42</td>
<td>5.74 (.61)</td>
<td>2.33**</td>
<td>4.56 (1.24)</td>
<td>5.04 (.97)</td>
</tr>
<tr>
<td>Bond (max 7)</td>
<td>5.33</td>
<td>5.95 (.46)</td>
<td>4.67**</td>
<td>5.33 (.51)</td>
<td>5.70 (.71)</td>
</tr>
<tr>
<td>CALPAS-G (max 28)</td>
<td>22.00</td>
<td>20.83 (2.81)</td>
<td>13.00**</td>
<td>18.72 (3.80)</td>
<td>19.55 (3.26)</td>
</tr>
<tr>
<td>Patient Working Capacity (max 7)</td>
<td>5.33</td>
<td>4.61 (.88)</td>
<td>3.67</td>
<td>4.78 (1.13)</td>
<td>4.57 (1.16)</td>
</tr>
<tr>
<td>Working Strategy Consensus (max 7)</td>
<td>5.00</td>
<td>5.17 (.96)</td>
<td>2.33**</td>
<td>4.44 (1.82)</td>
<td>4.68 (1.32)</td>
</tr>
<tr>
<td>Patient Commitment (max 7)</td>
<td>6.33</td>
<td>6.06 (.83)</td>
<td>3.67**</td>
<td>5.44 (1.11)</td>
<td>5.80 (1.01)</td>
</tr>
<tr>
<td>Member Understanding &amp; Involvement (max 7)</td>
<td>5.33</td>
<td>5.00 (.87)</td>
<td>3.33*</td>
<td>4.06 (.98)</td>
<td>4.50 (1.06)</td>
</tr>
<tr>
<td>GCQ Engaged (max 6)</td>
<td>3.40**</td>
<td>4.17 (.54)</td>
<td>1.80**</td>
<td>3.37 (1.09)</td>
<td>3.79 (.92)</td>
</tr>
<tr>
<td>Conflict (max 6)</td>
<td>0.00**</td>
<td>1.08 (.68)</td>
<td>1.30</td>
<td>.96 (.37)</td>
<td>1.07 (.84)</td>
</tr>
<tr>
<td>Avoiding (max 6)</td>
<td>1.33**</td>
<td>2.56 (.96)</td>
<td>3.00</td>
<td>3.28 (.68)</td>
<td>2.92 (1.14)</td>
</tr>
<tr>
<td>GCG Self-leader</td>
<td>13.86**</td>
<td>9.79 (2.07)</td>
<td>12.30**</td>
<td>8.82 (3.43)</td>
<td>8.98 (3.02)</td>
</tr>
<tr>
<td>Self-other group members</td>
<td>9.15**</td>
<td>7.54 (1.05)</td>
<td>10.57</td>
<td>9.75 (3.02)</td>
<td>8.60 (2.56)</td>
</tr>
</tbody>
</table>

* Client ratings that differed from the mean of the entire sample of 30 clients by more than one standard deviation.

** Client ratings that differed from the mean of the his/her own therapy group (n = 6) by more than one standard deviation.

Jill’s self-other differentiation ratings at week six portray a similar picture. Jill viewed herself as more dissimilar to both the group leaders and the other group members than others in her group did. She also saw herself as more dissimilar than the group
leaders than the entire sample of thirty clients did on average. Once again this might be taken as reflecting her CCRT pattern in that the ‘wish’ component of her conflictual pattern, the desire to belong and be accepted may have been in conflict with her feelings of dissimilarity to others. If she had actually developed more of a sense of social cohesion (i.e. identifying with other in the group and contrasting this group identity with a distinct other group – possibly the group leaders), in the early stages of group development it might be expected that a greater dissimilarity to group leaders would be complemented with a lesser dissimilarity to other group members. Jill’s self-other differentiation ratings seem to indicate that she was still maintaining her separateness from the group and the group leaders up to session six.

Interestingly, by session sixteen (Table 27) Jill scored the conflict subscale within one standard deviation of the mean of the entire sample of 30 and the mean of her own group. However, she rated perceived level of engagement and avoiding more than one standard deviation above the mean for all 30 cases and the mean of her own group. That is, Jill reported higher than average levels of engagement and avoidance behaviour in her group. This might suggest that the success of her therapy meant she was no longer over-identifying with and internalising her conflict and failing to notice the avoiding behaviour of others. In fact she may have been more acutely aware of the avoidances of others the further she progressed with her own recovery process.

The other notable changes in Jill’s ratings between sessions six and sixteen were that by the end of treatment she was more that one standard deviation above the full sample of 30’s mean and the mean of her own group for the ‘member understanding and involvement’ subscale of the CALPAS-G, and she saw herself as less dissimilar from the
other group members in her group than others did. Her scores were also more than one standard deviation above her own group’s mean for the ‘task’ agreement subscale of the WAI and the total CALPAS-G score. These ratings appear to indicate that Jill identified more with her group, was more engaged in the activities of therapy and felt understood and connected with others as the group progressed over time. It might also be suggested that the more she progressed with her own recovery process, the more she allowed herself to gain from the therapeutic factors present in her group.

Perhaps the most interesting change was in regards to her self-other differentiation ratings. Jill changed from seeing herself as more dissimilar than the group leaders to seeing herself as similar to the group leaders as others in her group did by session sixteen. This amounts to her approximately halving the level of dissimilarity she perceived between herself and the group leaders over the life of the group. Even more dramatic was the change in perception of dissimilarity to the other people in her group. Similarly she approximately halved the dissimilarity rating. However, this meant that she changed from perceiving herself as more dissimilar to others in the group than the majority of others saw themselves to be, to perceiving herself as less dissimilar to others. This seems to reflect her significant progress towards mastery of her primary CCRT pattern. That is, her tendency to internalise and be overly responsible for her conflicts with others, leaving her feeling different, isolated and disconnected from others, appears to have changed as she allowed herself to identify and connect with the group.
Table 27. Mean ratings of alliance, group cohesion, group climate and self-other differentiation end of therapy for both Jill, Jack, their individual groups and the entire 30 case sample.

<table>
<thead>
<tr>
<th></th>
<th>Jill’s therapy group (n = 6)</th>
<th>Jack’s Therapy Group (n = 6)</th>
<th>Combined data from all 6 groups (n = 30)</th>
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<tbody>
<tr>
<td></td>
<td>End of treatment (mean)</td>
<td>End of treatment (mean) (std. dev)</td>
<td>End of treatment (mean) (std. dev)</td>
</tr>
<tr>
<td>WAI (max 21)</td>
<td>18.33</td>
<td>17.89 (.82)</td>
<td>12.00 * ***</td>
</tr>
<tr>
<td>Goal (max 7)</td>
<td>5.50</td>
<td>5.82 (.32)</td>
<td>4.50 *</td>
</tr>
<tr>
<td>Task (max 7)</td>
<td>6.25 **</td>
<td>5.87 (.34)</td>
<td>2.67 * **</td>
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<tr>
<td>Bond (max 7)</td>
<td>6.58</td>
<td>6.20 (.38)</td>
<td>4.83 * **</td>
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<tr>
<td>CALPAS-G (max 28)</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>24.33 **</td>
<td>21.02 (2.24)</td>
<td>11.00 * ***</td>
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<tr>
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<td>5.33</td>
<td>4.14 (1.48)</td>
<td>2.67 * **</td>
</tr>
<tr>
<td>Patient Commitment (max 7)</td>
<td>7.00</td>
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<td>1.33</td>
</tr>
<tr>
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<td>6.67 * **</td>
<td>5.28 (.87)</td>
<td>4.00 *</td>
</tr>
<tr>
<td>GCQ</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>5.20 * **</td>
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<td>2.60 *</td>
</tr>
<tr>
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<td>.50 **</td>
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<tr>
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<td>7.65 (.91)</td>
<td>15.19 * **</td>
</tr>
<tr>
<td>Self-other group members</td>
<td>5.62 * **</td>
<td>7.19 (1.40)</td>
<td>16.04 * **</td>
</tr>
</tbody>
</table>

* Client ratings that differed from the mean of the entire sample of 30 clients by more than one standard deviation.
** Client ratings that differed from the mean of the his/her own therapy group (n = 6) by more than one standard deviation.
Jack’s group process variable ratings.

Jack’s alliance, group cohesion, group climate and self-other differentiation measure ratings represent a stark contrast with Jill. As can be seen in Table 26 Jack rated all the alliance and group cohesion scales early in therapy more than one standard deviation below the mean produced by the entire sample of thirty cases, except for the ‘patient working capacity’ subscale of the CALPAS-G. A similar variation in relation to the mean and standard deviation scores collected from his therapy group alone was also found, with only ‘patient working capacity’ and ‘member understanding and involvement’ subscales falling within one standard deviation of the group’s mean. This suggests that Jack generally perceived a poorer alliance and less cohesive group than other group members within his particular therapy group and in comparison to the entire sample. Furthermore, Jack’s ratings of group climate only varied from the mean of the entire sample of thirty cases and his particular group on the ‘engaged’ subscale score. That is, he perceived his group as displaying similar levels of ‘conflict’ and ‘avoidance’ as others did, but as being less ‘engaged’ than others did.

Up to session six, Jack perceived himself as being considerably dissimilar to the group leaders to the point of being more than one standard deviation above the means produced by his own group and the entire sample of thirty clients. He did however perceive himself as dissimilar to the other clients in his group no differently than the other group members perceived themselves to be.

Interestingly, by session sixteen (Table 27) Jack’s alliance, cohesion and group climate ratings remained more than one standard deviation below the mean of the entire sample of 30. However, the ‘patient working capacity’ subscale also fell below one
standard deviation below the entire sample mean. This suggests that Jack maintained his perception of disconnection from, and doubts about the potential helpfulness of, his therapy group over the course of treatment.

In terms of Jack’s self-other differentiation ratings, both his perception of himself as being dissimilar to the group leaders and the other group members increased substantially over the life of the group. Whereas up to session six, Jack reported a similar degree of dissimilarity as others did, by the end of treatment his perception of the degree of his dissimilarity to other group members was almost double the mean for the entire sample and close to one third more than the average of his own group. That is, Jack appeared to decrease the degree to which he identified with others the more time he spent with them.

Relating these results to Jack’s primary CCRT pattern and the interactions that formed his significant events, it might be suggested that the pervasiveness and persistence of his CCRT pattern was reflected in his failure to form constructive therapeutic relationships. As mentioned earlier this can be noted in Jack’s rigidity and narrowness of response options (i.e. a consistent RS) despite the majority of the responses from others (observed ROs) being inconsistent with the RO predicted by his primary CCRT pattern. This also supports Klee et al.’s (1990) suggestion that the client’s capacity to develop relationships and the presence of a relational style that is likely to elicit negative responses from the therapist and others can impact on the formation of a effective working alliance and eventual therapy outcome.

It might also be argued that Jack’s desire to be understood and experience empathy (i.e. the ‘wish’ component of his primary CCRT pattern) was likely to be in
persistent conflict with his belief that others in the group (including the group leaders) did not possess the capacity to help, connect with, and understand him. It could be speculated that his doubt about the potential others had in relation to understanding and helping him was fuelled by his perception that others were substantially different or dissimilar to him.

In summary, both of the cases outlined above seem to be good examples of how ratings of group process measures such as alliance, cohesion, climate and self-other differentiation appear to have some meaningfully associations with the person’s transference template. That is, the perceptions of alliance, cohesion, and aspects of climate and self-other differentiation seem to be associated with the degree of mastery of primary CCRT patterns these clients’ demonstrated during the significant events.
Chapter 7

Conclusion
This concluding chapter highlights the main findings of the four studies and summaries the importance of these findings in relation to advances in: depression, group therapy, repertory grid, CCRT, mastery, and significant events research. To start, this thesis had two overriding aims:

1. To address gaps in the previous research literature regarding:
   a. how relationship phenomena operates within group therapy situations and how they are related to group developmental processes and treatment outcome; and
   b. by exploring in some depth how the interactions that occur during group therapy sessions may be associated with perceptions of the group and represent attempts to resolve previous conflictual interpersonal relationship dynamics of group members.

2. To advance research that integrates qualitative-phenomenological and clinical-quantitative research methodologies. That is, to specifically combine both nomothetic (attempting to capture patterns and similarities between ‘voices’) and idiosyncratic (giving precedence to the ‘individual voice’) data accounts of experiences and behaviours occurring as part of group members’ individual recovery processes from depression.

This thesis met these aims by combining standard quantitative group process measures that capture different group-as-a-whole aspects of the therapeutic relationships (alliance, cohesion and climate) with an emerging measure of specific group relationships (repertory grid method). The repertory grid method was developed within Personal Construct Therapy. Although the theory of Personal Construct Therapy was not used to
direct therapy or interpret finding in this set of studies, the repertory grid method did provide the opportunity to explore self-other differentiation processes of group members within the context of group developmental processes.

Perhaps the greatest challenge of this thesis was to examine the group process and outcome data in terms of Supportive Expressive Therapy theory at both group and individual client levels. Supportive Expressive Therapy combines interventions aimed at firstly developing therapeutic relationships (therapeutic alliance, group cohesion and an engaged group climate) to a point were the client’s repetitive conflictual relationship patterns become clearer (at least for the therapist) and there is adequate support for them to start the work to address these problematic relationship patterns. Therefore, this thesis examined the clients’ mastery of their problematic relationship patterns in relation therapeutic relationship factors and group development processes. This examination focused on therapist identified significant therapy events for each client. This method not only provided qualitative data regarding the components of these significant events it also provided quantitative data regarding the perceived impact of each event of the clients’ depression recovery processes, and how helpful or hindering of these processes each event was. This thesis also demonstrated via case studies that individual recovery processes can be examined in terms of the abovementioned perspectives.

The literature review in chapter one of this thesis, which was recapped and focused at the start of each of the studies, outlined the context and rationale for the specific studies. Within this context it was the intention of the researcher to identify key interpersonal relationship variables generally associated with the depression treatment process and outcome across a set of small therapy groups, and then to examine the
meaning of these variables within the context of individual recovery processes involving the interpersonal domain.

The notion of ‘psychological recovery’ shifts the emphasis from a restricted focus on symptom management or amelioration, which highlights the symptom to functioning relationship, to a more phenomenological-existential account that emphasises personal meaning, forward movement and subjective experience often linked to perceptions and experiences of the person’s interpersonal world (Sheldon, Williams & Joiner, 2003; Grenyer, 2002; Anthony, Cohen, Farkas, & Cohen, 2000; Whitwell, 1999; Deegan, 1988). The methodologies utilised and findings in this thesis highlight the advantages of exploring the subjective experiences (at least in terms of the interpersonal environment of group therapy) of clients pursuing recovery from depression. That is, this thesis emphasises the value of clinicians endeavouring to understand the relationship histories of individual clients and how this might influence their perceptions of conflict within interpersonal environments (like group therapy), and represent a challenge to forming effective working relationships. To this end, the findings of this thesis offer some support for Gelso and Carter’s (1985) suggestion that there may be a reciprocal influence of transference and ‘real’ relationship dimensions on working alliance. The interaction of these factors may also include the self-other differentiation dynamics that appear to be important to the developmental processes of group therapy. Therefore, as a clinician attempts to build a therapeutic alliance with a client (and facilitate the development and maintenance of therapeutic relationships between group members) as a structure to support the individual’s recovery process and as a foundation upon which to initiate more
specific therapy techniques, it might be helpful to engage a framework within which the client’s transference template can be examined.

Bachar, Canetti, Yonah and Bonne (2004) found that Supportive Expressive (SE) group therapy was only slightly inferior to individual Supportive Expressive therapy in terms of treatment gains, however the economic and interpersonal skills enhancement advantages of SE group therapy led the authors to recommend it as an effective treatment modality for people with chronic mental health problems. Although the SE therapy Bachar et al (2004) used resembled more generalist or interpersonal psychotherapy (as compared with the SE therapy based on psychoanalytic principles targeting CCRT patterns used in the current thesis), the emphasis on interpersonal support and exploration resonates with the treatment used in this thesis. The current thesis examined recovery in terms of the relationship between perceptions of interpersonal relationship phenomena and outcome across thirty people with depression and six small therapy groups. However, the strength of this thesis in relation to its overriding aims is the examination of indicators of mastery of conflictual interpersonal relationship patterns as a method of tracking individual recovery processes within group therapy situations. Another aspect of this thesis that makes it significant is the finding of preliminary evidence that interpersonal recovery processes might be mapped against group developmental processes via the mastery of CCRT patterns and self-other differentiation processes.
Study one:

1. examined the relationship between working alliance, group cohesion, group climate, and self-other differentiations,
2. conducted a preliminary dimensional analysis of group process, and
3. examined group members’ perceptions of specific relationships within the group therapy context using a repertory grid method.

Study one offers preliminary evidence for different dimensions of group cohesion which reflect progressive developmental processes in group therapy. There were four main findings in study one. One, that working alliance is not analogous with group cohesion, but is intimately involved with it when considered in the context of the dimensionality of functional and relational factors involved in the development of a group. Two, that dimensions of group cohesion are best considered and defined progressively over the life of the group and that fluctuation in perceptions of alliance, cohesion and group climate might be associated with group developmental processes. Three, that perceived levels of conflict, and where the conflict lies, appears to have a significant influence on defining primary dimensions of cohesion, particularly when considered in relation to self-other differentiation processes. Four, for this study sample there was an emergent finding that group cohesion may consist of three main underlying dimensions: task, social and vertical.

More specifically study one found that the relationship between individual group members and group leaders appeared to be influenced by a number of coexisting relational demands which might be best considered in relation to the emerging
dimensions of cohesion. The first of these dimensions, ‘task cohesion’ appeared to mirror some of the components of working or group alliance (i.e. ‘task’ and ‘goal’ agreement, engagement, etc.). The ‘bonding-with-group-leaders’ component appeared to be more associated with ‘self-other group members’ differentiation and engagement processes earlier in treatment. The more specific relational issues seemed to be more broadly and likely associated with the second dimension, ‘social cohesion’ and the third dimension ‘vertical cohesion’. Whereas the second dimension appeared to primarily reflect processes of individuation and belonging to the group, the third dimension, seemed to more specifically reflect processes of taking responsibility for the direction of the group.

Therefore, study one advanced research understandings regarding the dimensions of group cohesion. These advances were in relation to insights into the management of client perceptions of conflict within the group and self-other differentiation processes. Although repertory grid methods have been used to examine aspects of self-other differentiation in group therapy (Caine, 1981) no studies have been identified that examine these differentiation process within Supportive Expressive group therapy for depression. Study one highlights the value of using repertory grid methods to examine these self-other differentiation processes by offering Euclidean distance measures of dissimilarity between self, other group members, and group leaders. Perhaps the most interesting finding from study one is that dissimilarity to others appears to reflect group developmental processes. Specifically, group members appear to move from a position of seeing group leaders as different and perhaps holding more responsibility for the group process earlier in therapy, to a position of seeing themselves as more responsible for these therapy processes. It could be cautiously argued then that those group members
who started to see themselves as more responsible for their own recovery processes identified more with the group leaders as the group progressed over time.

Study two examined the differential ability of alliance, group cohesion, group climate, and self-other differentiations measures (measured early in treatment) to predict outcome. The main conclusions of study two were that outcome in group therapy for depression can be considered from two differing but related perspectives. Group members appear to be able to identify improvement and treatment success independent of changes in depressive symptomatology. The specific findings were that working alliance (as measured by the WAI) was not related to outcome as were self-other differentiation measures. Group cohesion (as measured by the CALPAS-G) had the strongest association with outcome. However more specifically, client perceived levels of ‘conflict’ in the group (as a component of the group climate) and perceptions of the group members’ ability to work actively and purposefully in treatment (Patient Working Capacity), emerged as being significant associated with outcome for this sample. Previously there were only two studies that directly examined the relationship between perceptions of conflict within the group climate and treatment outcome (McCallum, et al., 2002; Ogrodniczuk & Piper, 2003) with neither finding a significant relationship. Consequently, a conclusion that might be drawn from these findings is that the efficacy of alliance or group cohesion measures in terms of predicting group therapy outcome might benefit by having a closer focus on issues of perceptions of conflict within the group. However, the outcome predictive ability of single measure of conflict needs to be treated with some caution.
Considering perceptions of conflict within the group appear to fluctuate in relation to stage of development that the group may be negotiating, if conflict was measured at different stages in the life of the group it may have been found to a less reliable outcome predictor, as has been previously found in the group climate literature (McCallum, 2002; Ogrodniczuk & Piper, 2003). In fact Kivlighan and Lilly (1997) found that patterns of process change had better outcome predictive ability than specific process measures alone. Furthermore, Burlingame et al (2004, p. 675) suggested that superior outcomes were found “when cohesion and interpersonal work showed a continuous increase, and measures of conflict showed an early but brief increase.” Burlingame et al (2004, p. 673) reviewed the Kiel Group Psychotherapy Study and reported “patients with better outcome increasingly perceived the group as high on conflict and avoidance, suggesting an evolving perception of interpersonal work.” Burlingame et al (2004, p. 674) go on to suggest that there are two group developmental models: “those showing linear changes over the course of a group and those finding evidence of stage alterations, particularly a conflict/differentiation stage characterized by negativity and resistance that follows an earlier positive engagement phase.” Therefore, there is some support within the group therapy literature that suggests that when conflict is considered in relation to group developmental processes it has some utility as an outcome predictor.

Study Three added a more idiosyncratic dimension to the previous studies by exploring factors that might reflect the personal meaning of interpersonal interactions occurring in significant therapy events. Study three:

1. explored the transference dimension of the therapeutic relationships with particular emphasis on CCRT patterns and progress towards mastery of interpersonal conflict,
2. examined the association between the group therapy outcome predictors of ‘perceived conflict’ and ‘patient working capacity’ and CCRT patterns,

3. examined the helpfulness of specific therapy events and whether these events had utility as markers of the pervasiveness and resilience of the client’s CCRT patterns, and

4. examined the relationship between CCRT patterns and progress towards mastery of interpersonal conflict during significant therapy events.

Study three demonstrated that the examination of significant helpful and hindering events during the course of treatment might be seen as windows through which individual interpersonal recovery stories can be heard, and examined in relation to mastery of repetitive conflictual relationship themes. A number of general conclusions were tentatively drawn from study three. First, mastery was a process that appeared to increase over the life of the group. Second, the two aspects of the therapy where efforts towards mastery of core interpersonal conflict patterns were most notable, and most predictive of treatment outcome with this sample, were in the ‘presenting themes’ and in how clients adjusted the way they responded to others (observed RS). That is, mastery and ultimately treatment outcome appeared to be reflected in how well clients controlled old unhelpful interpersonal response patterns, and how they integrated their experiences through the telling of their stories. Third, the processing required formulating and telling one’s story appears to be relatively distinct from controlling one’s response patterns. That is, immediate response behaviours may assist with the telling and hearing of stories, however, the telling of the story itself seems therapeutic. Fourth, mastery of repetitive
conflictual relationship themes appeared to be related to symptom reduction and well being. Fifth, the therapeutic benefit of participating in the group was related to one’s perception of the group-as-a-whole in terms of level of conflict and working capacity for this sample. It was suggested that this perception might be related to the transference of conflictual relationship theme expectancies onto the group. In particular, those who benefit more from group therapy appeared to take more responsibility for mastery of conflictual relationship patterns, especially how they themselves contribute to maintaining these patterns.

If others in the group responded to the client in a manner predicted by the CCRT pattern, the client appeared to be more likely to perceive the group as conflictual and have a poorer treatment outcome. It was speculated that if clients found evidence in the response behaviours of others in the group to support their CCRT patterns, the pattern may be more likely to be maintained. The overall conclusion for study three was that consideration of transference dynamics is important for understanding and maintaining effective therapeutic relationships within group therapy situations.

*Study Four (Case Studies)* considered the individual ratings of perceptions of group relationship phenomena and the individuals’ CCRT patterns in relation to therapist identified significant therapy events. Study four:

1. examined the significant therapy events in relation to the individual recovery processes for each case, and
2. investigated how the ratings of alliance, cohesion, climate and self-other differentiation measures by each of the two cases with different treatment outcomes appeared meaningful within the context of each person’s CCRT.
This study found that the interpersonal dimension of recovery could be explored across the different components of the therapeutic relationship, namely, the therapeutic alliance (and group cohesion), the transference relationship, and to some degree the real relationship in terms of the actual interactions during the significant events. The mastery ratings of the interactional components of the significant events meant that progress with recovery could be examined at an individual level.

It was concluded in study four that both of the cases examined (Jack who did not respond well to treatment and Jill who did respond well) seemed to demonstrate how ratings of group process measures such as alliance, cohesion, climate and self-other differentiation appeared to have some meaningful associations with the person’s transference template. That is, the perceptions of alliance, cohesion, and aspects of climate and self-other differentiation seemed to be associated with the degree of mastery of primary CCRT patterns these clients demonstrated (or failed to demonstrate) during the significant events.

_Overall discussion and conclusions_

The findings of study one suggest that the therapeutic factors of group therapy (Yalom, 1995) in tandem with group developmental processes (Cissna, 1984; Mennecke, Hoffer, Wynne, 1992; MacKenzie, 1983; Kivlighan & Goldfine, 1991; Kivlighan & Lilly, 1997) are associated with treatment outcomes. There was also some support for group developmental stages even though the measures were collected at only two time points (early in treatment and at the end of treatment).
It would be interesting if future research examined whether client hopefulness regarding recovery prospects is associated with self-other differentiation processes and readiness to engage in recovery supporting activities. Social cohesion might be seen as including the potential struggle involving the development of a ‘social identity’ whilst maintaining a ‘personal identity’, and how this might be reflected in the shifting dissimilarity ratings between self-group leaders and self-other group members. Future research in this area might offer further support for the speculations that vertical cohesion and shifts in self-other differentiation ratings reflect group members’ struggles over the life of the group to take more ownership and responsibility for the direction and functioning of the group therapy process. Overall, further applications of repertory grid methods to examine self-differentiation seem warranted to explore some of the basic therapeutic factors of group therapy (e.g. instillation of hope, universality of problem, Yalom, 1995).

To the knowledge of the researcher, exploring group therapy processes via repertory grid methods using fixed constructs, specifically chosen to capture the main characteristics of group cohesion, has not been done before. Although the studies in this thesis focused on the key self-other differentiation indices generated from the group cohesion grid data across the entire sample, more specific analyses could be conducted on the basis of individual client grids (Caine, et al., 1981). That is, more in depth phenomenological explorations are possible with repertory grid data including the examination self-other dissimilarity ratings related to individual group members, or by examining differences within the specific constructs. It would also be interesting the compare self-other dissimilarity data generated from grids where the constructs are
provided (as with the GCG) and self-other dissimilarity data generated from grids where the constructs are generated by individual clients themselves.

In the case studies, both clients saw themselves as considerably dissimilar to the group leaders and reported less dissimilarity to other group members early in therapy. However, by the end of treatment the client who responded well to treatment (Jill) significantly decreased her dissimilarity scores while the client who responded poorly to treatment (Jack) significantly increased his dissimilarity ratings in relation to both self-group leader and self-other group members. This triggers some speculation that although hope, identity and personal responsibility for recovery have been nominated as key features of individual recovery processes (Andresen, Oades, & Caputi, 2003), some clients may be more ready to deal with identity and self responsibility for recovery issues, and may be consistently less hopeful than other clients. Study three and the case studies offer some evidence that reflects this notion of readiness to progress with recovery, with a particular emphasis on the influence of pervasiveness and control of the client’s CCRT patterns.

Study three represented one of the first known CCRT or mastery studies of group therapy, with only one previous study found by the researcher that applied the CCRT method to examine the interactions between the group members’ structure of conflicts and group therapy outcomes (Strass, et al., 1995). Although Bachar et al. (2004) reported a study that used Supportive Expressive therapy in a group setting they did not report any specific examination of mastery of CCRT patterns. Study three reported that mastery and ultimately treatment outcome appeared to be reflected in how well clients controlled old unhelpful interpersonal response patterns, and how they integrated their recovery
experiences through the telling of their stories. Furthermore, pervasiveness and control of client CCRT patterns (in particular the response of self) was also associated with the client’s perception of the potential helpfulness of others in the group. Interestingly, this reflects one of the main finding of study two. Clients’ perceptions of capacity of others in the group to work constructively together and ultimately help the individual client was the best predictor of treatment outcome. Therefore, it might be speculated that a client’s readiness to engage effectively in her or his own recovery process may be related to how attached she or he is to her or his CCRT patterns and how this attachment affects her or his perception of the value of others in assisting her or him with her or his recovery.

Finally, it is worth reiterating some of the limitations and implications of this set of studies. The sample size of 30 client participants (contributing to one of six small therapy groups) remains recognised as a limitation even through specific measures (see ‘limitations and strengths’ in chapter two) were taken to reduce the risk of Type 1 errors contaminating the results. Consequently, it is recognised that further examination of the issues addressed in this thesis with a larger sample would be useful by way of confirming or challenging the findings. It is also recognised that although there are several advantages in exploring therapists’ perceptions of significant therapy events (e.g. being able to examine the events within the context of the therapeutic model utilised by the therapists), there are other advantages of being able to access specific client views of the salient features of their therapy experiences. The third limitation that was recognised throughout the studies is that specific process and outcome measures were collected at only two time points (on or before session 6 and after the final session 16) over the course of the group therapy treatment. Considering this thesis discusses in some depth the
expected fluctuations in some process measures (e.g. group cohesion, working alliance, and conflict) in relation to group developmental stages, future studies would be strengthened by collecting process measures more frequently and matching these data with group developmental stage indicators.

As mentioned above, although the findings of this thesis do not allow for confident conclusions to be drawn, they do have significant exploratory value. Therefore, future research using the methodologies of this thesis, or extensions of them, appears to be warranted. For example, the use of repertory grids using constructs generated by the individual clients themselves might offer more detailed insight into the unique construal processes of group members, and how this might add meaning or explanatory value to client ratings of group relationship phenomena. It would also be valuable to include the client’s parents and partners alongside the self and other group members as elements in repertory grids. This might allow for a more direct comparison of CCRT patterns with distance measures generated from the repertory grids, thus potentially offering clearer insight into how the individual group members’ transference templates overlay their perceptions and relationships with other group members. Using the methodologies of this thesis with a much larger sample might also offer the opportunity to examine the causal direction of specific variable relationships (e.g. mastery of CCRT patterns with self-other differentiation, with outcome, with alliance and cohesion ratings etc.).
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Appendices
Appendix 1

1. Significant events scale – Therapist

2. Helpful Aspects of Therapy (revised) – Client
(Significant Events Scale) Therapist (revised, 23.4.2001)

Of the events that occurred during your counselling treatment with ____________, please list the 5 most significant or important psychotherapy events for your client? (By "event" we mean something that happened at some point during the treatment. It might be something you said or did, or something your client said or did. For example, significant events could be: you the therapist saying something that seemed to give your client a new way of looking at a problem, or, you may have responded to your client in a way that made your client feel really understood, supported, positively challenged, etc., or a particular event may have left you feeling that your client was relating to you in a way that was significantly different from other relationships your client has had, or, you may have been surprised by something your client said or did, etc. Significant events could also include those events that seemed to have a negative or hindering effect on the client or the counselling process. That is, hindering events are those that made your client doubt that this treatment or you as his/her therapist was going to be able to help him/her move forward in dealing with his/her problems. For example, you may have said or did something that appeared to make your client feel misunderstood, disrespected, judged harshly, unsupported, or patronised, etc., or an event may have left your client feeling unsafe, untrusting, disconnected, like avoiding, or isolated, etc. Alternatively, you might consider certain client behaviours or characteristics, or external or systemic issues, as hindering.)

Secondly, indicate why, in your view, each event was significant.

Thirdly, using the following scale please rate how significant each event was in relation to impact on the overall treatment process.

<table>
<thead>
<tr>
<th>1</th>
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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
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</thead>
<tbody>
<tr>
<td>No impact</td>
<td>Slight impact</td>
<td>Moderate impact</td>
<td>Strong impact</td>
<td>Very Strong impact</td>
<td></td>
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</table>

Finally, using the following scale please rate how helpful or hindering each event was.

a) From the point of view of when the event was actually happening, then
b) From the point of view of what has happened since this event, how helpful do you now see it as having been?

<table>
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<tbody>
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<tr>
<td>Y</td>
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</table>
Significant event One

Please describe the event – (what you did, what the client did)…

In the context of the whole treatment, please describe what made this event significant…. 

Which session (approximately) did this event occur? ___________________

Where in the session did this event occur (eg. First 20 minutes, middle 20 minutes, last 20 minutes)?

About how much of the session’s time did the event take? ______________

In your view, how significant/important was this event in the context of the whole treatment…

<table>
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Hindrance - Helpfulness Rating

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<thead>
<tr>
<th>At the time of the event</th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

Please describe what was happening for you during this event:

What were you thinking?

What were you feeling?

What were you trying to do (if anything)?

How did you react?

How did your client react?

In the context of the whole treatment how would you rate this event now

<table>
<thead>
<tr>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

Mark each statement below according to how strongly you felt that it was true, or not true, of your counselling relationship, at the time of the event, Please mark every one.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

1. I am genuinely concerned for my client’s welfare

2. My client has some fears that if s/he does the wrong thing, I will stop working with him/her

3. I am clear and explicit about what my client’s responsibilities are in therapy.

4. I find what my client and I are doing in therapy is unrelated to his/her current concerns

5. We are working toward mutually agreed upon goals

6. As a result of these sessions, my client is clearer as to how s/he might be able to change.
Significant Event Two

Please describe the event – (what you did, what the client did)…

In the context of the whole treatment, please describe what made this event significant….

Which session (approximately) did this event occur? ______________________

Where in the session did this event occur (eg. First 20 minutes, middle 20 minutes, last 20 minutes)?

About how much of the session’s time did the event take? ______________________

In your view, how significant/important was this event in the context of the whole treatment…

<table>
<thead>
<tr>
<th>Significance Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
</tbody>
</table>

Hindrance - Helpfulness Rating

At the time of the event

| -4 | -3 | -2 | -1 | 0 | 1 | 2 | 3 | 4 |

Please describe what was happening for you during this event:

What were you thinking?

What were you feeling?

What were you trying to do (if anything)?

How did you react?

How did your client react?

In the context of the whole treatment how would you rate this event now

| -4 | -3 | -2 | -1 | 0 | 1 | 2 | 3 | 4 |

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Significant Event Three

Please describe the event – (what you did, what the client did)…

In the context of the whole treatment, please describe what made this event significant…

Which session (approximately) did this event occur?

Where in the session did this event occur (e.g. First 20 minutes, middle 20 minutes, last 20 minutes)?

About how much of the session’s time did the event take? __________

In your view, how significant/important was this event in the context of the whole treatment…

<table>
<thead>
<tr>
<th>Significance Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

Hindrance - Helpfulness Rating

At the time of the event

-4 | -3 | -2 | -1 | 0 | 1 | 2 | 3 | 4

Please describe what was happening for you during this event:

What were you thinking?

What were you feeling?

What were you trying to do (if anything)?

How did you react?

How did your client react?

In the context of the whole treatment how would you rate this event now

-4 | -3 | -2 | -1 | 0 | 1 | 2 | 3 | 4

Mark each statement below according to how strongly you felt that it was true, or not true, of your counselling relationship, at the time of the event. Please mark every one.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
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<th>Always</th>
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<tr>
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6. As a result of these sessions, my client is clearer as to how s/he might be able to change.
Significant Event Four

Please describe the event – (what you did, what the client did)…

In the context of the whole treatment, please describe what made this event significant…

Which session (approximately) did this event occur?________________

Where in the session did this event occur (eg. First 20 minutes, middle 20 minutes, last 20 minutes)?

About how much of the session’s time did the event take? ______________

In your view, how significant/important was this event in the context of the whole treatment…

<table>
<thead>
<tr>
<th>Significance Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

Hindrance - Helpfulness Rating

At the time of the event

| -4 | -3 | -2 | -1 | 0  | 1  | 2  | 3  | 4  |

Please describe what was happening for you during this event:

What were you thinking?

What were you feeling?

What were you trying to do (if anything)?

How did you react?

How did your client react?

In the context of the whole treatment how would you rate this event now

| -4 | -3 | -2 | -1 | 0  | 1  | 2  | 3  | 4  |

Mark each statement below according to how strongly you felt that it was true, or not true, of your counselling relationship, at the time of the event, Please mark every one.

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Significant Event Five

Please describe the event – (what you did, what the client did)…

In the context of the whole treatment, please describe what made this event significant….

Which session (approximately) did this event occur?________________

Where in the session did this event occur (eg. First 20 minutes, middle 20 minutes, last 20 minutes)?

About how much of the session’s time did the event take? ______________

In your view, how significant/important was this event in the context of the whole treatment…

| Significance Rating |
|--------------------|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

Hindrance - Helpfulness Rating

<table>
<thead>
<tr>
<th>At the time of the event</th>
</tr>
</thead>
<tbody>
<tr>
<td>-4</td>
</tr>
</tbody>
</table>

Please describe what was happening for you during this event:

What were you thinking?

What were you feeling?

What were you trying to do (if anything)?

How did you react?

How did your client react?

In the context of the whole treatment how would you rate this event now

| -4 | -3 | -2 | -1 | 0 | 1 | 2 | 3 | 4 |

Mark each statement below according to how strongly you felt that it was true, or not true, of your counselling relationship, at the time of the event, Please mark every one.

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5. We are working toward mutually agreed upon goals
6. As a result of these sessions, my client is clearer as to how s/he might be able to change.
1. Of the events that occurred during your counselling treatment, which one do you feel was the most **helpful** or **important** for you personally? (By "event" we mean something that happened at some point during the treatment. It might be something you said or did, or something your therapist said or did. For example, a helpful event could be: the therapist may have said something that gave you a new way of looking at a problem, or, the therapist may have responded to you in a way that made you feel really understood, supported, positively challenged, etc., or a particular event may have left you feeling that the way you and your therapist related to each other was significantly different from other relationships you have had, or, you may have surprised yourself by something you said or did, etc.)

2. Please describe what made this event **helpful/important** and what you got out of it.

3. How **helpful** was this particular event? Rate it on the following scale. (Put an "X" at the appropriate point on the line, half point ratings are O.K., eg. 4.5)

4. Which session (approximately) did this event occur?

   Where in the session did this event occur (eg. First 20 minutes, middle 20 minutes, last 20 minutes)?

5. About how much of the session’s time did the event take?
6. Did anything else particularly **helpful** happen during your counselling treatment?
   YES    NO
   IF YES, please describe this event (or events briefly)

7. Of the events that occurred during your counselling treatment, which one do you feel was the most **hindering** for you personally? (*Hindering events are those that made you doubt that this treatment or therapist was going to be able to help you move forward in dealing with your problems. For example, your therapist may have said or did something that made you feel misunderstood, disrespected, judged harshly, unsupported, or patronised, etc., or an event may have left you feeling unsafe, untrusting, disconnected, avoiding, or isolated, etc.*)
8. How **hindering** was this particular event? Rate it on the following scale. (Put an "X" at the appropriate point; half-point ratings are OK; e.g., 4.5.)

![Scale](image)

9. Which session (approximately) did this event occur?

   Where in the session did this event occur (eg. First 20 minutes, middle 20 minutes, last 20 minutes)?

10. About how much of the session’s time did the event take?

11. Did anything else particularly **hindering** happen during your counselling treatment?

   **YES**  **NO**

   IF YES, please describe this event (or events briefly)
Appendix 2

Group Cohesion Grid
This Grid is concerned with the impressions you have of the part(s) you, the other group members, and the group leaders play in the group and how you relate to each other, and the group as a whole. The column named ‘Ideal Self’ refers to how you would like to be in the group. It is possible of course that your ideal self might be quite similar to how you currently see yourself.

Please place a number between 1 and 10 in the boxes on the right below.
For example, if your impression of group member ‘1’ is that s/he is often supportive, then write a ‘7’ or ‘8’ in the column under that person’s name in line with the ‘supportive - unsupportive’ question.

<table>
<thead>
<tr>
<th>Not committed to group</th>
<th>Committed to group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doesn’t contribute to group</td>
<td>Contributes to group</td>
</tr>
<tr>
<td>Untrustworthy</td>
<td>Trustworthy</td>
</tr>
<tr>
<td>Unsupportive</td>
<td>Supportive</td>
</tr>
<tr>
<td>Submissive</td>
<td>Dominating</td>
</tr>
<tr>
<td>Disagrees with the group goals</td>
<td>Agrees with the group goals</td>
</tr>
<tr>
<td>Doesn’t understand me</td>
<td>Understands me</td>
</tr>
<tr>
<td>I don’t like</td>
<td>I like</td>
</tr>
<tr>
<td>Doesn’t help the group to solve problems and keep working</td>
<td>Helps the group to solve problems and keep working</td>
</tr>
<tr>
<td>Is not like me</td>
<td>Is like me</td>
</tr>
<tr>
<td>Is isolated in the group</td>
<td>Fits into the group well</td>
</tr>
</tbody>
</table>
Appendix 3

CCRT pattern rating scale
Part 2 CCRT

Given all that you now know about your client, please identify the major Core Conflictual Relationship Theme patterns that you have observed operating in this person's life

PRIMARY CCRT PATTERN

Wish :

Responses of the other person :

Responses of the self :

Please give two examples of this CCRT pattern in the clients functioning as reported by them or observed by you

Example 1
Person in which this pattern was present (circle) : Mother / Father / Other Relative / Lover / Friend / Acquaintance / Therapist
What happened ?

Example 2
Person in which this pattern was present (circle) : Mother / Father / Other Relative / Lover / Friend / Acquaintance / Therapist
What happened ?

1. Pre-treatment/Early- treatment Pervasiveness Rating
In the early phase of treatment, and in reflection upon the client's life, how strong or pervasive was this CCRT pattern? (ie. to what extent was it the dominant feature of their interpersonal relationships? A rating of 0 indicates that it was neither strong nor pervasive ie. the pattern was weak and did not apply across all relationships; a rating of 10 indicates that it was a very strong pattern in that it was present in most or all relationships and had a marked impact upon them)

Very Weak 0 1 2 3 4 5 6 7 8 9 10 Very Strong

2. Post-treatment/Late-treatment phase Pervasiveness Rating
In the late phase of treatment, and following therapy, how strong or pervasive was this CCRT pattern? (ie. to what extent was it the dominant feature of their interpersonal relationships? A rating of 0 indicates that it was neither strong nor pervasive ie. the pattern was weak and did not apply across all relationships; a rating of 10 indicates that it was a very strong pattern in that it was present in most or all relationships and had a marked impact upon them)

Very Weak 0 1 2 3 4 5 6 7 8 9 10 Very Strong
3. Pre-treatment ratings of insight

At the beginning of therapy to what extent do you think your client was aware of their CCRT pattern? (ie. were they able to express insight or self-awareness of it?)

\[\text{Very Weak Insight} \quad 0 \quad 1 \quad 2 \quad 3 \quad 4 \quad 5 \quad 6 \quad 7 \quad 8 \quad 9 \quad 10 \quad \text{Very Strong Insight}\]

4. Post-treatment ratings of insight

By the end of therapy to what extent do you think your client was aware of their CCRT pattern? (ie. were they able to express insight or self-awareness of it?)

\[\text{Very Weak Insight} \quad 0 \quad 1 \quad 2 \quad 3 \quad 4 \quad 5 \quad 6 \quad 7 \quad 8 \quad 9 \quad 10 \quad \text{Very Strong Insight}\]

5. Pre-treatment ratings of control

At the beginning of therapy to what extent do you think your client was able to control their CCRT pattern? (ie. were they able to change their behaviour so as not to repeat the pattern?)

\[\text{Very Weak Control} \quad 0 \quad 1 \quad 2 \quad 3 \quad 4 \quad 5 \quad 6 \quad 7 \quad 8 \quad 9 \quad 10 \quad \text{Very Strong Control}\]

6. Post-treatment ratings of control

By the end of therapy to what extent do you think your client was able to control their CCRT pattern? (ie. were they able to change their behaviour so as not to repeat the pattern?)

\[\text{Very Weak Control} \quad 0 \quad 1 \quad 2 \quad 3 \quad 4 \quad 5 \quad 6 \quad 7 \quad 8 \quad 9 \quad 10 \quad \text{Very Strong Control}\]
CCRT Components Ratings : INSIGHT

1. Please rate to what extent they had insight into:
The RO Response of Other (ie. the degree to which they were aware that they perceived others behaving towards them in a certain way)

a. At the Beginning of Treatment :

   Very Weak Insight 0 1 2 3 4 5 6 7 8 9 10 Very Strong Insight

b. At the End of Treatment :

   Very Weak Insight 0 1 2 3 4 5 6 7 8 9 10 Very Strong Insight

Comment : Please describe how (if any) they were able to verbalise insight into the RO at the end of treatment (eg. what did they say? Any quotes or brief commentary would be welcome) :

2. Please rate to what extent they had insight into :
The RS Response of Self (ie. the degree to which they were aware that they habitually responded to others in a characteristic way)

a. At the Beginning of Treatment :

   Very Weak Insight 0 1 2 3 4 5 6 7 8 9 10 Very Strong Insight

b. At the End of Treatment :

   Very Weak Insight 0 1 2 3 4 5 6 7 8 9 10 Very Strong Insight

Comment : Please describe how (if any) they were able to verbalise insight into the RS at the end of treatment (eg. what did they say? Any quotes or brief commentary would be welcome) :
CCRT Components Ratings : CONTROL
3. Please rate to what extent they had control over:

The RO Response of Other (ie. the degree to which they were able to modify their relationships so that others did not (or were not perceived to) respond to them in the same way):

a. At the Beginning of Treatment:

   Very Weak Control 0 1 2 3 4 5 6 7 8 9 10 Very Strong Control

b. At the End of Treatment:

   Very Weak Control 0 1 2 3 4 5 6 7 8 9 10 Very Strong Control

Comment: Please describe how (if any) they were able to show through their behaviour that they had control over the RO at the end of treatment (eg. examples of behaviours or reports of behaviours that did not have the characteristic RO as a feature (ie. had another response of other that was not consistent with their CCRT pattern)):

4. Please rate to what extent they had control over:

The RS Response of Self (ie. the degree to which they were able to modify their relationships so that they did not respond to others or interpersonal situations in the same way)

a. At the Beginning of Treatment:

   Very Weak Control 0 1 2 3 4 5 6 7 8 9 10 Very Strong Control

b. At the End of Treatment:

   Very Weak Control 0 1 2 3 4 5 6 7 8 9 10 Very Strong Control

Comment: Please describe how (if any) they were able to show through their behaviour that they had control over their RS at the end of treatment (eg. examples of behaviours or reports of behaviours that did not have the characteristic RS as a feature (ie. had another response of self that was not consistent with their CCRT pattern)):
SECONDARY CCRT PATTERN

Some clients have more than one CCRT. Upon reflection, please identify (if any) a secondary pattern you have observed operating in this client's life. (note: this pattern may not necessarily have been present at the beginning of therapy)

Note: If there is no secondary pattern present, in any phase of treatment, please skip to Part 3.

Wish:

Responses of the other person:

Responses of the self:

Please give two examples of this CCRT pattern in the client's functioning as reported by them or observed by you

Example 1
Person in which this pattern was present (circle): Mother / Father / Other Relative / Lover-Partner / Friend / Acquaintance / Therapist
What happened?

Example 2
Person in which this pattern was present (circle): Mother / Father / Other Relative / Lover-Partner / Friend / Acquaintance / Therapist
What happened?

1. Pre-treatment/Early-treatment Pervasiveness Rating
In the early phase of treatment, and in reflection upon the client's life, how strong or pervasive was this CCRT pattern? (ie. to what extent was it the dominant feature of their interpersonal relationships? A rating of 0 indicates that it was neither strong nor pervasive i.e. the pattern was weak and did not apply across all relationships; a rating of 10 indicates that it was a very strong pattern in that it was present in most or all relationships and had a marked impact upon them)

Very Weak 0 1 2 3 4 5 6 7 8 9 10 Very Strong

2. Post-treatment/Late-treatment phase Pervasiveness Rating

In the late phase of treatment, and following therapy, how strong or pervasive was this CCRT pattern? (ie. to what extent was it the dominant feature of their interpersonal relationships? A rating of 0 indicates that it was neither strong nor pervasive i.e. the pattern was weak and did not apply across all relationships; a rating of 10 indicates that it was a very strong pattern in that it was present in most or all relationships and had a marked impact upon them)

Very Weak 0 1 2 3 4 5 6 7 8 9 10 Very Strong
TERTIARY CCRT PATTERN

Some clients have more than one CCRT. Upon reflection, please identify (if any) a tertiary pattern you have observed operating in this client's life. (note: this pattern may not necessarily have been present at the beginning of therapy)

Note: If there is no tertiary pattern present, in any phase of treatment, please skip to Part 3.

Wish:

Responses of the other person:

Responses of the self:

Please give two examples of this CCRT pattern in the clients functioning as reported by them or observed by you

Example 1
Person in which this pattern was present (circle): Mother / Father / Other Relative / Lover-Partner / Friend / Acquaintance / Therapist
What happened?

Example 2
Person in which this pattern was present (circle): Mother / Father / Other Relative / Lover-Partner / Friend / Acquaintance / Therapist
What happened?
1. Pre-treatment/Early-treatment Pervasiveness Rating
In the early phase of treatment, and in reflection upon the client's life, how strong or pervasive was this CCRT pattern? (i.e. to what extent was it the dominant feature of their interpersonal relationships? A rating of 0 indicates that it was neither strong nor pervasive i.e. the pattern was weak and did not apply across all relationships; a rating of 10 indicates that it was a very strong pattern in that it was present in most or all relationships and had a marked impact upon them)

| Very Weak | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very Strong |

2. Post-treatment/Late-treatment phase Pervasiveness Rating
In the late phase of treatment, and following therapy, how strong or pervasive was this CCRT pattern? (i.e. to what extent was it the dominant feature of their interpersonal relationships? A rating of 0 indicates that it was neither strong nor pervasive i.e. the pattern was weak and did not apply across all relationships; a rating of 10 indicates that it was a very strong pattern in that it was present in most or all relationships and had a marked impact upon them)

| Very Weak | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very Strong |