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Mastery through psychotherapy

Brin Felix Grenyer

*University of Wollongong*

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Mastery through Psychotherapy

A thesis submitted in partial fulfilment of the requirements for the degree of

Doctor of Philosophy (Clinical Psychology)

from

University of Wollongong

by

Brin Felix Swain Grenyer, BA(Hons), MSc.

Department of Psychology

1996
Abstract

This study investigated the relationship between the mastery of maladaptive interpersonal patterns, assessed from narratives told during psychotherapy, and outcome of psychotherapy. A psychoanalytic account of the processes of mastery through psychotherapy was developed and empirically tested. Mastery was hypothesized to develop as long standing repetitive core conflictual relationship themes are worked through in psychotherapy. Mastery was defined as the development of self-control and self-understanding in the context of interpersonal relationships. A content analysis Mastery Scale was developed to quantify degrees of self-control and self-understanding in the accounts of relationship narratives patients tell early and late in psychotherapy. Verbatim transcripts of 41 patients (29 females, mean age 25) seen in dynamic therapy were scored for mastery. Results indicated: (1) The inter-rater and test-retest reliability of the Mastery Scale was excellent. (2) Changes in mastery level over the course of therapy were significantly related to changes in observer ratings of psychological health-sickness and therapist ratings of patient satisfaction, success and improvement. In addition, the patient’s own judgements of changes in their symptoms and main target problems paralleled changes in the mastery of interpersonal conflicts found in their narratives. (3) Early therapeutic alliance predicted gains in mastery over therapy, and (4) changes in the response of self component of the Core Conflictual Relationship Theme paralleled changes in mastery. (5) Patients with a personality disorder appeared to make particularly clinically significant gains in mastery. (6) Of all the narratives of relationships told by patients in psychotherapy, changes in mastery of the relationship with their parents showed the strongest association with clinical changes. This suggests that mastery of this primary relationship with the parents is particularly therapeutic. Overall these results are consistent with the proposition that symptoms abate with the mastery of core interpersonal conflicts. The results support the importance of the development of mastery as an central mechanism of improvement through psychotherapy.
I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma of a university or other institute of higher learning, except where due acknowledgement is made in the text.

Brin F.S. Grenyer
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Chapter 1

Introduction

For the past century psychotherapy has been the object of scientific study in the quest to understand how it might help people with mental disorders. Central to this study is an understanding of the essential process of change that comes about through psychotherapy. What does psychotherapy do? How does it lead to change? What change does it bring about? One psychological construct that appears to encompass the change process is mastery. Frank underscores the role of mastery when he suggests that “All successful therapies implicitly or explicitly change the patient’s image of himself from a person who is overwhelmed by his symptoms and problems to one who can master them” (Frank, 1971, p. 357, my emphasis). Despite its evident importance, mastery as a concept is poorly defined and seldom researched. Yet it is implicitly or explicitly evoked as a central ingredient in nearly all therapy approaches (see Liberman, 1978), and is conceptually related to concepts such as locus of control (Rotter, 1966), attributional processes (Alloy, Abramson, Metalsky & Hartlage, 1988; Seligman & Elder, 1985; Weiner, 1988), morale and hope (Frank, 1974; Frank, 1968; Gottschalk, 1974), competence (White, 1959), and ego strength (Barron, 1953; Jacobs, Muller, Eisman, Knitzer & Spilken, 1968).
In cognitive therapy, Beck discusses how the patient achieves a “sense of mastery” (p. 232) and how this mastery is acquired: “psychological problems can be mastered by sharpening discriminations, correcting misconceptions, and learning more adaptive attitudes. Since introspection, insight, reality testing, and learning are basically cognitive processes, this approach to the neuroses has been labelled cognitive therapy” (Beck, 1976, p. 20). For Beck, it is a lack of mastery that leads people to seek psychotherapy: “Those who come to the professional helper, and inadvertently acquire the label of patient or client, are drawn from the residue who have failed to master their problems” (Beck, 1976, p. 215). He thus acknowledges that the central aim of therapy is to foster mastery.

In psychoanalysis, Freud discusses how neurotic patients try to achieve therapeutic resolution through “mastering or binding” the various threads of their problem (Freud, 1920, p. 35). Freud observed at the end of one of his successful cases: “...in these last months of his treatment he was able to reproduce all the memories and to discover all the connections which seemed necessary for understanding his early neurosis and mastering his present one” (Freud, 1937, p. 217, my emphasis). In researching psychodynamic psychotherapy, Luborsky discusses how “patients in psychotherapy develop an increased sense of mastery expressed in part as greater tolerance for their thoughts and feelings” (Luborsky, Crits-Christoph, Mintz & Auerbach, 1988, p.160). In psychodynamic therapy approaches, mastery is used to denote the hoped for consequence of the process and outcome of psychotherapy.
Aims

Although there is considerable concordance among the different schools of psychotherapy concerning the centrality of patients achieving mastery for therapeutic change, what actually constitutes mastery remains ambiguous. How can its essential elements be understood and defined theoretically? Can it be measured empirically?

In order to reduce the complexity of the task, this study will concentrate on mastery in psychoanalytic theory and therapy. There have been a number of calls for the development of measures of outcome that relate directly to the theory of change as developed by psychoanalysis (e.g. Luborsky, Barber & Crits-Christoph, 1990; Strupp, 1989). If dynamic psychotherapy is hypothesized to lead to mastery, then measuring mastery and assessing its relationship to other indicators of outcome should provide a good test as to whether dynamic psychotherapy is effective.

The concept of mastery developed here is ultimately one that can apply across a broad range of theories. Its application and veracity, therefore, is not limited to psychoanalysis, and the findings of this study may contribute to psychotherapy research generally.

This study maintains that psychotherapy is a process of mastering, and what is achieved in successful therapy is mastery. Mastery is both a process and an outcome and is therefore central to psychotherapy.
This thesis has three major aims. The first is theoretical, the other two empirical.

1. To show how mastery is central to the psychoanalytic theory of therapy.

2. To develop an empirical measure of mastery (the Mastery Scale) and evaluate its reliability and validity as a measure of therapy process and outcome.

3. To investigate the relationship between changes in mastery and other centrally important variables in psychotherapy: the therapeutic alliance, the transference, diagnosis, and object relations.

**Brief orientation to the thesis**

The following briefly orients the reader to the way that each chapter furthers these three aims. Chapter 2 locates the central concerns of the thesis within contemporary trends in psychotherapy research. Chapter 3 develops a metapsychological basis for a psychoanalytic theory of mastery presented in Chapter 4. These two chapters therefore address the first aim of the thesis.

Chapter 5 shows in particular how the thesis arose out of current empirical research investigating the helping alliance and transference and reviews related relevant studies on change processes in
psychotherapy. The development of a scale measuring mastery is presented in Chapter 6. This serves as a prolegomenon to a set of empirical studies in the following chapters investigating changes in levels of mastery over the course of psychodynamic psychotherapy. Chapter 7 investigates the reliability and validity of the scale. Chapters 6 and 7 therefore address the concerns of the second major aim of this thesis.

In Chapters 8 and 9, the Mastery Scale is compared to recent measures of the helping alliance and transference respectively. The next two chapters partition the sample according to diagnosis (Chapter 10) and object relations (Chapter 11) to further investigate the meaning of changes in mastery. Chapters 8 to 11 therefore address the third aim of the thesis. The final chapter summarizes the thesis, discusses its strengths and limitations, and concludes with a review of implications for future research.
The development of the theoretical and empirical meaning and the measurement of mastery contributes in an important way to developing an understanding of the mechanisms and outcomes of psychotherapy. The following discussion locates this study within the central themes and concerns of empirically based psychotherapy research, that is best characterized by the work of members of the Society for Psychotherapy Research, the Society for the Exploration of Psychotherapy Integration and the studies reported in Bergin and Garfield's *Handbook of Psychotherapy and Behaviour Change* (4th Edn) (Bergin & Garfield, 1994) and a recent review of international programmatic studies and research teams investigating psychotherapy (Beutler & Crago, 1991). This chapter is intended as a broad brushed outline of how the concerns of this study may be located within contemporary trends in psychotherapy research. It is by no means exhaustive in its review of the field, nor is it intended to be so. More detailed discussions of specific studies of immediate relevance are reserved for later chapters.

Two fundamental questions in the science of psychotherapy research are first, "does it work?" ie. is psychotherapy an effective treatment for
mental disorders when analysed using appropriate research methodology? Second, if it does work, "how does it work?" ie. what is the process by which it works? These two fundamental questions underly two major areas of study in psychotherapy: studies of psychotherapy outcomes, and psychotherapy processes.

The early years of scientific psychotherapy investigations were primarily concerned with developing a theoretical understanding of the process of the treatment, with intense focus on single case studies (e.g. Freud, 1905a; Freud, 1918). From the start attempts were made to collect together these single case studies in order to draw firmer conclusions concerning whether the outcomes of psychotherapy were positive (e.g. Fenichel, 1920-1930; Jones, 1926-1936). A controversial study by Eysenck based on 24 early studies of psychotherapy from 1920 to 1951 concluded that the findings “fail to support the hypothesis that psychotherapy facilitates recovery from neurotic disorder” (Eysenck, 1952 p.323). That conclusion has been repeatedly and successfully challenged almost as soon as the article appeared (e.g. Luborsky, 1954; Luborsky, 1972).

More recently there has been a growing sophistication of research methodologies applied to studying psychotherapy and the ways of evaluating outcomes. The overwhelming conclusion from the last twenty-five years of research on psychotherapy is that it is highly effective, with a multitude of excellent comparative and summative reviews (e.g. Andrews & Harvey, 1981; Lambert & Bergin, 1994; Luborsky, Chandler, Auerbach, Cohen & Bachrach, 1971; Smith & Glass, 1977; Smith, Glass & Miller, 1980). Howard has concluded that
with over 500 studies demonstrating efficacy, psychotherapy is the 'best documented medical intervention in history' (Howard, 1993). Recent reviews all share the view that psychotherapy is effective when compared to no treatment or placebo treatment.

Having established the overall effectiveness of psychotherapy, researchers have increasingly turned their attention to investigating in more detail the processes of psychotherapy (Beutler & Crago, 1991; Orlinsky, Grawe & Parks, 1994). This has in part arisen because comparative studies of psychotherapy typically conclude that there is no difference in overall effectiveness between therapies of different theoretical orientations (see for example Elkin et al., 1989; Luborsky, Singer & Luborsky, 1975). This is despite measurable differences in the delivery and technical aspects of each treatment (e.g. DeRubeis, Hollon, Evans & Bemis, 1982; Luborsky, Woody, McLellan, O'Brien & Rosenzweig, 1982). Some authors claim that therapy specific effects can be found, but studies have not been designed to provide optimal opportunities to detect these (e.g. Beutler, 1991). The more common view is that general characteristics shared among the therapies probably override in therapeutic potency any specific techniques unique to a therapeutic modality. Authors have suggested that a likely common or nonspecific factor is the helping relationship with the therapist (e.g. Bordin, 1979; Rozenzweig, 1936). Rogers considered the therapeutic relationship as providing the “necessary and sufficient conditions” of change (Rogers, 1957). The helping relationship is also known as the therapeutic alliance, the working alliance, and the therapeutic bond. As Bordin states "I propose that the working alliance between the
person who seeks change and the one who offers to be a change agent is one of the keys, if not the key, to the change process” (Bordin, 1979, p.252). In general, research has supported this view, and it is now accepted that one of the singularly most important variables that has been established as basic to therapeutic effectiveness is the quality of the relationship between the therapist and patient (e.g. Horvath & Symonds, 1991). Orlinsky and colleagues noted after an extensive review of all empirical studies of the helping alliance that “the strongest evidence linking process to outcome concerns the therapeutic bond or alliance, reflecting more than 1,000 process-outcome findings” (Orlinsky et al., 1994, p.360). The various aspects of the therapeutic alliance studied include the therapist's level of engagement, collaborativeness and affirmation of the patient; and the patient's level of engagement, expressiveness, and affirmation of the therapist. There are two often used methods of assessing the therapeutic alliance: (1) by having the patient and therapist complete questionnaire ratings of the alliance during the course of therapy; or (2) by inspecting transcripts or audiotapes of psychotherapy and making ratings based on indications of the quality of the alliance.

Although the therapeutic alliance is known to predict outcome, it is not known what are the precise mechanisms that make this variable effective. What is the reason why a good relationship with a therapist leads to improvements in mental health? How does that relationship influence mental functioning? What are the specific elements of the relationship that are linked to change?

The therapeutic alliance has long been an important element in
psychodynamic psychotherapy. Freud discusses how "the patient's happy trustfulness makes our earliest relationship with him a very pleasant one" (Freud, 1913, p.126). As the relationship develops, there remains a positive part of the patient-therapist relationship that is well grounded in reality, and continues for the benefit and success of the therapeutic collaboration. The helping alliance is "admissible to consciousness and unobjectionable", and "persists and is the vehicle of success in psycho-analysis exactly as it is in other methods of treatment" (Freud, 1912a, p.105). For Freud, the therapeutic alliance is the ego-syntonic part of the 'transference' relationship with the therapist. Freud clearly sees the therapeutic alliance as being not only an important causal element in the success of psychotherapy, but also a common or non-specific factor that applies in other forms of therapy as well.

A common way of classifying the principle techniques of psychodynamic psychotherapy is to divide them into the 'supportive' and the 'expressive' (e.g. Luborsky, 1984; Wallerstein, 1986). Part of the supportive aspect of psychotherapy is the helping alliance. The expressive part includes the use of transference interpretations aimed at fostering self-understanding. Two of the major areas of contemporary research into psychodynamic psychotherapy concern these two aspects: the supportive, with research on the helping alliance (e.g. Gaston, 1990), and the expressive with research focussing on interpretations (e.g. Fretter, 1984; Silberschatz, Fretter & Curtis, 1986) based on formulations of the transference pattern (for research on measures of the transference see the special edition of *Psychotherapy Research*, Luborsky & Barber, 1994).
There is considerable debate as to the distinctiveness of the therapeutic alliance and transference (Henry et al. 1994; for a fuller description of transference, see chapter 5). Some authors argue that the two terms are describing similar processes and stress that the main focus of therapy should be on interpreting the transference (e.g. Curtis, 1979). Others maintain that the two aspects are distinct, a view that has some empirical support (Gaston, 1990). Gaston found that ratings of positive transference were unrelated to ratings of the alliance in a sample of 32 patients. This is the only study that has empirically explored this issue, and it remains to be seen whether or not such findings can be replicated using different samples and different methods of rating the alliance and transference.

It is pertinent that one of the most important empirically based measures of transference (the Core Conflictual Relationship Theme (CCRT) (Luborsky & Crits-Christoph, 1990)) evolved by accident out of a process of trying to understand in depth the therapeutic alliance. Using transcripts from psychotherapy, Luborsky’s method was to “... describe the patient’s typical relationships and examine how the helping relationships fit into these. It was these experiences, in attempting to describe each person’s patterns of relationships, that led me to what I came to recognize as a deep psychic structure: the Core Conflictual Relationship Theme” (Luborsky, 1977, p.368). This serves to illustrate the intimate connection between the therapeutic alliance and more dynamic transferential representations of the patient’s typical relationship patterns. It may be that the therapeutic alliance is a simple and observable measure of the ability of the therapist and patient to form a basic relationship that, through its vicissitudes, also touches the
patient’s (and therapist’s) deeper core relational (hence transferential) patterns. The Core Conflictual Relationship Theme method is a measure of transference, and assesses patients’ characteristic ways of relating across interpersonal relationships. This method is elaborated in Chapter 5.

The common clinical view is that the supportive aspect of the relationship between the patient and the therapist is the bedrock, upon which the more expressive, interpretive aspects rely. This is certainly consistent with Freud’s view of the therapeutic alliance. The stronger the supportive relationship, the deeper the exploration that can be afforded into more maladaptive and pathological beliefs and transferential patterns of relating. The more fragile the relationship, the more the clinician needs to devote to fostering support at the expense of expressive activity (see for example Grenyer, Luborsky & Solowij, 1995).

Empirical support for this view comes from the work of the Mt Zion (now called San Francisco) Psychotherapy Research Group (Silberschatz, Curtis, Sampson & Weiss, 1991; Weiss, 1990; Weiss, Sampson & Group, 1986). Through an intense study of psychotherapy transcripts of Mrs C, a patient in long term psychoanalysis, a number of complementary studies have shown how the patient needs a trusting relationship with the therapist in order to feel safe enough to reveal and explore deeper thoughts, feelings and behaviours. Part of the way that the patient develops this feeling of safety is through the therapist’s ability to ‘pass tests’ ie. respond to the patient in a way that does not confirm their ‘pathological beliefs’ or their core maladaptive
relationship pattern. In other words, the helping relationship is important, but must go beyond simply being a non-differentiated 'good' relationship; it must also address the patient's need to *master* their problems. The mastery of the problems proceeds through the therapist's sensitivity to the patient's deeper transference relationship problems and conflicts.

Weiss discusses how the findings from their group have implications for our understanding of the therapeutic alliance. He discusses how "Ordinarily ... a patient who consciously hates the analyst, who wishes to terminate, or who is manifestly bored and indifferent to his treatment is thought to have a poor therapeutic alliance with the analyst" (Weiss, 1986, p.330). Based on the research and theory concerning the testing of deep seated transference patterns, it may in fact be that the patient is "unconsciously working closely with the analyst ... Indeed, a patient's wish to stop treatment, his hatred of the analyst, or his boredom may indicate that he has made considerable progress in his treatment and is working with the analyst more directly than before" (p. 331).

From a psychoanalytic point of view then, progress in psychotherapy probably occurs across a spectrum of relationship intensities, from the basic sense of concordance between the therapist and patient to the deeper levels of interpersonal exploration of the patient's central problems. What is crucial is how the patient comes to achieve a sense of mastery of their interpersonal difficulties. It is on this issue that this study hopes to make a contribution.
In summary then, although the cutting edge of contemporary psychodynamically based psychotherapy research spreads across many fronts, two major areas of interest attracting high-quality research are in understanding the therapeutic alliance and the transference. Common to both these areas is an attempt to understand how interpersonal processes influence psychotherapy outcomes. An underlying driving force behind this research is the finding that although psychotherapy has been shown to be efficacious, psychotherapies of different practical and theoretical orientations appear to lead to similar outcomes. This has lead researchers to focus on common factors in psychotherapy, and the one that has drawn the most interest and most research support is the quality of the interpersonal relationship between the therapist and the patient. A study of the therapeutic alliance has lead psychodynamic researchers deeper into examining the interpersonal functioning of patients, with a major area of focus being on understanding the transference. What has so far received only scant research is how patients come to master these interpersonal problems, both at the level of the relationship with the therapist and more generally in relationships with others. This involves a focus on the patients themselves, and how through their work in therapy they overcome their difficulties. Focussing on mastery, then, might help unlock the problem of how the alliance and the transference lead to therapeutic change. It might also help to elaborate in more detail some of the mechanisms of the change process.

It can thus be seen that studying mastery might help to uncover a central change process in psychotherapy. Such research is consistent
with, and follows from, central research activity occurring across a large number of leading contemporary psychotherapy research groups. Developments in science usually proceed by the hypothetico-deductive method (Popper, 1934). It is appropriate, therefore, at this point to consider in more detail the psychodynamic theory of mastery - both its metapsychological bases (Chapter 3) and clinical propositions (Chapter 4). Further empirical studies of direct relevance to the development of the Mastery Scale not reviewed in this chapter will then be introduced in detail (Chapter 5), with an account of how the Mastery Scale was derived and prepared for empirical testing.
This chapter considers the basic assumptions that are to be made in developing a coherent theoretical account of mastery. Metapsychology is the essential framework of assumptions made in developing a psychological theory. In psychoanalysis, there are two metapsychological systems that are relevant to mastery. The first is Freud's classical instinctual drive theory, that he developed mainly in the few years before and after 1915 (e.g. Freud, 1915b; Freud, 1915c) and maintained in its most coherent form up to 1923 (with the publication of The Ego and the Id, Freud, 1923). It is the theoretical position that he was working from when he wrote his most important clinical papers on technique (1912-1915, collected in volume 12 of the Standard Edition). Although he modified his 'classical' theory later on in his life, the basic threads of his position remained with him all his life. The basic position is that psychoanalytic psychology is a causal science based on determinist principles. Psychoanalysis is underpinned by a theory of motivation driven by the workings of basic biological processes (called instinctual drives). As proposed by Maze, his early theory is his
most compelling and coherent (Maze, 1983). In contrast to the classical theory is the autonomous ego psychology school, a revision of the classical theory, that has been developed over the past 50 years and continues to be a major influence in modern psychoanalytic thinking (Eagle, 1984).

Classical Freudian drive theory is a suitable theoretical basis for understanding the process of mastery. This theory of mastery is in contrast to the theory in the later ego psychology accounts. In this later view, there is a drive that 'seeks to master', and this mastery drive or mastery instinct is a faculty of the ego, independent of the primary drives. Such an ego psychology view has a contemporary appearance, for example, in Weiss' control-mastery thesis developed as part of the Mt Zion psychotherapy research group (Weiss et al., 1986, Weiss, 1990). Eagle very carefully elaborates how Weiss' work rejects the classical Freudian drive theory, and traces the lineage of his ideas to ego psychology conceptions of psychoanalysis that define drives by their aim (such as the aim or instinct to master) rather than by their source (in basic biological processes):

As is the case with all the other recent developments in and modifications of psychoanalytic theory I have considered, the Mt Zion group both implicitly and explicitly rejects Freudian instinct and drive theory. The basic image of the person that emerges is not one who is primarily engaged in the direct and indirect pursuit of instinctual gratifications, but one who is seeking mastery of the conflicts, anxieties, and destructive beliefs that cause him suffering and limit his satisfactions, productiveness, and awareness. This emphasis on mastery links the work of the Mt Zion group to the concepts of Hendrick (1943) and White (1960; 1963). Indeed, the formulations of the Mt Zion group can be seen as an elaboration and application of Hendrick's and White's concepts to the therapeutic situation. One can also find links between the Mt Zion formulations and both Fairbairn's emphasis
on ego aims and certain of Rogers’ (1959; 1961) concepts. However, Weiss and Sampson ignore all these links. Instead they try to show how their formulations are derived almost entirely from Freud’s late writings, an attempt which appears more political than scholarly (Eagle, 1984, p. 100-101).

It is useful to expand upon this ego psychology view of the ‘instinct to master’ and trace the lineage that Eagle sketches from Hendrick, through White, to Weiss. The importance of this discussion is that Weiss’ control-mastery theory is a recent credible psychoanalytically based account that proposes mastery as a concept of central importance. Since the present study also proposes mastery as a central psychoanalytic concept, it is necessary to carefully differentiate the present view of mastery from that of Weiss and his predecessors.

Hendrick (1943) in a paper ‘Work and the pleasure principle’, argues that the pleasure of achieving something is a pleasure in itself, and does not need to be traced back to basic instinctual drives. Hendrick gives the example of “when a housewife takes pleasure in cleaning up she is normally not merely finding a substitute for a tabooed pleasure in dirt; nor is she merely preparing a clean genital substitute (her house) for exhibition to her guests that evening; nor simply protecting herself from the reproaches of her finger-snooping mother-substitute lady-friends ... she is also performing work; and in those hours of house cleaning which yield pleasure ... the pleasure is primarily again in the job well done, in efficient performance of a useful task” (Hendrick, 1943b, p. 323). He then argues based on this that “the work principle be regarded as an expression of an instinct to master whose goal is control or alteration of environmental situations through the effective development of integrated intellectual and motor functions”
Hendrick thus clearly enunciates his view of mastery. The desire to master work (such as house cleaning), is an ego function that does not need to be traced back to primary drives in the id.

Later, in a discussion of this ‘instinct to master’, he states that “this hypothesis was suggested to provide a dynamic explanation of the force impelling the development and exercise of ego functions” (Hendrick, 1943a, p.561). Hendrick tries to counter the criticisms of his colleagues, including Thomas French, Karl Menninger, Robert Waelder and Edward Bibbring, who criticize his departure from the classical drive theory (see Hendrick, 1943a). In response to these criticisms he does soften his position, yet still maintains the existence of an instinct to master as a faculty of the ego related to “efficiency of performance” (Hendrick, 1943a, p.565).

Some twenty years later, Robert White also proposed the existence of “independent ego energies” (White, 1963). The importance of the idea of independent energies for the ego psychologists is that it allows more lofty ideals, such as the intrinsic pleasure in work and in achieving mastery of something, to be given a place within psychoanalysis free from the necessity to trace these back to more base and basic biological drives. White develops a theory very close to Hendrick’s mastery theory, but in the place of the word ‘mastery’ he uses the term ‘competence’. White begins with the basic observation that children, and animals, through their play, appear to be doing more than just gratifying basic instincts. Through play, children seem to be actively seeking mastery of their environment through their inquisitive
explorations of things. He sees this as evidence that the classical drive theory is an inadequate one for explaining the meaning of behaviour.

In an important passage, he states:

A whole series of workers, including Harlow (1953), Butler (1958), Montgomery (1954), Berlyne (1950), and Meyers and Miller (1954), have pointed out that animals show persistent tendencies toward activity, exploration, and manipulation even when all known primary drives have been satiated. Clearly the original drive model, based on hunger and other internal deficits, stands in need of extensive revision (White, 1960, p.101).

A consideration of these observations leads him, like Hendrick, to suggest that the classical drive theory needs revision by the addition of independent ego energies or drives.

Independent ego energies and their satisfactions are conceived to be just as basic as the instincts. They are not, however, related to particular somatic sources or to consummatory patterns of discharge. Conceivably they can be equated with the inherent energy of the nervous system. But their significance for development lies in their direct relation to the formation of psychic structure. Effectance is a prompting to explore the properties of the environment; it leads to an accumulating knowledge of what can and cannot be done with the environment; its biological significance lies in this very property of developing competence. Instinctual energies, of course, likewise produce action, effects, and knowledge of the environment, thus making a contribution to competence. Both their contribution is necessarily narrower than that of neutral energies which stand ever ready to promote exploration for its own sake. (White, 1963, p.185-186)

White therefore wants the ego energies to be seen as basic, but he does not want to tie them to a more basic biological or somatic source. He proposes that there is an instinct that drives humans to explore and develop competence in the environment, just as Hendrick proposes there is an instinct for work. The two theories therefore share
essentially the same ground with the same theoretical aims and directions (see also Hartmann, 1958, for another theorist proposing autonomous ego instincts that have as their primary aim adaptation).

Weiss’ control-mastery thesis is highly similar to Hendrick and White’s theories, but develops this within an explicitly psychotherapy research focus. Like his predecessors, Weiss also wants to develop the idea of the ego having autonomous drives in contrast to the classical drive theory of Freud. He sees these ego drives as having a similar aim: to develop control or mastery of the world. To emphasize the fact that the ego is autonomous in his theory, he calls it the ‘higher mental functioning hypothesis’ in contrast to the deterministic mechanical classical instinctual drive theory of Freud that he calls the ‘automatic functioning hypothesis’. Like White, who began with a consideration of human and animal development (White, 1960), Weiss draws upon the infant and developmental psychologists in outlining his case. He refers specially to the work of Stern, noting:

Stern (1985, p. 238) has written that his direct observations of infants do not support the idea of one or two basic instincts. According to Stern, motivation needs to be reconceptualized as organized by interrelated systems that unfold developmentally. These are classified as “ego instincts,” and they include attachment (to parents), exploration, certain perceptual preferences, cognitive novelty, and pleasure in mastery (Weiss, 1993).

The idea that one of the primary motives is mastery of the world is highly similar to White’s notion of competence. Weiss wants to put the ego instincts including the mastery drive at the center of his psychology. He thus no longer merely wants to suggest an addition,
like a footnote, to the basic drive theory. He wants to overhaul it: "...the present theory assumes that the patient’s central organizing motive is to adapt to his interpersonal world" (p.206). Adaptation, mastery, competence are all terms that have a similar lineage and can be seen as arising from the wish by some theorists to get rid of the idea that we are driven by our basic biological processes and substitute the idea that we act out of desires to explore and master our world.

**Critique of the ego-psychology view of mastery**

There are a number of difficulties with the ego-psychology view, all of which center around the problem of trying to separate drives or energies from a basic somatic source. The following arguments point out these conceptual muddles and difficulties, and point out how the classical instinctual drive theory avoids these problems and is therefore the preferred theoretical base on which to build an understanding of mastery (in this context, see also Mackay, 1989; Maze, 1987; Maze, 1993).

The first point is that there is nothing conceptually wrong with ego instincts. Freud conceived of these as modifications of id impulses in the light of experience in the world (e.g. Freud, 1923). The problem is that Hendrick, White and Weiss (among others) want them to be independent and autonomous of basic biological sources. What remains unclear in these author’s accounts is why we want to achieve mastery. Why bother to work? Why try to achieve competence? To say merely, as these authors do, that we have a drive or instinct to achieve mastery and competence is a pseudo-explanation. The point is that these authors need a basic theory of motives specified by their
source (in definable processes) rather than by a theory of motivation specified by their aim (to achieve mastery). This is discussed in detail shortly. These authors must implicitly assume a basic drive theory in order to explain why we do anything at all, including why patients try to improve or master their psychological conflicts.

Freud’s classical determinist view of psychology is that ultimately all human behaviour can be understood as being motivated by a relatively small set of primary biological drives (Freud, 1915b; Mackay, 1989). This theory of motivation is parsimonious in that all behaviour can be linked to its source within biological processes, a position similar to the assumptions of biological psychiatry, the neurosciences and molecular biology today. As a theory it avoids problems with defining motivational principles by their aim, for example in the instinct or tendency to ‘self-actualize’ in Maslow’s theory. Teleological theories of motivation defined by aim have the problem that it is never clear how many aims there are. For instance, is there an ‘instinct to master’, an ‘instinct to get food’, an ‘instinct to be competitive’, an ‘instinct to learn’ etc? It is never clear where to stop such a list. For example, the question “why did she suck her thumb?”, in a theory defined by aim or goals, could be explained as “to satisfy her thumb sucking instinct”. Similarly, a cat stalking a bird might be said to have a ‘hunting instinct’, but this explains nothing, and is circular in reasoning: it just renames the observation in a form that implies we know more than we do.

Teleological descriptions are adequate in ordinary conversation, but perform very badly in scientific discourse. That is why Freud set out to develop a theory of psychology that was mechanistic, that rested upon
basic laws and explanatory principles just as molecular biology rests upon DNA as a fundamental element. Freud rested his theory of psychology upon basic biological processes (called, archaically, instincts) that are irreducible and fuel behaviour (Freud, 1895b). Although Freud’s ideas about the functioning of the nervous system (such the hydraulic model) are obsolete, that does not preclude more modern knowledge of biological processes being substituted within the basic structure of Freud’s metapsychology.

Is there good reason to postulate a mastery or competence instinct? Freud anticipated the problem of where to draw the line with how many instincts there are, when he stated:

What instincts should we suppose there are, and how many? There is obviously a wide opportunity here for arbitrary choice. No objection can be made to anyone’s employing the concept of an instinct of play or of destruction or of gregariousness, when the subject-matter demands it and the limitations of psychological analysis allow of it. Nevertheless, we should not neglect to ask ourselves whether instinctual motives like these, which are so highly specialized on the one hand, do not admit of further dissection in accordance with the sources of the instinct, so that only primal instincts - those which cannot be further dissected - can lay claim to importance. (Freud, 1915b, p.123)

Which drives are most basic and primary was never fully enunciated by Freud. What appears clear however, is that the ego psychology view that mastery is a basic instinct cannot be defended, on the grounds that there is no obvious biological source. A question of primary importance is whether or not we need to add an extra level to Freud’s basic instinctual drive theory, namely, independent ego drives, in order to account for the observations of Hendrick, White and Weiss. In the
case of Hendrick’s housewife, it seems reasonable to argue that anyone who cleans their house is gratifying their self-preservation instinct by cleaning away dirt, dust, bacteria, mould, and invading rodents and insects, and are thus helping to maintain sufficiently sanitary conditions to prevent infections and disease. Second, cleaning the house is also a way of contributing to the well being and favour of the person’s cohabitants, upon which the person may rely in a complementary fashion for love and erotic satisfaction. The pleasure of the work can be tied, without any conceptual difficulty, to the satisfaction of these needs. So a criticism of Hendrick, White and Weiss’s position is that the additional ego drives are unnecessary, and therefore do not satisfy Occam’s razor: the principle that the fewest number of assumptions are to be made in the explanation of a thing.

Another problem with the idea of mastery or competence, as developed by these authors, is that there are no obvious criteria for meeting this goal. What might be masterful competence for one person might be beginners’ level for another. What one considers to be competent another might consider to be incompetent. The concept therefore relies upon subjective accounts that preclude the objectivity required for an objective science. This is in contrast to the instinctual drive theory where basic needs are clearly gratified and satiated through a biological source.

Hendrick, White and Weiss are all impressed by infant developmental research that suggests that young children appear to actively seek mastery of their environment. In a similar context, and following
research with young children separated from their parents, and studies by others (e.g. Harlow & Zimmermann, 1959), Bowlby proposes that the need for attachment is primary (Bowlby, 1988). Freud would no doubt agree that attachment is centrally important, but would insist that ultimately this should be explained further, in that "all the emotional relations of sympathy, friendship, trust, and the like, which can be turned to good account in our lives, are genetically linked with sexuality and have developed from purely sexual desires ... " (Freud, 1912a, p.105). Similarly with mastery or competence, an infants' inquisitiveness can be seen ultimately as motivated by the need to satiate drives (for example, discovering what is edible by putting all variety of objects in the mouth, can be linked to the self-preservative instincts including the hunger drive). Mastery can thus be adequately explained within the classical theory. Where to draw the line as to what is primary and what is secondary is a matter of debate, and one that will not be entered into here. The essential point is that in the classical theory there are a small number of irreducible drives that are primary and linked directly to biological processes from which the multitude of needs can ultimately be linked. Maze makes that point that in psychotherapy, tracing the original source of the need may not be of primary importance. In discussing a case of Joseph's, he points out that "Joseph's strategy was to bring him to see what it was that he was doing in the 'here and now'; that he was acting out these feelings with regard to her, not merely to an imago of his parent. Yet this is not to deny the instinctual basis of his behaviour, nor that it had begun as an instinctual reaction in early life, and one might argue that the recognition of such a basis is necessary to understand the irrationality of his behaviour. In some such terms one may be able to see the
complementarity of object-relations theory and a clarified instinctual-drive theory” (Maze, 1993, p.469).

As mentioned by Eagle above, this idea that we have some inherent drive to master is similar to Carl Rogers’ ideas applied to psychotherapy. On Rogers’ view, once the therapist has provided a good therapeutic alliance, that is all that is necessary and sufficient for change, since inherent within the patient is a drive to master their problems or ‘self-actualize’ (Rogers, 1957). Similarly for Weiss, once the patient feels safe with the therapist (who has passed their ‘tests’), then the patient will allow their problems to rise up from the unconscious and be mastered. He states that “patients bring forward their pathogenic beliefs as well as other unconscious thoughts and feelings only when they decide they may do so safely ...It seems that the cognitive capacities of the unconscious mind have been under appreciated and that human beings can unconsciously carry out many intellectual tasks, including developing and executing plans for reaching certain goals” (Weiss, 1990, p. 109). The implication of this theory for psychotherapy, as he develops it, is that patients exert a degree of control over their instinctual drives and can regulate their expression within therapy based on whether or not it is safe to do so. Such an idea, as true as it may be, does not need the additional postulation of an independent mastering and controlling mechanism to achieve these tasks for the reasons outlined above. It should be stressed here that the empirical research on psychotherapy by the Mt Zion group is not affected by these theoretical arguments, what is being brought to task is the adequacy of the theoretical basis used to direct and explain the empirical research. The point is that patients are more
likely to be motivated to master their problems in psychotherapy because of symptoms such as depression and anxiety that have arisen due to the patient being unable to successfully meet their primary basic needs (such as for a close loving sexual relationship), rather than because of a mastery instinct.

A central feature of the classical drive theory is that one drive can only be opposed by another drive. For example, if we assume there is a need for self-preservation and a need for affiliation, we can understand the enormous conflict that some people experience in close loving relationships where there is also domestic violence. Two needs are in conflict and have to be reconciled in some way. Needs that are unfulfilled or threatened lead to anxiety and other symptoms (Freud, 1926).

In summary, the view of mastery postulated by ego psychologists is argued to be inadequate because of problems with their conceptualization of the motivation of behaviour. The classical drive theory of Freud avoids these problems, and is argued to be an adequate theoretical base upon which to understand a theory of mastery. It should be noted here that the classical theory is probably one of a number of theories that meet criteria for theoretical coherence and clarity. The classical theory is conveniently chosen here as a good example from which to build a theory of mastery. The next chapter turns the focus of this discussion onto how mastery might be understood within the classical instinctual drive theory.
Chapter 4

Mastery in the Context of the Psychoanalytic Theory of Clinical Change

The central argument of this chapter is that a good way to articulate and conceptualize psychoanalytic psychotherapy is to understand it as the process of mastery. This is argued for based on a reading of Freud’s writings on the process of change through psychoanalysis. Freud’s term for this process of change that the patient engages in is ‘working through’, although as shown below, Freud also used the term mastery in a similar way to that developed here. It is argued that mastery can be convincingly seen as the process and outcome of the working through process, whereby the ego comes to master the unconscious conflicts bound up in the repetition compulsion. In more modern psychotherapy research terms, the person achieves mastery of their core cyclical maladaptive relationship (transference) pattern or schema.

This chapter necessarily reflects the archaic ‘psychic energy transfer’ language of Freud, since it presents an attempt to explicate Freud’s writings on working through to develop the notion of mastery. Where possible, more contemporary vernacular is used to show how the basic Freudian ideas can be transferred into a modern psychotherapy research context. This is done to demonstrate how the classical drive theory and processes in therapy are related and how mastery can be
understood using both nomenclatures. The masterer (ego or self) and the mastered (conflicts or relationship patterns) are therefore alternatively articulated in classical terms as the ego drawing energy from the bound up impulses in the id (as in Freud’s famous maxim ‘where id was, there ego shall be’), and in modern psychotherapy research language as the self or patient learning to understand and control their problematic relationship patterns.

**Working through**

Freud explicitly wrote about working through only twice. However, his two treatments of the concept came at very different points in the development of his metapsychology. The first exposition of working through, in 1914, falls into the period of his first theory of metapsychology, which was based on unconscious, preconscious and conscious processes. This paper has the title ‘Remembering, Repeating and Working-Through’ (Freud, 1914). As argued in the previous chapter, this first metapsychology based on instinctual drives has been argued to be the most coherent one for understanding mastery. Most weight will therefore be given to this 1914 paper. By about 1920, Freud prepared a second metapsychology which he presented in *The Ego and the Id* in 1923. His second discussion of working through, in 1926 (Freud, 1926), falls into this latter period. In order to understand the 1914 account of working through, it is important to first sketch out in more detail the basics of his metapsychology that were introduced in the previous chapter.
Freud's metapsychology is described as dynamic because he posited that the basic constituents of the psychical apparatus are based on motivational principles defined by their source in the instinctual drives. He conceived of a topographical model of mind that is split into a conflict between conscious and unconscious forces. The basic theory or metapsychology was constructed in synchrony with clinical observations of patients, and was altered as fresh evidence from his case studies necessitated theoretical revisions. The first analyses of patients were those with 'hysterical' symptomatology, and the first methods were aimed at removing symptoms (Breuer & Freud, 1895). Freud from the outset believed in a determinist causal theory of mind, and the method of cure was to trace the causes of the symptoms in mental life, the hidden logical links between "thoughts" and symptoms, and reveal them to the patient. These "thoughts" are more correctly termed "wishes" or "phantasies" which imply a motivational basis.¹

Through the analysis of dreams, the hypnotic method and later the method of free-association, Freud was led to the conclusion that these wishes are hidden from conscious mental life by forces of repression or censorship that keep them unconscious. The mind was thus conceived in a topographical division between conscious contents that are presented to the mind with ease, preconscious contents that are bound in verbal language or 'word presentations' that lie at the boundary between the two systems, and unconscious desires that are without

¹ This is the chief departure point between dynamic psychologists and cognitive-behavioural information-processing psychologists. The latter posit the existence of irrational or pathological thoughts as the genesis of psychopathology, yet deny their motivational basis, relying instead on models of learning and the cognitive-structural development of thinking.
linguistic organization. The unconscious system is the reservoir of primal instinctual drives that 'seek gratification' (Freud, 1915c). Unconscious mental life is in the form of primal libidinal phantasies, images, and dreams. The instinctual drives are defined by their source in physiological structures such as those regulating hunger and sexual consummation. Within the unconscious are the secret impulses that social and civilized society do not admit - destructive or aggressive wishes or forbidden sexual phantasies such as those between the infant son and his mother, which became known as the oedipus complex, whereby the son is symbolically threatened with castration by the father for such wishes. Freud noted in an early letter to Fliess: "I have found, in my own case too, falling in love with the mother and jealousy of the father, and I now regard it as a universal event of early childhood...If that is so, we can understand the riveting power of Oedipus Rex...the Greek legend seizes on a compulsion which everyone recognizes because he feels its existence within himself. Each member of the audience was once, in germ and in phantasy, just such an Oedipus, and each one recoils in horror from the dream-fulfillment here transplanted into reality, with the whole quota of repression which separates his infantile state from his present one" (Freud, 1897, p. 265).

The mind is thus composed of primary and secondary processes - the primary being the unconscious that is unconstrained by any logical laws of association or reality demands and the secondary being the conscious that is so constrained.

The psychoanalytic technique resting on this metapsychology is based on resistance analysis. The function of neurotic symptoms is to defend the personality against unconscious impulses that are unacceptable.
The method is to investigate the unconscious wishes, to bring these to the patient’s awareness, wherein the symptom will disappear as it no longer has a protective function to perform. Resistances are the forces of censorship that attempt to keep the unconscious wish hidden. The principal task of analysis is the systematic removal of the resistances that attempt to block the repressed material. Freud noticed that these unconscious or libidinal wishes manifest themselves in behaviour, in the sense that they attach themselves or transfer themselves to others in the patient’s life including the analyst. The analysis of transference thus became an important analytic technique because the repressed wish or memory is repeated in behaviour and is thus observable. In fact the libidinal wishes appeared to be increasingly transferred onto the object of the analyst thus creating a transference neurosis in place of the symptom neurosis (Freud, 1912a). The focus of analytic technique thus shifted to an analysis of transference wherein the key to the repressed unconscious wishes could be found and overcome within the present analytic situation.

The paper on technique “Remembering, Repeating and Working-Through” (Freud, 1914) is a detailed and central exposition of psychoanalytic technique based on this theory of mind and motivation employing the central technique of resistance analysis. It was published by Freud at the age of 58 and by this time many of the cornerstones of psychoanalysis were complete including the early Studies on Hysteria (Breuer & Freud, 1895), the Interpretation of Dreams (Freud, 1900), and the Three Essays on the Theory of Sexuality (Freud, 1905b). The term ‘psycho-analysis’ was chosen by Freud because it implies the breaking or
separating out of elements just as the chemist proceeds in analyzing substances. The goal is to then bring repressed material that has been found in one part of the mind into the patient's consciousness, to create a link and a subsequent synthesis.

Freud commences the 1914 working through paper (Freud, 1914) by outlining the history of the psychoanalytic technique as it has been practiced since its inception with the collaboration with Breuer. The process had originally commenced with the idea that strangulated affect or pent-up emotion caused symptoms, and hypnosis utilizing catharsis to free or release these fixations was the method of cure. The use of hypnosis was abandoned as it was unreliable with many patients and could not control for the extremes of transference-love, as occurred to Breuer in his case of Anna O. The technique of free-association was instigated to investigate blocks in memory or forgetting. These were the resistances that served to hide the underlying causes of the symptoms. Freud had originally thought that real trauma underlies the sole cause of the neuroses. The method was thus the recollection of the memory of the trauma and its abreaction. Freud modified this theory and came increasingly to recognize that although trauma was important, it was the conflicts between innate instinctual forces and phantasies that were most heavily repressed and active in the aetiology of the neuroses (Freud, 1917).

It should be noted at this point that while free association was the method of choice selected by Freud, the psychoanalysis of other material collected in other ways was not precluded. For example, Freud himself furnished case analyses based on published material from
diaries and notes of others, such as in the 'Schreber' case (Freud, 1911) and the small work on Leonardo DaVinci (Freud, 1910). The central feature was the analysis and uncovering of underlying repressed mental conflicts between the unconscious and conscious processes. In the case of a patient in therapy, however, there is an expectation of help and therefore the analysis of the dynamics of the psychopathology occurred in a process involving the analysis of resistances. Rendering any change in the patient required more strenuous effort, and this is properly what Freud referred to as 'working through'. Working through as a concept took the place of abreaction in the early hypnotic method. Interpretation and the helping relationship are the tools of the analyst in the working through process. Central to the process of working through are:

1) recollection, and
2) repetition

which will be considered in turn.

*The role of recollection within the working through process*

Recollection involves the recovery of the 'forgotten' material of childhood or from some time earlier in the patient's life. The process of forgetting is the falling away of links, the dissociation of memories from conscious life. In the recall of the earliest memories, what often emerges are 'screen memories'. Screen memories are compromise formations between the forces of remembering and those of resistance to remembering. The forces of resistance cause a displacement to occur.
Freud gives an example taken from a study of early memories by V. and C. Henri where a professor of philology's earliest memory was of a table laid for a meal and upon it a basin of ice. Contemporaneous with the memory of the table was the death of his grandmother - a severe trauma - which was forgotten and in its place was the basin of ice. Freud states that in the analysis of these fragments "unsuspected wealth of meaning lies concealed behind their innocence" (Freud, 1899, p.309). Screen memories may serve as a screen for events and wishes occurring prior to (e.g. in earliest infancy) or subsequent to (e.g. in adolescence) this memory.

In forgetting, a causal chain may be found linking the nature of the material to the suppression of it from consciousness. Freud dealt with this subject at length in his *Psychopathology of Everyday Life*. The process of working through in recollection is the effort expended by the patient to find the meaning behind the screen memories, to trace the causal chain in forgetting back to the source of the repression. Interpretation is thus used by the analyst as a tool to help overcome these blockages of memory and thinking.2

*The role of repetition within the working through process*

Repetition is the second aspect of importance to the working through process. Repetition is a form of remembering that is displaced into

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2 It would be a mistake to argue that interpretation, rather than working through, creates change. The analyst assists the change process by interpretation, but it is the effort expended by the patient that brings forth the material. It is noticed in forgetting names, for example, that the name quite often presents itself to consciousness in a flash, well after the effort expended to remember it has been abandoned and the thoughts are on quite a different topic. Interpretation helps the process by trying to remove the forces blocking the memory, but the surfacing of the material is not caused by interpretation but by the effort (working through) of the analysand.
action or behaviour: "...the patient does not remember anything of what he has forgotten and repressed, but acts it out. He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it. What interests us most of all is naturally the relation of this compulsion to repeat to the transference and to resistance. We soon perceive that the transference is itself only a piece of repetition, and that the repetition is a transference of the forgotten past not only on to the doctor but also on to all the other aspects of the current situation" (Freud, 1914, p.150-151)." Freud first discovered the repetition known as transference some years earlier in the Studies on Hysteria, where in the last few pages of the work he writes about instances where treatment has come to a standstill and the process of recollection has dried up. In such instances it may be noticed that "the patient's relation to the physician is disturbed...(the patient is) transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis" (Freud, 1895c, p. 389-390). This compulsion to repeat is present at the very beginning of treatment and "As long as the patient is in treatment he cannot escape from this compulsion to repeat; and in the end we understand that this is his way of remembering." (Freud, 1914, p.150).

Transference is thus a repetition, which in action replays the forgotten past. Freud sees transference as a resistance because it is a mechanism that resists conscious remembering of unconscious material. The task of the analyst through interpretation is to understand the transference and re-link it with the psychical repressed from which it has become split off into behavioural acting out. Transference as repetition-
compulsion is a phenomenon that presents itself in all aspects of the patient's life, not just in the analytic situation. The analyst must beware of instances of resistance to the analysis manifesting themselves outside the therapy hour, that attempt to undo the work that has been achieved.

The transference pattern of relating to the therapist is only one instance of the patient's broader personality-like pattern of relating to others throughout their life. Freud states: "each individual, through the combined operation of his innate disposition and the influences brought to bear on him during his early years, has acquired a specific method of his own in his conduct of his erotic life ... This produces what might be described as a stereotype plate (or several such), which is constantly repeated - constantly reprinted afresh - in the course of the person's life" (Freud, 1912a, p.99-100). One of the chief tasks of psychotherapy is to bring this repetitive pattern of relating to the awareness of the patient so that it can be understood and controlled. This is particularly the case in instances where a repetitive way of behaving (e.g. interpersonal withdrawal) is preventing the fulfillment of wishes (e.g. to be close to others) driven by instinctual drives (e.g. to seek sexual gratification).

The emotional conflicts characterizing the transference template are analysed within the present relationship with the therapist: "This struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act, is played out almost exclusively in the phenomena of transference ... for when all is said and done, it is impossible to destroy anyone in absentia or in
effigie” (Freud, 1912a, p.108). The curative factor implied here is the taming of instinctual impulses by intellectual understanding - by making “manifest” the transference template - by bringing it into awareness as it reproduces in the relationship with the therapist.

Transference makes it clear that “we must treat his illness, not as an event of the past, but as a present-day force” (Freud, 1914, p.151). When the transference is mildly positive, memories may be recovered without undue resistance. But if this transference, with the passing of time turns hostile or extremely intense the memories dry up and the transference resistance blocks the progress of therapy. What is then seen is the illness repeating itself and the symptoms and pathological character-traits in full view. In the course of treatment the patient is encouraged to take an active interest in the mechanisms of the pathology, to come to know them, and thus for them to become “an enemy worthy of his mettle” (Freud, 1914, p.152). Thus there must be a will to overcome the pathology, the will that presumably drove the person to seek treatment. Freud cautions, however, that this will may not be consistent, and in the course of treatment the patient may retreat from the cure in various ways, by “luxuriating in their symptoms” (p.153) or acting out outside the therapy in a way that brings harm and a deterioration in the condition. The handling of the transference is the way to prevent extremes of repetition compulsion: “Provided only that the patient shows compliance enough to respect the necessary conditions of the analysis, we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his ordinary neurosis by a ‘transference-neurosis’”(p.154).
Through the transference the infantile conflict is understood in vitro and in statu nascendi, where the therapist stands as an imago of the father or family member who is the object of the unconscious wish or phantasy. The transference is thus used as therapeutic material understood as resistance to remembering that contains within it the material to be recollected: "From the repetitive reactions which are exhibited in the transference we are led along the familiar paths to the awakening of the memories, which appear without difficulty, as it were, after resistance has been overcome" (Freud, 1914, p.155). The point is, the closer the unconscious contents are to being recollected, the stronger the resistances and the greater the likelihood that the psychic material will be acted out in the transference. The focus of treatment thus increasingly turns to the transference resistance and the overcoming of that resistance is crucial for the cure to be effected.

*The process of working through*

Having elaborated the twin processes of recollection and repetition, it now remains to discuss how they are combined in the working through process leading to mastery. The task of the analyst is to create a frame in which the analysis and interpretation of repressed psychic wishes can proceed. Freud maintains that the what is required is to overcome resistances to complete recollection, that manifest themselves in screen memories, forgetting, and repetitions in behaviour of which transference is of the prime importance. Insight and improvement do not follow necessarily from a single stroke of brilliant interpretation. Rather, Freud maintains that the patient

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3 As is attempted in "wild" psychoanalysis, which Freud counsels against.
must undertake to work against the unconscious instinctual forces within themselves that drive the symptoms and seek to maintain the repression. This painstaking process of change that the patient undertakes is termed “working through”:

I have often been asked to advise upon cases in which the doctor complained that he had pointed out his resistance to the patient and that nevertheless no change had set in; indeed, the resistance had become all the more stronger, and the whole situation was more obscure than ever. The treatment seemed to make no headway. This gloomy foreboding always proved mistaken. The treatment was as a rule progressing most satisfactorily. The analyst had merely forgotten that giving the resistance a name could not result in its immediate cessation. One must allow the patient time to become conversant with this resistance with which he has now become acquainted, to work through it, to overcome it, by continuing, in defiance of it, the analytic work according to the fundamental rule of analysis. Only when the resistance is at its height can the analyst, working in common with his patient, discover the repressed instinctual impulses which are feeding the resistance; and it is this kind of experience which convinces the patient of the existence and power of such impulses. The doctor has nothing else to do than wait and let things take their course, a course which cannot be avoided nor always hastened. If he holds fast to this conviction he will often be spared the illusion of having failed when in fact he is conducting the treatment on the right lines (p.155).

Working through is a core mechanism of change in psychoanalysis. Freud stated: “This working-through ... is a part of the work which effects the greatest changes in the patient and which distinguishes analytic treatment from any kind of treatment by suggestion.” (Freud, 1914, p.155). Working through requires a “period of strenuous effort” (Freud, 1926 p. 159) and “may in practice turn out to be an arduous task for the subject of the analysis” (Freud, 1914, p.155).
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The role of fixations in the working through process

The resistances that necessitate working through are in the unconscious: "The dynamic factor which makes a working-through of this kind necessary is not far to seek. It must be that after the ego's resistance has been removed the power of the compulsion to repeat - the attraction exerted by the unconscious prototype upon the repressed instinctual process - has still to be overcome. There is nothing to be said against describing this factor as the resistance of the unconscious" (Freud, 1926, p.159-60). The power of the compulsion to repeat is, as Freud elaborates, an "unconscious prototype" containing the libidinal or destructive impulses. This prototype is marked by its "attraction" to the primary "instinctual process". Freud is referring here to the way the libidinal wish gains a 'quota of affect' from the reservoir of instinctual energy that drives the repetition compulsion.

Repetition phenomena such as dreams, symptoms, obsessive rituals, acting out behaviours, transference reactions, are all phenomena that are re-enactments of certain elements of unconscious conflict or trauma. Freud discussed in many passages how primary instinctual energy becomes attached to libidinal wishes or objects and how this then leads to a fixation at a developmental stage or psychical inertia. Once the wish becomes fixated, it is then compulsively repeated, until undone through working through. Strachey, Freud's translator and editor, points out the connection between working through and fixation: "The concept of 'working-through', introduced in the present paper ['Remembering, Repeating and Working-Through'], is evidently
related to the 'psychical inertia' which Freud discusses in several passages" (in a footnote to Freud, 1914, p.156).

Psychical inertia is fixation, as Freud himself makes clear: "this specialized 'psychical inertia' is only a different term, though hardly a better one, for what in psychoanalysis we are accustomed to call 'fixation'" (Freud, 1915a, p. 272). 'Fixation' refers to the often observed clinical fact that archaic childhood attachments persist in an arrested form in the adult client. The attachments may have many forms, such as a libidinal wish toward the father that persists into adulthood, or a fetish for mother's lingerie. Freud talks of fixations as an "adhesiveness of the libido" (Freud, 1916-17a, p.393). This implies that libidinal energy is available to become attached to objects. Events that cause such adhesions are numerous, but Freud mentions "first and foremost, seduction by other children or by adults" (Freud, 1905b, p.168). As well as using the term "adhesiveness", which refers to the mechanism of attachment of libido and objects, he also uses the expression "inertia of the libido", which refers to the resulting arrested development. Freud talks of "the inertia of the libido ...its disinclination to give up an old position for a new one" (Freud, 1930, p.108). This idea of inertia or fixation led Freud in later years to the concept of a death instinct that arrests development.

In discussing analytic technique, Freud outlines the importance of such instances of arrested development as forces that work against the progress of therapy: "The forces against which we have been struggling during our work of therapy are, on the one hand, the ego's antipathy to certain trends in the libido - an antipathy expressed in a
tendency to repression - and, on the other hand, the tenacity or adhesiveness of the libido, which dislikes leaving objects that it has once cathexed” (Freud, 1916-17b, p. 508). Working through is the arduous process of the decathexis of the psychic fixation of id to object. It involves removing the adhesion that has created psychical inertia. As Freud makes clear, it is one of the two central aspects of analytic therapy - removing the resistances and then detaching libidinal energy from the object. Working through in turn frees up libidinal energy to be used in the service of the adult ego.

Mastering the energy bound up in psychological symptoms

When energy becomes fixated on an object, it is usually the result of a failure to master this stimulus. In traumas, the organism is flooded with excitations, therefore “another problem arises ... - the problem of mastering the amounts of stimulus which have broken in and of binding them, in the psychical sense, so that they can be disposed of” (Freud, 1920, p.30). Freud considers that attempts at mastering stimuli are usually successful in everyday life. This everyday process of mastery can be seen in, for example, children’s play: “It is clear that in their play children repeat everything that has made a great impression on them in real life, and that in doing so they abreact the strength of the impression and, as one might put it, make themselves master of the situation” (Freud, 1920, p.16-17, my emphasis).

Traumas arrest psychic development until the problems are mastered. Freud sees the repetition compulsion as an unsuccessful attempt at mastery, that ultimately usually needs to be addressed through the
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process of psychotherapy. In traumatic dreams that include flashbacks, Freud notes that "these dreams are endeavouring to master the stimulus" (Freud, 1920, p. 32). In children's play, for example, "children repeat unpleasurable experiences for the additional reason that they can master a powerful impression far more thoroughly by being active than they could by merely experiencing it passively. Each fresh repetition seems to strengthen the mastery they are in search of" (Freud, 1920, p.35, my emphasis). It is thus clear that the work of analysis is in overcoming the compulsion to repeat, to work through it, and master the conflict underlying its presentation.

The development of mastery

If it is assumed here that the major outcome of the working through process is mastery, what then is achieved in mastery? On a fundamental level, according to Freud's classical instinctual drive theory, energy that has been bound up or fixated in the id, where it fuels the repetition compulsion, needs to be released so that it can be used effectively by the ego - such that 'where id was, there ego shall be'. These released energies are used in productive acts that satisfy the demands of reality, the id (in the long run) and also the super-ego. The above discussion has shown these processes in detail as Freud enunciated them. At the same time as he employs the language of his energy drive theory, Freud also talks in terms sensible to the psychotherapist in training, who he sees as his audience when writing his papers on technique. In describing the benefits of the prospective
therapist undergoing analysis with a senior analyst, Freud highlights what might be considered to be the two fundamental aspects of mastery seen from the perspective of psychotherapy: "everyone who wishes to carry out analyses on other people shall first himself undergo an analysis by someone with expert knowledge ... Anyone who can appreciate the high value of the self-knowledge and increase in self-control thus acquired will, when it is over, continue the analytic examination of his personality in the form of self-analysis" (Freud, 1912b, p.116-117, my emphasis).

Self-knowledge and self-control are considered by Freud in this extract to be the benefits of psychoanalysis and are held here to be the two fundamental aspects of mastery. It is worth considering how the processes of working through, as discussed above, may in fact lead to increases in self-understanding and self-control, and hence, mastery. This work will also contribute the first steps towards developing a measurement of mastery. The following seven summary statements or conclusions about what changes in psychotherapy as a result of working through are offered as being consistent with the classical drive theory and its application to psychotherapy as outlined. During psychotherapy, as a result of working through:

1. **Self-understanding is developed about the transference resistance and other forms of the repetition compulsion in the person's life.** Through therapy, and especially during transference analysis, the therapist engages the patient in the job of noticing and bringing to awareness the mechanisms of their pathology.
2. Self-understanding is developed about the prior causative trauma or fixation and how these have been active in present relationships through the repetition compulsion. Freud sees the recollection of past events and tracing neurotic symptoms to their roots as being one important task of therapy. He also wants to show how these past patterns of relating are repeating themselves in the present.

3. Relationships with others will improve given the self-understanding of the distorted and maladaptive transferential repetitive relationship patterns. One of the therapists' tasks is to help link the transference relationship with common patterns of relating that are active in the patient's life.

4. Self-understanding of relationships with others should improve given the greater degree of objectivity obtained following the process of working through. Working through makes links between forces and ideas that have previously been separated. Through these increases in self-understanding the person should be able to focus more clearly and objectively within relationships with others.

5. Self-control in the ego is enhanced through the releasing of the energy that had been bound up in the fixation of the id to an object. This is consistent with the basic drive theory of energy transfer. The ego is bequeathed greater resources and energies that can be used to help stabilize and control executive mental functioning.

6. Self-control increases as the repetition or acting out behaviours are lessened and new ways of responding in relationships emerges. Libido
becomes freed from its unconscious bonds or fixations, and becomes available to be used towards new objects.

7. **Self-control increases due to the enhancing of the ego's power to self-analyse conflict.** The ability to engage in an analysis of the self arises out of these general increases in self-knowledge and self-control, and this self-analysis should operate as a protective factor against psychopathology.

The first four of these outcomes relates to self-knowledge, and the final three to self-control. The reason why it is "self" knowledge and control, is a recognition of the fact that there is a distinction between the masterer (the self that masters) and the mastered (the conflicts). Unlike the ego psychology view, where the person is driven by their instinct to master, here the masterer works on mastering conflicts ultimately because of the pressure from the primary drives that are either in conflict or are not being gratified.

Of the two fundamental elements of mastery, self-knowledge and self-control, it is important to consider which of the two may be the primary element that most predicts change in psychotherapy. Freud makes it clear that self-control is primary, because it signals that there has been a successful transfer of energy that enhances the ego. In fact, he warns against putting too much importance on self-understanding: "In the course of the treatment yet another helpful factor is aroused. This is the patient's intellectual interest and understanding. But this alone hardly comes into consideration in comparison with the other
forces that are engaged in the struggle ... The patient, however, only makes use of the instruction in so far as he is induced to do so by the transference” (Freud, 1913, p.143-144). Transference, as has been seen, is the primary sphere in which analysis proceeds, and it is the internal conflictual relationship patterns that require to be not only understood, but more importantly, to be controlled and mastered.

In another passage, Freud cautions against accepting intellectual evidence as a sole basis for assessing the progress of analysis : “in the earliest days of analytic technique we took an intellectualist view of the situation. We set a high value on the patient’s knowledge of what he had forgotten, and in this we hardly made any distinction between our knowledge and his ... we hastened to convey the information and the proofs of its correctness to the patient, in the certain expectation of thus bringing the neurosis and the treatment to a rapid end. It was a severe disappointment when the expected success was not forthcoming” (Freud, 1913, p.141). The psychodynamic psychotherapy researcher Strupp emphasizes the importance of self control when he states that “One of the chief purposes of psychotherapy, if not the primary purpose, is to promote the acquisition of self-control” (Strupp, 1970, p. 393).

What needs to be emphasized is that mastery is achieved through emotional effort - the effort required to re-experience the past, to abreact it, which only then leads to a sense of a continuity or mastery by the patient of their history. Freud maintained that the therapist must get the patient to “re-experience some portion of his forgotten life ... which will enable him, in spite of everything, to recognize that what appears
to be reality is in fact only a reflection of a forgotten past. If this can be successfully achieved, the patient’s sense of conviction is won, together with the therapeutic success that is dependent on it” (Freud, 1920, p. 19). Mastery as self-control is achieved when the patient no longer unknowingly reacts emotionally to conflicts in the present because of forgotten past traumas, but rather sees the present for what it is without undue distortion.

Freud discusses how when mental conflict arises, an essential talent is for there to be sufficient internal self-control resources to master these threats when they arise: “under the influence of education, the ego grows accustomed to removing the scene of the fight from outside to within and to mastering the internal danger before it has become an external one” (Freud, 1937, p.235). There must be adequate ego-strength or resources to deal with external and internal conflicts, and the process of working through aims to endow the ego with these resources so that conflicts can be successfully mastered.

The concept of mastery

It was argued in this chapter that mastery can be convincingly seen as the outcome of the working through process, whereby the ego comes to master the unconscious conflicts bound up in the repetition compulsion. To formally summarize, mastery is defined as the acquisition of self-control and self-understanding in the context of interpersonal relations. A person with mastery therefore has a greater sense of adaptive control over their emotional reactions when faced
with conflicts in interpersonal relationships and is more able to understand the origins and motives behind these conflicts. A person without mastery blindly reacts with great distress to a wide domain of interpersonal situations without awareness of the sources of their conflicts and problems. The next chapter reviews a small number of studies that are congruent with the idea of psychotherapy as being the development of mastery. An examination of these studies, and gaps and omissions in them, will prepare the way for a discussion of how the empirical work was designed.
Chapter 5

Review of Psychodynamic Psychotherapy Research Relevant to Studying Mastery

A number of studies that have attempted to investigate psychodynamic changes over the course of psychotherapy are relevant to the development of mastery. As discussed in the previous chapter, mastery is defined as the acquisition of self-understanding and self-control in the context of interpersonal relations. An important part of the development of mastery involves the working through of the repetition compulsion (including the transference). Relevant studies are those dealing with empirical measures of transference and changes in transference and self-understanding over the course of psychotherapy.

Excluded from the current review are traditional psychotherapy outcome studies that only look at changes in symptoms. Also excluded are studies that have a more remote relevance to the processes of mastery. Although virtually all studies of psychodynamic psychotherapy directly or indirectly investigate aspects of the change process developed by Freud, it is well beyond the bounds of this study to review all these studies (for more comprehensive reviews, see for example Henry et al., 1994; Lambert & Bergin, 1994; Luborsky et al., 1990; Luborsky et al., 1988; Luborsky & Spence, 1978; Orlinsky et al.,
1994; Strupp, 1992). What follows, then, is necessarily a selective number of studies that are most pertinent for this study selected from a very deep pool of research.

**Research into the transference pattern**

People come to psychotherapy usually because the severity of their psychological symptoms has become unbearable and they are unable to obtain relief on their own. Chapter 2 introduced the therapeutic alliance and the transference as two key areas of interest in contemporary psychodynamic psychotherapy research. Methodologically, this research depends on advances in the audio recording of psychotherapy sessions (Mahl, Dollard & Redlich, 1954; Rogers, 1942), which provides more reliable evidence into the process of psychotherapy than relying upon therapists' case notes. Recorded sessions are usually transcribed verbatim and qualitative and quantitative studies are made on the transcripts. This methodology to some extent answers the concerns of critics of psychoanalytic scientific method who have in the past criticized the evidential basis of subjective case reports (for discussions of psychoanalytic research and the scientific method see Grünbaum, 1986; Wallerstein, 1993). Since the transference and the therapeutic alliance are both interpersonal phenomena, the key data of relevance in this context are the instances where the patient discusses their interpersonal relationships in psychotherapy.

Freud recommends to prospective therapists that "what the material is
with which one starts treatment is on the whole a matter of indifference” with the instruction to the patient to “say whatever goes through your mind” (Freud, 1913, p. 134-135). The opening communications by the patient are generally along the lines describing the history of the difficulties, the symptoms of distress, and how these manifest in their daily living. A common feature to be found in such accounts are narratives of interactions with others.

Luborsky and colleagues have found through the intense study of verbatim transcripts of psychotherapy that narratives of interpersonal interactions are ubiquitous throughout the course of the psychotherapy encounter (Luborsky, Barber & Diguer, 1992). It is no surprise that these narratives are illustrations of the problems brought to therapy, and are frequently of negative conflicts: “Negative interactions are more memorable and so are more ready to be told than positive ones because they deal with conflicts in relationships that are harder to master. The remembering and telling probably is in the service of trying to master the conflictual relationships” (Luborsky et al., 1992, p.284, my emphasis). As developed in previous chapters, the patient is attempting to master their problems and conflicts within the psychotherapy hour, and one way of doing this is through the telling of narratives of conflictual relationship problems. Recent research is increasingly being focused on the significance of narratives in psychotherapy, and more broadly in psychology generally, since they contain rich information into how people attempt to make sense of adversity and maintain coherence in their lives (see for example Cohler, 1991; Viney & Bousfield, 1990).
Early in his career Freud noticed the connection between the stories patients tell and their problems: "it still strikes me as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science... Case histories of this kind are intended to be judged like psychiatric ones; they have, however, one advantage over the latter, namely an intimate connection between the story of the patient's suffering and the symptoms of his illness..." (Freud, 1895a p.231). Since the stories told to the therapist have an "intimate connection" to the "suffering", it is reasonable to conclude that these conflictual interpersonal narratives probably contain within them the core of the neurosis.

In current psychotherapy research, focus has increasingly been on investigating this transference 'template' or pattern. Sigmund Freud's translator (James Strachey) originally used the term "stereotype plate" (Freud, 1912a, p.100), this has been renamed "transference template" after the German psychoanalyst Helmut Thomä suggested to Lester Luborsky that it was a better translation from the original German. This is important for the concept of mastery since it is through the analysis of transference that mastery is developed (as this present study proposes). Despite its importance as a clinical concept in psychoanalysis, up until the early 1950s there was little attempt to investigate transference in quantitative terms, and it is only in the last 15 years that research advances have allowed the development of objective measures.

Chance operationalized transference by defining it as the similarity of
description between the significant parent and descriptions of the psychotherapist given by the patient (Chance, 1952). Various researchers have developed Q-sort questionnaires of self-descriptions that are used to compare descriptions of therapists (e.g. as nurturing, critical or a role model), with descriptions of father or parent figures. A set of studies by Crisp, for example, found that attitudes towards the therapist during therapy changed with, or prior to, symptom changes (Crisp, 1966). This follows from a psychoanalytically-derived view that symptoms arise from, and are shown in, relationship conflicts. Luborsky concurs, considering that a lessening of symptoms proceeds with changes in the pervasiveness of transference-related core conflictual relationship themes (Luborsky et al., 1988, p. 156). Other early measures of transference included systematic clinical formulation and rating methods, whereby judges made independent ratings of transference. Such studies suffer from the disadvantage that there is little agreement about the way formulations are made by clinicians, and consequently there is often low statistical reliability in such studies.

Recently, there have been at least twelve new methods developed to assess such repetitive patterns in psychotherapy. Some of the methods were designed to measure transference reactions, and some from the perspective of psychodynamic diagnosis and formulation. Although they outwardly appear different, the same kinds of phenomena are being measured - namely, the structure and features of the transference template.

Definitions of transference differ - the narrow view is that the object of transference is the therapist and what is transferred is from early
images of childhood. The broad view is that transference refers to the overall patterns of relationships that patients have with all people in their life. To be consistent with the earlier chapters, this latter broader definition is more correctly termed the repetition compulsion, however psychotherapy researchers have embraced the broader use of the term transference, so this will be followed here. The point is that narratives told about interpersonal conflicts with others outside the consulting room are just as important pieces of evidence of the transference (or repetition compulsion) as those enacted with the therapist. Empirical research has found significant correlations between the quality and amount of transference interpretations by the therapist and clinical outcome, which supports the crucial role of focusing on the present transference relationships both inside and outside the therapy room in therapeutic change (e.g. Crits-Christoph, Cooper & Luborsky, 1988; Silberschatz, Curtis & Nathans, 1989).

These new approaches to researching transference phenomena employ content coding methodologies using transcripts or tapes recorded from in vivo psychotherapy sessions. The following are among the measures available: Core Conflictual Relationship Theme (Luborsky, 1977); Configurational Analysis (Horowitz, 1979); Frame Method (Teller & Dahl, 1981); Script Method (Carlson, 1981); Patient's experience of relationship with therapist (Gill & Hoffman, 1982); Consensual Response Formulation (Horowitz, Weckler & Doren, 1983); Dynamic Focus (Schacht, Binder & Strupp, 1984); Plan Diagnosis (Weiss et al., 1986); Idiographic Conflict Formulation Method (Perry, Augusto & Cooper, 1989). Many of the methods have only been investigated once. Perhaps the most important and heavily researched of the
methods developed to date is the Core Conflictual Relationship Theme (CCRT), to which most others have been compared (see Psychiatry, Vol. 52, August 1989, and Psychotherapy Research, Vol. 4, Issues 3 & 4, 1994, for comparative studies of the transference measures). It is also perhaps the quickest, simplest and most reliable to use, and has a large body of research supporting its reliability and validity (Luborsky, 1977; Luborsky, 1990a; Luborsky & Barber, 1994; Luborsky & Crits-Christoph, 1990; Luborsky & Diguer, in press).

The significance of the CCRT for the present discussion is that it codes the person's needs or wishes and how successful they are at gratifying them within the context of relationships with others. It thus can be seen to draw heavily upon Freud's basic theory of drives (expressed as wishes, needs and wants) and their gratification or frustration (through successful or unsuccessful interactions with the person's social environment). Here therefore, is an important link between Freud's metapsychology of instinctual drives and its application within a modern psychotherapy research tool.

Structure of the Core Conflictual Relationship Theme (CCRT) method

Luborsky's CCRT technique (Luborsky, 1977; Luborsky & Crits-Christoph, 1990) involves the extraction from therapy transcripts of narratives told by the patient that detail relationship interactions, such as those with close relatives, friends or the therapist. Relationship narratives are often identified by an index such as "I remember when ..." or "Like, for example, when ...". Narratives of relationships often
illustrate a problem, or emphasize an observation, and contain within them the transference template - the regular characteristic conflictual personality style of the patient.

Morgan and Murray (1935) analysed phantasies from Thematic Apperception Test responses into a tripartite structure of "(1) a driving force (or fusion of forces in the subject) (2) an object (or group of objects) toward which or away from which the force is directed, and (3) the outcome of their interaction expressed in terms of subjective feeling - satisfaction or dissatisfaction" (Morgan & Murray, 1935, p. 293). Luborsky's CCRT method also has three elements and is very similar to this approach. First is the wishes of the speaker, which correspond in psychoanalytic theory to instinctual needs. The wish for example might be to obtain love and nurturing. The second element is the reactions of others to the patient, such as hostility or aggression. The third is the response of the self - for example - withdrawing and becoming depressed. The three elements of the CCRT therefore code the dynamics of the relationship interaction, and document the basic attempt by the patient to get their needs or instinctual drives satisfied. They narrate the expression of a wish, how this was received and responded to by another person, and then how this response of the other in turn affected them.

What are found in the narratives of patients studied with the CCRT? By and large, research with the CCRT has supported its validity as an objective personality measure of the transference template (Luborsky, 1990a; Luborsky, Crits-Christoph, Friedman, Mark & Schaffler, 1991). 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 narratives told by patients in psychotherapy show marked conflicts that generally involve wishes being met with negative responses 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. CCRTs of early memories of parental figures are similar to relationship episodes about other people in the present: a result consistent with the view that the transference template originates in early experiences. The CCRT of narratives of interactions told in dream recall are highly consistent with the CCRT of interactions in the waking state, adding weight to the pervasiveness of the transference template and its unconscious derivatives (Luborsky & Crits-Christoph, 1990). The CCRT is only a relatively new tool, and there are over 40 studies currently in progress utilizing it, extending it, and continuing to assess its validity. The question of importance here is how can we measure if the patient has developed mastery of their problematic transference patterns? Next are reviewed some approaches to looking at such dynamic changes in psychotherapy.

Dynamic changes in psychotherapy

French (1958) developed a reintegrative model of recurrent cycles in psychoanalysis, whereby conflicts are repeatedly activated and attempts are made at their mastery. French discussed how problems in the external world have an internal resonance - just as narratives also contain a blend of reality and phantasy. He wrote that "primary problems in adjustment to external reality and ... secondary problems
concerned with *mastery* of internal pressures ... gives us another criterion by which we can recognize a patient’s successive neurotic cycles. Each cycle begins with a primary problem and continues then with problems of *internal mastery* until the activated pressures are discharged” (French, 1958, p.115-116, my emphasis). This working through cycle is akin to Freud’s comment that analysts must bring the “pathological character-traits” and other daily compulsive recurring phenomena “piece by piece, within the field and range of operation of the treatment” (Freud, 1914, p.151-152)

Pfeffer (1963) conducted a research study utilizing French’s model, involving follow-up interviews with successfully analysed patients. Although the interviews were conducted by a different therapist from the treating analyst, he noticed two striking phenomena. First, the patient approached the interviews as if they were in analysis. Second, the symptoms and transference conflicts dealt with in the original analysis briefly recur. These conflicts do not last for long: “the quick subsidence of symptoms appear to support the idea that conflicts underlying symptoms are not actually shattered or obliterated by analysis but rather are only better *mastered* with new and more adequate solutions” (Pfeffer, 1963, p.234, my emphasis). In other words, the conflicts are not fully resolved or cured, but rather are mastered.

In concert with these findings, the patient’s image of the analyst following analysis is not of a ‘neutrally experienced helpful physician who has given assistance’, as would be predicted by those who maintain that the transference is shattered at the end of successful
analysis (as reviewed a little later in this chapter). Rather, Pfeffer found that the transference remains alive and well, it is just better mastered by the patient.

This mastery is of the form of providing solutions to the repeated conflict: "in analysis repetition is not eliminated, but rather the content or substance of what is repeatable is changed. That is to say, the neurotic repeats the conflicts of the infantile past, whereas the satisfactorily analysed patient in new situations that require mastery is capable, in addition, of repeating the solutions of these same conflicts as achieved in the analysis" (Pfeffer, 1963, p.241, my emphasis). Since Pfeffer was studying long-term analytic patients, it is not surprising that the transference repetitions became recognizably organized around infantile conflicts. Thus a remarkable feature of mastery is the rapid regression and progression from and to infantile conflicts in the service of the adaptive ego functions.

Based on this study, it would seem reasonable to hypothesize that the narratives of successful patients should show similar CCRT conflicts late-in-therapy as early-in-therapy. However, what should change is the mastery of the conflict, such as greater recognition of reality; self-questioning of reactions; greater monitoring and ease of emotional reactions; insight into the past-present transference links. This present study sets out to investigate if this is in fact the case. As Pfeffer notes, the neurotic conflict is repeated "as well as the repetition of the adaptation facilitating resolution of these same conflicts" (Pfeffer, 1963, p.242).
Schlesinger and Robbins (1975) utilized the same research design as Pfeffer, and also found that a 'repetition' in 'miniature' of the analytic process was evident in the follow-up interviews of successfully analysed patients, even when they are interviewed by an analyst unknown to them. They argue against the "analytic myth" that the outcome of an ideal analysis is the obliteration of the transference neurosis, and put forward evidence that the conflicts remain, with the difference that the patient develops mastery over them. They studied in a single case repetitious patterns of conflict and the attempts at mastery that these successively instigated. As the case moved towards termination, the cycles of transference conflict intensified. Towards the end of analysis, a full cycle was evident within a single session. In the six follow-up interviews two years and nine months after termination, all the relationship themes from the analysis were still evident: "The case study demonstrates a persistence of the recurrent pattern of conflicts. It is our hypothesis that such recurrent patterns of conflict remain relatively immutable as a childhood acquisition. They are a unique outcome of the maturational and developmental influences shaping an individual's early experience and are intrinsic to the organization of the infantile neurosis" (Schlesinger & Robbins, 1975, p.776).

However, rather than signalling the analysis' failure, the authors noticed a change in the mastery of the transference template: "The effect of the analysis is not any obliteration of conflict, but changes in the potential for tolerance and mastery of frustration, anxiety, and depression through the development of a self-analytic function" (Schlesinger & Robbins, 1975, p.776). Aspects that the authors consider
part of this self analytic function include - the ability of the patient to self-observe their internal reactions, to question them, and to see the links and connections of their reactions with the past; the ability to control regressive emotions, and understand them when they occur; the ability to acknowledge libidinal wishes that were initially repressed. In sum, the patient’s “ego resources were enhanced for self-analytic work in the mastery of her conflicts” (Schlesinger & Robbins, 1975, p.778).

Crits-Christoph and Luborsky explored the changes brought about in dynamic psychotherapy using the CCRT (Crits-Christoph & Luborsky, 1990a). They reasoned that the repetitive maladaptive relationship conflicts that typify the transference template should become less pervasive over the course of therapy. That is to say, the CCRT pattern (of wishes, responses from others, and responses from self, as discussed above) should become more positive, with a wider range of relationship patterns indicating greater flexibility in emotional responding to conflicts. They hypothesized also that a decreased pervasiveness of conflictual relationship patterns should parallel the reduction in symptoms, since the two are causally related in psychodynamic theory. The individual ratings of two judge’s CCRTs were transformed into standardized categories, then combined with 95% agreement, to form a single CCRT formulation. The five units included in this study were the wish, positive and negative responses from other, and positive and negative responses from self. Pervasiveness was defined as the sum of relationship narratives with identical CCRT patterns, divided by the total number of relationship
This study was thus simply assessing change in the CCRT pattern over therapy - with the hypothesis that the pattern should disperse (ie. become less pervasive) over successful psychotherapy. Thirty-three non-psychotic patients from the Penn Psychotherapy Project were included, with psychodynamic treatment varying between 21 and 149 weeks (median 43) with sessions usually once or twice a week. Early sessions (typically sessions 3 and 5) and late sessions (around the 90% mark, to avoid termination issues) were transcribed and two judges coded the CCRT components. Symptomatic improvement was assessed by a modified self-report Hopkins Symptom Checklist-85, and the clinician-assessed Health Sickness Rating Scale.

The results supported the hypothesis that over the course of dynamic psychotherapy the pervasiveness of negative CCRT components significantly decreases. Not surprisingly, the wishes, which correspond to instinctual needs, did not alter in pervasiveness - 66.3% early-in-therapy versus 61.9% late-in-therapy, indicating that these are relatively stable within the personality. Significant decreases were found in the pervasiveness of negative responses from others (40.7% to 28.5%), and negative responses of the self (41.7% to 22.8%). Significant increases were found for positive responses from others (8.6% to 18.7%), and positive responses of the self (13.4% to 19.1%). These results were by and large related to symptom reduction on the two measures. A striking finding was that despite the decrease in pervasiveness, much of the CCRT patterns were still evident. The dynamic changes were small, with considerable transference patterns evident despite narratives.
symptom improvement. This is consistent with the findings of Pfeffer (1963) and Schlesinger and Robbins (1975) reviewed above, who also found that the transference template remains relatively intact over psychotherapy.

Although the measure of pervasiveness used by Crits-Christoph and Luborsky is highly relevant to dynamic theory, it does not appear to go far enough in capturing the concept of mastery found to be the significant outcome of dynamic therapy by Schlesinger and others. Despite the small but significant changes in the transference patterns evident in the above studies, by and large it would seem reasonable to conclude from this study that transference phenomena are alive and well in the most successfully analysed patients, and that this is not indicative of the failure of therapy. What has not been empirically verified on a large sample is the hypothesized development of mastery.

**Studies of self-understanding**

A second study by Crits-Christoph and Luborsky, this time on a slightly expanded sample (43 patients) from the Penn Psychotherapy Project, investigated changes in self-understanding of transference patterns (Crits-Christoph & Luborsky, 1990b). Self-understanding is an important aspect of mastery. Only two early sessions (generally sessions 3 and 5) were scored. Originally it was hoped to compare these two early sessions with two later sessions, but this was abandoned due to difficulties in deriving meaningful and comparable scores for the later sessions (P. Crits-Christoph, personal communication, 1993).
problem is discussed in greater detail below. Five-point rating scales (0 to very much) were constructed for self-understanding. These were rated on the patient's self-understanding or insight as evidenced in the transcript for the CCRT in general (i.e. their awareness of their transference pattern) and the CCRT towards specific people - the therapist, parents, and two main other people. Each rating was originally divided into the three CCRT components (wish, response from other, response of self) giving three separate scores per rating, but these were averaged to give a single score of self-understanding. Thus, four ratings per patient were made on self-understanding (general, therapist, parents, others). Each session was read as a whole then rated by two judges on the self-understanding scales.

The results suggested that this method of scoring was quite good (intraclass correlation for pooled judges = 0.85). The level of self-understanding in general for these early sessions was generally low (scores around 2.16; with 2.5 being average self-understanding on 5 point scale), and did not differ in any clear way between the two sessions. The data were then further analysed assessing levels of patient symptomatology (measured by Health-Sickness Rating Scale for the two sessions) and improvement in self-understanding between the two sessions. Results suggested that there were no changes between sessions, but that overall level of self-understanding was related to outcome in some analyses.

This study relied on finding a convergence between patient self-statements and CCRT components, and difficulties were found in
coding later sessions. This measure of insight was tied to specific material to do with particular people (i.e., therapist, parents, two prominent others) and after fifty or so weeks of therapy it would hardly be surprising that the content of the material and the specific persons referred to in the narratives would change. It may be, for instance, that the patient and therapist have discussed the transference so often that it is seldom mentioned after 50 sessions. Unless the patient is specifically asked or probed for statements related to insight then it may be that the insight is present but does not come up as self-statements which can be coded. This problem cannot be overcome easily, and threatens any attempts to make content comparisons of self-statements between early and late sessions. The authors suggest that one solution is to study a single content theme throughout a brief therapy.

One approach to this was by Blacker who traced a single memory over multiple instances in therapy using process notes (Blacker, 1975). Blacker found that over therapy the patient shifted from being a passive observer to being an active and insightful commentator, a change attributed to a strengthening of the ego. It might just as well be said that the person's mastery increased.

Another approach, that uses the method of tracing a theme throughout psychotherapy, comes from the Sheffield psychotherapy research group (Field, Barkham, Shapiro & Stiles, 1994). This study relies upon what is known as the 'assimilation model' that hypothesizes change in psychotherapy based on a manifestly cognitive information processing model that proposes that patients need to clarify, understand, synthesize and accommodate problematic experiences into cognitive
The Assimilation of Problematic Experiences Scale has 8 levels: warded off, unwanted thoughts, vague awareness, problem statement/clarification, understanding/insight, application/working through, problem solution, and mastery. Fully assimilated experiences are said to be mastered, which the authors describe as when the "client successfully uses solutions in new situations; this generalizing is largely automatic, not salient. Affect is positive when the topic is raised, but otherwise neutral (i.e., this is no longer something to get excited about)" (Stiles et al., 1992, p.83). This view of mastery involves how much a previously problematic experience can be talked about with ease. It does not address the issue of changes in transference patterns or self-control (even though these may be present), but mainly measures the patient's ability to solve their problem with self-understanding.

Field and colleagues (1994) studied a transcribed single case of psychodynamic-interpersonal psychotherapy of 8 sessions in duration. A problematic theme was selected for study based on the patient's self-reported problems. All passages where the patient discussed the relationship with her mother or some parental theme were extracted for analysis from 4 sessions (1,3,5,7), with 245 passages extracted. These were then reduced to 65 passages on the basis of whether judges could recognize the mother theme within them. These were then evaluated as to how meaningful they were in relation to the patient's core problem, with 24 passages meeting the criteria and used in the subsequent analysis. These 24 passages were then randomly presented to judges to rate on the assimilation scale. Results indicated that, at
least for this theme, there were increases in assimilation as predicted by the model.

The problem with methods that try to trace single themes throughout psychotherapy is the enormous loss of data that typically occurs towards the end of therapy. In other words, the content of the problems that a patient comes to therapy with often changes as the therapy proceeds. Even in a very short therapy of 8 sessions, there was a large reduction in usable passages (from 245 to 24) based on whether or not judges could recognize and score all the required features. This raises questions about how valid and generalizable the results are in terms of the overall process of change. Indeed, with a longer therapy sample (over 50 sessions) Crits-Christoph had to abandon trying to match similar themes. These difficulties will probably always negatively affect attempts to trace literal content themes through therapy. A better approach is to look at changes in the process of how problems are discussed irrespective of specific content, for example, looking at changes in the CCRT pattern is a preferred method rather than looking for relationship episodes about the same person throughout therapy.

Another method of studying self-understanding that has been investigated at Vanderbilt University involves the utilisation of a questionnaire administered to the patient (Connolly, Hollon & Shelton, 1993). Patients are probed as to the degree to which they see their current problems as being related to the past. It thus specifically targets how much a patient understands the links to the origins of their problems, but does not assess awareness of the transference pattern in
the present. Being a questionnaire, it also has limitations as to what
correspondence there is between the responses the patient gives and
how they conduct and understand themselves in real interactions. A
virtue of transcript methods is that genuine interactions and narratives
are unobtrusively recorded in real time.

A recent study by Weiss and colleagues (O'Connor, Edelstein, Berry &
Weiss, 1994) assessed insight over the course of therapy, and found a U-
shaped curve - patients begin with high levels of insight, progressively
loose this insight as therapy proceeds (due to the patient ‘testing’ the
therapist, Weiss suggests), then re-gain it at the end of therapy.
However, this finding may be an artifact, in that the early interviews
and late interviews from this project specifically probed for insight
statements, whereas middle sessions did not (G. Silberschatz, personal
communication, 1993).

*Are transference conflicts fully resolved or better mastered?*

Since a fundamental principle of psychoanalytic technique is analysis of
the transference, it follows that the ideal outcome of therapy should
involve some change in the pervasive negative transference patterns.
There are two major theories of outcome of dynamic psychotherapy.
One holds that transference reactions, particularly those that are
negative and conflictual, are resolved in successful psychotherapy
(Davanloo, 1980; Ekstein, 1956). For example, a recent account by
practitioners working under Davanloo’s methods, states that “This
constant experiencing and linking of conflicts is believed to rapidly
resolve neurotic symptoms and interpersonal patterns” (p. 84) such
that at termination “review shows no residual problems” (p.95) (Laikin, Winston & McCullough, 1991).

The second and more widely held view is that conflicts and transference reactions continue even after successful psychotherapy. In *Analysis Terminable and Interminable*, Freud questioned the extent to which conflicts could be resolved. Freud noted that it was only “the optimists’ expectations ... that there really is a possibility of disposing of an instinctual conflict (or, more correctly, a conflict between the ego and an instinct) definitively and for all time” (Freud, 1937, p.223). Given the dialectical oppositions inherent in psychoanalytic metapsychology, it would be inconsistent to argue that instinctual forces can be eliminated. And on a clinical level, radical changes in personality are only seen in severe psychotic or dissociative disorders, not as the result of successful psychotherapy. Mastery of emotional transference conflicts appears to be the appropriate outcome of psychotherapy, not the unlikely view that psychological tendencies or problems can be cured, in the sense of being entirely resolved and eradicated.

What tends to change in successful psychotherapy is the patient’s ability to “identify cues to recognition of the central relationship problems... since the relationship problems typically reappear in many seemingly different contexts” (Luborsky, 1984, p.124). This involves “structural changes” in personality (Luborsky et al., 1988, p. 158), that is, alterations in the mastery of transference conflicts. Analytic patients seem to internalize the image of their therapist and the kinds of interpretative techniques that the therapist uses to understand psychological conflict
(Meissner, 1981). In short, they develop through the internalization of therapeutic gains the ability to self-analyse. For example, in an empirical study discussed above, Pfeffer suggests that "the intrapsychic image of the treating analyst is used to cathect, comprehend, and comfortably adapt" (Pfeffer, 1963, p.240). This internalization is thus the basis for the development of the ability to self-analyse and to therefore maintain mastery over emotional transference conflicts.

**Conclusions for studying mastery**

There are a number of conclusions that can be made from the above discussion. These are itemised below.

**Overall conclusions, with a focus on design and method**

1. There are no studies that specifically target the study of mastery, seen as self-control and self-understanding, in a unified project.

2. Studying underlying processes appears to be a more effective research strategy than tracing literal content themes.

3. Although there has been a study of the changes in pervasiveness of the transference (CCRT) pattern, no study has looked at the mastery of the pattern.

4. Transference patterns appear to change only slightly over the course of therapy.
5. What appears to change in therapy is the mastery of these transference patterns.

Some clinical signs that appear to indicate mastery

There are some aspects of mastery found in the above studies:

Mastery appears to involve ...

- changes in the potential for tolerance and mastery of frustration, anxiety, and depression.
- the ability to control regressive emotions, and understand them when they occur.
- the ability to acknowledge libidinal wishes that were initially repressed.
- greater recognition of reality and self-questioning of reactions.
- greater monitoring and ease of emotional reactions.
- insight into the links and connections of their current reactions with the characteristic ways of behaving in the past.
- being able to provide adaptive solutions to long-standing transference conflicts.
- the ability to identify cues that activate and maintain the central maladaptive relationship patterns.

The next chapter discusses how the results of this chapter and other chapters were synthesized into the development of the Mastery Scale.
Chapter 6

Development of the Mastery Scale

The previous chapters have located the concept of mastery within current trends in psychotherapy research, the theoretical basis for mastery was developed, the basic factors that make up mastery were presented, and some preliminary observations were made about how mastery might be measured.

This chapter transfers these findings into the development of an empirical measure of mastery. First, the considerations of the past chapters are revisited and brought together. Second, an overall strategy is presented for the development of the scale. Third, the way the scale was constructed is presented. Finally, the scale is described.

Summary of the concept of mastery

Having refined the concept of mastery in the previous chapters, the following is a recapitulation of the most important aspects of mastery to be considered in constructing a scale.
Definition of mastery

Mastery is defined as the development of self-understanding and self-control in the context of interpersonal relations.

Aspects of self-understanding

During psychotherapy, as a result of working through:
- Self-understanding is developed about the transference resistance and other forms of the repetition compulsion in the person’s life.
- Self-understanding is developed about the prior causative trauma or fixation and how these have been active in present relationships through the repetition compulsion.
- Relationships with others will improve through the self-understanding of the distorted and maladaptive transferential repetitive relationship patterns.
- Self-understanding of relationships with others will improve given the greater degree of objectivity obtained following the process of working through.

Aspects of self-control

During psychotherapy, as a result of working through:
- Self-control of the ego is enhanced, probably through the releasing of the energy that had been bound up or fixated.
- Self-control increases as the repetition or acting out behaviours are lessened and new ways of responding in relationships emerges.
• Self-control increases through the enhancing of the ego's power to self-analyse conflict.

General qualities of mastery

General qualities of mastery include:

• the potential for tolerance and mastery of frustration, anxiety, and depression
• the ability to control regressive emotions, and understand them when they occur
• the ability to acknowledge libidinal wishes that were initially repressed
• the recognition of reality and self-questioning of reactions
• the monitoring and ease of emotional reactions
• insight into the links and connections of their current reactions with the characteristic ways of behaving in the past
• the ability to provide adaptive solutions to long-standing transference conflicts
• the ability to identify cues that activate and maintain the central maladaptive relationship patterns

In summary, a person with mastery has a greater sense of adaptive control over their emotional reactions when faced with conflicts in interpersonal relationships and is more able to understand the origins and motives behind these conflicts. A person without mastery blindly reacts with great distress to a wide domain of interpersonal situations without awareness of the sources of their conflicts and problems.
If psychotherapy leads to the development of mastery, it should be possible to measure changes in mastery, and to see the operation of various aspects of that change, by the inspection of psychotherapy transcripts. An important question to be addressed is: what is the appropriate unit of analysis in the investigation of transcripts?

Development of scoring methodology

Selecting the unit of analysis

The first problem facing psychotherapy researchers is in selecting the unit of analysis for empirical investigations. There are many different units, ranging from entire therapies, parts of therapies, single sessions, large passages, turns of speaking between patient and therapist, the first 20 minutes of a session, the first 5 minutes, sentences, clauses, single words, parts of a word (e.g. the endings of words), non-verbal noises and even silences. The unit selected depends primarily on the research question and the best way of approaching that question.

Chapter 2 discussed how a major focus of psychodynamic research centers around the helping alliance and the transference. Common to both these areas of interest is the attention to the patient’s interpersonal relationships and their ability to form and successfully maintain relationships. The principal question of interest in Chapter 4 is how the transference pattern is worked through leading to mastery. Chapter 5 presented in detail how this contemporary research approaches the study of relationships through the extraction and analysis of narratives
of relationship episodes as told by the patient within psychotherapy. This appears to be a very fruitful and dynamically rich source of information (Luborsky et al., 1992). It follows that if the relationship narratives are a fertile source of information concerning the transference, then they should also contain within them information on how well the transference is mastered (self-understood and self-controlled). A **basic necessity in constructing a Mastery Scale therefore, is to take the relationship narratives told by patients in psychotherapy as the primary database for measurement.**

This decision means that the CCRT and the Mastery Scale are measured using the same evidential basis. In contemporary psychotherapy research terms, what is being measured is **mastery of the CCRT.**

**Choosing a rating method**

Having selected the narratives about relationships, the relationship episodes (or REs) as the database, the question arose as to how to use this data to measure mastery. There are two immediately obvious approaches that can be taken. The first is to have judges read each RE and make global ratings of mastery on the passage (on a likert scale, for instance). This first approach has been widely used, for example by the Mt Zion psychotherapy research group in their studies of Mrs C (Weiss et al., 1986). The second option is to derive a measure of mastery by content analysing thought units or sentences. This involves finding patient statements that indicate an aspect of mastery and assigning a score to this statement. This technique has also been widely used, for
example by Gottschalk and colleagues (Gottschalk, 1987; Viney, 1983).

There are a number of problems with judges making global ratings (for a detailed discussion see Strupp, Chassan & Ewing, 1966). The first problem is that judges' ratings can be very unreliable (although certainly not always). This has been found to be the case particularly when rating complex psychodynamic concepts. Because passages present a lot of information, different judges can be influenced by different factors and details that can lead to differences of opinion. Also, because different judges focus on different sections, it could even be argued that they are scoring phenomenologically different passages.

However, under certain situations, using global judgements have proven very useful in psychotherapy research. This has particularly been the case where the size of the data to be scored is small, such as a sentence, or a small passage (as in the symptom-context method Luborsky, in press-b). This is probably because judges can readily see the meaning of the passage more accurately when there are smaller amounts of data. Content analysis requires larger sized extracts in order to derive valid results. For instance, Gottschalk recommends that passages contain a minimum of 70 words to derive valid measurements of psychological constructs using his content-analysis method (Gottschalk, Winget & Gleser, 1969).

A further potential problem with global rating methods is that in order to rate complex dynamic concepts, highly trained psychodynamic clinicians are required. It is not always feasible nor cost effective to have a team of dynamically trained clinicians willing to devote
considerable time to the task of scoring. Even with highly trained judges, there can be divergences of opinion (sometimes heated) between therapists about the definition and meaning of dynamic constructs. What can end up happening is that judges ratings are based on their own projections or phantasies about the meaning. This can be an additional source of error. Weiss et al. (1986) had experienced judges undergo rigorous training involving many practice transcripts in order to try to calibrate their judges to minimize such divergence.

Although this is scientifically legitimate, it can also have the negative effect of creating an idiosyncratic culture of judges who apply shared private meanings of constructs. Although this increases inter-rater reliability, attempts to replicate the results by other research teams may fail because they do not share the same private meanings. This would then call into question the face validity of the findings. One recent example of this involved two independent research teams making dynamic formulations of two psychotherapy cases using the same method, with considerable divergence in the resulting formulations between the two groups (Messer, 1991).

Content analysis avoids many of these problems. Content analysis is like sophisticated data matching: clauses of patient's speech are compared to the pre-ordained scorable units of analysis in order to find matches. By and large, people with a good grasp of the English language can be trained to be reliable raters, without the need to be psychodynamically trained (Gottschalk et al., 1969). Often, the clauses or thought units that can be scored using the content analysis scale are pre-marked, so that judges all score the same pre-identified clauses.
Judges are therefore scoring an identical data base. Because the coding task is highly formalized, inter-rater reliability tends to be very high, and the application of private meanings and idiosyncratic judging tendencies are minimized. Another advantage of content analysis scales is that they remain very close to the content of what the patient actually said. This is in contrast to global measures, that involve higher degrees of abstraction from the actual content.

One important limitation of content analysis is that it is very time consuming, and judges are required to make many thousands of judgements rather than usually under one hundred using the global rating method. There have been attempts to computerise the content analysis rating task, with moderate success (Gottschalk & Bechtel, 1989).

As with any tool, the content analysis scale has to demonstrate good internal and external validity in order for any results produced using it to be meaningful. The CCRT measure uses a content analysis approach, and has demonstrated good concordance with Freud’s concept of transference (Luborsky et al., 1991). One important assumption of content analysis is “that the language in which people choose to express themselves contains information about the nature of their psychological states” (Viney, 1983, p.559). Given this, coding the actual information as it is discussed verbatim increases the proximity of the research tool to the actual psychological constructs of interest.

Because of the demand for high reliability, replicability and validity, content analysis was selected as the appropriate technique to measure
mastery.

Content analysis appears to lend itself particularly well to psychotherapy research, and was already being used in the very earliest years of quantitative studies of psychotherapy process (Auld & Murray, 1955). This is probably because it involves the fine-grained analysis and classification of patient meanings, a central concern of psychoanalysis.

Choosing an approach for deriving content categories

Having chosen to use content-analysis applied to relationship narratives told by patients in psychotherapy, the next concern was to consider how the basic definition of mastery and its indications (discussed above) could be transferred into a content analysis scale. The method selected to make this transition was 'task analysis' - a systematic way of studying the links between data and theory in psychotherapy research. Task analysis is a widely respected method of discovering new ways of doing psychotherapy process research (Rice, 1992). Task analysis is actually highly similar to the method that therapists, including Freud, use to make sense of their patients - by listening closely to what patients actually say and how they say it.

'Task analysis' or the 'events paradigm' is a discovery-oriented approach to psychotherapy research (Mahrer, 1988; Rice & Greenberg, 1984b). The focus is on events occurring within psychotherapy as the proper units of research, that can be studied and documented at the level of the single case. Hallmarks of this approach are (Rice & Greenberg, 1984a):
1. The focus is on recurrent phenomena within the therapeutic hour and across hours and clients.

2. Implicit theoretical or practical interests determine the selection of change processes for study.

3. The research proceeds in a ‘rational-empirical’ fashion, with a zigzag between observations of the data and refinements of formulations and conceptions of underlying processes.

4. The patterns in the phenomena are more important than simply dosage or amount.

5. Descriptive observations take precedence over statistical inference.

6. The client’s operations are the focus of interest rather than therapist technique.

7. Individual differences are not error terms but rather part of the equation in understanding change processes.

8. The processes under study are investigated within their context or surround phenomena.

9. Large scale verification of models is only undertaken once detailed knowledge of the influence of variables is discovered.

According to this approach to psychotherapy research, the identification of variables of interest from tapes or transcripts is not made according to mechanical rules such as the first five minutes, all instances of the word “anger” etc. Rather, passages are selected based on their relevance to the process under study. Thus, the identification relies on the “human integrator” who has the sophistication to understand and identify context, implied meanings and subtle shifts in discourse. As Greenberg states:
Phenomena important to change are easily observable by students of psychotherapy when they directly observe the process of psychotherapy. Concrete phenomena such as avoiding talking about something, anxious or hostile reactions to particular situations, increased self-disclosure, deeper experiencing, and even more abstract phenomena such as transference or insight can all be observed and studied (Greenberg, 1986, p.713).

Similarly, it should equally be the case that mastery should be manifest from the direct observation of therapy transcripts.

**Two pilot study cases**

Having selected the unit of analysis, the method to be used and the general approach to studying the transcripts, two successful pilot cases of dynamic psychotherapy were then transcribed and studied using a task analysis approach.

Both patients were seen in therapy at Northfield's Clinic, the outpatient unit of the Department of Psychology at the University of Wollongong. Both patients were referred to the Clinic by their local community doctors. The first patient (Mrs E) was treated by the author. Mrs E was 35 years old at the time of therapy with a long history of episodes of major depression. The second patient (Mrs F) was treated by a 35 year old female psychotherapist working at the clinic. Mrs F was 22 years old with generalized anxiety disorder. The advantage of having the author in the position of both therapist and researcher on the first pilot case was his great familiarity with the content of the therapy material. The second pilot case afforded the opportunity to inspect a different
case from the perspective of an observer. The author transcribed verbatim both psychotherapy cases. Both patients made large gains over the course of their psychotherapy in symptom reduction and in feelings of well-being.

Ethics approval for the research was obtained from the University Ethics committee (the consent form appears in Appendix 1). Informed written consent for the therapy to be audiorecorded and used in research was obtained from both patients prior to the commencement of therapy.

Transcripts from throughout each therapy, (particularly those early-in-therapy and late-in-therapy) were inspected in detail using a task analysis approach. Relationship episodes were extracted using the recommendations of Luborsky and colleagues (Luborsky, 1990b). Details about transcribing and extracting relationship narratives are given on pages 9 -12 of the Mastery Scale manual in Appendix 2. The relationship episodes (REs) were then divided into grammatical clauses (by inserting a slash ‘/’ to indicate the division of the clause) using established published guidelines (Auld & White, 1956; Gottschalk et al., 1969). The details of these rules are provided on pages 13-14 of Appendix 2.

The transcripts were then inspected in detail and notes were made about the therapeutic patterns evident in the passages. Using the task-analysis approach, a preliminary list of mastery categories, based on the conceptual summaries given above, were written on one sheet of paper, and next to that sheet was put the collection of transcript REs.
Gradually, as each clause and significant passage from the different transcripts were inspected, with notes made about the various psychological states evident in them, the list containing the mastery categories grew. The first discovery using these methods was that statements indicative of mastery were in abundance throughout the material. This was an exciting discovery.

By way of illustration, an unclaused passage where Mrs E discusses aspects of her relationships early-in-therapy is contrasted with an unclaused episode late-in-therapy. $P = $ Patient. $T = $ Therapist.

**Early-in-therapy extract**

$P:$ Silence in seconds : thirty three [(cries hard)]. My husband, everyday he tries to (loud sniff), to make me happy but (breathes out)...(pause) (cries) he is very worried about - [T : he is worried] (very quietly:) yeah (teary voice:) I know he is worried because, everyday I talk with him, and I said “the only thing I want to do is go to Italy” and he says “what can I do?” Um I plead to him everyday - I put pressure, pressure on him. ... And he doesn’t feel (breathes out) (unclear words) because sometimes I see that he is very very quiet and thinking about something. ... And I ask him ... and he says (sniffs) (very quietly:) “I am thinking - what can I do? ... for you? - If I can help you but ... you see now we are very ... and if I ask for another loan it will put more more pressure more” (loud sniff) and ... his job is no - it’s not enough, we have six people in our family. (breathes out) ... And it’s ... it’s very ... you know very ... difficult situation. Sometimes at the end of the (breathes out) ... fortnight we don’t have ... money to buy milk or something like that. ... And (sniffs) my husband says “don’t worry - tomorrow I will go to the bank” “Yeah but we have to pay for things for this and that - and the money is gone again!” ... (sniffs) It’s no ... , very (breathes out) hard to ... to pay for everything (takes tissue) ... it’s very ... [Silence in seconds : sixteen (tears)] Especially when you have children, and everyday the children need something - they need some shoes or, um, from school they ask for money for this, money for that ... and your children and your (quickly:) children say "I need this!" but "I don’t have money" and they say (high pitched:) (loudly:)”go to the bank!”. That is the answer they give ...
T: So you feel that there is, that they have so many needs... it's hard to meet them [P: yeah]... (very quietly:) very hard to meet them and you want to be a good mother and [P: yeah] give them things.

P: Yeah because, that is the other thing that I have been thinking about... Um, when I was a girl, a little one, I didn't have toys, um, I didn't play. ... And I was always like this you see? (tears) And I always thought "if I get married, and I have children, I will never stop them playing - or if they want something - I will try to give it to them" [T: mm] and ... you know ... I don't know, I was thinking like that... and I know, I know when my children ask me for a car or a toy and I can't get, I feel bad !... And so my husband said "if you didn't have toys when you were a little girl it doesn't mean they have to be given all..."

T: (quietly:) So the the needs of your children, when you can't meet them, reminds you again of the pain of when you were young, and what it was like not to have toys and not to be able to play...

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_Late-in-therapy extract_

P: ... on Friday after I came here, I went back to my place, and in the afternoon I tried to talk to my husband. I mean, at night, because he was working on the afternoon shift, and he came back very late on Friday. And we didn't do it. And on Saturday morning everything started. Our conversation started with jokes and things like that, and then we started to talk seriously, and it was good. [T: mm] Um ... I thought he would not understand what I wanted to tell him. Because I didn't know either! I knew the relation and connection here in therapy, and it was new for me, and new for him too.

T: So what did you talk about?

P: Well, we talked - ... (breathes out) (soft laugh) you know, the thing I said to him, um "do you know how my therapist thinks about you?" And he said "what does your therapist think about me?" "Not in you, it is the connection we found, we have found today" And he said "what is the connection?" And I said "I haven't really been thinking about this, but today I have been seeing a new thing. My therapist and I talked, and my therapist
told me - he made me see the connection - but this thing doesn’t mean you are that person - it is just what, the feeling that I have, for that reason.” And I, I, told him what was the connection that we saw. T : Between him and your father ? P : Yeah. And ... he just put his head down and was thinking for a few seconds, or a few minutes, I don’t remember really. And then he said “what is your therapist doing ?” And I said “doing what ?” And he said “I thought he is trying to make you better” And I said, “that is what we are trying to do - feel better, and think in a different way, forget about everything”. Then he said to me “OK I’m so sorry, maybe you are right, maybe you don’t -” Because, I didn’t know my reaction when I get angry with him is ... suddenly [T : mm] so ... he saw, he said to me something like that “I know you can’t control yourself now, but you have to do it, you have to learn to control yourself and and be more polite ! (soft laugh) Not so angry, so irrational when you get angry - you explode ! You don’t know, and you don’t see who is in front of you, who is getting your anger.”

T : He said that ?

P : Yeah. And ...

T : And that is very much along the lines of what we were talking about.

P : Yeah. And then, well, we started talking, and then he said, he said to me “OK, from now on, you are the mother, you are the person who knows when the children need something, or when you need something, and. Make a list, and if we can’t get the things this fortnight, we will the next fortnight ... [narrative truncated here]... because if the children need it, we have to buy it, but, That is not the reason to get angry with me or, ... because I don’t know if you don’t tell me”. I understood him, because that is my problem, I always wait until the last minute to tell him the children need this, that. So at that moment I saw a lot of things. I was wrong, and. And he was, um, different too. He saw everything, maybe, he was wrong, I don’t know, or, but. That day, on Saturday morning, we fixed a lot of things. Everything was - like when you open a window and the sun comes inside, lights all of the house.

These two extracts demonstrate very different moments in the therapy. In the early extract, the patient is clearly distressed by her problems.
She wants to flee from her feelings and expresses a desire to escape to Italy. She is feeling guilty and helpless in not meeting the demands of her children, yet has some realization that the guilt is linked to feelings aroused by her own deprived childhood. She can observe the impact that her emotions are having on her husband, yet remains desperate.

In the later extract, the patient is reporting a significant therapeutic change in her life as a result of an insight gained through therapy. She had been reacting to her husband as if he was her father. This insight has led her to respond to her husband in a new way. The achievement of psychological mastery is experienced as 'when you open a window and the sun comes inside, lights all the house.'

It became clear as many extracts like these were studied that it was important to include in a Mastery Scale not only indications of mastery such as insight, but also indications of lack of mastery. This would make the scale useable across the whole range of levels of mastery - from obvious examples where mastery is very low, to passages where mastery is very high. As discussed in the general outline of mastery at the beginning of this chapter and elsewhere, low mastery involves low self-understanding and low self-control, with the patient typically reacting blindly with great distress to a wide domain of interpersonal situations without awareness of the sources of their conflicts and problems.

In the first extract there are a number of indicators of low mastery:

- She feels a great need to escape (to Italy).
- She is impulsive, pleading with her husband and putting pressure on him.

- She is distressed about the idea of her supplies running out - in this case money, and perhaps her ability to help her children.

- She is clearly unable to control and regulate her emotional life at this point.

- She is unable to benefit at this point from her self-understanding about her own childhood deprivation.

However, there are some aspects of the extract that show higher mastery:

- She maintains contact with her husband and children and can consider their point of view.

- She demonstrates some ability to think about her feelings.

- She can make links between her present situation with her children and her own childhood where she felt deprived, even though this link is not not useful to her at this stage.

It is clear from this extract that patients do not uniformly show either high or low mastery: in fact different levels of mastery can be found within the same passage. This reinforces the importance of using content analysis as opposed to a global rating method. In the global rating method, one judge could conceivably concentrate on the distress, another on the insight statement, and so each could arrive at different scores. In contrast, content analysis allows for all aspects and degrees of mastery to be captured and scored. The variation in mastery level also points to the complexity of the mind within Freud's theory: whereas
some aspects are clearly within the bounds of the ego (e.g. the link with her childhood), other aspects show a falling away of links and 'unbound energies' (e.g. the impulsiveness).

In the second extract, from the sixty-eighth hour, there are a number of indications of high mastery:

- She is clearly showing self-control in the passage involving jokes, and the conversation with her husband.
- She is able to integrate and internalize the therapists' interpretations and work through them.
- She has self-understanding into a repetitive pattern involving the transfer of feelings about her father onto her husband.

Clearly then, on the basis of the evidence from these passages, there has been a considerable shift in mastery from early to late-in-therapy. Although these passages are widely contrasting, it was found that others are often in the 'middle' of mastery. That is, they are struggling with their difficulties and making some progress, but have not yet achieved complete self-understanding or self-control. The following extract, from Mrs F's therapy, demonstrates this middle ground.

T : And the incident with Auntie Dee has compounded things

P : Oh um, we haven't heard from her for a couple of days and Nan went around this morning and told her to come around and talk to me and get it sorted out. Because I didn't want to go around there, because Janet was there ... probably (unclear words) flew off again ... so Auntie Dee came around and we had a bit of a talk but - it's not, it's not resolved really. It's not back the way it was before we had the argument. But, we talked about it and ... she doesn't like to talk about things, she just likes to forget about it. I, I do too, to a certain extent, but I can't pretend that it never
happened. She is the type of person - she hasn’t rung or come around since it has happened. She is the type of person that would leave it a fortnight and then come around as if nothing had happened.

T: This is what Janis said on Wednesday, isn’t it?

P: Yeah yeah, so she hasn’t been around or rung. Rung anyone, not even the rest of the family. And Nan just went around there this morning, because she has been really worried and upset the last couple of days. So she went around and told her to come around. When she came around she just walked in and sat down. She didn’t want to say anything - I had to talk to her and I - and when I started she said “I’d rather just forget about it” and I said “I would too, I’d rather forget that thing happened but we sort of got to talk about it a bit, and then once we have talked about it then we can leave it”. That was very frustrating, not - waiting these last couple of days - not knowing what was going on, what was happening. And I felt really, I don’t know, at loose ends I suppose.

T: You felt angry?

P: Mm, angry, I was more upset at first but as ... the last few days have gone on, I’ve got more and more angry about it. ... I was cranky at her - for not coming around and talking to me about it.

T: Not giving you the opportunity to say what you wanted to say

P: Yeah, yeah, I was getting madder at her, thinking - “she’s she’s got no right to... to start something and then just - to start a fight and then walk away and leave it” and I was ... oh ... I didn’t, when we had the fight I really didn’t get to say anything because I was too upset. And those two were yelling. And, well I - even when the fight happened I didn’t really say anything. And, she came around and had her say and I didn’t really get to - to say my say, and the last ... first I was upset because it happened and I just wanted to fix it and the last two days ... you know, her not coming around - it’s sort of building up and building up and when she came around this morning, and she was gone, I was glad that we had done it. And got it over with. And now we can sort of ... just try and go on.

T: So what did you get over? How did it help you?

P: Well, I was scared about talking to her.

T: Because?
P: I don't know, I just was ... I felt

T: That you would be rejected or was it - was that what it is?

P: Well, a bit of that and bit of - that we'd have like another fight. And (unclear words) trying to smooth it over. And ... well I'm, I'm not really that type of person either. I don't like confrontations ... I'm a bit like Aunty Dee, and I can understand how she feels, sometimes I'd rather just forget about things ... but something that big you just can't leave. Otherwise things - well they just won't be the same. You have to ... I need to talk about things but I'm scared about doing it and I find it hard to do it ... I know myself - if I don't - if I didn't - ... even though I was scared, I knew that it was ... I had to do it, and I had to make myself do it ...

T: So what were you scared that might happen?

P: Well, that we would have another fight, or, or she wouldn't believe what I was saying ...

T: Wouldn't believe what I was saying, because she wasn't believing you last time, was she? [P: no] If people don't believe you, what do you feel?

P: (very quietly:) (pause) um, that like I am lying or (unclear words)

T: You feel that you are lying because -

P: - what they would think - that I was lying (spoken together with therapist)

T: - that you were lying yeah.

P: and ... I know that I wouldn't lie over something like that, with Auntie Dee, and ... just the fact that you are being really honest - and they, they don't believe you -

T: So what is the feeling you have, when you are in that situation?

P: Frustration. (pause) Upset, and just ... feel ... I don't know, like you can't ... can't cope or ... (pause)

T: Cope with what?

P: With her not believing me.
The overall picture here is of the patient struggling with her interpersonal tendency to avoid confrontations that so obviously distress her. She is angry at how the other person is avoiding the issues, but recognizes that she herself has a similar pattern of reacting to interpersonal difficulties. Although having some insight into both her and the other person’s pattern of relating, she does not feel in control of the situation. She clearly struggles to master her feelings, but nevertheless is persecuted by her perception that the other person harbours negative thoughts towards her.

This passage shows evidence of quite a range of mastery levels. Quite good mastery is shown by:
- Her self-understanding of her repetitive tendency to avoid confrontations.
- Her awareness of the interpersonal nature of the difficulties.
- Her considering the other person’s point of view and weaknesses in the situation.
- Her struggles to improve the situation.

Instances where she shows lower levels of mastery include:
- Her interpersonal avoidance.
- Her feelings of being persecuted by the other.
- Her inability to think or assert herself during one episode.

In constructing the Mastery Scale, it became apparent from these samples that there needed to be a broad coverage of different levels of mastery in the scale. Lower levels should relate to failures of mastery
manifested by problems such as cognitive disturbances. Middle levels should relate to the struggle to improve, such as self-questioning perceptions of relationship conflicts. Higher levels should demonstrate mastery, for example having awareness of one’s transference patterns and being able to derive pleasurable experiences from relationships.

The content and different scoring levels of the Mastery Scale

Given the different levels of mastery observed, it was decided to try to construct the Mastery Scale by fitting different concepts into different levels. The importance of a middle level is the shift from a focus on the person’s distress to the interpersonal aspects of their situation. That is, at the middle level, the person begins to consider other perspectives and points of view about the problematic relationship episodes, and this shows a level of maturity of ego functioning not present in the lower level. Since a crucial focus of psychotherapy research is on relationship factors in psychotherapy, it is significant that the middle phase of mastery involves the intense scrutiny of interpersonal perceptions and styles of relating. The shift from middle functioning to high mastery occurs following the successful working through of the middle phase. Self-understanding is gained through observing the self and others in many different interpersonal conflicts. This leads to a greater sense of adaptive control both emotionally and intellectually in relationship situations.

The Mastery Scale went though approximately twenty-seven editions over an intensive four months of full time development. During pilot testing, some important factors emerged. From the beginning it was
hoped that the regulation and control of emotional life could be distinguished in the transcripts from the expressions of intellectual cognitions (ie. a "feel" versus "think" distinction). However, judges found it almost impossible to distinguish the emotional from the intellectual when analysing transcripts. In other words, the two elements were welded together in the way patients discussed their problems. One upshot of this discovery was a confirmation that what was being studied was mastery, not the independent and separate contribution of self-understanding and self-control.

As the scale developed, an explicitly object-relations and interpersonal focus ensued. This arose naturally out of the interest in focussing on the interpersonal (transferential) patterns of relating and how the patient was experiencing their relationship with others and responding to it. Within this was a sensitivity to the components of the CCRT - the responses of others and of the self in relationships. Because the mastery measure was explicitly about the self (self-understanding, self-control), it was decided to only code references to the self and obvious indications of self functioning. Intrusions into the relationship episode by others (e.g. by direct quotations made by the patient of others' speech) were not coded. What was coded however, was how the patient attempted to process and understand these other points of view.

A summary of the final scale appears below. The full Mastery Scale (Grenyer, 1994) and manual for use appear in Appendix 2 and represent an important part of this thesis. The assignation of numerical values to the content categories, from 1 to 6, was made slowly over the entire period of the scale's development. The combination of a theoretical
background and a close inspection of the psychotherapy process in the transcripts helped to guide what weight was given to each category. As discussed in Chapter 4, Freud makes it clear that self-control is of greater value the self-understanding alone. Therefore, the self-control categories tended to be given a score of 6 and the insight items a score of 5 to reflect this position. For convenience, the six levels of the scale were then given their own name to help show the hypothesized direction of mastery. The six levels are:

1. **Lack of impulse control.** This is where the instinctual energies are clearly in an unbound and unmastered state.

2. **Introjection and projection of negative affects.** This is where the energies overwhelm the ego and are channelled into the defenses or are split off into projections (Freud, 1940).

3. **Difficulties in understanding and control.** This is where the ego is particularly focussed on the process of working through.

4. **Interpersonal awareness.** Here the ego has enough resources to begin to respond more maturely within the interpersonal sphere.

5. **Self-understanding.** Awareness is gained about repetitive personality patterns and their historical precedents and contemporary manifestations.

6. **Self-control.** Emotional and intellectual regulation within interpersonal relationships is achieved. In Freud’s terms, a person at this level can successfully ‘love and work’ - the two hallmarks of mature functioning.

A central assumption of the scale is that the 'psychological' distance
between each level is constant, and that therefore the scale is parametric and linear. The justification for this assumption rests upon the fact that all other reputable and validated content analysis scales of this type make the same assumption (for reviews, see Gottschalk, 1987; Viney, 1983). Arguments for and against this kind of assumption, and what constitutes 'permissible statistics', are the subject of debate amongst statisticians (Lord, 1953; Michell, 1980) With no obvious resolution or recommendation either way in the debate it was considered reasonable to adopt the assumptions of previous content-analysis procedures.

Scoring the Mastery Scale

There are a number of approaches to scoring content analysis scales, with each carrying different assumptions about the underlying constructs embedded in the transcripts. Common to almost all approaches is the assignation of a single content category per scorable clause. Having assigned categories to the clauses that are scorable within an extract, the problem is how to accrete the scores. All methods must somehow derive a mean or corrected score - in other words the raw sum of scores is divided by a correction factor that standardizes each scoring occasion (ie. each psychotherapy transcript extract).

The simplest method is to simply sum the scores and take the final score as the data point. This method is used in the 'counting signs' method of scoring the helping alliance (Luborsky, Crits-Christoph, Alexander, Margolis & Cohen, 1983). The assumption behind this
method is that a transcript is much like a questionnaire - all that is required is the add up the scores. Unlike questionnaires, however, that have a set number of questions, in psychotherapy transcripts there is the potential for great variability in the number of 'questions' or instances indicative of the helping alliance. The way that this method tries to get the denominator equal to 1 is by having a uniform period of time in which the measure is rated: usually the first 20 minutes of the therapy. That there is variability in how much each patient talks within 20 minutes (some talk very fast, others very slowly) is ignored by this measure. The significance of the number of words spoken is that the greater the number of words, the more chance there is of finding scorable helping alliance content. The helping alliance scale treats this variable as random error. Although not entirely a psychometrically sound method of scoring, it is simple, has obvious appeal, and appears to differentiate good from poor helping alliances.

A second method, that devised by Gleser in collaboration with Gottschalk (Gottschalk et al., 1969), is to take the number of words spoken by the patient as an important moderator of the raw summed score. The Gottschalk-Gleser 5-minute speech sample scales are designed to measure transitory psychological states, and therefore the most important variable is the quantity of the state (such as anxiety) within a known number of words. In order to get a valid measure (i.e. enough chances of detecting the signal among the noise), a minimum of 70 words is required per sample. For technical reasons, in this method 0.5 is added to every score, but more importantly the entire result is subject to a square root transformation to correct for skewness. The aim is to reduce the correlation between the number of words
spoken and the affect score to zero.

An alternative method, and one that was devised for the Mastery Scale, is to correct the raw summed score in a different manner. Mastery is more a trait-like personality measure (it investigates repetitive ways of interpersonal relating) rather than a fleeting psychological state. Therefore, the measure should be relatively independent of the number of words spoken. It is irrelevant to this particular measure if a patient talks for five or ten minutes on a topic and gives no indication through their speech whether or not they have high, low or moderate mastery. What is important, however, is what level of mastery is displayed in those passages that do contain information on mastery. It was therefore decided to sum the mastery scores and divide by the number of scored clauses. This method therefore isolates those clauses that contain information on mastery and only scores those. The word count is irrelevant in this context.

The formula therefore provides the mean Mastery Score:

\[
\text{Mastery Score} = \frac{\sum x}{N}
\]

Where:
\[
\sum x = \text{the sum of the values of the individually scored clauses in the sample.}
\]
\[
N = \text{the total number of scorable clauses in the sample.}
\]
Mastery Scores can then be combined and contrasted in various research designs within and between subjects. The use of the Mastery Scale in different contexts depends, as in all scientific research, on the quality of the raw data collected, the adequacy of the design, and the appropriateness of the methods of statistical evaluation employed and conclusions drawn.

Individual sub-elements of the Mastery Scale can be investigated. Frequencies of Mastery Scale categories can also be computed and profiles of categories within and across subjects can be graphically represented and interpreted.
The final Mastery Scale

The Mastery Scale was then considered complete. Each category appeared to be clear and to be easily applied to the transcripts. There did not appear to be overlap between the categories. The transcripts inspected did not contain indications of mastery that could not be coded into one of the 23 categories. The scale appeared to have face validity in terms of coding mastery as understood from the definition of mastery and the general theoretical principles underlying the concept as outlined at the beginning of this chapter. The categories in Level 5 and 6 of the scale closely paralleled the outline of mastery in Chapter 4. This did not happen by accident, since the construction of the scale using task-analysis proceeds in a hypothetico-deductive fashion with a theoretical outline of the phenomenon to be studied guiding the search and discovery of the empirical categories. The close relationship between the theory and the final scale is illustrated in Table 6.1, with focus on Level 5 and 6. The final Mastery Scale appears in Appendix 2. The next chapter details the empirical test of the reliability and validity of the Mastery Scale by applying it to a sample of 41 patients from the Penn psychotherapy research project.
Table 6.1. The relationship between the psychodynamic theory of mastery (outlined in Chapter 4) and the empirical measure of mastery (Chapter 6). Data is presented for Level 5 and 6 of the scale, that focus on self-understanding and self-control.

<table>
<thead>
<tr>
<th>Theoretical Summary (Chapter 4)</th>
<th>Mastery Scale category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-understanding is developed about the transference resistance and other forms of the repetition compulsion in the person’s life.</td>
<td>5Q. Expressions of insight into repeating personality patterns of self</td>
</tr>
<tr>
<td>2. Self-understanding is developed about the prior causative trauma or fixation and how these have been active in present relationships through the repetition compulsion.</td>
<td>5R. Making dynamic links between past and present relationships</td>
</tr>
<tr>
<td>3. Relationships with others will improve given the self-understanding of the distorted and maladaptive transference repetitive relationship patterns.</td>
<td>5S. References to interpersonal union</td>
</tr>
<tr>
<td>4. Self-understanding of relationships with others should improve given the greater degree of objectivity obtained following the process of working through.</td>
<td>5T. Expressions of insight into interpersonal relations</td>
</tr>
<tr>
<td>5. Self-control in the ego is enhanced through the releasing of the energy that had been bound up in the fixation of the id to an object.</td>
<td>6U. Expressions of emotional self-control over conflicts</td>
</tr>
<tr>
<td>6. Self-control increases as the repetition or acting out behaviours are lessened and new ways of responding in relationships emerges.</td>
<td>6V. Expressions of new changes in emotional responding</td>
</tr>
<tr>
<td>7. Self-control increases due to the enhancing of the ego’s power to self-analyse conflict.</td>
<td>6W. References to self-analysis</td>
</tr>
</tbody>
</table>
Chapter 7

Reliability and Validity of the Mastery Scale

Having constructed a Mastery Scale based on psychoanalytic theory, a crucial step is to subject it to empirical evaluation. This chapter represents the culmination of the second major aim of this thesis, which is:

2. To develop an empirical measure of mastery (the Mastery Scale) and evaluate its reliability and validity as a measure of therapy process and outcome.

There are three hypotheses to be tested:

H1 That the Mastery Scale can be reliably applied by judges working independently with good inter-rater and test-retest reliability.

H2 That the Mastery Scale will demonstrate good internal consistency.

H3 That patients rated as showing greater gains in mastery will have larger gains on measures of general psychological health-
sickness and reductions in symptoms than those patients showing fewer gains in mastery.

The first two hypotheses concern whether or not the scale is technically sound and can be reliably applied. The third hypothesis is more central to the psychoanalytic theory of clinical change. The process of change in psychotherapy according to psychoanalytic theory was presented in Chapter 4. The process was described as one of mastering the conflicts, with the outcome being a high level of mastery. It follows that patients who show gains in mastery should also improve on objective ratings of psychological health-sickness (Luborsky et al., 1993a). The assessment of the validity of the Mastery Scale is also a test of the psychoanalytic theory of clinical change. Luborsky and colleagues noted in relation to the 'dodo bird' finding that all psychotherapies have equivalent outcomes (discussed in Chapter 1), but that the measures of outcome typically employed were not designed to measure specific types of psychodynamic changes:

The outcome measures may not be representative of the treatment's intended outcomes. The most typical example is dynamic psychotherapy: the therapy emphasized the development of insight, yet its outcomes are typically measured by global ratings of improvement - which may neglect changes in insight. The usual outcome measures also do not make an adequate distinction between short-term and long-lasting improvement, nor do they make a distinction between the parallel related changes referred to as nonstructural and structural change. A structural change is one that makes a long-lasting change in a central component of the transference. (Luborsky et al., 1993b, p.510)
The Mastery Scale has been designed to overcome these shortcomings. It measures both changes in insight and self-control in relation to basic interpersonal transference patterns contained within narratives of relationship interactions.

Given that there are a number of widely used and accepted outcome measures (McCullough, 1993), it was decided to compare the ratings of change in mastery from early to late-in-therapy with changes in health-sickness, as measured by the Health-Sickness Rating Scale (Luborsky, 1962; Luborsky, 1975) and with the patient’s ratings of change on their target complaints (Battle et al., 1966). A number of other comparative outcome measures were also used, as described below. This research design ascertains whether the Mastery Scale is measuring the kind of change that is recognized by researchers, clinicians and patients as being clinically meaningful. In short, if mastery is a key psychodynamic change variable, it should lead to and be associated with broad changes in global mental health and symptomatic improvement.

**Method**

The investigation of changes in mastery over the course of psychotherapy was conducted *ex post facto* from the verbatim transcripts of 41 patients from the Penn psychotherapy research project (Luborsky et al., 1988). The patients were seen in therapy in the American city of Philadelphia between the years 1968 and 1973. The conduct of the psychotherapy and its initial outcomes was funded by a 5
year National Institute of Mental Health research grant to Lester Luborsky and Arthur Auerbach.

Subjects

Forty-one patients (29 females, 12 males, mean age 25 (range 18-48)) were chosen as a representative sample from 72 patients comprising the Penn Psychotherapy Project (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). These forty-one patients comprised ten of the most improved patients, ten of the least improved, and twenty one middle patients. The sample has been used in a number of previous psychotherapy research studies (e.g. Luborsky & Crits-Christoph, 1990; Luborsky et al., 1988). Twenty-six patients were single, 7 were married and 6 were divorced or separated. Five had graduated from high school only, 19 had completed some college education, 6 had completed college and a further 11 were undertaking or had completed a graduate degree.

The sample had a mixed diagnostic picture according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (3rd ed.; DSM-III, American Psychiatric Association, 1980). Fifteen had primary diagnoses of Dysthymia and 11 Generalized Anxiety Disorder, while the rest of the primary and secondary diagnoses were mainly Cluster A (8 schizoid, 3 schizotypal), Cluster B (4 histrionic, 1 narcissistic) and Cluster C (3 compulsive, 3 passive-aggressive) Axis II personality disorders.
Psychotherapy Treatment

Treatment was based on weekly individual time-unlimited 'supportive-expressive' psychoanalytic psychotherapy (Luborsky, 1984) within a mean treatment length of 54 weeks (range 21-149 weeks). Therapy was conducted by 31 psychiatrists (mean age 36, range 26-56). Of these, 17 were residents, 9 had up to 10 years post-residency experience and 5 had more than 10 years experience. The residents saw their patients in an outpatient clinic, and the post-residents saw their patients in private practice. Thirty of the therapists were married and 23 had children.

Judges

Four judges scored the Mastery Scale. Two judges were clinical psychologists, one judge was a doctoral level research psychologist and one was a doctoral level psychoanalytic theorist. Judges were paid an hourly rate for scoring. Judges were trained on a set of practice transcripts (see pages 61-95 of the Mastery Scale scoring manual in Appendix 2). Each judge scored a transcript independently, and then scores were compared and discussed at a round table meeting. Then the next transcript was scored and compared, and so on through all practice transcripts. This process took approximately 5 and a half hours to complete. By the end of this process, judges were in agreement for greater than 90% of the time for each scorable clause.
Psychotherapy transcripts

Verbatim transcripts of psychotherapy sessions collected during the Penn Psychotherapy Project formed the data base. The transcripts were made for earlier studies (Luborsky et al., 1988). For each patient, these were from early-in-therapy (generally sessions 3 and 5) and two or three transcripts from late-in-therapy (at the 90% completion mark).

By evaluating transcripts from early and late, it should be possible to detect any changes in self-understanding and self-control in the narratives over the course of therapy. Transcripts from the very first sessions and very last sessions were avoided. Early-in-therapy, the first couple of sessions are often more constrained and involve a deal of fact finding and information giving. By the third session, patients usually are at the stage where they can comfortably narrate relationship episodes that contain their conflicts. Late-in-therapy, patients are having to come to terms with the termination of the relationship with the therapist, and this can bring forward a temporary return of symptoms and problems. Therefore, sessions 3 and 5 and sessions at the 90% mark (and the sessions immediately before this) were used (Luborsky et al., 1988).

Narratives of interactions called relationship episodes (REs) served as the scorable units of analysis of mastery as discussed in Chapter 6. Relationship episodes had been identified from the transcripts of early and late sessions in an earlier CCRT study (Luborsky & Crits-Christoph, 1990). There were usually 10 REs from early-in-therapy and 10 REs from
late-in-therapy for each patient.

*Procedure for scoring the Mastery Scale*

The REs were cut out from the transcripts and randomized between sessions and patients. This was to prevent judges having other cues as to the progress of the patient in therapy. The aim was for each RE to be scored on its merits, uncontaminated by prior knowledge. A random number code was given to each RE prior to randomization so that the data could be reassembled into the original order after judges had completed scoring.

The REs were divided into grammatical clauses by marking off the claed speech units with a slash ‘/’ according to the conventions adopted by Auld and White (1956) and Gottschalk, Winget and Gleser (1969). See Appendix 2 pages 13-14 for detailed rules for clasing transcripts. The following is an example of three marked clauses, with mastery scores in parentheses: /I'm afraid of myself, (2E) /because it's a father-lover sort of thing. (5Q) /It's also this hangover from when I was real young. (5R) /.

To facilitate the process of scoring, one judge read all the REs and identified all the clauses that could be scored using the Mastery Scale, a technique also used in CCRT research to control for location or position disagreement (as opposed to scoring disagreement). This judge completed this task after the data had been randomized, so there were no clues as to which patient the RE came from nor whether the RE was from either early or late-in-therapy. The judge completed this task after
having read and claused the entire RE.

These scorable clauses were consecutively marked with a number next to the first slash. e.g. /$^1$I'm afraid of myself /$^2$because it's a father-lover sort of thing. /$^3$It's also this hangover from when I was real young/. A blank sheet of paper with numbers running down it in columns was used to record the judge's mastery scores. The mastery score was written next to the number corresponding to the clause on the coding sheet.

The usual method of scoring by a content analysis is to have judges write the score immediately above the relevant clause on the transcript. This method has been used throughout the Mastery Scale manual in Appendix 2. However, since each RE was scored twice, this would have meant having two copies of each RE (one for each judge) which proved impractical given the huge size of the data base (running to many thousands of pages). Therefore the numbering method was used since this meant that only one physical copy of each RE was needed.

All the REs were scored twice using the Mastery Scale. Each RE was independently scored by two of the pool of four trained judges. Each judge was given a random portion of the total number of REs to score. No individual judge scored the same RE twice. Judges were blind to which patient told the RE, when in therapy it occurred, and the treatment outcome status and other clinical variables. In fact, the outcome data were only made available from Philadelphia once the entire data base had been scored. One of the 23 mastery categories from 1A - 6W was assigned to each of the codable clauses by the judges.
Each of the 23 category choices comes with its own built-in score (1-6) representing one of the six levels in the scale. These scores were used in the compilation of statistics. Mastery scores were calculated for each RE by summing all the scores and dividing by the number of scorable clauses to arrive at a mean mastery score per narrative (see details of this method in Chapter 6). These scores were then used to calculate average levels of mastery for each patient early and late-in-therapy.

Outcome measures

Outcome measures were collected at the commencement and termination of therapy as part of the original Penn psychotherapy project (Luborsky et al., 1988). Because the original Penn study was concerned with predicting outcomes, a large number of variables were collected. The authors of the Penn study made a number of composite measures, which combined a large number of the predictive outcome measures into single variables. Although this suited the purpose of the Penn study, for the present study it was considered important to select a few well known and widely used outcome measures. This would facilitate reviewers of the research in making judgements about the findings based on familiarity with these measures. The measures selected were as follows:

1. The Health-Sickness Rating Scale (HSRS) (Luborsky, 1962; Luborsky, 1975) was one of the first scales designed to predict and measure the outcome of psychotherapy. It has had over 45 years of continuous use since its inception at the Menninger Foundation, Kansas, in 1949. It is a
clinician-rated measure of mental health based on an interview. It is usually assessed prior to, and following the end of psychotherapy. It consists of eight graphic 100 point scales: one global scale and seven specific scales: (a) the ability to function autonomously; (b) seriousness of the symptoms; (c) subjective discomfort and distress; (d) effect on the environment; (e) utilization of abilities; (f) interpersonal relationships; and (g) breadth and depth of interests. The global scale is the most often used in research, and has been slightly modified to form the Global Assessment of Functioning (GAF) (also known as the Global Assessment Scale or GAS) (Endicott, Spitzer, Fleiss & Cohen, 1976) - which forms Axis 5 of DSM-IV (American-Psychiatric-Association, 1994). Yet the mean of the eight subscales of the HSRS is more reliable than the single-item global scale (Luborsky & Bachrach, 1974). It was therefore decided in this study to use the mean of the eight subscales as the measure of psychological health-sickness (PHS) (Luborsky et al., 1993a). This mean has an internal consistency (Cronbach’s alpha) of “.87 pretherapy and .92 posttherapy” (Luborsky et al., 1988, p.88) The HSRS has shown good concurrent validity in a wide range of studies (Luborsky & Bachrach, 1974). For example, a factor analysis of 14 patient predictor variables showed that the HSRS was related to interpersonal relationships (.93), level of psychosexual development (.89), anxiety tolerance (.82), and ego strength (.79) (Kernberg, 1972).

2 & 3. The Prognostic Index - Control and Insight ratings (PI-control; PI-insight) (Auerbach, Luborsky & Johnson, 1972; Luborsky et al., 1988). Since the Mastery Scale incorporates self-control and self-understanding, it was decided to evaluate its relationship with a clinician-rated measure of self-control and insight evaluated at the
beginning and end of therapy. In this measure, a clinician interviews the patient and then rates 29 areas that are believed to be related to outcome. In a factor analysis of the index on 47 patients, insight was found to loaded .67 with the ‘patient’s aptitude for psychotherapy,’ and self-control .46 with ‘general emotional health’ (Luborsky et al., 1988, Table 7-5). It was decided to use these two measures, not as predictors of outcome, but as independently-rated global measures of insight and control that could help to understand aspects of the Mastery Scale.

4. Therapists’ rating of patient satisfaction, success and improvement (SSI). It was felt that a rating by the therapist, a primary participant in the therapy, would be a valuable addition to this validation study. The measure used was a composite of three ratings, all highly similar, that the therapist was asked to make at the end of therapy. They were ratings of patient “satisfaction” (Rogers & Dymond, 1954), “success” (Rogers & Dymond, 1954), and “improvement” (Luborsky, p. 233 in Waskow & Parloff, 1975).

5. The therapist’s rating of the patient achieving insight (TInsight). This was a likert-scale rating made by the therapist at the same time as making ratings of success, satisfaction and improvement. It was evaluated for the same reason as the prognostic index rating of insight: it could overlap to some degree with the Mastery Scale rating since an important component of the Mastery Scale is the patient’s insight.

6. Target complaints (Target) (Battle et al., 1966). In this measure, the patient is asked at the initial interview to name three problems with which they most want help. At termination the patient is then asked
to rate the change in severity of these three target complaints. It was
decided to use only the primary problem nominated by the patient,
since this is usually the central issue that the patient wants to change
during psychotherapy. Although some have criticized the method for
its lack of standardization (Mintz & Kiesler, 1982), its appeal has been
the fact that it personalizes the patient’s own goals in a way meaningful
to them.

7. **Symptom Checklist (SCL)** (Derogatis, Lipman, Covi, Rickels &
Uhlenhuth, 1970). The Hopkins Symptom Checklist (an early version
of the more contemporary SCL-90-R) was used as a patient-rated
measure of overall symptomatic improvement. The scale was
administered at intake and termination. It is widely used, and has
demonstrated adequate reliability and validity in many studies (e.g.

Of the seven measures used, therefore, four target general changes in
psychological health-sickness (HSRS, SSI, Target and SCL) while two
rate insight (PI-insight, TInsight) and one rates self-control (PI-control).
There are three ratings made by an observer (HSRS, PI-insight, PI-
control), two by the therapist (SSI, TInsight) and two by the patient
(Target, SCL).

**Data analysis**

1. **Inter-rater reliability.** Since the unit of analysis is the RE, the
resulting average mastery scores for each RE per judge were compared.
Pearson correlation coefficients were computed between each pair of judges. MINITAB (Ryan, Joiner & Ryan, 1990) was used to convert the raw Mastery Scale data into average levels per RE, and STATVIEW 512+ (Feldman, Gagnon, Hofmann & Simpson, 1988) was used to calculate the correlation coefficients.

2. Test-retest reliability. To assess the stability of scoring the Mastery Scale, 5 REs that Judge A and C had both scored were randomly selected and presented to them again 3 weeks after they had initially scored them. There were 45 individual clauses to be scored in total across the 5 REs. The correlation between their initial and retest scores per clause was calculated as the measure of test-retest reliability.

The same procedure was used to assess the test-retest reliability of Judge B and D, using 5 REs scored in common (representing 51 individual scored clauses). Reliability was calculated clause by clause, i.e. across all 23 categories of the scale.

3. Internal consistency. Proximities analysis was used to investigate the relationship between the 23 Mastery Scale categories. Of chief interest was whether or not the categories clustered together in a way as hypothesized by the assignation of the scores 1 to 6. This is a test of the internal consistency of the scale, i.e. whether the categories actually fit into the purported 6 levels of mastery. For example, if category ‘6W - References to Self-Analysis’ was regularly found in REs with categories 1A, 1B, 1C and 1D (the lowest hypothesized level of mastery), then this would bring into doubt as to whether ‘References to Self-Analysis’ actually deserves a mastery score of 6 - perhaps it is more associated with scores of 1, i.e. very low mastery.
The method used to investigate this was as follows. Each RE was investigated in turn, and a '1' was given to represent one or more appearances of a category. If the category did not appear (was not scored) in that RE it was given a '0' (zero). In other words, '1' indicates the presence of a category and '0' indicates its absence. This was thus a binary analysis. It was hypothesized that categories that are similar (proximate) in mastery level should cluster together, and categories that are remote (distant) in mastery level should appear together rarely.

In psychotherapy terms, patients who show low mastery should have many instances of low mastery categories in their REs, and should not have mixed in with that lots of high mastery categories. Although for each individual case there will probably be a diverse scatter of mastery categories, overall the global trend across all patients and all REs should be for the categories to appear in the hypothesized levels appearing in the Mastery Scale.

The similarity measure used was Phi, which is the binary form of the Pearson product-moment correlation coefficient (SPSS-X, 1988, p.831). It is argued that a cor relational method is the most appropriate and robust statistic for making comparisons between complex RE patterns. The data were converted into binary form using MINITAB (Ryan et al., 1990) and analysed using the CLUSTER module (using average linkage between groups) and PROXIMITIES (Phi) modules of SPSS-X. Results were presented as a dendrogram (tree diagram) showing the relationships between the mastery categories.
4. Change in mastery over therapy. A paired (repeated measures) t test was used to investigate changes in overall mastery from early to late-in-therapy. An estimation of the clinical significance of this change was made by calculating an Effect Size estimate.

5. Relationship between mastery and the outcome variables. Following the recommendations of various authors (Fiske, 1971; Kazdin, 1994; Luborsky et al., 1988; Manning & DuBois, 1962), residual gain scores were calculated for those measures where there were early and late evaluations (mastery, HSRS, SCL). The residual gain score takes into account the extent to which the gain is related to the severity of the patient's problem at intake. For example, a patient whose problem is very severe at intake has potentially a large amount that can be gained in order to reach optimal functioning. In contrast, a patient who is only mildly symptomatic can only improve by a small degree to reach optimal functioning. The residual gain score takes this difference in initial level into account, and is appropriate for correlational designs such as the present study. In other studies that compare treatments using analysis of variance, it is appropriate to control for initial level by using it as a covariate.

Results

1. Inter-rater reliability

There were 794 REs in total in the data base (an average of 19 per patient). Given that the data base was scored twice (1588 REs), Judge A
scored 437 REs, Judge B 463 REs, Judge C 391 REs and Judge D 297 REs. Inter-rater agreement was uniformly high with correlation coefficients among the four independent judges as follows.

**Table 7.1. Relationship between judges' mastery scores**

<table>
<thead>
<tr>
<th>Judge</th>
<th>Correlational Relationship</th>
<th>$r^2$</th>
<th>REs scored in common (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A vs. B</td>
<td>$r = .75$</td>
<td>.56</td>
<td>187</td>
</tr>
<tr>
<td>A vs. C</td>
<td>$r = .77$</td>
<td>.60</td>
<td>161</td>
</tr>
<tr>
<td>A vs. D</td>
<td>$r = .81$</td>
<td>.66</td>
<td>89</td>
</tr>
<tr>
<td>B vs. C</td>
<td>$r = .79$</td>
<td>.63</td>
<td>149</td>
</tr>
<tr>
<td>B vs. D</td>
<td>$r = .85$</td>
<td>.73</td>
<td>127</td>
</tr>
<tr>
<td>C vs. D</td>
<td>$r = .89$</td>
<td>.66</td>
<td>81</td>
</tr>
</tbody>
</table>

These results show an impressive degree of reliability between judges, although there were slight variations between different pairs of judges. However, taking the standard Pearson correlation coefficient, the agreement is significant in all cases at $p < .00001$, ie. the likelihood of this result being due to chance is less than .001%. Judges' mastery scores were therefore averaged in all subsequent analyses.

2. **Test-retest reliability**

Test-retest reliability was assessed by selecting 5 REs at random and
presenting them to judges again after a period of three weeks. Test-retest reliability was good, with Judge A's test-retest reliability being $r = .77$, Judge B $r = .80$, Judge C $r = .92$, and Judge D $r = .89$. Although these data were calculated on a relatively small sample of scored clauses (45 for Judges A and C and 51 for Judges B and D), the results are all highly significant at $p < 0.0001$.

3. **Internal consistency of the Mastery Scale.**

The entire scored sample of 794 REs were converted from mastery scores (1 - 6) into binary scores (1 = category appears in RE, 0 = category does not appear) and these data were subject to a proximities analysis using Phi, the binary form of the Pearson Correlation Coefficient. The result, presented as a dendrogram (a tree diagram), shows the way the categories cluster together according to their relationship with each other. The results are presented in Figure 7.1 and are considered in the discussion.
### Figure 7.1 The Internal Consistency of the Mastery Scale (N=41)

A dendrogram (tree diagram) of similarity between Mastery Scale categories, representing the binary form of the Pearson product-moment correlation coefficient (Phi).
4. Changes in mastery over the course of therapy

To investigate changes in mastery scores across the 41 patients over the course of therapy, a paired t test between early and late mastery scores was calculated. An average mastery score was calculated for each patient early-in-therapy and late-in-therapy. The change in mastery was highly statistically significant (t = 4.94, df = 40, p > .0001). The effect size (ES) calculated was large (ES = 1.35). When compared to the published effect sizes in other psychotherapy studies, the changes detected by the Mastery Scale can be considered to be of clinical significance (Lambert & Bergin, 1994). The trend in this psychotherapy sample was thus for patients to display greater levels of self-understanding and self-control in their interpersonal relations late-in-therapy.

To illustrate these typical changes in mastery from early to late-in-therapy, consider one patient (Figure 7.2). Ms S, a 24 year old divorced graduate student with no children, was seen in once weekly therapy for 41 weeks with the goal to help change her difficult ‘personality patterns’. Her psychodynamic therapist was a 31 year old married resident psychiatrist. Early-in-therapy she expressed suffering (2E) due to conflictual interactions with others that led to her avoiding relationships (2H). When in close relationships she felt worthless and guilty (2F) and encouraged men to hit her (1D). Towards the end of therapy she could see (5Q) that her global view that “men are evil” was due to unconscious hostility towards an abusing person from her childhood (5R). She therefore began to struggle free from these bonds
(4P) and enjoy relationships (5S) in a new way (6V). These conflictual patterns also appeared within the early transference relationship with her therapist. Towards the end of therapy she could express with confidence to her therapist that “you basically seem good to me now” (6V), thus showing some mastery over her interpersonal problem.

Moving back from the single case, described above, to the entire sample, it was decided to investigate overall changes in mastery.
categories from early to late. Figure 7.3 shows the percentage of change in the frequency of Mastery Scale categories appearing in narratives from early to late in psychotherapy for all 41 patients. The data confirm the cluster analysis that the first half of the scale represents 'sickness' and the second half 'health'. Dimensions indicative of poor mastery (categories 1A - 3L) show a reduction in appearance in narratives late-in-therapy, whereas interpersonal awareness, self-understanding and self-control dimensions (categories 4M - 6W) show a corresponding increase in appearance late-in-therapy.

Figure 7.3. Change in the frequency of Mastery Scale categories appearing in narratives late in psychotherapy, expressed as percent change from early-in-therapy. Data is for 41 patients. Dimensions indicative of poor mastery (Categories A - L) show a reduction in appearance in narratives late-in-therapy, whereas interpersonal awareness, self-understanding and self-control dimensions (Categories M - W) show a corresponding increase in appearance late-in-therapy. Data at 0% indicates no change in the percentage of appearance of categories from early to late.
5. Relationship between mastery and the outcome variables

The relationship between Mastery Scale residual gain scores and outcome variables were calculated using Pearson correlations and appear in Table 7.2. Significant relationships were found between mastery change scores and observer, therapist, and patient ratings of outcome, but not for the insight and control ratings. Figure 7.4 shows the data for the Health-Sickness Rating Scale residual change scores plotted against the Mastery Scale residual change scores.

Table 7.2 Pearson correlations between Mastery Scale residual change scores and clinical outcome scores. N = 41.

<table>
<thead>
<tr>
<th>Observer Ratings of Outcome</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Sickness Rating Scale residual change score (HSRS)</td>
<td>.51***</td>
<td></td>
</tr>
<tr>
<td>Prognostic Index Control item</td>
<td>.30</td>
<td></td>
</tr>
<tr>
<td>Prognostic Index Insight item</td>
<td>.01</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapist Rating of Outcome</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist rating of patient satisfaction, success &amp; improvement</td>
<td>.47**</td>
<td></td>
</tr>
<tr>
<td>Therapist rating of patient achieving insight</td>
<td>.12</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Ratings of Outcome</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of change of primary target complaint (Target)</td>
<td>.59***</td>
<td></td>
</tr>
<tr>
<td>Symptom Checklist residual change score (SCL)</td>
<td>-.53***</td>
<td></td>
</tr>
</tbody>
</table>

** p < .01
*** p < .001
Discussion

This chapter aimed to evaluate the reliability and validity of the Mastery Scale as a measure of therapy process and outcome. The results support both the reliability and validity of the scale (Grenyer & Luborsky, in press-a). Each of the three hypotheses tested will be discussed in turn.

**H1** That the Mastery Scale can be reliably applied by judges working independently with good inter-rater and test-retest reliability.
The results overwhelmingly support this hypothesis. Both the inter-rater and test-retest reliability of the Mastery Scale were shown to be acceptable and quite impressive. Good inter-rater and test-retest reliability was probably achieved in part because the judging task was highly structured, obviating disagreement that can result from methods based on unguided complex inferential judgements. Judges did not assess levels of mastery per se; the corresponding scores were already built into the category choices. This method of content analysis has proved a very powerful way of identifying underlying constructs (Gottschalk, Winget, & Gleser, 1969). In addition, judges were also well trained prior to scoring the data.

**H2 That the Mastery Scale will demonstrate good internal consistency.**

The results verify that the Mastery Scale has internal consistency. The clusters fall neatly into two large groups split at the middle of the Mastery Scale (between 3L and 4M). One dimension can be conveniently called 'sickness' and the other 'health'. Within the sickness dimension are a number of sub-clusters. These could be labelled (moving from top to bottom on the graph) 'negative symptoms' (categories 1A, 1B, 2E), 'conflictual interpersonal relations' (2F, 2G), 'cognitive confusion' (1C, 2H, 3J, 3K, 4O), 'helpless dependency' (1D, 2I). Within the 'health' dimension, a number of sub-clusters are discernable: 'interpersonal sensitivity' (4N, 5S, 5T), 'self-assertion' (4M, 4P), 'self control' (6U, 6V) and 'self-understanding' (3L, 5Q, 6W).
There are a number of categories that are worthy of note. First, two categories do not appear to be in the correct place. 'Questioning the reaction of self' (category 4O) is given a mastery weight of 4, and should fit into the 'health' dimension, yet it appears in the 'sickness' dimension alongside the other cognitive confusion items. Similarly, 'references to positive struggle with difficulties' (category 3L) is given a weight of 3 and should appear in the 'sickness' dimension, yet appears among the insight items. It may well be the case that one improvement in the scale would be to swap the position of these items. However, it would be worth first seeing if this discrepancy replicates on a different sample before altering this aspect of the scale.

Also of interest is the position of 'making dynamic links between past and present relationships' (5R) which fits into the 'health' cluster but does not cluster with any other category. This is a very puzzling result. In fact, it only clusters very abstractly with the rest of the 'health' dimension. It may be that it is a 'superordinate' category, that has special importance in mastery, or alternatively it may simply be too unique in its presentation to have consistently clustered with other categories. A final explanation is that this cluster occurs very rarely in REs (only 6.5 % of REs had this category), and so the lack of data may have prevented it clustering in a confident way with any other variable.

**H5** That patients rated as showing greater gains in mastery will have larger gains on measures of general psychological health-sickness and reductions in symptoms than those patients showing fewer gains in mastery.
The results support this hypothesis. There were significant relationships between the Mastery Scale scores and measures of change assessed by observers, the therapist and the patient (Table 7.2). For example, changes in Health-Sickness Rating Scale (HSRS) were significantly related to changes in mastery. This is clearly seen in Figure 7.4. These results are consistent with the view that patients who are sicker are less able to see the interpersonal dynamics of their predicament, and tend to react more helplessly and painfully to problems in getting their needs met.

Perhaps of most interest, the patient's own judgements of changes in their main complaint (Target) paralleled changes in the mastery of interpersonal conflicts found in their narratives. This suggests that changes in mastery are not only related to changes in reported symptoms, but also to the fulfilling of the patient's main goal in therapy.

It is of interest that both the observer Insight and Control ratings from the Prognostic Index and the therapist's rating of insight did not show a significant relationship with mastery (Table 7.2). The Prognostic Index Control item was very close to being significant (r = .30) given that the criterion of significance at p < 0.05 is 0.308. There was therefore a marginally significant relationship between the measure of control and mastery, which supports the notion that part of the Mastery Scale is self-control.
The two ratings of insight (Prognostic Index, and therapist-rated insight) were not related to mastery, although the trend was in the expected direction. Researchers have often found it difficult to detect relationships between insight and clinically relevant change. For example, in his careful analysis of the case material from 42 patients in the Menninger Psychotherapy Research Project, Wallerstein found that 45% of patients who had made clinically significant structural changes did not have parallel changes in insight, and another 7% made large changes in insight but no clinically-relevant structural change (Wallerstein, 1986). What is common to the Wallerstein study and the two measures of insight employed here (the Prognostic Index and therapist measure of insight) is that they are all based on subjective global ratings of insight. It may be that they suffer in validity due to the demands made on judges to make a single global judgement of such a complex construct as insight. In support of this view, research with the Prognostic Index has found that considerable variation exists between different judges' scoring patterns (Luborsky et al., 1988). What is needed are guided and well validated measures of insight, which at present are only in the pilot stage of development (Crits-Christoph, Barber, Miller & Beebe, 1993).

In addition, the Mastery Scale subsumes insight and control into a single concept, mastery, which is different in important ways from either variable. It was found in the scale development that it was difficult to separate the intellectual (as an insight) from the emotional (as in control), which supported the view that what was being measured overall was mastery. Nevertheless, it would be expected that at least a moderate relationship should be found between mastery and
the measures of insight, as it was for control. Further research using different measures of insight (e.g. Weiss et al., 1986, p. 387) and also control (e.g. Shapiro & Bates, 1990) are needed to further investigate this issue. The categories of self-understanding used in the Mastery Scale might provide a useful starting point for constructing a better rating scale of insight.

It could be argued that the reason why the insight ratings did not correlate with the Mastery Scale is because the scale is a poor measure of insight. However, as shown in Figure 7.3, the insight components of the scale did shift in meaningful ways. The insight components of the scale also appear to have face validity. The judges who scored the scale agreed that they were able to use the categories to indicate the kinds of insights they observed in the transcripts. Another possibility is that the scale puts more weight on the control items (which have a weighting of 6, whereas insight items have a weighting of 5), and therefore this acts to reduce the likelihood of finding a positive relationship with insight. Two thirds of the Mastery Scale, for example, might reflect control, with one third insight. A balance of this nature (if true), would be in line with Freud's well known views cautioning against taking insight as necessarily synonymous with true structural change (as discussed in detail in Chapter 4, p. 48-50, with the implications for scoring mastery in Chapter 6, p. 98).

Further inspection of the change data for the individual categories of the Mastery Scale (Figure 7.3) reveals some interesting findings. In general, psychotherapy leads to a diminution in three of the lower levels of mastery: lack of impulse control, introjection and projection
of negative affects, and difficulties in understanding and control (categories A - L). This indicates that there is a general reduction in distress and confusion in interpersonal relationships over the course of psychotherapy.

As predicted, certain dynamic variables showed an amplification over therapy, such as expressions of self control (6U), which showed a large (16.5%) increase. It is of interest that a few dynamic variables showed no change, for example, making dynamic links between past and present relationships (5R). This could be partly attributed to the paucity of appearance of this category, since only 6.5% of narratives in therapy contained scorable clauses for this category. It may be that this category is dynamically important in therapy, but that our method is not sensitive enough to reveal this significance. The superordinate nature of this category is suggested by the internal consistency analysis discussed above.

As indicated by the modest percentage changes in Figure 7.3, there is support for the view that psychotherapy does not completely eliminate relationship conflicts, but rather helps people to gain mastery over them. The case study of Ms S illustrates the clinical relevance of the Scale's categories.

In summary, the results reported in this chapter support the reliability and validity of the Mastery Scale and the importance of the psychodynamic concept of mastery within a theory of clinical change in
The next four chapters investigate the relationship between changes in mastery and other centrally important variables in psychotherapy: the therapeutic alliance, the transference, diagnosis, and object relationships. These studies were designed to extend the investigation of the meaning and validity of the Mastery Scale and to use this new tool to investigate fundamental areas of current psychotherapy research. The central aim of these following chapters is encompassed in the third aim of this thesis:

3. To investigate the relationship between changes in mastery and other centrally important variables in psychotherapy: the therapeutic alliance, the transference, diagnosis, and object relationships.

Each of the four areas of experimental work will be presented in turn.
Chapter 8

The Relationship between Mastery and the Therapeutic Alliance

Although there are a large number of studies comparing the therapeutic alliance to traditional measures of outcome, few investigate its relationship with process measures of the internal workings of therapy. The importance of this task, as reviewed in Chapter 2, is in furthering our understanding of why the therapeutic alliance appears such a potent therapeutic ingredient. The current state of progress on the alliance has been almost entirely devoted to developing measures of the alliance and evaluating their relationship to outcome (for a comprehensive review see Horvath, Gaston & Luborsky, 1993). The field is therefore ready to extend this research with studies that look in more detail at how the alliance relates to other key process variables.

The current study aims to investigate how much changes in mastery can be predicted from an early measure of the therapeutic alliance. The theoretical importance of this question lies in the fact that what is mastered in therapy are the interpersonal transference-related conflicts. A supportive helpful relationship with the therapist should provide the bedrock for the interpersonal conflicts to be worked through. The alliance is measured early-in-therapy because measuring the alliance later in therapy can lead to a confounding of outcome with alliance (for
example if the therapy is going well in terms of a reduction in distress, then the patient will tend to consider and respond to the therapist more favourably). Early-in-therapy alliance measures mostly avoid this difficulty. It is predicted that those patients who go on to show the most significant gains in mastery will be the ones who had developed a good alliance with their therapist early on in treatment. The hypothesis is therefore:

**H1. The strength of the patient’s therapeutic alliance early-in-therapy is positively related to their gains in mastery.**

The mastery scores used in this analysis were taken from the earlier reliability and validity study (Chapter 7). The helping alliance scores were also taken from an earlier published study (Luborsky et al., 1983).

### Method

#### Subjects

The subjects were the same as described in Chapter 7, with the single exception that one patient’s scores on the Helping Alliance were not available, making a total N of 40.

#### Measures

1. **The Mastery Scale.** This is described in Chapter 6 and its reliability and validity are presented in Chapter 7. The mean early-in-therapy...
mastery scores and the residual gain scores were used in the analyses in this study.

2. Penn Helping Alliance Counting Signs Method (HAcS) (Alexander & Luborsky, 1986; Luborsky, 1976; Luborsky et al., 1983). This method involves finding literal or nearly literal cues of the quality of the helping alliance from the content of patients' speech in transcribed therapy sessions. As a method it is therefore similar to other content analysis methods such as the Mastery Scale and the Gottschalk-Gleser scales (Gottschalk et al., 1969). The specific content that is considered to be "signs" of the helping alliance broadly falls into two types. First is the patient's perception of the therapist as being helpful, supportive and facilitative of the treatment goals. Second is the sense that the therapist and patient are working together as a joint team with a positive bond. Both of these two types are rated as being either positive, meaning that the characteristic is present, or negative, meaning that the opposite is true (signs that the therapist is unhelpful and the relationship is poor). Full scale details are given in Alexander and Luborsky (1986).

In this method, an external judge reads the transcripts for instances in the dialogue that are scorable for therapeutic alliance. Each instance is then rated for intensity on a 5-point likert scale (from 1 = very low, to 5 = very high). The sum of the positive intensity scores is subtracted from the sum of the negative intensity scores to arrive at a difference score. In each analysis reported here the difference score was used as the measure of the helping alliance. The first 20 minutes of session 3
and session 5 were scored (Luborsky et al., 1983).

The inter-rater reliability of this method applied to the Penn sample is acceptable and has been reported elsewhere (Luborsky et al., 1983). The data that were used in the following analyses were the average scores of the two raters.

Data analysis

Two analyses were performed. A Pearson correlation coefficient was calculated in order to assess the relationship between early-in-therapy mastery scores with early-in-therapy alliance scores. The second analysis addressed the question of the ability of the helping alliance scale to predict gains in the mastery of interpersonal conflict. A simple regression analysis was performed. In each case the N = 40, with degrees of freedom = 39.

Results

The relationship between the early-in-therapy helping alliance score with the early-in-therapy mastery score was significant \( r = .32, p < 0.05 \). The \( r^2 \) revealed that 10.1% of the variance of early mastery was accounted for by the helping alliance.

The ability of the early-in-therapy alliance scores to predict gains in mastery was represented by the regression equation \( y = -.073 + (.049 \times x) \). The relationship between the variables was significant \( F = 16.46, p < \).
.0002. In all, 30.2% of the variance of the gains in mastery could be accounted for by early helping alliance. The relationship between the variables is shown in Figure 8.1.

\[ r = 0.55 \ p < 0.001 \]

Figure 8.1. Relationship between early Penn Helping Alliance versus Mastery Residual Change

**Discussion**

The hypothesis of this study was that the strength of the patient’s therapeutic alliance early-in-therapy is positively related to their gains in mastery. The results strongly support this hypothesis. Patients who had a better relationship with their therapist early-in-therapy went on to make larger gains in the mastery of their interpersonal conflicts (see Figure 8.1).
As was found in the first analysis, it appears that patients who have higher initial levels of mastery are able to form better relationships with their therapists. This result is hardly surprising: a person who has serious and pervasive interpersonal conflicts would be expected to have difficulty forming positive relationships with others, including their therapist.

Overall, about one third of the variance of gains in mastery can be accounted for by the helping alliance. This underscores the importance of being able to form one good relationship - with the therapist - in order to master more pervasive and maladaptive relationship conflicts. It is probably also the case that the support from the relationship with the therapist helps the patient to bear the task of understanding and controlling their long term interpersonal difficulties. How these longer term transference-related difficulties are mastered is the subject of study reported in the next chapter.
Chapter 9

The Relationship between Mastery and Transference

Chapters 2 and 5 introduced and discussed current psychotherapy research on transference, with particular attention to the Core Conflictual Relationship Theme (CCRT) method (Luborsky, 1977; Luborsky & Crits-Christoph, 1990). The present study examines the relationship between mastery and one aspect of the CCRT, namely, the positive and negative dimension of the response of other and the response of self, as discussed below.

In the CCRT method, the basic transference pattern is derived from three components: the wishes, needs or intentions (W) expressed implicitly or explicitly by the patient towards the other person, the response from the other (RO) person to these wishes, and the corresponding response of self (RS) that the interaction evokes.

When a person’s relationship narrative is of the form "I wish (W) to be loved, and the other person (RO) is affectionate, and I (RS) feel close" then the outcome of the RO and the RS are positive: ie. that their need to be loved is satisfied. Luborsky (1990) defines positive as "noninterference or expectation of noninterference with the satisfaction of wishes and / or a sense of mastery in being able to deal
with the wishes" (p.26).

On the other hand, if the RE is "I wish (W) to be loved, but the other person (RO) rejects me, and I (RS) become frustrated" then clearly the outcome of satisfying the wish in this interaction is negative: the person feels frustrated at being rejected. Luborsky (1990) defines negative as "responses that mean to the patient that interference with satisfaction of the wishes has occurred or is expected to occur" (p.25).

Freud discusses how in relation to the therapist both positive and negative transference patterns are likely to emerge: "we must make up our minds to distinguish a 'positive' transference from a 'negative' one, the transference of affectionate feelings from that of hostile ones". The wishes may be seen as expressions of instinctual drives that may or may not have clear unconscious roots - for example sexual drives may be manifest in affiliative wishes. Positive responses of other and self usually refer to successful gratification of drive-derived wishes, whereas negative dimensions refer to unsuccessful gratification of drives, as discussed in Chapter 4 and 5. The importance of this for mental health is that according to psychoanalytic understanding undischarged instinctual drive energies manifest in negative symptoms such as anxiety that may eventually lead the sufferer to seek psychological treatment.

By and large the major focus of treatment interventions within psychotherapy is on the negative transference. Negative transference is generally considered to mean the projection of hostile and paranoid feelings into relations with the therapist and others in the patient's life.
The expectation of a negative outcome in terms of the wish leads the patient to project this negative expectation into relationships with others. Since in psychoanalytic theory symptoms arise directly out of these maladaptive patterns, it is predicted that increases in mastery evidenced in more positive CCRT narratives should be associated with greater feelings of well being and health and more negative CCRT patterns should be associated with lower interpersonal mastery.

On this last point, it is hypothesised that people who exhibit greater levels of positive CCRT components will more often be able to get their needs and wishes met through their interpersonal relationships and this should be reflected in associated increases in mastery. For them, narratives will typically contain more positive interactions than patients in psychotherapy who are experiencing greater difficulties. The hypothesis is therefore:

**H1 More positive CCRT patterns will be associated with increases in mastery.**

Two studies were conducted. The first investigates changes in the positive-negative dimension using the original CCRT scores from the Penn psychotherapy project (N = 41). The second study re-scores a small sample of the data (N = 8) using more rigorous methodology and an advanced method for scoring the positive and negative dimension.
**Study 1**

**Method**

**Subjects**

The subjects were the same as described in Chapter 7.

**Measures**

1. **The Mastery Scale.** This is described in Chapters 6 and 7. The mean early, late and residual change scores were used in the analysis.

2. **Core Conflictual Relationship Theme (CCRT).** Two CCRT components from early and late-in-therapy were utilized, the response of self (CCRT-RS) and response of other (CCRT-RO). The sum of the negative responses were subtracted from the sum of the positive responses and divided by the total number of responses to obtain a score early and late-in-therapy reflecting the overall degree of positivity-negativity for each of the two CCRT components (CCRT-RS and CCRT-RO) for each subject. A residual change score for positivity-negativity was then calculated to capture change across the course of therapy.
Data Analysis

Percentages of positive and negative components were calculated to facilitate in the description of the data. The relationship between the two sets of variables (mastery and CCRT) were investigated by calculating Pearson correlations. The average of two judges scores were used for both the mastery and CCRT measures.

Results

The first analysis was to describe the proportion of negative to positive CCRT components for both the response of other and response of self. The results appear in Table 9.1. In general, four fifths of CCRT components were negative, with little change over therapy.

<table>
<thead>
<tr>
<th></th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>RO - Early-in-therapy</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>RO - Late-in-therapy</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td>RS - Early-in-therapy</td>
<td>21</td>
<td>79</td>
</tr>
<tr>
<td>RS - Late-in-therapy</td>
<td>24</td>
<td>76</td>
</tr>
</tbody>
</table>
The relationship between the mastery and CCRT scores were calculated with the results in Table 9.2. There were few significant relationships between the positive-negative CCRT scores and mastery. Of most interest, late in therapy scores on the response of self component were significantly related to changes in mastery ($r = .37$, $p < 0.05$). This suggests that one improvement in mastery over therapy is in the patient’s ability to cope with their responses to transference-related interpersonal conflict.

### Table 9.2  Relationships between Positive-Negative CCRT versus Mastery Scores ($N = 41$). Data is for early and late-in-therapy, and residual change over therapy.

<table>
<thead>
<tr>
<th></th>
<th>Mastery-Early</th>
<th>Mastery-Late</th>
<th>Mastery-Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>RO - Early</td>
<td>0.58**</td>
<td>0.37*</td>
<td>0.26</td>
</tr>
<tr>
<td>RO - Late</td>
<td>0.02</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>RO - Change</td>
<td>0.08</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>RS - Early</td>
<td>0.32*</td>
<td>0.22</td>
<td>0.21</td>
</tr>
<tr>
<td>RS - Late</td>
<td>0.16</td>
<td>0.27</td>
<td>0.37*</td>
</tr>
<tr>
<td>RS - Change</td>
<td>0.13</td>
<td>0.08</td>
<td>0.14</td>
</tr>
</tbody>
</table>

** $p < 0.01$  * $p < 0.05$
Discussion

Consistent with earlier studies, narratives from both early and late-in-therapy were overwhelmingly negative (see Grenyer & Luborsky, in press-b). There was only a slight reduction in the negativity of narratives from early to late, in the order of approximately 4%.

The analysis of the relationship between the RO and RS dimensions and mastery revealed some interesting findings. Early positivity-negativity was significantly related to early mastery levels for both the RO and RS dimension. Late-in-therapy RS was significantly related to the change in mastery over the course of therapy. This suggests that increases in mastery over therapy are being reflected in the late-in-therapy response of self, with a slight increase in more positive responses.

Several problems with the above data lead to a small re-analysis. These CCRT data were the result of the first application of the CCRT to a large psychotherapy data set, and as such the methods employed were not as rigorous as the recent CCRT methodology recommended (Luborsky, in press-a). First, the judges each scored the REs freely and independently and therefore combining their scores is not always meaningful. Second, judges were not instructed to carefully evaluate the positive-negative dimension, so some of the data may not be as valid as would be hoped. Third, judges (inconsistently) used a "neutral" category in addition to the positive and negative dimension. The neutral category is no longer recommended in scoring the CCRT, for both theoretical
and empirical reasons. Theoretically, Freud considered that transference reactions could be either positive or negative with respect to wishes and that only gratification or frustration was possible, i.e. a 'neutral' outcome was not (Freud, 1912a). Empirically, recent research by Fazio and Bargh suggest that all perceptions are emotionally tinged with a positive or negative valence, that appear to be automatic and instantaneous (Bargh, Chaiken, Govender & Felicia, 1992). For these reasons, a small subsample of the data were re-scored using the most up to date CCRT scoring procedures. This comprises Study 2.

**Study 2**

**Method**

**Subjects**

A subsample of eight subjects were chosen from the 41 patients on the basis of their changes in mastery scores: 4 were the subjects who showed the greatest gains in mastery over psychotherapy and 4 were those that showed the least gains. In this way it was ensured that the sample covered the full range of positive and negative CCRT scoring possibilities. All 8 patients were single, had never married and had no children. There were 3 females and 5 males, mean age 24 (range 20-35). Educationally they were mixed: one had only finished high school, three were in college, two had completed college and a further two were engaged in higher degrees. All were undergoing psychoanalytic
psychotherapy, with a mean duration of 49 weeks (range 30 - 92 weeks). There were 7 therapists, with a mean age of 32 (range 26 - 43). All therapists were married, 4 had children, all were psychiatrists and 5 were residents at the time.

Measures

1. The Mastery Scale. This is described in Chapters 6 and 7. The mean early, late and residual change scores were used in the analysis.

2. Core Conflictual Relationship Theme (CCRT). The current rating method stipulates that each RO and RS component extracted should be rated using one of the following four categories: NN = strong negative, N = moderate negative, P = moderate positive, and PP = strong positive (Luborsky, in press-a). For research purposes, these correspond to scores of -2, -1 and +1, +2 respectively. Although positive and negative scores are only applied to the RO and RS components, it is important in scoring for these to be evaluated in the context of the expressed or implied wishes. This is because the RO or RS is only positive or negative depending on the success in relation to gratifying a wish. To date there is no published data on the reliability of this new method of scoring.

Procedure

Transcripts from early-in-therapy (sessions 3 and 5) and late-in-therapy (at the 90% completion mark) formed the data base, and relationship episodes (generally 10 early-in-therapy and 10 late) were extracted and
CCRT scored. These transcripts were the same ones used to score the Mastery Scale as described in Chapter 7. Prior to the judges rating task, an independent judge (BG) located all scorable CCRT components to ensure that judges each scored the same thought units. Two independent judges rated the degree of positivity-negativity for the RS and RO components across the 8 patients. The two judges were both doctoral level psychoanalytic researchers. A total of 159 Relationship Episodes were scored using the CCRT.

Results

Inter-rater reliability

The reliability of the judges’ scoring was examined in two ways. First, reliability was assessed by taking the RE as the unit of analysis. Over 159 REs, the inter-rater reliability using Pearson’s correlation coefficient was high. For the RO dimension, \( r = .73, p < 0.0001 \), and for the RS dimension, \( r = .81, p < 0.0001 \). Second, instances of scoring with perfect agreement between judges scoring were examined. For the RO, 119 of the 159 scored REs were scored identically between judges (75%), and for the RS, 117 were scored identically (74%).

Inter-rater reliability was then investigated taking subjects (\( N = 8 \)) as the unit of analysis rather than REs (\( N = 159 \)). Average +/- scores for each subject for each judge were calculated. The results are shown in Figure 9.1. The inter-rater reliability for the RO component was \( r = 0.92 p < \)
0.0001, and for the RS, \( r = 0.96, p < 0.0001 \).

![Inter-rater Reliability](image)

**Figure 9.1.** Inter-rater reliability between two judges scores on the positive and negative dimensions of the CCRT (\( N = 8 \)).

*Changes in positive-negative dimensions over the course of psychotherapy*

The distribution of positive and negative scores for the RO and RS dimensions were investigated using this new scoring method. Given the high inter-rater agreement, the data from the two judges was pooled. Overall, for the RO there were 13% NN (very negative) scores, 54% N (negative), 29% P (positive) and 4% PP (very positive) scores. For the RS, there were 24% NN, 50% N, 19% P and 7% PP scores. These results are very similar to the distributions of positive and negative
components found in other psychotherapy samples, and are in accord with those found for all 41 patients in study 1 above. In general, it seems that the bulk of transference CCRT narratives told by patients in psychotherapy are negative, that is, wishes and needs are often unsatisfied.

In order to investigate changes in the proportion of positive and negative components over the course of psychotherapy, percentages of each component early and late-in-therapy were calculated. The data were further differentiated into the 4 most improved and the 4 least improved patients. This was done to graphically illustrate some of the patterns of change in the positive-negative dimensions. The results for the RO dimension appear in Figure 9.2 and for the RS dimension in Figure 9.3. Taking the RO dimension first, it can be seen that for the 4 most improved patients there is a reduction in the number of negative (N) components and a slight increase in the number of positive (P and PP) components from early-in-therapy to late-in-therapy. For the 4 least improved patients, the pattern is very similar. It appears in general that there is a slight reduction in the perception of others as blocking the gratification of wishes, however overall the perception of others in the REs is negative throughout therapy.

The RS dimension reveals a different picture. For the 4 most improved patients, there are large reductions in negative (NN and N) components over therapy, and corresponding large increases in positive (P and PP) components. This is indicative of an increase in the satisfaction of wishes and needs. In contrast, for the 4 least improved patients the number of very negative (NN) components actually
increases by 15%! Similarly the number of positive (P) components decreases. As the judges commented, these patients actually seemed to be getting worse - their relationship narratives were more conflictual and negative towards the end of therapy compared with their initial level.

Figure 9.2. Percentages of the Response of Other (RO) component of the CCRT for 4 highly improved patients (best) and 4 least improved patients (worst) measured early in psychotherapy (early) and late in psychotherapy (late).
Figure 9.3. Percentages of the Response of Self (RS) component of the CCRT for 4 highly improved patients (best) and 4 least improved patients (worst) measured early in psychotherapy (early) and late in psychotherapy (late).

**Relationship to mastery**

The final aim of this study was to investigate the relationship of the positive-negative dimension to the Mastery Scale. Table 9.3 presents the results of the analyses.
Table 9.3 Relationships between Positive-Negative CCRT versus Mastery Scores (N = 8). Data is for early and late-in-therapy, and residual change over therapy.

<table>
<thead>
<tr>
<th></th>
<th>Mastery-Early</th>
<th>Mastery-Late</th>
<th>Mastery-Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>RO - Early</td>
<td>.02</td>
<td>.36</td>
<td>.49</td>
</tr>
<tr>
<td>RO - Late</td>
<td>-.23</td>
<td>0</td>
<td>-.14</td>
</tr>
<tr>
<td>RO - Change</td>
<td>-.19</td>
<td>-.12</td>
<td>-.27</td>
</tr>
<tr>
<td>RS - Early</td>
<td>.68*</td>
<td>.37</td>
<td>.25</td>
</tr>
<tr>
<td>RS - Late</td>
<td>.23</td>
<td>.88*</td>
<td>.84*</td>
</tr>
<tr>
<td>RS - Change</td>
<td>-.20</td>
<td>.55</td>
<td>.59*</td>
</tr>
</tbody>
</table>

* p < 0.05

Unlike Study 1, after using the new scoring conventions the RO component was not related to mastery, either at intake or termination. In contrast, the RS component appears to be related in an important way to changes in mastery. There was significant concordance between the RS components and the Mastery Scale scores both early and late-in-therapy. The RS late-in-therapy measure appeared to be a particularly good index of psychological mastery.

There was a large relationship between RS late and residual change in mastery scores (r = .84, p < 0.05). There was also a strong concordance between the RS late scores and the late-in-therapy mastery scores (r = .88, p < 0.05).
Discussion

Using the revised method of scoring the CCRT, the changes in positivity-negativity in psychotherapy patients is small from early-in-therapy to late-in-therapy, yet the change that does occur appears to be clinically very meaningful. These findings, however, only related to the changes in the Response of Self dimension of the CCRT, which shifted in clinically meaningful ways.

It appears from the data in this study that the Response of Other dimension is probably not directly related to clinical changes. Although some relationships were found in study 1, these are not considered to be as reliable or valid as the findings from study 2 which used a more rigorous methodology. However, study 2 has a very small sample size, so the results can only be considered preliminary and in need of replication on a larger sample (increasing the sample size is currently being undertaken for a project outside the bounds of this study).

Fewer changes overall were found from early- to late-in-therapy in the percentage of +/- components in the RO dimension when compared with the RS (see Figures 9.2 and 9.3). The lack of a relationship between the Response of Other dimension of the CCRT could in part be because the Mastery Scale specifically limits scoring only to self-statements and self-reflections on others, whereas the CCRT is more broad in that statements made by others are scored. For example, direct quotations of others in narratives are considered scorables in the CCRT but are not in
the Mastery Scale.

It appears that the process of psychotherapy does not cure or resolve all intrapsychic conflicts. In fact, earlier research with the CCRT has shown that by and large the same CCRT patterns found early-in-therapy remain late-in-therapy (Crits-Christoph & Luborsky, 1990a). In other words, the transference template appears to be pervasive and resistant to change. This supports the idea that what changes in psychotherapy is a person's mastery of their problems. The concept of mastery, as self-understanding and self-control, is very much about the 'self' or 'ego' mastering the conflict. In CCRT terms, the thing that is mastered is the RS - the response of the self to the pressure of the wishes and the obstructiveness of the RO. The Response of Other component, in psychoanalytic terms, relates very much to the projection of the transference conflicts into relationships with others. It makes sense therefore, that if the transference template remains relatively immutable, that the projected RO components should also remain less malleable to change. It appears from this research that what leads to clinical change is the development of mastery by the patient of their own responses to the CCRT pattern. How the mastery of these long term interpersonal problems might be exacerbated by an ongoing diagnosed personality disorder has been a topic of debate in psychotherapy circles and is the subject of the next study.
Effectively treating personality disordered patients remains a challenge to clinicians. The expert consensus from a recent meta-analysis of treatments in psychiatry (Quality-Assurance-Project, 1990, 1991) is that long-term dynamic psychotherapy is the treatment of choice for most personality disorders. The Australian Westmead Hospital research on dynamic psychotherapy for borderline personality disorder offers evidence that this form of treatment is useful and beneficial for the severely personality disturbed (Stevenson & Meares, 1992).

A recent study investigating factors associated with the comorbidity of personality disorders in major depression (Diguer, Barber & Luborsky, 1993) found that those with personality disorders were more severe in psychiatric disturbance and less improved than those depressed patients without personality disorders. Consistent with other studies (Shea et al., 1990), dynamically oriented psychotherapy was beneficial for those with comorbid personality disorders.

In the Diagnostic and Statistical Manual of Mental Disorders (American-Psychiatric-Association, 1980; American-Psychiatric-
Association, 1994), Axis 1 codes the typical clinical disorders such as anxiety and depression and Axis 2 is reserved for the personality disorders. It appears that an Axis 2 personality disorder combined with an Axis 1 clinical disorder leads to the worst prognosis (Docherty, Fiester & Shea, 1986). In particular, research has focussed on the relationship between depression and personality disorders (Klein, Kupfer & Shea, 1993).

Some researchers have criticized the diagnosis of individual personality disorder types because there appears to be an obvious overlap between the symptoms considered to be central in many personality disorders (Morey, 1988). For example, anger is part of borderline, histrionic, narcissistic and antisocial personality presentations. This has lead some researchers to recast personality disorders away from the typical symptom checklists to a more dynamic interpersonal focus (Benjamin, 1993), a project consistent with interpersonal psychoanalytic theory (Sullivan, 1953).

Personality disorders present particular difficulties for clinicians because manifest defects in the developmental psychosocial integration of the personality make forming and maintaining a helping supportive therapeutic relationship with the patient particularly challenging. A principal deficit in personality disorders is in initiating and maintaining mature interpersonal relationships.

Contemporary psychoanalytic theory of personality emphasizes that a central goal and marker of change for personality disordered patients is
the ability to form and maintain mature interpersonal relationships (Kernberg, 1984). Mature interpersonal functioning presupposes the development of a coherent sense of self and identity and adequate control over emotional impulses (Erickson, 1963; Galatzer-Levy & Cohler, 1993). It was therefore decided to investigate if dynamic therapy leads to changes in the mastery of interpersonal problems for the subset of patients from the Penn psychotherapy project with personality disorders. It was decided to compare this group to those without personality disorders.

Despite clinical wisdom, expert consensus, and research evidence that interpersonal, relationship-based psychotherapies are particularly effective in the treatment of patients with personality disorders, there is little empirical evidence to indicate the mechanism underlying treatment effectiveness. It is hypothesized that patients with a personality disorder, because of the pervasiveness of their problems, will be more resistant to change and therefore will not show as much benefit from psychotherapy as those without a personality disorder.

It was planned to examine the differential treatment effects of dynamic psychotherapy for Axis II personality disorders versus Axis I clinical disorders versus patients with dual Axis I and II disorders. It was hypothesized that:

**H1** Initial levels of psychiatric functioning will be worse in the Axis II personality disordered groups than the Axis I clinical disordered group.
H2 Initial levels of interpersonal mastery will be worse in the Axis II personality disordered groups than the Axis I clinical disordered group.

H3 Changes in interpersonal mastery and psychiatric functioning over the course of therapy will be greater for Axis I clinical disorders than the Axis II diagnostic groups.

H4 Changes in the Mastery Scale measure of interpersonal functioning will be significantly related to gains in psychiatric functioning in the Axis II personality disordered groups and the Axis I group.

Method

The same 41 patients used in the main validity study (Chapter 7) were used in the present study. Based on the sample’s DSM-III diagnoses (American-Psychiatric-Association, 1980), patients were partitioned into three groups: 17 with only an Axis I Diagnosis, 13 with only an Axis II personality disorder, and 11 with diagnoses on both Axis I and Axis II. Diagnoses were made by a psychiatrist based on a structured prognostic interview during the course of the original project. Diagnoses were originally made according to DSM-II but these were converted into DSM-III categories some years later after re-examination of the interview materials (Luborsky et al., 1988). Details of the range of diagnoses in each group are presented in Table 10.1.
Table 10.1: Clinical diagnoses of the three groups.

**Axis I Clinical Disorder Group (N=17)**

- 8 Dysthymia
- 7 Generalized Anxiety Disorder
- 1 Obsessive-Compulsive Disorder
- 1 Ego-dystonic homosexuality
- 1 Atypical Eating Disorder+
- 1 Inhibited Sexual Excitement+
  (+ secondary diagnosis with Dysthymia)

**Axis II Personality Disorder Group (N=13)**

- 5 Schizoid Personality Disorder
- 3 Schizotypal Personality Disorder
- 2 Passive-Aggressive Personality Disorder
- 1 Histrionic Personality Disorder
- 1 Mixed Personality Disorder
- 1 Atypical Personality Disorder

**Dual Axis I and Axis II Disorder Group (N=11)**

- 7 Dysthymia
- 4 Generalized Anxiety Disorder
- 3 Schizoid Personality Disorder
- 3 Compulsive Personality Disorder
- 3 Histrionic Personality Disorder
- 1 Passive-Aggressive Personality Disorder
- 1 Narcissistic Personality Disorder

Just as in Chapter 7, the measure of psychiatric severity was the Health-Sickness Rating Scale (HSRS) (Luborsky, 1962).

**Results**

The resulting demographic data and clinical measures across the three groups are presented in Table 10.2. In order to test hypotheses 1 and 2,
three-way analyses of variance (ANOVAs) with planned comparisons were calculated, with factors of Diagnosis (Axis I, Axis II or Dual), Demographic or Clinical measure (e.g. Age, Mastery) and Time (early-vs. late-in-therapy) Following the recommendations of various authors (e.g. Kazdin, 1986), differences between the groups were tested on the demographic and clinical measures by adopting a criterion of 20% difference ($p < 0.2$) as representing a significant variation between groups. This is in acknowledgement that a difference of 20% is clinically meaningful. Adopting the usual strict statistical criterion of 5% difference may prevent clinically-relevant differences between groups being shown, since finding differences between groups is more unlikely using this stricter criterion. As shown in Table 10.2, the only difference between groups was between Axis II and Dual I & II in initial early-in-therapy mastery, with the Dual group being worse.

Groups were equivalent in age, and length of treatment. The first hypothesis was that initial levels of psychiatric functioning will be worse in the Axis II personality disordered groups than the Axis I clinical disordered group. No such relationship was found on the measure of psychiatric functioning (Health-Sickness Rating Scale).

The second hypothesis was that initial levels of interpersonal mastery will be worse in the Axis II personality disordered groups than the Axis I clinical disordered group. Once again, no such relationship was found. However, levels of mastery were significantly worse for the Dual Axis I and II group compared with the Axis II only group ($p < 0.2$).
Table 10.2: Mean (SD) demographic and clinical measures for the three diagnostic groups.

<table>
<thead>
<tr>
<th></th>
<th>Axis I (N=17)</th>
<th>Axis II (N=13)</th>
<th>Dual I &amp; II (N=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (in years)</strong></td>
<td>25.1 (5.56)</td>
<td>25.1 (4.91)</td>
<td>24.7 (8.28)</td>
</tr>
<tr>
<td><strong>Treatment length</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(in weeks)</td>
<td>53.2 (29.44)</td>
<td>49.1 (23.28)</td>
<td>61.7 (36.86)</td>
</tr>
<tr>
<td><strong>Health-Sickness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating Scale (HSRS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At intake</td>
<td>481.5 (50.01)</td>
<td>457.7 (53.19)</td>
<td>482.0 (46.20)</td>
</tr>
<tr>
<td>At termination</td>
<td>532.8 (45.36)</td>
<td>485.2 (75.78)</td>
<td>531.9 (76.30)</td>
</tr>
<tr>
<td><strong>Mastery Scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early-in-therapy</td>
<td>3.108 (0.305)</td>
<td>3.146 (0.382)*</td>
<td>2.866 (0.392)*</td>
</tr>
<tr>
<td>Late-in-therapy</td>
<td>3.638 (0.643)</td>
<td>3.587 (0.537)</td>
<td>3.354 (0.651)</td>
</tr>
</tbody>
</table>

* indicates the group pairs that were significantly different (p < 0.2) in the planned comparisons.

The third hypothesis was that changes in interpersonal mastery and psychiatric functioning over the course of therapy will be greater for Axis I clinical disorders than the Axis II diagnostic groups. Correlations between early- and late-in-therapy mastery scores were taken into account by performing a one by three (mastery by diagnosis) analysis of covariance, with early-in-therapy mastery scores as the covariate and late-in-therapy mastery scores as the dependent variable. A similar but separate analysis was also performed for the HSRS.
There were no significant effects for diagnosis on the mastery measure (F (2,37) = 0.361, n.s.). The results for the Health-Sickness Rating Scale analysis were the same as the mastery score analysis (F (2, 37) = 1.255, n.s.), again with no significant effects of diagnosis. This suggests that there was no greater improvement in the Axis I disordered group compared with either Axis II group in either mastery or health-sickness.

The fourth hypothesis was that changes in the Mastery Scale measure of interpersonal functioning will be significantly related to gains in psychiatric functioning in both the Axis II personality disordered groups and the Axis I group. The specific relationship between changes in mastery during psychotherapy and HSRS outcome ratings of gain were investigated using Pearson correlations for each diagnostic group. Like the analysis of covariance used above, residual gain scores were calculated which control for the correlations between early and late scores (Manning & DuBois, 1962). Changes in mastery across psychotherapy were highly significantly related to gains in health-sickness for the dual diagnostic group (r = 0.74, p < 0.01), significant for the Axis II personality disorder group (r = 0.63, p < 0.05), but most surprisingly not significant for the Axis I clinical disorders group (r = 0.27, n.s.). The distribution of scores is presented in Figure 10.1.
Figure 10.1: Relationship between Mastery Scale Residual Change Scores and Health-Sickness Rating Scale Residual Change Scores for the three diagnostic groups.

Discussion

The aim of this study was to investigate process-outcome links in dynamic psychotherapy for personality disorders using the new measure of mastery. This began with the assumption, derived from previous research and clinical wisdom, that personality disordered patients are generally more severe in psychiatric functioning and do not evidence as large gains from psychotherapy compared with those with only an Axis I clinical disorder. The results of this study as a whole do not support this pessimism. Differences were found in the direction of those with a dual diagnosis having poorer levels of mastery early-in-therapy. However, personality disordered patients (even those with Dual Axis I and II diagnoses) were equivalent in
initial psychiatric severity (even using a very generous criterion of significance) and showed equivalently large gains from dynamic psychotherapeutic treatment. This finding is at odds with previous research (Diguer et al., 1993; Docherty et al., 1986). It appears that the present sample of diagnosed personality disordered patients were not as severe in psychiatric status as in other samples, although the dual diagnostic group did have significantly worse levels of mastery early-in-therapy. It is not clear how important this difference in severity is for the interpretation and generalizability of these results. Certainly, the following concluding remarks should be treated cautiously until further research is undertaken, particularly given the small and somewhat idiosyncratic sample size.

Another aim was to investigate the differential effect of diagnosis on changes in mastery of interpersonal processes shown in patient's narratives told in psychotherapy with externally rated objective measures of clinical outcome. Significant relationships were found between changes in mastery and health-sickness ratings in the personality disordered groups, but not in the Axis I clinical group. This could be cautiously interpreted as follows. First, it is proposed that gains in mastery, the development of self-understanding and self-control in the context of interpersonal relations, is a particularly salient and important mechanism of change in patients with a personality disorder (or, at least, for patients in this sample). Because dynamic psychotherapy is intimately concerned with interpersonal functioning both inside (via the analysis of transference) and outside of the therapy, from these results it appears to be a particularly helpful form of treatment for patients with personality disorders.
Second, although interpersonal mastery improved over the course of dynamic therapy in the Axis I group (Table 10.2), it showed only a non significant trend towards being related to clinical outcome. This suggests that the principal mechanism of change in the Axis I group probably lay elsewhere, and that interpersonal mastery, although important, may not be the central mechanism. It may be, for example, that a focus on the emergence of symptoms of helplessness and anxiety may be a more potent change mechanism for this group. Nevertheless, this result is puzzling and is in need of replication with another (larger) sample.

There are several limitations in this study. First, the sample size in each group was small; it is possible that the results may not generalize to the larger patient population. Second, the range of diagnoses were reasonably heterogeneous. It would have been preferable to have focussed either on one diagnostic group in the comparisons (for example dysthymia versus schizoid personality disorder) or at least have a larger sample with more equal representation of diagnostic groupings (or clusters of personality disorders). Further studies on larger samples are recommended.

Despite these limitations, these results provide cautious reason to be optimistic in treating personality disorders, particularly when utilizing a dynamic treatment that focuses on improving self-control and self-understanding in interpersonal relationships. The final study in this chapter considers which particular interpersonal relationship is the most salient to focus on in therapy.
Chapter 11

The Significance of Changes in the Mastery of Different Interpersonal Relationships through Psychotherapy

This final study is concerned with investigating in more detail the types of conflictual interpersonal relationships told in psychotherapy and the significance of these for clinical change. Freud discussed how in the final analysis the real effort in therapy occurs in the present relationship with the therapist. He states that “we must treat his illness, not as an event of the past, but as a present-day force. This state of illness is brought, piece by piece, within the field and range of operation of the treatment, and while the patient experiences it as something real and contemporary, we have to do our therapeutic work on it” (Freud, 1914, p.151-152). Further, not only must the contemporary nature of the patient’s problems be the focus of analysis, but these must be welded into the immediate relationship with the therapist. Freud emphasizes this in the following passage:

The doctor tries to compel him [the patient] to fit these emotional impulses into the nexus of the treatment and of his life-history, to submit them to intellectual consideration and to understand them in the light of their psychical value. This struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act, is played out almost exclusively in the phenomenon of transference. It is on that field that the victory must be won - the victory whose expression is the
permanent cure of the neurosis (Freud, 1912a, p.108).

If changes in the relationship with the therapist via the transference are so signal, as Freud maintains, then these changes should be manifest in the narratives told by the patient about the therapist (which includes therapist-patient enactments). How the patient relates to the therapist, within the transference relationship, should improve in mastery from early- to late-in-therapy and parallel gains health-sickness. The first aim of the present study is to investigate the changes in mastery across the course of therapy in narratives told about the therapist. The second aim is to also investigate changes in narratives told about significant others in the patient's life, including narratives about their lovers, parents, family, friends and acquaintances. The third aim is to investigate whether narratives of early childhood memories improve in mastery. Early memories hold a special place in the theory of psychoanalysis, and probably contain within them the core nuclear conflict that drives the repetition compulsion (as discussed in Chapter 4). Changes in the mastery of early memories should be clinically important and should also parallel changes in health-sickness.

For convenience, in this study the term 'object relations' is used to refer to the significant interpersonal relationships that the patient tells narratives about in therapy. Although technically 'object relations' refers broadly to "the subject's mode of relation to his world ... that is to some extent or other phantasized" (Laplanche & Pontalis, 1988, p.277), it is convenient here to use the term as it emphasizes the dynamic transference nature of the patient's relations and their role in the gratification of the patients needs.
Luborsky and colleagues investigated the kinds of people that patients commonly tell narratives about in psychotherapy (Luborsky, Barber, Schaffler & Cacciola, 1990, p.118-119). Studying a sample of 33 patients from the Penn psychotherapy research project, they found that 76% of patients tell narratives about their therapist, 85% about their family, 73% about their intimate relationships, 60% about friends, 45% about authority figures, and 36% about co-workers and people in general. This suggests that the three most important relationships in patients lives at the time of analysis are with their family, therapist and intimate partner.

Given Freud’s central emphasis on the relationship with the therapist, the following hypothesis was evaluated:

**H1 Patients rated as having larger gains on measures of general functioning and symptoms will show the greatest gains in mastery of their relationship with the therapist.**

No specific hypothesis was made about changes in the mastery of early memories nor about narratives told about others in therapy, such as work colleagues or family. The intention was simply to investigate these issues. This is the first such study to specifically investigate the significance of changes in narratives about different people across the course of therapy.
Method

Subjects

The same 41 patients described in Chapter 7 were used in this study.

Measures

A small selection of measures used in the validation study (Chapter 7) were chosen to conduct the initial analyses. Apart from the Mastery Scale, these were:

- one observer-rated measure, the Health Sickness Rating Scale (HSRS),
- one therapist-rated measure, the composite therapists’ rating of patient satisfaction, success and improvement (SSI), and
- one patient-rated measure, the patient’s rating of change on their primary target complaint (Target).

Each of these measures is described in full in Chapter 7.

Data analysis

There were five steps in the analysis of the data.

1. Each relationship episode by each patient was classified according to
the the object of the narrative (i.e. whether it was a narrative about the therapist, or the person's sister etc.). Unlike the earlier study discussed above, a new way of classifying and collecting together the narratives was derived. This was done in order to simplify the coding, to maximize the cell size of each category, and to make the categories more dynamically precise. For instance, instead of collapsing narratives told about the parents and other members of the family into one category 'family' (as Luborsky did in his classification discussed above), it was decided to divide these into narratives about 'parents' and narratives about 'family'. The latter contained all narratives about members of the patient's family and extended family excluding narratives about their parents. The intimate relations category was tightened into a category specifically about 'lovers' - defined as the central person in the patient's life towards which they have formed an erotic attraction. This was usually their spouse or steady girl/boy friend, but sometimes included un consummated desires expressed towards a particular person. All narratives were individually read to ensure the best categorization was made for each narrative. Narratives about all other people considered close to the patient but not holding a primary position as a lover, parent or family, were coded as 'friends'. The 'authority figures' category was dropped as it was difficult to make these judgements and was collapsed into an 'others' category that included persons who were more remote including neighbours, work colleagues and acquaintances. The resulting five categories derived were: therapist, parents, lovers, friends, others.

For interest, a sixth, phenomenologically different category was also analysed: early memories. This was defined as any RE that narrated an
event that happened before the patient turned 13 (ie. became a teenager). Where a memory narrative was clearly from the remote past but it was impossible to date within the patient's chronological age, it was accepted into the analysis as being an early memory. Narratives that were clearly recent or within at least the past 10 years, or where the patient was clearly an adult or a mature teenager were not accepted. The aim was to analyse early childhood memories.

2. For each patient, instances where one or more of the categories of narratives were discussed both early and late-in-therapy were highlighted for further analysis. For instance, if a patient told a narrative about their therapist early-in-therapy, but not late-in-therapy (or vice versa) these data were not included in the analysis. This is because it was the change in the narrative about a particular object (therapist, parents, lovers etc) that was of primary interest. The patient must have told one or more narratives within each category both early and late for the narrative to be accepted into the analysis. If a patient had early and late narratives in one category but not another, only those categories where there were early and late data were used.

3. For narratives that were accepted into the analysis from each patient (as described in step 2), the mastery scores for each object relations category were averaged to derive one mean mastery score for each category included (therapist, parents, etc) early- and late-in-therapy.

4. Residual gain scores were then calculated for each patient for each included category in order to quantify the degree of change in mastery over therapy for each specific object relations type.
5. The relationship between the mastery residual gain scores for each object relation and the nominated clinical outcome measures (HSRS, SSI, Target) were examined by Pearson correlations in order to investigate the specific importance of changes in each object relations dimension to clinical outcome.

Results

The number and type of narratives accepted into the study

Table 11.1 shows the number of patients (N) who had narratives both early and late-in-therapy for each of the five object relations categories. Also included is the mean number of narratives told per patient per category.

Table 11.1. Number of patients and mean number of REs for each of the five categories of object relations

<table>
<thead>
<tr>
<th>Object relation category</th>
<th>Number of Patients included</th>
<th>Mean number of REs included early and late</th>
<th>Mean REs (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist</td>
<td>25</td>
<td>4.04 (1.77)</td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>22</td>
<td>4.64 (1.56)</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>11</td>
<td>3.55 (1.44)</td>
<td></td>
</tr>
<tr>
<td>Lovers</td>
<td>29</td>
<td>8.07 (4.50)</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>33</td>
<td>7.30 (2.88)</td>
<td></td>
</tr>
<tr>
<td>Early Memories</td>
<td>8</td>
<td>5.25 (3.62)</td>
<td></td>
</tr>
</tbody>
</table>
As can be seen from these data, 61% of patients (25 out of 41) told one or more narratives about their therapist both early and late-in-therapy. 80% told narratives about others throughout therapy but only 27% told narratives about their family excluding their parents. Interestingly, only 20% continued to tell early memories both early and late-in-therapy. It must be cautioned here that generally only two sessions were sampled early-in-therapy and two late-in-therapy, there were probably many more narratives told by patients within these categories at other times in the therapy which were not included in this study.

Of those patients that did tell narratives early and late within one or more of the object relations categories, most of those narratives were about their lovers (a mean of 8 narratives per patient) or others (a mean of 7.3). Patients also told narratives about their family (mean of 3.6), therapist (mean of 4), and parents (mean of 4.6 narratives per patient).

The relationship between mastery of object relations and clinical outcome

Table 11.2 presents the results from the Pearson correlations between the mastery residual change scores for each object relation versus the three clinical outcome measures.
Table 11.2. Relationship between changes in mastery of object relations and three measures of clinical outcome (Health-Sickness Rating Scale: HSRS; therapists rating of success, satisfaction and improvement: SSI; and patient’s rating of change in their primary target complaint: Target)

<table>
<thead>
<tr>
<th>Object relation</th>
<th>HSRS</th>
<th>SSI</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist</td>
<td>-0.169</td>
<td>-0.192</td>
<td>-0.250</td>
</tr>
<tr>
<td>Parents</td>
<td>0.575**</td>
<td>0.541**</td>
<td>0.621**</td>
</tr>
<tr>
<td>Family</td>
<td>0.208</td>
<td>0.428</td>
<td>0.512</td>
</tr>
<tr>
<td>Lovers</td>
<td>0.389*</td>
<td>0.475**</td>
<td>0.358</td>
</tr>
<tr>
<td>Others</td>
<td>0.368*</td>
<td>0.274</td>
<td>0.219</td>
</tr>
<tr>
<td>Early Memories</td>
<td>0.376</td>
<td>0.117</td>
<td>0.592</td>
</tr>
</tbody>
</table>

*p < 0.05  **p < 0.01

The results from this analysis reveal a surprising finding: the strongest consistent relationship across all three outcome measures was with the changes in the mastery of the relationship with the parents. The second strongest relationship was with changes in the relationship with the patient’s lover, with a significant correlation with two of the three outcome variables (and almost significant for the third variable). The only other variable of note was a relationship between others and HSRS, which was not found in the two other measures SSI and Target. Contrary to the hypothesis, changes in mastery of the patient-therapist relationship were unrelated to any of the clinical outcome measures.

It was therefore decided post hoc to separate out the data on the parents and lover and enter these data into a multiple regression analysis to see whether the ability to encapsulate outcome, using the HSRS, could be improved by combining the two object relations variables. The results are in Table 11.3.
Table 11.3. Regression analysis investigating mastery of the parents and lovers narratives in relation to health-sickness outcome status

Dependent Variable : HSRS  
Independent Variables : Change in mastery of parents narratives and lovers narratives.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>B</th>
<th>Signif t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastery of Relationship Episodes with Parents</td>
<td>23.572</td>
<td>0.03*</td>
</tr>
<tr>
<td>Mastery of Relationship Episodes with Lovers</td>
<td>15.151</td>
<td>0.15</td>
</tr>
<tr>
<td>CONSTANT</td>
<td>6.93575</td>
<td>0.19</td>
</tr>
</tbody>
</table>

* p < 0.05

It is clear from the results of this study that the single most important variable that accounts for outcome is the change in the mastery of relations with the patient’s parents. The parents data significantly contributed to the model (p < 0.03), whereas the lovers data did not. The regression equation was then repeated with SSI as the dependent variable instead of HSRS and then with Target as the dependent variable. The resulting summary of the significance of beta were as follows:
Table 11.4. Regression analysis investigating mastery of the parents and lovers narratives in relation to Change in Target Symptom (Target) and Therapist rate Success (SSI). Only significance of beta is shown for each comparison.

<table>
<thead>
<tr>
<th></th>
<th>Sig t -Parents</th>
<th>Sig t -Lovers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Target Symptom (Target)</td>
<td>0.0187*</td>
<td>0.1765</td>
</tr>
<tr>
<td>Therapist rate Success (SSI)</td>
<td>0.0392*</td>
<td>0.0696</td>
</tr>
</tbody>
</table>

* p < 0.05

These further analyses confirm what was found with the HSRS multiple regression: that the changes in the relation with the parents is the single most important variable accounting for clinical outcome in this sample. For both the SSI and Target, the contribution of the parents data were significant (p < 0.0187; p < 0.0392, respectively), but not the contribution of the lovers data. The relationship between the mastery of relations with the parents and psychological health-sickness is shown in Figure 11.1.
Discussion

The hypothesis to be tested in this study was that patients rated as having larger gains on measures of general functioning and symptoms will show the greatest gains in mastery of their relationship with the therapist. This hypothesis is not supported, because no relationship was found between changes in the mastery of narratives about the therapist and clinical outcome scores. This appears to contradict Freud’s assertion that it is the transference relationship with the therapist that affords the most clinically relevant changes. It may be that patients more often concealed their feelings in discussing their relationship with the therapist and that this obscured clinically relevant changes.
meaningful changes in mastery. Alternatively, the transference relationship with the therapist may act as the medium or ‘container’ by which the work on the other relationship problems proceeds (Winnicott, 1956).

Some psychoanalytic thinkers and practitioners (but by no means all) interpret all narratives that patients tell as being related, connected and originating from feelings evoked in the current transference relationship with the therapist (e.g. Joseph, 1985). From this perspective, transference is seen as operating across all aspects of the therapeutic situation and is primarily triggered by the therapist-patient relationship. Such a view is at odds with the strategy adopted here of dividing up the narratives into the five categories of therapist, parents, family, lovers and others, since on this view they should all be manifestations of the patient-therapist transference relationship. However, the fact that clinically meaningful differentiations were found in this sample between the objects of the narratives argues against this broad view of transference. Freud acknowledged that there may be “several” characteristic transference patterns (Freud, 1912a, p.100). It was possible in this study to differentiate statistically between mastery levels of each object within the narratives, suggesting that the ‘repetition compulsion’ may act differentially depending on the prevailing relationship conditions. It would certainly appear from these results that changes in the relationship with the parents is central to mastering these conflicts.

The relationship between a child and its parents has been the subject of intense study in the attachment and bonding literature (e.g. Bowlby,
1988). Given that it is the primary and central bond that helps the child to learn to integrate their personality, it is hardly surprising that ruptures or difficulties in the patient’s relationship to their parents should be associated with psychopathology. The results from this study suggest that a potent change mechanism is the mastery of the patient’s relationship with their parents. It is probably the case that the relationship with the therapist is a vehicle for this change to occur, but it appears that the mastery of the relationship with the therapist does not change in a clinically meaningful way through therapy as Freud implies.

Considerable caution, however, should be placed on the interpretation of these data. Only 22 of 41 patients told narratives about their parents both early and late-in-therapy during the two early and two late sessions sampled. It may be that all 41 patients told narratives about their parents early and late during sessions that were not sampled. On the other hand, it may be that for only a half of the sample the mastery of the relationship with their parents was clinically important. The sample is relatively young (mean age 25) and were mainly at college, so it may well be the case that separation and individuation from their parents was a developmentally important goal at that time in their lives, and that older patients might have other concerns (Cohler & Galatzer-Levy, 1990). Clearly, the results of this chapter need to be replicated on another set of patients, with preferably a much larger number of sessions investigated early and late-in-therapy. Nevertheless, these preliminary findings are fascinating and have implications for our knowledge of the potent change mechanisms in psychotherapy.
Chapter 12

Conclusion

The fundamental finding of this research is that established maladaptive interpersonal patterns for meeting needs and wishes are able to be better mastered (understood and controlled) during the course of successful psychotherapy. Mastery was theorised to be part of the change process and has been shown to be an essential dimension of improvement in psychotherapy (Grenyer & Luborsky, in press-a). The example used in this study is psychoanalytic psychotherapy, however mastery is likely to be essential in any, if not all, psychotherapies. The evidence provided from this study is that theoretically relevant and central psychodynamic variables can be reliably measured directly from the content of verbal communications patients give in therapy. In concluding this thesis, first a summary of the findings will be given, followed by a discussion of the strengths and limitations of the research. Detailed discussion of the findings is not given here, as this can be found in the discussion sections within each chapter. The thesis concludes with a comment on the implications for future research and for the practice of psychotherapy.
Summary of the findings of this thesis

Perhaps the best way to summarize the results of this study is to revisit the three major areas of the thesis - the theoretical considerations, the testing of the Mastery Scale, and exploration of the scale in relation to other key areas of research.

Theoretical considerations

The first aim of the thesis was to show how mastery is central to the psychoanalytic theory of therapy. Although mastery appears to be a part of the theoretical account of most schools of psychotherapy, classical psychodynamic theory, with its theory of mind and motivation, provides a particularly compelling basis for understanding mastery.

Through Freud’s basic theory, the ego or self is seen as being the masterer, and the conflicts as the things to be mastered. Psychoanalysis theorises that conflicts are tied to basic problems in getting needs and wishes met in the context of interpersonal relations. These pervasive problems are probably due to earlier childhood difficulties combined with genetic disposition. These problems give rise to the repetition compulsion (of which transference is an example), which needs to be worked through in therapy. These problems are not resolved or cured through psychotherapy, but rather are mastered.

Concepts described in the classical language of psychoanalysis based on
energy transfer and working through, were given a more modern translation in contemporary psychotherapy research in the terms of mastery of interpersonal conflicts. Mastery was defined as the acquisition of self-control and self-understanding in the context of interpersonal relationships.

*Evaluation of the Mastery Scale*

The second aim of the thesis was to develop an empirical measure of mastery (the Mastery Scale) and evaluate its reliability and validity as a measure of therapy process and outcome. The scale was constructed based on the theoretical exposition and definition of mastery. Using a task-analysis approach, transcripts of psychotherapy were investigated in detail and content categories were derived that reflected different degrees of mastery. The basic technique adopted was content analysis, based on the success of this approach in previous studies.

Early and late-in-therapy transcripts were scored for 41 patients in the Penn psychotherapy research project. Each transcript was scored twice, and the inter-rater and test-retest reliability between the judges was assessed and was found to be good. The internal consistency of the scale was evaluated and was congruent with the underlying model of mastery. Changes in mastery were related in a meaningful way to changes in general psychological health and ratings of the success of therapy made by the therapist and patient. The scale was thus seen to have good convergent validity.
Relationship between mastery and other variables

The third aim of the thesis was to investigate the relationship between changes in mastery and other centrally important variables in psychotherapy: the therapeutic alliance, the transference, diagnosis, and object relations. Four separate studies were conducted to assess each of these four variables in turn.

The Mastery Scale was compared to a measure of the helping alliance (the Penn Helping Alliance counting signs method) assessed at the beginning of therapy. Early alliance between patient and therapist accounted for 30.2% of the gains in mastery achieved by the patient over the course of therapy. This indicated that the establishment of a good working relationship between patient and therapist contributes significantly to the mastery of interpersonal problems.

The Mastery Scale was compared to a measure of transference (the Core Conflictual Relationship Theme method). The positive and negative aspects of the 'response of other' and 'response of self' components of the transference measure were compared to changes in mastery. Changes in the positivity-negativity of the response of self dimension were significantly related to changes in mastery. Improved patients had more positive outcomes in their own responses to relationship conflicts compared with less improved patients who had negative outcomes.

In relationship to diagnosis, based on the Diagnostic and Statistical
Manual from the American Psychiatric Association, patients in the sample were divided into those with only a clinical Axis I disorder, those with only an Axis II personality disorder, and those with both Axis I and II disorders. Differential changes in mastery across the course of therapy were inspected for the three groups. There were strong significant relationships between mastery and psychological health for the two personality disordered groups but not for the Axis I group. This suggested that the development of interpersonal mastery is a particularly salient and effective goal for personality disordered patients.

Finally, changes in the mastery of different types of relationships were investigated. Narratives told by patients in therapy were classified into 5 groups: therapist, parents, family, lovers, others. Changes in the mastery of each of these groups from early to late were investigated by comparing these changes to clinical outcome measures. The strongest significant relationship with clinical change was for the mastery of the relationship with the parents. This suggests that focusing on mastering (through self-understanding and self-control) conflictual problems in the patient-parent relationship is highly valuable in achieving clinical change.
How dynamic psychotherapy works: an hypothesis

The results of this study fit in with the following tentative suggestions as to how psychotherapy works.

The basic efficacy of therapy rests on the establishment of a strong supportive therapeutic alliance between patient and therapist. The transference relationship with the therapist is a potent medium of therapeutic work, but does not necessarily change in a curative way over the course of therapy as was once thought. A principle mechanism of change in therapy is through the development of mastery, which involves the acquisition of self-control and self-understanding in the context of interpersonal relationships. An important part of the acquisition of mastery is the ability to change how one responds to interpersonal conflicts, rather than through a focus on how others respond to one's self. Pervasive interpersonal problems do not appear to be solved or cured in psychotherapy, but rather are better mastered. The acquisition of mastery through psychotherapy appears to be particularly useful for those with personality disorders. It appears that a fundamental conflictual relationship of importance is that between the patient and their parents. Mastery of this relationship is associated with large gains in therapy.

Vaillant summarizes some of these themes, although not within a causal account of mind, by stressing the importance of the therapist-patient dyad in fostering internal self-mastery: “another person can offer the individual in conflict a sense of shared competence and
unconditional positive regard. Such support can help us achieve mastery, and once that mastery is internalized, it becomes our own. Such learned mastery wards off helplessness and becomes a potent antidote to depression” (Vaillant, 1993, p.109). Through successful therapy the major sources of emotional conflict are mastered by developing an awareness and understanding of them and a sense of control over the conflict, which protects against the re-emergence of symptoms of psychological unease.

**Strengths and limitations of this study**

- **Strengths**

The major strength of this study is that important dynamic process variables have been systematically scored from the content of the patient’s verbal communications and linked to central outcome variables in therapy. These variables that have been reliably scored include such central dynamic concepts as insight into repeating personality patterns, dynamic links between past and present relationships, self-analysis, emotional self-control and the psychological defenses such as projection, forgetting and withdrawal.

The choice of content analysis obviated complex and possibly unreliable methods of scoring, that can arise when judges have to make sophisticated global judgements that rest heavily upon their personal predilections and theoretical persuasion. Patient statements are largely taken at face value, although the scale is not applied
mechanistically as a computer scores transcripts. The method relies upon the human integrator (the Mastery Scale judge) who brings their own emotional life into the process of scoring. The method devised is robust and captures an important dynamic change variable.

The classical Freudian theory of psychotherapy has been translated into a modern psychotherapy research context without loss of these core psychodynamic principles. The empirical research arises out of a comprehensive theory of clinical change. There are links drawn between the theory and the empirical results, with the data being used to test the theory. The theory however is not considered impervious to change, but rather the results are used to suggest modifications to the theory where necessary.

The thrust of this study fits into and contributes to an ongoing effort by researchers across the world to understand how psychotherapy works. The empirical approach was derived from well established methods of conducting research of this type. The particular concerns of this study arose out of previous research and was designed to further the understanding of how interpersonal processes play a role in psychotherapy.

Limitations

It is recognized, however, that what has been gained in predictive power has been at the expense of specificity. The concept and measurement of mastery is broad, and probably reflects many separate cognitive and affective psychological constructs, such as mood, hope,
anxiety, helplessness and locus of control. This study did not set out to investigate such specific inter-relationships, but instead subsumed aspects of these constructs within the view of mastery. In addition, this measurement of mastery may not include all factors important to the concept, such as the assessment of the degree to which an insight statement is salient to the person's core problems. Another limitation of this study is that the patient is studied in isolation. It would be of interest to look at the influence of therapist behaviours on the development of mastery.

Content analysis as a method is very time consuming, which will necessarily prevent it from being adopted routinely in clinical trials. Nevertheless, although it might have been easier to have devised a more simple Mastery Scale (for example by questionnaire), such a scale would probably be unable to measure the same concepts nor would it capture the same subtle therapeutic factors.

The sample size of this study \((N = 41)\) is very small when compared to the overall population of psychotherapy patients from which it is sampled. Aspects of the sample also caution against the generalizability of some of the results. For instance, the personality disordered patients were not found to be more severe in psychiatric functioning than those without a personality disorder, a result in contrast to other studies. The sample was relatively young and were predominantly sampled from a undergraduate university or college population. Some of the studies in this thesis that further partitioned the sample into smaller cell sizes (e.g. Chapter 11) are more acutely at risk of loosing generalizability.
Nevertheless it should also be emphasized that gathering larger samples and applying such methods is not easy: it is extremely time and cost intensive to record therapy, transcribe it, and apply these types of methods.

The analysis of the results in this study rest heavily upon finding correlations between process and outcome variables. It needs to be emphasized that finding a correlation between two variables does not necessarily mean that the two are causally related. It may be, for instance, that the correlation between mastery and health-sickness may be due to a third variable (such as the therapeutic alliance). However, it is difficult in this kind of research to avoid this correlation-causation dilemma, because establishing causal links requires the kind of tight control of variables that would in most cases destroy the natural phenomenon - psychotherapy - that is the object of interest (for further discussion of such process-outcome dilemmas, see for example Stiles, 1988; Wallerstein, 1993).

**Directions for future research**

The significance of this research lies in its contribution to the current effort of psychotherapy researchers to understand how interpersonal processes change through psychotherapy. This has lead out of past studies of the therapeutic alliance and contemporary measures of transference, which are both concerned with interpersonal functioning. The new measure of mastery developed may contribute to the development of dynamically-relevant measures of psychotherapy
process that enhance our understanding of the effective ingredients of clinical change.

There are a number of implications for future research. First, the results of this study need to be replicated on a different sample of patients to discount the possibility that the results obtained were specific to this group. Further comparisons could be made between changes in mastery and other measures of the therapeutic alliance and transference. In replicating the study on mastery and personality disorders, it would be preferable to have more homogeneous groups, such as depression versus borderline personality disorder. For the study of object relations, a larger number of sessions from psychotherapy should be sampled to ensure that the maximum number of patients have relationship episodes in all five categories (therapist, parents, family, lovers, others) both early and late-in-therapy. Research is needed to further understanding of the relationships between the variables. For example, Howard and colleagues charted the sequence of changes in process and outcome variables at different points in therapy to ascertain the sequence of changes through therapy (Howard, Lueger, Maling & Martinovich, 1993). Sampling from across therapy, not just early and late, would increase our understanding of the sequence of changes in different parts of mastery and how these relate to other clinical changes.

The methodological implications of various decisions in constructing the Mastery Scale should also be investigated. For example, having judges make scores for each relationship episode without the surrounding context could be evaluated by having a separate set of
judges code for mastery armed with this knowledge of the context. In addition, the Mastery Scale could be revised to take into account the response of other aspect of the CCRT. At the moment the Mastery Scale shows good concordance with the response of self component; changing the scoring to encapsulate the response of other might be a fruitful area of investigation. Similarly, it would be useful to investigate how the therapist, through their support and interpretations, influences the development of mastery in the patient.

This study has assessed the development of mastery in dynamic psychotherapy. It would be useful to assess whether such changes can be found in psychotherapies of other persuasions, such as cognitive therapy, experiential therapy and client-centred therapy. If such processes are also found in these therapies, then consideration needs to be given to the further "assimilative integration" of mastery within each of these explanatory models (Messer, 1992).

Just as the Mastery Scale reported in this study arose out of an intense study of transcripts of psychotherapy, future research will be able to refine the content categories and re-cast some of them to discover new aspects of psychotherapy. For the richest source of knowledge about psychotherapy is through studying and experiencing first-hand the actual process between therapist and patient. As Freud states "psychoanalysis ... is still linked to its contact with patients for increasing its depth and for its further development." (Freud, 1933, p.151).
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Appendix 1

Ethics consent forms for patients in pilot study (Chapter 6)

University of Wollongong Human Experimentation Ethics Committee
I, the undersigned, give ____________________________ (psychologist) permission to make an audio tape recording of my psychotherapeutic treatment, and to use the recordings for research. He has informed me that the recordings will be available only to him and to his research colleagues; and that in the event of any future scientific report or publication of the research, my anonymity is to be protected by deletion of identifying data.

I have been informed that my consent to have my psychotherapy recorded is not a requirement for receiving treatment.

I have been informed that the tapes will be erased at the completion of the study.

I have been informed that at the completion of the research study I will be advised of the results of the project.

I have been informed that I may contact the Secretary of the University of Wollongong Human Research Ethics Committee if I have any complaints about the conduct of the research. This project is being undertaken by Brin Grenyer, a doctoral student in clinical psychology and a registered psychologist. Dr Nigel Mackay is a Senior Lecturer in the Department of Psychology and is supervising this project.

With these conditions, I willingly consent to participate in the study by allowing audio tape recordings of my psychotherapy. However, I reserve the right to withdraw my consent for participation in the study at any time without the necessity of giving a reason, and without prejudice for my continued treatment.
Aims of the study.

This psychotherapy project is being conducted in the Department of Psychology of the University of Wollongong. We are interested in examining the way psychotherapy helps people. Those who come to psychotherapy often feel like their life is not under their control, that problems are overwhelming them and relationships with others are not as fulfilling as they would like. We are inviting volunteers who are seeking psychotherapy to consent to having their therapy audiotape recorded. The purpose of the audiotaping is to allow us to study how self-control and self-understanding of problems develops as the therapy progresses. We are particularly interested in the effect psychotherapy has on people’s feelings of mastery of their problems and difficulties.

Participation in the study.

Participation in this project is voluntary and there is no obligation to do so. Treatment will in no way be withheld or compromised by a refusal to participate. Participants may withdraw from this study at any time. Deciding to discontinue participation will not affect the treatment being received. You may expect no personal benefit from the study. However, the information gained from the study might be useful in helping to better understand the effects of psychotherapy. Participants will be informed of the results of the project on completion of the study.

Note that only researchers who are directly involved in this project will have access to the tapes. The tapes will be analysed by internationally recognised research methods that conform to stringent scientific and ethical principles. The tapes are secured in locked cabinets in a secure room and are erased at the end of the study.

You will not be personally identifiable in the results of this study. All personal identifying information (e.g., names of self, family, friends; biographical details; geographical details and other information of a personal nature) will not be included in any research report or publication arising from this study. Your identity will be protected and all information you give will be treated as strictly confidential.

This project has been approved by the Human Research Ethics Committee of the University of Wollongong. Complaints about the conduct of this research may be addressed to the secretary of the committee.

Project team.

This project is being undertaken by Brin Grenyer, a doctoral student in clinical psychology and a registered psychologist. Dr Nigel Mackay is a Senior Lecturer in the Department of Psychology and is supervising this project.
Appendix 2

Mastery Scale Manual

Includes full Mastery Scale and instructions for scoring

Note: This has also been published separately as a monograph
MASTERY SCALE I

A RESEARCH AND SCORING MANUAL

Brin F.S. Grenyer
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for Kees

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This research material has strict limits as to its use and distribution, to which you must agree before use this manual. Your use of this manual is your indication of your willingness to abide by these conditions. If you do not agree to these conditions, please do not use this manual and return it to the author if possible.

Anyone who reads personal interviews, particularly therapy interviews, is the recipient of professional confidences and is expected to maintain professional conduct and treat all data as strictly confidential. It is essential that you consider the interview material in this manual as private and personal communication from a vulnerable individual who would not willingly share their confidences with unfriendly strangers. Those who were interviewed understood that interview materials would be used only for serious scientific purposes, that those using the materials would maintain professional conduct and ethics, treating their confidences with respect.

In agreeing to use this research manual, you have two responsibilities:

(1) Not to discuss or refer to the content of the enclosed materials with anyone who is not directly connected with your research.

(2) Not to copy or distribute the research materials and transcripts, nor use or refer to these materials in any other project or research or teaching task.

Any violation will not only be unethical and an abuse of professional agreements, but will place therapy research of this nature in an unfavourable light. Any indiscretion on your part might deter people from seeking counselling or therapeutic help or from serving in research projects because they understandably fear their privacy might be infringed.
Introduction

The Mastery Scale, Version I, is a comprehensive psychotherapy process research tool. It was originally designed to investigate levels of mastery of transference-related interpersonal conflicts in patients undergoing psychotherapy. It has been developed based on a psychoanalytic model of psychotherapy, however it may be readily applicable to many clinical research investigations from different orientations. The data base used for the development of the Mastery Scale was that of extracts of psychotherapy where patients tell narratives about relationship interactions. It may also be applicable to narratives that have been collected outside of psychotherapy (for example, using the RAP - Relationship Anecdotes Paradigm Interview (Luborsky, 1990). It may also be applied to verbal samples that tap interpersonal dimensions (for example, 5 minute verbal samples elicited using the instructions of Gift, Cole and Wynne (1986)).

The intention is to provide an accurate, valid, and replicable measure of psychological mastery that can be used in different research contexts. The full theoretical basis and empirical supports of the concept of mastery is developed in detail elsewhere (Grenyer and Luborsky, in press), however a brief outline follows.

The Concept of Mastery

Mastery is defined as the acquisition of emotional self-control and intellectual self-understanding in the context of interpersonal relations. A person with mastery has a greater sense of adaptive control over their emotional reactions when faced with conflicts in interpersonal relationships and is more able to understand the origins and motives behind these conflicts. A person without mastery blindly reacts with great distress to a wide domain of interpersonal situations without awareness of the sources of their conflicts and problems. The tendency to repeat the same maladaptive ways of relating over a wide range of situations, relationships and occasions is known as in psychoanalysis as the action of the repetition compulsion (Freud, 1914). Researchers have, for convenience, referred to these pervasive maladaptive relationship patterns as, for example, the 'nuclear conflict' (Alexander and French, 1946), the ‘core neurotic conflict’ (Wallerstein and Robbins, 1956), or the ‘core conflictual relationship theme’ (Luborsky 1977). An example of the repetition compulsion is in the transference - where the patient repeats ('transfers') these maladaptive ways of relating towards the therapist. The transference relationship with the therapist is one special example of the general action of the repetition compulsion (Freud, 1914). Repetitive maladaptive patterns of interpersonal relating are not fully resolved or cured by psychotherapy (Schlessinger and Robbins, 1975). However, with effort they become better mastered, which leads to a growing sense of well being and a decrease in symptoms of psychological distress. 

In describing the benefits of the prospective therapist undergoing analysis with a senior analyst, Freud highlights the two fundamental aspects of mastery: “everyone who wishes to carry out analyses on other people shall first himself undergo an analysis by someone with expert knowledge ... Anyone who can appreciate the high value of the self-knowledge and increase in
self-control thus acquired will, when it is over, continue the analytic examination of his personality in the form of self-analysis” (Freud, 1912, p.116-117). It is proposed that the gains in mastery made in psychotherapy become internalized, and the process of self-analysis continues to influence the course of the patient’s life after therapy and protects against relapse. The Mastery Scale endeavours to capture the spirit of this definition.

We maintain that the development of mastery is a key process in how patients improve through psychotherapy, as well as being an essential quality of mental health. Clinicians readily recognize in their patients aspects of mastery but to date, mastery has not been quantifiable. With this scale we now have a research instrument to measure these changes that are so clearly observable in the speech of our patients.

The choice of narratives as the focus of the mastery scale

The Mastery Scale can be applied to verbal samples collected by a variety of means, as discussed below. However, it has been specifically designed to be applied to a particular part of the psychotherapy hour, when the patient tells narratives of relationship interactions. Luborsky and colleagues have found through the intense study of verbatim transcripts of psychotherapy that narratives of interpersonal interactions are ubiquitous throughout the course of the psychotherapy encounter (Luborsky, Barber and Diguer, 1992). These narratives are illustrations of the problems brought to therapy, and are frequently of negative conflicts: “Negative interactions are more memorable and so are more ready to be told than positive ones because they deal with conflicts in relationships that are harder to master. The remembering and telling probably is in the service of trying to master the conflictual relationships” (Luborsky et al. 1992, p.284). Narratives appear to illustrate the core conflictual relationship problems. They are therefore a particularly fertile source of evidence for assessing the degree in which such problems are mastered.

The choice of content analysis to measure mastery

The assumption of content analysis is that the manifest surface content contained within the speech of the patient contains valid and reliable information about their psychological states. By counting the number of instances of the specified content, and weighting it based on the underlying psychological dimension, it is possible to derive reliable and valid measurement of the construct. The method has the advantage that the dimensions are measured directly and naturalistically from patient reports, unlike questionnaires that predetermine the content and the range of possible responses. The method also does not require judges with a professional background in the psychological sciences. The judging task simply requires matching the surface speech content with the specified criteria. It thus avoids the problem of low inter-judge agreement that commonly arises in methods that demand making complex deep inferences about patient material.
Apologia

We have attempted in good faith to construct a scale that may be useful when applied to research questions in the psychological sciences. We have used the above definition as a guide in defining the concept of Mastery, and have attempted to develop the measure to reflect this construct. We recognize that there are many alternative definitions of mastery, and that the concept will be used in many contexts in quite different ways. We have made an attempt to make the Scale correspond closely to the construct we have defined, but we recognize that the scale may also measure within it other common psychological constructs to various degrees such as anxiety and mood. In as much as these other constructs relate to overall Mastery, we feel satisfied that we have achieved our aim. We also recognize that there are margins of error in our methods - the Scale is probably neither definitive in capturing the concept in question, nor does all of the scale reflect our concept. The Scale has evolved from an idea that was first enunciated by the author in Philadelphia in June 1993 and underwent many changes and revisions in the months that followed. The present version was adopted in Sydney in November 1993. It is hoped that as the Scale is used in further research contexts and comes under increasing critical scrutiny that modifications and new versions will improve on our present attempts. We welcome comments and critical feedback by users of this Manual.

Reliability and Validity of the Mastery Scale

We have examined the reliability and validity of the Mastery Scale on a sample of 41 patients from the Penn Psychotherapy Research Project. The full details of this study are reported elsewhere (Grenyer and Luborsky, in press). We present a brief overview of some of our findings. 

Reliability : Inter-rater reliability for 4 judges over 41 patients is excellent, and in the range of 0.75 - 0.89, and test-retest reliability 1 week later is between 0.86 - 0.97. A cluster analysis confirmed that the categories fell into the predicted order of levels of interpersonal Mastery in the scale. Validity : The scores have been validated against a number of important clinical outcome variables. Changes in Mastery over the course of therapy have been shown to be related to changes in a scale measuring degrees of psychiatric Health-Sickness (HSRS) (Axis V of DSM-IV) $r = 0.51$ ($p < 0.001$), the therapist’s rating of patient satisfaction, success and improvement $r = 0.47$ ($p < 0.01$), and the patient’s rating of change of their primary target complaint $r = 0.59$ ($p < 0.001$). It is also significantly related to the ‘response of self’ component of the Core Conflictual Relationship Theme method (Luborsky 1977) $r = 0.37$ ($p < 0.05$). These findings confirm that the scale is measuring the key dynamic variables of change in the context of interpersonal relationships as told in psychotherapy. Other studies using the scale are now in progress.
Acknowledgements

The development of this project would not be possible without the continuing support of Professor Lester Luborsky from the Centre for Psychotherapy Research, University of Pennsylvania. As well as providing outstanding guidance and advice throughout all aspects of this project he has generously allowed access to data from the Penn Psychotherapy Research Project. The author also gratefully acknowledges the expert guidance of Dr Nigel Mackay, who has supported and steered this project in many ways. Finally I would like to acknowledge the various judges and researchers who have made contributions to this project: Vera Auerbach, Mary Carse, Annalisa Dezarnaulds, Louis Diguer, Suzanne Johnson, Richard Rushton, Kelly Schmidt, and in particular Dr Nadia Solowij.
Collecting samples to study

The basic materials that are needed are speech samples. These may be transcripts of psychotherapy, records of interviews, responses to stimulus materials (e.g., the Thematic Apperception Test), or perhaps even written archival material such as diary entries. Although it may be possible to score some features of the Scale directly from audiotape or videotape, it is not recommended that the scale be coded from these materials alone until further studies are done to validate this method. A combination of transcript and tape would probably be optimal and improve the validity of ratings, but this has not been experimentally established, and other content analysis scales have not found the increase in accuracy to be significantly superior using audio material compared with written transcripts alone (Gottschalk, Winget and Gleser, 1969).

Instructions for collecting verbal samples

There are many different types of data collection available. Below are three methods that have proven very useful. All rely upon making audio recordings of speech for later transcription and analysis.

Prior to recording, the following information is recorded on the audiotape by the researcher:
1. Date of recording
2. Time of day
3. Identification code of subject
4. Interviewer or therapist making the recording.

A clear and clean recording is vital to ensure that the transcription is as faithful to the spoken speech as possible. Select a quiet and private echo-free room to conduct the therapy or interviews (Mahl, Dollard and Redlich, 1954). Endeavour to minimize all extraneous noise, disruptions and interruptions. Sensible precautions include diverting telephone calls and putting a warning sign outside the door. Ensure that the recorder and microphone are functioning and are placed close enough to the subject to maximize the ratio of the speech signal to ambient noise. Do not use tape recorders that are voice-activated, as the pauses and silences may be important pieces of information in understanding and coding the material.

It is important that the subject and interviewer are comfortable with the presence of the recording machine. We have found that if the interviewer or therapist is confident with the recording device and can model to the subject the absence of concern about it (to put the recording device 'out of mind' so to speak), then the interview usually proceeds smoothly. The interviewer should maintain appropriate eye contact with the subject to let them know that they are interested in what the subject has to say in the 'here and now'. The interviewer is therefore advised to avoid looking at the recording machine or fussing over it, and should monitor the comfort of the participant and promptly answer any concerns and allay fears (e.g., about confidentiality) early in the interview, preferably before the data is collected. The essential qualities of the interviewer include those
recommended in all therapeutic contexts, such as the ability to establish rapport, use listening skills, and empathize with the interviewees concerns (Egan, 1982).

The basic principles of collecting data are those developed by Freud in his method of ‘free association’. Freud wrote that “the patient must be left to talk, and the choice of subject matter left to him” - that is, that there should be a general invitation to speak about the subject’s experience without undue shaping of this by the experimenter. The three methods discussed below all share this feature. The interviewer is advised to avoid giving any more specific instructions as to content than that given in the methods below.

Method 1. Naturalistic psychotherapy sessions.

Before the beginning of a contract between therapist and patient to engage in psychotherapy, informed consent should be obtained from the patient (and if relevant, the therapist) for the therapy to be audio or video recorded. The consent usually involves signing a consent form that has been approved by an ethics committee. The conditions of such consent commonly includes the clause that the patient can withdraw consent for the audiotaping without prejudicing treatment in any way.

At the completion of the psychotherapy, verbatim transcripts of the sessions of interest are made and these form the data base for scoring the mastery scale. In psychotherapy, the therapist provides an invitation to speak, but does not direct or prescribe the content of the session. The data are naturalistic in the sense that it is for the patient to lead the discussion and furnish the content of the material as their own personal needs dictate.

Method 2. Relationship Anecdotes Paradigm (RAP) Interview method.

This method has been developed by Luborsky (1990b) and the reader is advised to consult this source for detailed information. The instructions are as follows:

Please tell me some incidents or events, each involving yourself in relation to another person. Each one should be a specific incident. Some should be current and some old incidents. For each one tell (1) when it occurred, (2) the other person it was with, (3) some of what the other person said or did and what you said or did, and (4) what happened at the end. The other person might be anyone - your father, mother, brothers and sisters or other relatives, friends or people you work with. It just has to be about a specific event that was personally important or a problem to you in some way. Tell at least ten of these incidents. Spend about three but no more than five minutes in telling each one. I will let you know when you come near the end of five minutes. This is a way to tell about your relationships. Make yourself comfortable and enter into this RAP session as you would with someone who you want to get to know you (Luborsky, 1990, p.103).

To derive good narratives, it is crucial for the investigator to use follow-up prompts where
necessary especially after the first narrative is told, to be sure the subject gives specific concrete events and not only generalised accounts. For narratives that are too short, the subject must be asked to “tell me more” about the events described. It is important to do this from the first narrative told to ensure that the subject understands how much detail to provide so that the data can be analysed usefully. The investigator should reduce the anxiety about finding narratives by suggestions such as “just tell me any incident, event or interaction with anyone that occurs to you now”. The person who is struggling with remembering exact details should be encouraged to “say what you remember now about it”. Similarly, the person who cannot remember narratives that are “important” should be invited to recall “events or incidents as you think of them”.

The RAP interview is tape recorded and lasts between thirty and fifty minutes. Relationship anecdotes can come from any period in the person’s life and it is preferable to have a variety of narratives. The narratives may be derived with specific research questions in mind. Examples of this are: (a) in marital therapy, derive narratives about each other; (b) in object relations studies, derive four narratives each of the main people in the person’s early life; (c) in psychiatric studies, narratives told in the context of a clinical evaluation could form the data base; (d) in addiction studies, narratives about relationships with other drug using acquaintances could be compared to non-using acquaintances (see Luborsky, 1990, p. 104, for more details on various methods).

The most important factor in deriving good narratives is that the subject be comfortable and have good rapport with the investigator. References to the confidentiality of the interview and the positive value of the subject’s contribution to understanding relationships can help to engender trust and cooperation.

**Method 3. Five minute speech samples.**

Five minute speech samples have been used for over 20 years and have proved to be very useful in clinical research contexts. The full guide to using these is found in Gottschalk, Winget, and Gleser (1969). The instructions are given following the establishment of rapport with the subject, and their responses are audio recorded. The original instructions of Gottschalk et al are as follows:

This is a study of speaking and conversational habits. Upon a signal from me I would like you to speak for five minutes about any interesting or dramatic personal life experience you have had. Once you have started I will be here listening to you but I would prefer not to reply to any questions you may feel like asking me until the five-minute period is over. Do you have any questions you would like to ask me before we start? Well then, you may begin.

Alternative instructions to these have been developed by Viney (1983) for use in clinical and health psychology research contexts. These instructions are:
I'd like you to talk to me for a few minutes about your life at the moment - the good things and the bad - what it is like for you. Once you have started I shall be here listening to you; but I'd rather not reply to any questions you may have until a five minute period is over. Do you have any questions you would like to ask now, before we start?

It is unclear at present how useful it would be to score the Mastery Scale on samples derived using the above two forms of instructions. It is preferable that what is assessed is aspects of interpersonal functioning. The following instructions focus on the subject’s perceptions of a relative or significant other (Gift, Cole and Wynne, 1986) and are recommended if 5 minute speech samples are to be used as the data base:

When I ask you to begin I’d like you to speak for five minutes, telling me what kind of a person (relative’s first name) is and how you get along together. After you’ve begun to speak, I’d prefer not to answer any questions until the five minutes are over. Do you have any questions you’d like to ask before we begin?

It should be cautioned that samples as short as those derived from the five minute method may not derive valid measures of complex constructs such as Mastery. Future studies are required to elaborate this important issue.
Instructions for transcribing verbal samples

The transcription of psychotherapy is a time consuming process; one hour of therapy can take 5 to 8 hours or more to accurately transcribe. Very detailed rules are available for transcribing verbal material (Sacks, Schegloff and Jefferson, 1978). A summary of some of these rules are as follows (taken from Elliott, 1983, which has examples of the following):

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Client speech, expressed sequentially as in C1, C2, C3 etc.</td>
</tr>
<tr>
<td>T</td>
<td>Therapist speech, expressed sequentially as in T1, T2, T3 etc.</td>
</tr>
<tr>
<td>H or h</td>
<td>out-breaths</td>
</tr>
<tr>
<td>‘h</td>
<td>in-breath</td>
</tr>
<tr>
<td>=</td>
<td>stands for ‘latching’ of one speaking turn into another without a pause</td>
</tr>
<tr>
<td>:</td>
<td>a stretching of a sound</td>
</tr>
<tr>
<td>0</td>
<td>something said over-softly</td>
</tr>
<tr>
<td>italics</td>
<td>raised loudness or pitch</td>
</tr>
<tr>
<td>t</td>
<td>tongue click</td>
</tr>
<tr>
<td>()</td>
<td>parentheses enclose uncertain hearings</td>
</tr>
<tr>
<td>(4.1)</td>
<td>numbers in parentheses are time in seconds</td>
</tr>
</tbody>
</table>

For the purpose of scoring the Mastery Scale, such detailed transcription rules are preferable, but not essential. In fact, as long as the words spoken are recorded, then the scale can be calculated. It should be emphasized that all transcriptions are more or less accurate renditions of what is said, and that a “perfect” transcription is unachievable with our present state of technology and the limits of verbal language in recording voiced speech. Bordin and colleagues discuss these and some other sources of error in psychotherapy process research of this nature (Bordin, Cutler, Dittmann, Haraway et al 1983).

Other rules that are useful in preparing transcripts are the following:

1. All partial words, stutters and repetitions are included.
2. Non-verbal vocalizations such as ‘ah’ and ‘um’ are included.
3. An independent listener checks the entire transcript with the recorded tape for accuracy.
4. The transcripts are triple spaced, with a wide margin on the left hand side.
The following conventions (written mainly in brackets in the transcript) have been devised by the author to cover some of the most common speech and non-speech events in psychotherapy, and have proven useful to adopt in the transcription process:

**General conventions:**

(silence in seconds : x) - for long pauses - approximately longer than 5 seconds
(pause) - for shorter hesitations
(unclear word/s) - for a word or words that are indecipherable from the recording
Underlined - for words or phrases that are emphasized by the speaker
[ ] - for containing an utterance of the other speaker whilst the main speaker is talking eg. [Uh-hu]
{Client} Client’s name explicitly referred to - not recorded to protect identity
{Therapist} Therapist’s name explicitly referred to - not recorded to protect identity

**Non-speech communications**

(tears)
(cries)
(sniffs)
(loud sniff)
(takes tissue)
(blow nose)
(cries hard)
(laughs)
(soft laugh)
(swallows)
(sharp cough)
(breathes in)
(breathes out)
(breathes in & out)
(loudly breathes in & out)
(soft laugh)

**Intonation**

(normal voice :)
(bitter voice :)
(breathy voice :)
(teary voice:)
(quickly :)
(slowly :)
(quietly :)
(very quietly :)
(loudly :)
(high pitched :)
(low pitched :)
(shakily :)
(smiling voice:)

(ts [tongue click + breath]
Scoring the Mastery Scale

Two types of researchers are recommended to score the Mastery Scale. The first type of researchers (called clusers) prepare the transcripts for the judges. Preparation includes transcribing the material, identifying narratives (if applicable) and dividing the speech into grammatical clauses. The second type of researchers (called judges) is responsible for assigning mastery scores to the clauses.

The unit of interest is the single sample of transcribed speech. This is usually a single narrative (also called a relationship episode or RE), of an interaction between the speaker and another person(s). The sample may also be a 5-minute speech sample, or a diary entry etc. For each sample, the individual scored clauses are summed and divided by the number of scorable clauses to derive a single mastery score for that sample (which is the mean score):

\[
\text{Mastery Score} = \frac{\sum x}{N}
\]

Where:

\(\sum x = \) the sum of the values of the individually scored clauses in the sample

\(N = \) the total number of scorable clauses in the sample

Mastery Scores can then be combined and contrasted in various research designs within and between subjects. The use of the Mastery Scale in different contexts depends, as in all scientific research, on the quality of the raw data collected, the adequacy of the design, and the veracity of the methods of statistical evaluation employed and conclusions drawn.

Individual sub-elements of the Mastery Scale can be investigated. The relative frequencies of Mastery Scale categories can also be computed. Profiles of categories within and across subjects can be graphically represented and interpreted.
Instructions for preparation of psychotherapy transcripts for scoring

The following methods are used when the data base for scoring the Mastery Scale are transcripts of psychotherapy. When the materials are derived through other means, (eg. 5-minute speech samples), the following can easily be modified to suit that purpose.

Research Steps (carried out by the clauers)

1. Remove or obscure sensitive information in the transcripts (if it has not already been done), such as:

   - information that may identify the subject of the research (eg. names, ages, places, nationality etc).

   - information that records the number of the session, the date of the session, etc. This information may bias the judges (eg. information that the session occurred late in therapy vs early).

2. Identify and extract all narratives or relationship episodes (REs) from the transcripts.

   The method for extracting relationship episodes was devised by Luborsky, and detailed instructions of the method appear in Luborsky (1990a) and should be consulted when identifying REs. The following is a brief overview of this method.

   Relationship Episodes are defined as “a part of a session that occurs as a relatively discrete episode of explicit narration about relationships with others or with the self” (p. 15-6). These discrete episodes are identifiable because the narratives tend to have a stereotypic structure: (a) a beginning introduction eg. “I will give you an example, yesterday I saw Kelly and she ...”; or “I am depressed. (pause) The phone rang last night. It was Kylie and ...” (b) a middle, where the main details of the interaction are described, often with recollection of what each person said; and (c) and end, where the story as it happened is finished, before moving back into a more general discussion or a change of topic. A single horizontal line is drawn at the start of the narrative (at the beginning of the introductory comments or story) and another is drawn at the end (when the explicit telling is finished). Sometimes a story is interrupted by a digression, and then the rest of the story is finished afterwards. In this instance, the start and end of the first part of the story are marked, with a note at the end “continues on page x” - and on page x the beginning of the recommencement of the story is again marked as is the end. The digression is thus “cut out” and is not scored. Generally, judges only read the relationship episode - they are not provided the context of the rest of the session.

   The people (apart from the narrator) in the RE are noted in the margin (eg father and mother). Sometimes the other person may be explicitly the therapist - either a recollection of an episode that happened earlier, or an enactment at the time between therapist and patient (eg. an argument about the cost of the therapy sessions). Occasionally the person may narrate an episode about
themselves only, which is more than self-description and can be scored. It may be useful to note whether the narrative occurred early in the person’s life or is a recent event.

Narratives are judged for completeness on a 5-point scale. Only those that are 2.5 or greater in completeness are used and scored. A 2.5 narrative or above has three identifiable components: (a) a wish by the speaker, either explicitly stated or clearly inferable (eg. I wanted to get help from Pete); (b) a reaction of the other person to that wish (eg. Pete told me to go away and stop bothering him); and (c) a reaction of the self (speaker) to the interaction (eg. I felt rejected and hurt). This is the basic structure of the Core Conflictual Relationship Theme method (Luborsky, 1990). A narrative such as “Pete came over to my house and we played records all afternoon before I got very tired again” is not scored because it is not clear what the reactions of the other (Pete’s reactions) are in this example.

(3) Divide the narratives into clauses

Transcripts are of spoken speech, and need to be divided into grammatical units (clauses) in order to apply content-analysis techniques. This is made by using slash marks (“/”) to indicate the division of the clause. A valid and reliable method has been developed by Auld and White (1956) for this purpose. The only exception to the rules of Auld and White used here are that nonrestrictive dependent clauses are also divided, as are independent clauses. This alteration makes this method of clausing consistent with the rules adopted by Gottschalk, Winget and Glesser (1969), and the reader is referred also to that work which also includes many scored examples. For a more general introduction to the rules of grammar consult Strunk and White (1959).

Some rules for dividing verbal transcripts into clauses

1. Only independent and nonrestrictive dependent clauses are divided. A clause contains a subject and a predicate, and may or may not contain other complements and modifiers.Clauses are either independent or dependent. Main independent clauses are normally separated by full stops, commas and conjunctions such as “and”, “or”, “but”. Dependent (subordinate) clauses are either restrictive (they modify the meaning of the main clause) or nonrestrictive (they add additional information to the main clause).

Restrictive subordinate clauses only qualify the main clause, are not preceded by a comma, and are not divided. They are usually introduced by words such as “that”, “what”, “when”, “where”, “who”, “how”, “if”. eg. /It was hot when I was in Rome /; / Rome is where I found love /

Nonrestrictive dependent clauses are divided since they add additional independent information, are usually preceded by a comma, and are usually introduced by words such as “because”, “since”, “when”, “which”, “who”, “that”, “although”, “even though”, “so”, “so what”. eg. /I went to Rome, / which was hot /; / I had a Roman holiday, / where I found love /
2. In the case of elliptical sentences, the subject or predicate may be missing, but the context makes the whole meaning clear. In these cases, the phrase is also divided. For example, if the therapist says "are you cold?" and the client replies "yes", the "yes" is treated as a separate clause because it can be understood to be saying "/yes I am cold/".

3. False starts are not divided, eg. "/yeah I was going - I was going to Rome/"

4. Filler phrases such as "you know" added to clauses are not divided. eg "/I am going to Rome, you know/".

5. Clauses that are interrupted by other clauses, as if in parentheses, are divided separately. eg. "/I am going - /Lise asked me to marry her, /going to Rome, /where I'll get married/".

6. Unlike Auld and White, silences are not considered separate units.

7. Therapist statements are not claused or scored, unless that is part of the research design.

Decisions as to where to divide verbal samples are not always clear-cut, and differences of opinion can arise which cannot be resolved by experts because the rules of grammar allow for different interpretations of the same problem. It is preferable to have one clauser undertake the whole task to keep constant this source of error (Gottschalk et al 1969).
Identifying which clauses can be scored for mastery

There are two approaches to scoring the claued transcripts:

Method 1: Judges decide which clauses are scorable for mastery.

The first approach is to get each judge to decide which clauses are scorable for mastery. The judges then score these identified clauses.

Method 2: Clauers decide which clauses are scorable for mastery.

The other approach is to have one clauer identify (by underlining, or some other marking convention) all scorable clauses prior to the judges assigning their content codes. This involves deciding which clauses are indicative of mastery. Only clauses that can be meaningfully scored on the Mastery Scale are identified. Clauses that are ambiguous in respect to mastery or need a very high degree of abstraction or context to derive mastery scores should not be identified. Statements in patient narratives that are quoted directly verbatim from others are generally not identified. eg. /He said “I don’t know why you are acting this way today”/ is not scored. However, the following would be identified as scorable on the Mastery Scale since it is from the patient’s phenomenological perspective: /He seemed to be very confused about my behaviour/.

The advantage of the latter approach is two-fold: first, all judges make ratings on the same clauses, making calculations of inter-judge agreement easier. Second, the task for the content-coding judges involves considerably less labour, an important consideration as the cost of coding is high and the extra task in addition to scoring can rapidly lead to fatigue. We have compared both approaches on a set of REs and have found the results to be highly correlated (above 0.85) between the two methods.

We favour method 2. The clauer who identifies the scorable clauses should be very experienced and highly trained with the scale. Clauses to be identified for scoring are those that relate directly to mastery and can be rated according to the content analysis method. Clauses that are ambiguous in respect to mastery or need a very high degree of abstraction or context to derive mastery scores should not be identified.
Instructions to psychotherapy judges

Psychotherapy provides a forum for patients to work on their difficulties with the assistance of a therapist. The material brought to therapy by patients typically contains narratives of conflictual interpersonal relationships which they wish to master. These narratives have been extracted from psychotherapy transcripts. You are to rate these narratives on a research content-analysis scale.

Directions

(1) Rate each narrative separately before proceeding to rate the next narrative. Rate the narratives in the order in which they are presented to you. Read the narrative first to get a feel for the relationship interaction.

(2) The scale requires you to make specific judgements about individual sentences (clauses). You are not rating the process as a whole.

(3) There can only be one score per clause.

(4) You will only be coding references to the self and the subject’s perceptions of others in relation to their interpersonal experience.

(5) If the scorable clauses are not already identified, you will need to decide which clauses are indicative of mastery. Score only clauses that can be meaningfully scored on the Mastery Scale. Clauses that are ambiguous in respect to mastery or need a very high degree of abstraction or context to derive mastery scores should not be scored. Statements in patient narratives that are quoted directly verbatim from others are generally not scored. eg. /He said “I don’t know why you are acting this way today”/ is not scored. However, the following would be scored as 4N since it is from the patient’s phenomenological perspective : /He seemed to be very confused about my behaviour/.

(6) If the scorable clauses have already been identified, only score these clauses and no others. Record the scores above the underlined units or on a score sheet provided.

(7) Occasionally you will find that individual aspects of the clause suggest different scores. You are rating the clause as a whole so the choice of the rating must reflect the whole clause, not one part of it. If in doubt, score the major theme that best reflects the mastery of the patient. If you cannot decide between two alternative codes, choose the higher code.

(8) Sometimes you will have difficulty in rating a clause. Generally your first or initial reaction to the clause is your most reliable guide in these instances.

(9) You are coding manifest or “surface” content - you do not need to make sophisticated inferences about the clause. You are coding content, not mood. Mood is relevant only if it is
revealed explicitly in the content. You should generally take what the patient says at face value.

(10) Reported fantasies and dreams are coded for content in exactly the same way as other material.

(11) Occasionally you will need to consider the context in making a score. As a general rule, you should make a conservative inference based firmly on contextual evidence that occurs close to the clause, rather than making abstract inferences based on remote evidence.

(12) Remember that psychotherapy does not change a person into a genius or a god. You should consider scores in the 5 or 6 range to represent good, not outstanding, functioning. If the narrative is generally indicative of psychological health and well being according to the criteria stated, then you should consider using these scores if appropriate.

(13) Sometimes there will be a confusion as to whether you are scoring the performance of the person in therapy or their performance in the interaction that they narrate. The truth about what really happened in the relationship interaction is unknown to you (and the therapist), so the only evidence you have to score mastery on is the verbal narrative of the interaction as told in therapy. The way the narrative is told may be just as important as the features of the interaction described. You are judging the patient's present mastery. It does not matter at what time the interaction actually happened (eg. it may be when they were 5 years old). References to old ways of relating should be scored as they typically can relate to functioning in the present and can be differentiated from late narratives in the research design if needed.

For example, consider the statements “I used to get so angry when he did that / but now I don’t”. The first clause is scored 2F - Expressions Indicative of Negative Projection Onto Others - even though the statement is in the past tense. The second clause is scored 6V - Expressions of New Changes in Emotional Responding because the old pattern of anger has been modified. The person is talking in the present about new changes in their emotional reactions.

Note that talking in the past tense does not necessarily mean that the person is discussing an old way of relating. The statement “I got angry” is still scored because the assumption of this method is that patients are reporting problems in the attempt to assimilate them more fully into the functioning of their ego (Valliant, 1993). We take what they say seriously and at face value, because what is in their speech (no matter how distorted) is a window into their inner functioning and can thus be interpreted for mastery. The assumption of this scale is that statements concerning mastery are not all of equal importance: those at level 6 are indicative of very high mastery, those at level 1 very low mastery and so on.
The Mastery Scale

Mastery Scale I

**Level 1 Lack Of Impulse Control**

1A Expressions Of Being Emotionally Overwhelmed
1B References To Immediacy Of Impulses
1C References To Blocking Defences
1D References To Ego-Boundary Disorders

**Level 2 Introjection and 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 And 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 And 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

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Level 1
Lack of Impulse Control

1A Expressions of being Emotionally Overwhelmed

Being globally emotionally overwhelmed and distressed. State described is extreme and dominates the person’s state of mind. Regressive features.

/I exploded/
/Everything all started/
/It is extremely painful/
/Nothing is easy/
/I felt very bad/
/I hate myself/
/I felt really sick/
/Everything is black/
/My sickness controls everything/
/It is all too much/

Clinical Example 1A.1

2F
/He ought to open up his eyes / and look where his mother lives / if he wants to be ashamed of what he’s, y’know, his parents. / Look at, oh, oh. I saw so many colours, / that room just went around. / And when he walked away / Jack said to me ‘Who the hell is he to ask a question like that ?! It’s none of his business !!’ / He said ‘Why didn’t you open your mouth ?’ (pause) / I said ‘Jack, I just couldn’t. I just couldn’t’ / All the way home I was burning and burning and burning, / and my stomach’s killing me. /

Clinical Example 1A.2

2H
/I didn’t feel like being with people, / I was really depressed. / And all of a sudden I burst out crying and crying and / I just felt really horrible (pause) / and that scared me. /
Clinical Example 1A.3

I met a boy that I fell in love with, you know, / and he said 'I don’t care’. / He didn’t care. / He didn’t care. / About me or anything, / and so, I mean, I was, this really upset me. / I was in shock, / and, uh, that’s when I really wanted to commit suicide / and that’s when I was very, / uh, uh, oh, what was it? / I was very emotional about it. /
IB References To Immediacy Of Impulses

Extreme loss of control in mind and actions. Overwhelming urgency to gratify needs. Overwhelming urgency to escape

• Being out of control in mind and actions

/ I was heavily intoxicated and reckless / 
/ I want to destroy with a sledgehammer / 
/ I have lost all control / 
/ I couldn’t stop laughing / 
/ I want to smash everything / 
/ I couldn’t stop myself thinking about it / 

• Overwhelming urgency to gratify needs

/ I put pressure, pressure on him / 
/ I pleaded to him / 
/ I begged her to let me do it / 
/ I would do anything at all to get it / 
/ I want it badly / 
/ All I want is this / 

• Overwhelming urgency to escape

/ I want to get out of here / 
/ All I want to do is escape / 
/ As soon as possible I want to go / 
/ I felt really trapped / 

Clinical Example 1B.1

1A
/ I just. I felt bad. / You know, I just felt like you know, I felt like a little kid. / You know, 
1B
Like I wanted my own way / and I couldn’t have it / and it really made me mad. / I just 
1B 1A 1B
wanted to stamp my feet / and just cry / and say ’I have to go home, / you have to let me’ /
Clinical Example 1B.2

1B
/I was getting very hyper, y’know? / And I asked the cook ‘Is such-and-such a thing cooked to order?’ / He said ‘What gets you all hyped up?’ / I said ‘You do’. / And so I
1B
just turned around and ran and ran. / And I was waiting for an incident. / I was. / I was
1B
really feeling hyper. / I wasn’t in a mood to argue. / I, I had to be active. / I just had to do
1B
something. / Physically, I just had to do something. /

Clinical Example 1B.3

1A
/ Now, my children upset me, / still, uh, something terrible / because, uh, I don’t have this
1B
control, y’know, that I speak of. / I just go to pieces / and feel driven to hit them, / and I
1B
lose all control of myself / and I go into the bedroom and scream. /
1C References To Blocking Defences

Blockages in thinking and feeling; repression of affects; denial, forgetting, numbness, avoidance.

• Denial

/ I’m OK / and I don’t want to change anything /
/ I act normal /
/ It doesn’t bother me /
/ It doesn’t worry me at all /

• Forgetting

/ Oh, what was I saying ?
/ Something just slipped my mind /
/ I don’t remember what happened /
/ I forgot everything about what happened /

• Numbness

/ I can’t think /
/ I can’t concentrate on anything /
/ I feel blank about this /
/ I feel at a loss /
/ I feel nothing /
/ There is a void inside me /
/ I feel very sleepy /
/ I was asleep through it all /

• Avoidance

/ I just ignored it all /
/ I pretend that it didn’t happen /
/ I don’t think about anything in particular /
/ I can’t get down to it /
/ I just didn’t do it /
**Clinical Example 1C.1**

Therapist: Had you come close to having sexual relations with the prior one or is there something about -

Patient: / Yes, I mean I can’t remember. / Yes and no. / I mean like I make out with them and everything / but um - no, I think that that was like you know the first you know the first time. / I was I was sort of drunk. / I can’t - I can remember what happened /

**Clinical Example 1C.2**

Therapist: Now you started saying something and then you stopped.

Patient: I did ? (softly) ...

Therapist: Of course

Patient: Don’t say of course. / I’m trying to remember. / That’s what I’m sitting here trying to do. / I-I don’t know what I was going to say /

Therapist: I see

Patient: Now you think I’m awful.

Therapist: Why do you say that ? ...

Patient: Because it seems like, / I was thinking about what I was saying / and I, something else ran through my mind / And it confused me / because I was more or less thinking of two things, / and then I couldn’t remember what I was thinking about originally. / And I was talking. / I don’t even remember what I was talking about. / Reminded me of when I was a child; / something went through my mind /

**Clinical Example 1C.3**

Patient: / Well I don’t - I don’t remember. /

Therapist: Why not ?

Patient: / Because I’m not. / If I don’t remember - / I’d like to remember what he said, / so I can comment on it. / I don’t remember what he said. /

Therapist: It may be deliberate that you’re trying to block them out.

Patient: / It’s not undeliberate that I’m trying to block it out. /
1D References To Ego-Boundary Disorders


• Dependency, submission and masochistic passivity-aggression

/ I fall under his spell when I’m with him /
/ I want my mummy and go home /
/ I need someone to tell me what to do /
/ I really had a love crush on him /
/ I am subservient to you /
/ I felt possessed by him /
/ I told him to hit me /
/ If you told me to believe it I would /
/ I need someone to tell me what to do /
/ I leaving all the decisions up to you /

• Identity instability

/ I don’t have an identity /
/ I don’t feel that I’m me /
/ It feels like it happened to someone else, not me /
/ I feel like a conglomeration of bits and pieces /
/ It just seemed to invade my body / and then it suddenly left /
/ I feel like a different person each time I arrive /

• Omnipotent narcissism

/ I just watch and observe others /
/ I deserve special treatment /
/ I live in my own world /
/ I know you think about me all day /
/ People should be calling me to offer me help /
/ They will let me go to the front of the queue /
/ I want it for me /

• Ego-boundary ruptures

/ He spoke to me in my dream / and commanded me to act this way /
/ She can read my mind /
/ The lecturer is always looking at me / and giving me secret love messages /
/ It is like they are an extension of me /
Clinical Example 1D.1

I'm just - All I can do is watch. And as soon as I - as soon as I go out with them, I'm inta their life / and I'm - and I'm - and I don't know what ta do. / I mean I wanna just sit back and observe them / ... / But I mean when I do that I just - I just dissolve. / I'm not me. / I'm not - I'm not a person. / I'm nothing. / I'm just - I'm just (hesit.) this sh- this mirror reflecting their - the way they are. / And I have no way of- of getting into their life /

Clinical Example 1D.2

I'm a very I'm a loner more than like it's more of a of an isolation / uh an isolation instead of an independence / and like when I depend on somebody, / I lose my independence almost, / I lose my identity getting so close to somebody. / You know I sort of merge with them. / I mean like they have to make - It's like I just well, I really it's really - it's strange, / it's uh uh I'm not aware of them as another person - / I'm aware of them as somebody who makes me do something /

Clinical Example 1D.3

I don't feel that I'm me. / I feel that I'm just a conglomeration of a lotta (pause) bits and pieces / and (pause) everything else from a lotta people, y'know. / I don't think I ever thought anything out on my own /
Clinical Example 1D.4

/ Sometimes when people look at ‘cha / they look as though they’re looking at a point in the 1D middle of your brain / rather than at your eyes / or your face, / or they’re lookin’ through 1D ya’, / an-tha’s almost. / I’m making it into somethin’ physical / unless you just like, reach 1D through or something, / as though I was laid open /
Level 2
Introjection and Projection of Negative Affects

2E Expressions Of Suffering From Internal Negative States

References to the self suffering - anxieties, melancholia, mania, guilt, shame, jealousies.

/ I felt panicked /  
/ I suffered a lot with depression /  
/ I’ve been feeling hyperactive /  
/ I feel so jealous and envious /  
/ I am ashamed at myself /  
/ I am useless and unworthy /  
/ I should have done a lot of things better /  
/ I’m frustrated about it /  
/ I started shaking /  
/ I got mad at myself /  
/ I am very upset about it /  
/ I really hate myself /  
/ I feel so guilty /  
/ I’m scared / and nervous /

Clinical Example 2E.1

/ Last week I was - I was so upset - / and I didn’t sleep for nights and nights and / I was feeling guilty for this, that and the other, / and (pause) I mean I - I know I did something wrong, /

Clinical Example 2E.2

/ I’m also saying / that I don’t know whether or not this is is, a manipulative thing / that I really didn’t know, / that I was that upset / and confused / and distraught / that I was not even trusting when I was sitting down / and really trying to write an honest letter. /
Clinical Example 2E.3

/ And yet when I got home I, you know, I just, I don’t say any, I say less than I normally say / and I just feel dead / and I feel like a sad sack, / you can’t even think of, you know, something to say. /

Clinical Example 2E.4

/ At one point I got very uptight with my mother / when she just asked me a question about a cross word puzzle / and it just struck me that her tone of voice seemed harsh / and I just sort of like got very anxious at that point. / And, and, I, I just pressed the pencil against the radiator and broke it / and went upstairs and started pacing up and down / because I thought like, well, here’s an event that just transpired / that (pause) that it would be hard for me to explain to anybody what I was so upset about / (short laugh - pause) and I don’t know what to do about it. / Like, I, I, I just feel lost. /

Clinical Example 2E.5

/ I don’t know why I told her that. / I was terribly hurt / or upset about that (pause) that thing last Autumn / when he was taking me out (pause) / and to me when he wanted to take me out it seemed, it see-/ it seemed like he didn’t care / (pause) and I was (pause) really wanted to hurt him. /
Appendix 2: Mastery Scale Manual

2F Expressions Indicative Of Negative Projection Onto Others

Negative internal states directed toward others - anger and blame; cynicism and repressed rage; resentments and defiance; revengeful and sadistic feelings; domination and manipulation of others. Patients’ negative emotions are intended to upset the others’ feelings.

/I exploded at him /
/I got madder and madder at him /
/I blamed him for all my problems /
/I am not going to budge an inch /
/I was cranky at her /
/I just stormed out of the room /
/I was angry / because he never listens /
/I screamed at him /
/It’s all his fault ! /

Clinical Example 2F..1

2F /I started hating my mother. / Not like - not like my mother, not like hating her because she’s my mother, or anything, / or disliking her, you know. / I mean, like, if she weren’t my mother, she’d be fine, you know, like. / But she just -, I’m just turning into- I’m just turning into the type of person she is. / It’s utterly unable to relate to people, like, that, / and that’s what screwed me up. / And I don’t want to have kids if I’m going to mess them up like that. 2F / And I hate her for that. /

Clinical Example 2F.2

/We talked about stuff, / and I said to my sister ‘c’mon’ / and we went in my room. / She said ‘I’m not interested’. / I said ‘Jesus, you never are!’ / so the hell with her ! /

Clinical Example 2F.3

2F /Well this is what makes me MAD, / and that’s - and - I’m just as angry at you for imposing this feeling on me / as I am for my husband doing it. / Why is it that I am the one who’s supposed to always be something, / to do something. / Why is it that I’m the one that always has to take the action ? /
2G Expressions Indicative Of Negative Projection From Others

The other is perceived to be punishing and rejecting self. Paranoiac ideation about others’ motives. No compassion or understanding of the other’s point of view. Feeling laden down and the victim of the other. Others may be unaware of distress, since the malevolent affects are a projection of the negative internal states of the patient.

/I get the feeling a lot of people think I’m dumb /
/They are not interested in me /
/They are playing a game against me /
/He is trying to get something out of me /
/She punishes me /
/I felt she didn’t care about me /
/You are making this hard for me /
/I imagine she will be disappointed in me again /
/I felt she was hostile towards me /
/He uses me for his own ends /

Clinical Example 2G.1

/I just sit there. /I mean why, you know, so I don’t say anything / and then, you know, people just don’t bother talking to you, /’cause you’re not playing their stupid little game, / and then they think you’re stupid. /

Clinical Example 2G.2

/The one date I did have was the first night, / and um, it was a blind date, / of which I have had - this was - that was the second one in my life. /I don’t believe in having blind dates. /
/I’d rather see ’em first. /And she was a really nice girl, / but it bothered (laugh) for some reason I thought she didn’t like me. /Just because she didn’t - she just didn’t talk a lot. /
/And I found out later she didn’t talk to anybody. /She just didn’t know - she was shy. /
/But I had this thing in my mind / that she didn’t like me. /I don’t know. /I’ll just keep away from her. /
Clinical Example 2G.3

2G
Patient: / You’re gonna be impossible, aren’t you? (pause)

Therapist: Why do you say that?

2G
Patient: / ’cause you’re very disturbed with me. / You are. / You’re very annoyed with me (pause) / I can tell. / I can. /

Therapist: Why am I annoyed with you?

3J
Patient: / I don’t know. / Just with me. / You have been for a while. (pause) / Did you know that? / I did. (pause) /

Therapist: You seem to be able to identify my feelings better than yours today.

3J
Patient: Yours are obvious. / Mine are all mixed up. /

Clinical Example 2G.4

4M
/ If they really love me / why aren’t they over here, you know, / so we could bang / and I get impatient / and I get mad (pause) / and I got like that - that last night. / I felt like he wasn’t paying enough attention / and oh ‘you’re just like everybody else - / one thing - you, you know, you really don’t care about me, you know ah, / all you wanta do is sleep with me you know’. / Well, I didn’t say those things to him, / I was scared that what I was thinking was really true, / that y’know, he really didn’t care about me, / yeah, I don’t believe that, / I don’t think that that’s the case. / I think it might be the case if I continue the way that I’ve been doing. / I might push it into being the case. /
2H References To Interpersonal Withdrawal

Avoiding, withdrawing and isolating the self from others. Interpersonal difficulties. Timidity in approaching others, moving away from others.

/ I don’t initiate friendships / 
/ I don’t want to get involved with people / 
/ I didn’t talk to him / 
/ I deliberately didn’t go and see him / 
/ I don’t want to relate to others / 
/ I didn’t tell him everything I wanted to / 
/ I didn’t sit with them / 
/ I can’t relate to them / 

Clinical Example 2H.1

/ I don’t want to get involved with somebody / because I know I’m- I’m going to end it, / 
and so I just go around I don’t bother with people. / I don’t want to get involved with 
people. / I’m afraid to get involved with people. / I just want them to stay out of my life / 

Clinical Example 2H.2

/ Well for instance, he wanted to uh (pause) he wanted to go down to the beach / and and I 
just - and I cancelled out on it / and (pause) and uh, a few other times he has - he has uh, 
changed his plans to fit mine / and then I have uh, you know, I cancelled out. / 

Clinical Example 2H.3

/ and he says “If anything, they think about - they think of you as being ah one who 
doesn’t involve yourself too much at work” / Which is true. / Like, you know, since I’ve 
been (hesit.) um sort of anxious around people / like I’ve been - I have not been the most 
sociable person in the world by any means. /
21 Expressions Of Helplessness


/ There was nothing I could do /
/ I don’t care /
/ I just sat there /
/ I can’t help it /
/ I don’t care about anything /
/ I just shut up and didn’t say anything /
/ I am going to give up /
/ These pills will cure me /
/ I’m not good enough at it /
/ I just couldn’t make him go away /
/ I want to give up /
/ I couldn’t find out what was wrong with me /
/ I can’t get on with anything /

Clinical Example 21.1

/ And I thought, well, you know, I’d come home (pause) / and you know, show her I did have something to offer after all (pause) / but I didn’t feel that I, you know, I didn’t feel any different (pause). / I didn’t do anything. / I just - you know, I walked around. / I watched the golf. / I went to the parties / and I drank and I slept and I ate / ... / I don’t f- I don’t feel worthwhile. / I don’t - I don’t feel I’ve anything to offer. /

Clinical Example 21.2

/ I feel, y’know, I just don’t have any balls. / I can’t stand up to anybody. / I can’t say ‘no I don’t want to distribute the goddam leaflets, go call somebody else’ y’know, / and I can’t say, uh ‘I don’t want you in the house’ / or ‘I do want you in the house’. /
Clinical Example 21.3

21 / I'm not effective, y'know, with the children, that's definite. / So that, that in itself y'know 21
is is a problem for me. / As far as discipline goes, it, but - I just, just give in. / It isn’t 21
working out / and there is nothing I can do about it. /
Level 3
Difficulties in Understanding and Control

3J Expressions Of Cognitive Confusion

Inability to predict or understand, things being left unresolved, uncertain, confused.

/I don’t know /
/I don’t know why /
/My dreams are very confused and mixed up /
/I don’t know why he changed the way he did /
/I guess things haven’t really been sorted out at all /
/I wasn’t sure what to do /

Clinical Example 3J.1

3J
/I guess I don’t really know what my problems are, / or I do, / and then I - one day I think
3K
it’s this thing, / and then another day I think it’s another thing. / But - as far as she goes, /
4M
she can say exactly what her problems are. / Like my whole thing’s just a- is all hazy. /

Clinical Example 3J.2

/I feel, y’know, I love him, sure. / You can’t begin to be through all I’ve gone through
3J
all your life without, without love there. / I don’t know. / I’m not sure if there’s love there. /
3J
I don’t know. / It’s happening though. /

Clinical Example 3J.3

/I know, I can see a card in one way / and start to send it to somebody like oops, y’know
/they might see it in 10 different ways, / so I end up having a great collection of cards / that
3J
I don’t send to anybody. / I can’t figure things out / and (sighs) not figure them out. /
3J
That’s why I’m sorry. / I apologize for that. /
3K Expressions Of Cognitive Ambivalence

Struggling to understand; partial awareness and hypothesizing; difficulties communicating or putting things into words.

/ Well it was sort of like this /
/ It is hard to explain how it was /
/ I don’t know whether to feel one way or the other /
/ I seem to be making sense of it / but I am unsure /
/ It might be beginning to come together in my mind now /
/ Sometimes I think that / but other times I don’t /
/ I sort of said that /
/ I suppose that it was like this /
/ I don’t seem to be able to say it very well /

Clinical Example 3K.1

Patient: I was talking to another girl about it / and uh, we were just talking about it, / I don’t know, / the subject just came up / and she said she met a girl who was a homosexual, you know, / and all this and uh, I sorta felt homosexual. / ... /

Therapist: And here it points to express some of your own feelings.

Patient: / Well, I just felt that, uh, oh what it is, it, / that before it may have been latent / and the feelings of homosexuality, / but they seem to be coming to the surface. / And, uh, I didn’t feel physically attra - why, she is an attractive woman. / Ah, I didn’t want to touch her. / Ah, I don’t know, / I just of, homosexuality in itself / that, uh, perhaps I, that this maybe is a better life for me. /

Clinical Example 3K.2

/ Am I gonna take those pills again ? / I was wondering if I’m strong enough not to take them. (pause) / It takes willpower, y’know. / I haven’t thrown them out. / They’re still in the house. (pause) / It’s just like when I stopped smoking. / Just one more. / Maybe tomorrow, I’ll take another one, / but not today .. /
Clinical Example 3K.3

Therapist: So there were a few things you could have said clearer?

Patient: Well, uh, maybe. I said maybe, well maybe I said what he took down. But, uh, at that time was only the second time that I've spoken in a session like that. And, uh, I'm being, I mean he was, sort of I'm not sure. I don't know, maybe I shouldn't have felt like, ah, he was against me but umm I felt like he wasn't really for me.
3L References To Positive Struggle With Difficulties

Expressions of struggling with difficulties, seeking change and control. References to effort, hope, engagement in struggle to get better and improve.

/ I am trying to get myself better and under control /
/ I had to face it instead of ignoring it /
/ I have to put up with it /
/ I want to get over this /
/ I can’t pretend that it never happened /
/ I am always trying to be the best I can /
/ I know I had to do it /
/ Talking and thinking about these things is very painful and hard /
/ If I really want to do it I can /

Clinical Example 3L.1

/ I like him a lot (sighs) / and I don’t want to make any mistakes (laughs) / I don’t want to start the same patterns over again. /

Clinical Example 3L.2

/ I wouldn’t, y’know, have, I wouldn’t be constantly, uh, feeling anxiety. / I would probably be a little calmer / but that would be the only thing / because it would mean I would probably be still -- / I would still be working just as hard on my problems. /

Clinical Example 3L.3

/ If the clothes need washing, / he’ll just go ahead and wash them. / ‘Cause he’s trying to understand me, he said. / And I try to get these things done / because I know that he’ll be happy when he comes home. /
Clinical Example 3L.4

I’d want to see her, / but I, I couldn’t just stand and wait. / I’d have to fortify myself with reasons for being in that place / ‘while I was going over to get a Coke’, / and then I changed my mind and / ‘I came out to get some fresh air’ / and I changed my mind again and / ‘I was going back to get the Coke’ / and I looked at the displays in a display case, / and everything just, to justify the fact that I was in any given spot when she should happen to, if she should happen to appear. /

Clinical Example 3L.5

/ I just met her. (pause) / But, you see, the whole thing is, / I want to try to, try to, (pause) get, get to know her if if possible, y’know, / if it’ll work out. /
Level 4
Interpersonal Awareness

4M References To Questioning The Reactions Of Others

Probing, assessing and challenging others reactions rather than blindly accepting them.

/I asked him why he thought this /
/I don’t agree with the way she is approaching it /
/She criticized me / and I asked her what it was that was bothering her /
/I asked him to tell me what he thought instead of just shutting up /
/I told him to stop because he was disturbing the children /
/She shouldn’t be cranky with me /
/Do you know what I am saying ?

Clinical Example 4M.1

/ Well when I asked you about it, / you - it didn’t seem to me that you were being very straightforward, / you were like sorta, you had the answer / then you were thinking up a justification for it. / That was my impression of what you were doing, / which led me to, at least partially led me to think the way I was thinking. /

Clinical Example 4M.2

/ And he does the same things about my sister’s boyfriend / because they’ve gone together now for 5 years / and he doesn’t understand why they aren’t married. / He has this fairy tale idea of romance, / but I mean, he just, he loused up his own life / so I don’t know why he thinks he should, you know, try to give us advice. /
Clinical Example 4M.3

/ Another thing she said was “why’d you ever go into therapy in the first place ?” (laughs)
/ And after telling me I was schizoid, / I mean I-I mean I would think that the-that’s a silly
question. / Like, a person who’s schizoid is bound to have problems. /

Clinical Example 4M.4

/ He picked out just that one thing to, uh, y’know, pinpoint. / But then I said ‘well you have
to look at the, uh, situation a little more openly than that.’ / I mean, you can’t, uh, put it
down to one thing. / You know, you can’t say, because he cries / that he’s gonna, uh, he’s
gonna become, he’s gonna be feminine.’/
4N References To Considering The Other’s Point Of View

Clear consideration of alternative perspectives; compassion and understanding towards an other person; consideration of how the other may be viewing the self; listing qualities of the other.

/ He is sensitive about things like that /  
/ I can see from her point of view /  
/ Maybe he did this because of y /  
/ It could be that he reacted because of y /  
/ I wasn’t sure if he would understand /  
/ I can understand how she feels /  
/ I know he doesn’t mean it / because he is just a boy /  
/ I know he suffered /  
/ I can see she was jealous /

Clinical Example 4N.1

4N / I think they, y’know, sort of, you know, put their hopes in me in a way, you know. / They 4N 4N want, they want me to succeed. / You know, they want me to-to ah do well, all things that 4N they, well, especially well, / my father probably is, you know, he would feel more proud of me and all / if I succeed or anything if I did well. /

Clinical Example 4N.2

4N / He’ll be worried sick / that he won’t just, won’t come out of his surgery. / It’ll be, uh, very 2E upsetting. / And after all he is 70, uh, 71. / And his health isn’t in the best condition. / I 4N guess he, I’m hoping someday he’ll try and get better. / It’s just the way he takes things. / 4N He’s just afraid. /

Clinical Example 4N.3

2E / So, I had had about half a beer by that time, / an’ like I was kind of annoyed, / but I know 4N 4N the mood he was in, / an’ I knew he was- he wanted to get angry at somebody. /
Clinical Example 4N.4

/ One day my father came, / and he said ‘I have failed to inspire you - you don’t practice
your religion.’ / For him, it’s like saying that he’s a shit. / He doesn’t see it as a
condemnation of me. / He says it’s a condemnation of himself. / He says ‘I have failed to
inspire you.’
40 References To Questioning The Reaction Of The Self

Awareness of role of the self - one's own contribution to conflict or situation.

/ I wonder whether I do something to create conflict /
/ I asked myself why I felt this about her /
/ It was my fault really /
/ What can I say? /
/ I am seeing this in more of a negative way than it really is /
/ I can see now that I caused this / and made her feel bad /
/ I realized there are things that need to be dealt with here /
/ I questioned my reaction in this situation /
/ I think maybe I was the problem /

Clinical Example 40.1

/ Is it comfort I'm looking for? / Or someone to say "poor me"? / I don't really don't I'd like to know that, / I don't know it. /

Clinical Example 40.2

/ I wondered if he wanted to talk about it / and yell about it. / After that I, I didn't think about it, / but I came home (pause) / I suppose I should have said something. /

Clinical Example 40.3

/ And (pause) well, anyway, that is one of the things I do / and I suppose one of the things I have to stop doing / because (pause) i-it's uh, it's just, y'know, too great of a burden to carry around, / having to be right all the time / or having to be, uh, taken seriously all the time. /
4P Expressions Of Interpersonal Self-Assertion

Standing up for self with confidence. Acting independently and stating views with ease. Free expression of ideas previously difficult to discuss. Pro-social attempt to get needs and wishes met displaying emotional modulation.

/ I told him to stop interrupting me before I had finished speaking /
/ I stood up against the bully /
/ I asked him to stop calling me at home / because I needed some privacy /
/ I said I found her behaviour offensive when she acted that way /
/ I am not going to be pushed around /
/ I stated clearly what my fears were in this instance /
/ She knows now that I do not agree with the proposal /

Clinical Example 4P.1

/ He'd already mentioned to me about my hair. / He said it was gettin’ pretty long / and I
4P said to him like ‘whoa, just let me do my own thing. / I don’t bother you - you don’t me.
4P / It’s gonna get a lot longer’ / and he said just ‘okay’ /

Clinical Example 4P.2

/ He was always yelling at me that he would never be happy and everything like that. / So, I
4P got out of that / because I didn’t want to be his whole life - / like I didn’t want to be
4P responsible for his sanity - / you know so responsible because he couldn’t stand on his
own two feet, you know? /

Clinical Example 4P.3

/ I said to him ‘Listen, Doctor, I don’t know what you’re saying to me. / Are you telling me
4P she’s competent or incompetent? / He was fumbling and ignoring me. / So then I declared
4P that he was unable to make decisions himself (laughs) and / I made my own decision that
the woman was not competent for the position. /
Clinical Example 4P.4

/I looked up to him, / but on the other hand, um, (pause) / he has not in any way tried to

/force me / or tried to, uh, interest me in any way. / And I will not permit it if he ever tries. /

/And I have enough stamina if, you know, myself to (pause) brush it off / rather than being

/scared to death / like I was before./ So I don’t want to push, being pushed around anymore /
Level 5
Self-Understanding

5Q Expressions Of Insight Into Repeating Personality Patterns Of Self

Making a self-observation about one's own personality - insight into transference pattern.
Awareness of maladaptive interpersonal patterns of relating to others.

/ I always see a part of myself in others / and I realize I was fighting with a part of myself /
/ I am the type of person that reacts this way /
/ I realize I have a problem being confident with people / unless I know them really well /
/ When I was young I was insecure, / and even now I have difficulties /
/ I know / I am always worrying about these issues /
/ I know it is hard for me to respond like that /
/ I am the sort of person who likes to behave in this way /
/ When he asked me that question / I saw what he was getting at - / that I am like that /
/ I know I have a tendency to react that way in many situations /

Clinical Example 5Q.1

/ I say men are evil. / Consequently, I act as if I - the situations / I have to agree to situations
where I can prove it. / And, you know, this is, this is what I think happens, / I don't know
what. / And I don't go out and say that now I am going to lace. / But this seems to be
what's happening. / You know, and I don't do it intentionally. /

Clinical Example 5Q.2

/ It seems that one experience, / a kind of recurring thing that has happened throughout my
life / is that like I'll know somebody for awhile. / Then I'll start picking out flaws / and then
sort of concentrate - start, well concentrating on their flaws / or ah looking at those rather
than the whole thing. / And I kinda have done that with Ed. /
Clinical Example 5Q.3

/ I know what you are doing. / I know why I’m doing - I know what you’re doing. / I understand exactly what is going on. / I understand. / I’m asking for reassurance. / I’m asking for you to tell me something / and you just won’t do it. /
5R Making Dynamic Links Between Past And Present Relationships

Observations about similarities and differences in the patterns of relating between present situations and past relationships.

/ I saw him like he was my father /
/ I can see now that this is related to my upbringing /
/ I treat my boss in the same way as I treat my father /
/ He controlled me like my mother did /
/ I used to see him in a different way than I do now /
/ I thought of my mother in that situation, because she used to do the same thing /
/ I can see now that the past and the present are different /
/ I'm turning into the sort of person my mother is /
/ I see you in the same way as my favourite teacher /
/ I know my reaction towards my children is because of my own upbringing /

Clinical Example 5R.1

/ I was standing in line to - going to the cafeteria / and this guy came out, very (deep breath) suave / and well not suave, / but - a- very proud of himself, / and - and a - can't think of a word (pause) / - arrogant and with a smile on his face / and a toothpick / this is the point / a toothpick, / and a - for no reason I jus' felt like hitting him all of a sudden, y'know, / and I didn't, / of course I didn't do anything, / but I jus' felt like hitting him. / An' I couldn't understand why, / but the first thing that came to me was, / I don't know whether this has any bearing on it, / but my father used ta chew on a toothpick a lot, a lot y'know /

Clinical Example 5R.2

Patient: / So now I'm listening to him /
Therapist: / And what do you think about that? /
Patient: / It's not good. / He's just being like my mother again. / Like I-I just../
Therapist: So who are you going to listen to?
Patient: / I should listen to myself, / but he's just like another mother image to me /
Therapist: Well, you're letting him be.
Patient: / Yeah, lots of times I'll even come out and tell him, / “who do you think you are,
Appendix 2: Mastery Scale Manual

5R
my mother?" (pause) / Like I transferred all my dependence and my, y’know, ah, from
5Q
from my mother on to him. / Like I listen to what he tells me to do now. /

Clinical Example 5R.3

5S
Patient: / I was dreaming the fact that she was, uh, so gentle and all that, / so warm, (pause) /
40
so I guess maybe I don’t hate her as much as I thought I did. /

Therapist: When you think of a gentle and warm person, what comes to mind?

1C
Patient: (pause) / As soon as you said that, I sorta had a block. (pause) / And two faces
went through my mind, / my girlfriend and my mother. (pause) / Um (pause) I wonder if in
some way, (pause) um, in some strange way, / I - I equate my girlfriend with my mother. /

Clinical Example 5R.4

2E
/ Most people don’t think of me as a scared person. / I’m afraid of myself. / (pause) 5R
Because it’s, I don’t know it’s you know, it’s a sort of a mixture / - a father-lover sort of
5Q
thing / because it’s, it, it is a romantic guilt. / But it’s also, it’s also this thinking that (pause)
5R
it’s also this hangover from when I was real young. / And when I really try to, uh, you
know, I try to explain - / and I try, I wind up on a train, / I hid in the luggage car behind
something / and trying to, and they got me, came and got me / and brought me back. / And
it’s those moments when I thought that, you know, see my father / if he was really great he
5R
would have let me. / But still I have to keep him great. / And I do the same to you. /

Clinical Example 5R.5

2E
/ Peter was eating chicken, and / somehow he struck me the wrong way, / and I got sick, / I
got really, you know, so I could feel I was all hot in my face, / and I was, I - I really got ill, / 5R
and the only thing I could see, you know, I-I could see him - / I could only see him as my
stepfather. /
5S References To Interpersonal Union

Interpersonal support, closeness, communication. Approaching others, intimacy between people including physical. Offering and giving help to others or seeking and receiving help from others. Benefaction to the self from positive patterns of interpersonal relating.

/I know that /I can talk to her if /I need to /
/I called her up on the telephone /
/Our conversation is full of jokes and laughter /
/I went to the doctors for assistance in these problems /
/I was trying to be there for her and help her /
/We slept together last night /
/She has helped me a lot to get over this /
/Coming to psychotherapy is a big help /
/Talking to someone is a relief /
/We get on really well /
/He really made me feel good about it /
/I felt respected by him /

Clinical Example 5S.1

5S
/I went with a friend who is very close to me. /And in many ways it was a beautiful 5S weekend, /because, an, it's the first time in a long time I've shared a lot of experiences with people. /Just as an example, /if we're driving /and we see a nice sunset /or something like that, /we'll stop. /And we did that. /And there are very few people I really can do that with. 6U /
/It was very, I felt very, ah, fulfilled by things like that. /That went on the whole weekend /5S and we got on together extremely well. /

Clinical Example 5S.2

5S
/They did an awful lot for me. (pause) /Like when they bathed me, /and they washed me, /3J changed the dressing on my leg and neck. / (pause) and, uh, (pause) so maybe, I don't 5S know (pause) /I just felt that they did enough for me. /It's funny, I can't forget that. /
Clinical Example 5S.3

/ I was there today / and he had - it was really amazing. / He had all this - he was cooking lunch for me (laughs) on this hot plate. / He was making steak and string beans and potatoes (laughs) and everything. (laughs) / Well, there was not enough time to have lunch / and to try to compose music, / I mean to help write songs, / to have sex and, / y’know do the whole thing in an hour / but, you know, we got certain things accomplished. (laughs). / Yesterday I thought, well that it was going to develop into a full-blown affair. / I don’t know, the scene had such- it had such romantic potential . /

Clinical Example 5S.4

/ I said we were going down there as friends, / and uh, at first when I got down there, it was very, very much beautiful. / and, uh, and we got into our room / and we made love and things like that. /
5T Expressions Of Insight Into Interpersonal Relations

Insight into other people and the dynamics of their relationships with the self.

/ I see now that my parents had trouble with this /
/ She is the type of person that will react in this way /
/ I think at first we were both hung up with problems /
/ We differ in our views of this situation /
/ I know I have the same problem as he does /
/ He is as stubborn as I am /
/ We rub each other the wrong way /
/ I know it is true about him /
/ I recognize he won't change on this issue /
/ I notice the way they react to one another /
/ I know how he feels about these things /

Clinical Example 5T.1

5T 4N 4N
/ She is something like me. / She’s afraid too. / It’s like I - I know exactly how
4Q uncomfortable she is when we’re looking at each other. / I don’t like to look at people when
5T 5T I talk / and neither does she. / ... / And I also know how defensive she is with people / and
5T 5T she does the same thing I do. / Maybe not the same degree or maybe not in the same ways, /
5T but the same sort of thing. /

Clinical Example 5T.2

6U
I talked to him very calmly / and told him that the house was more important than anything
else / and that I just didn’t feel anything else could go on until the house was done, if then. /
And so he made all sorts of promises and everything, he wouldn’t take any more (laughs)
5T three day vacations, etc., etc. / I also said to him / that since the two of us tended to behave
5T irresponsibly on our own / that I didn’t feel that we needed to encourage each other to
behave irresponsibly. /
Clinical Example 2T.3

What I am saying is that, uh, I am, uh, mild-mannered, / and he is very -- he's strong, y'know, / he's, he's strong-willed, / so he's y'know, at one end of the pole, / and I'm at the other end, / but we're not really meeting. /
Appendix 2: Mastery Scale Manual

Level 6
Self-Control

6U Expressions Of Emotional Self-Control Over Conflicts


/Everything is alright/
/I will stand back and see how it goes/
/I feel I’m a capable person/
/I’ve just got to let this sort itself out/
/I realize these things can’t be changed overnight/
/I negotiated a peace between us that will stick/
/I left my anger in that situation and got on with other things to build a better relationship/
/When things go wrong I have enough patience/
/I feel good enough to go home/
/I feel loved and respected/
/I felt okay about this/
/I didn’t take it to heart/
/I realize it is up to me to get it done/
/I said that it was sensible to do it in this situation/

Clinical Example 6U.1

/6U 6U/
/I like the freedom to choose to come and go, when I want to, as I want to, the way I feel like it, rather than having this thing forced on me. Like he comes up at ten o’clock with “come over and and cook me dinner” / And I’ll just say “no” /
Clinical Example 6U.2

/ I can be very enthusiastic of him / and I can get really excited about things, / you know, I / can also be very critical / but I’m also more, like not so much up and down, / but my, as I / used to be with many different opinions, / I just seem to have a lot of enthusiasm in one / direction or the other. / And I just feel very emotional actually and that too, / what I want / from him, / which I feel better. / I feel more stabilized with him. / 

Clinical Example 6U.3

/ I was serving as his blasting target, you might say. / But I kn- I e- I knew what he was / doing / an’ I kind of like (hesit.) said, ya know, took it with a grain of salt. / An’ we / continued to talk / and have a couple more beers, / and yh-w-we generally had a good night. / By the end of the night he was in a good mood / and I felt good that I had gotten him into / a good mood / by the time (hesit.) he left the place. / 

Clinical Example 6U.4

/ I’ve dated a lot of different fellows. / Now I’m just dating one and, / uh I guess it’s, uh, / sort of, um, making myself feel that I am attractive / and someone is interested / and it’s sort / of an ego builder sort of thing. / I really had a good time. / (pause) I met this fellow slightly / last week and, uh / I flirted last night / and he took my phone number. / It’s fun. / It’s sort / of reassuring, you know (pause) / It’s good to feel like a woman. / It’s good to feel very / feminine. /
6V Expressions Of New Changes In Emotional Responding

Changes in emotional reactions that are non-trivial, adaptability and flexibility in responses. Overcoming maladaptive repetitive patterns of reacting to problems and relationships.

/ My feelings in this situation are different now than before /
/ This is a new feeling for me /
/ It is like I have opened my eyes for the first time /
/ It doesn’t seem so bad now as it did in the past /
/ I felt better about myself this time /
/ My feelings have changed and / I don’t feel as bad /
/ Yesterday my reaction was different /
/ It is getting easier now to do it /
/ It doesn’t worry me as much /
/ I look back and see what / I was like compared with now /

Clinical Example 6V.1

/ You know, I really find myself really disagreeing with my sister-in-law / where I think that / for years I sort of accepted her as the oracle / even though she was having terribly serious problems with herself. / And I was sitting down there on a Sunday / and finally you know / for the first time - / you know this has happened twice now - / I didn’t find myself boring / out my problems / or you know, throwing my behaviour out for her to make judgements of / or to please her / or to show her how I’d improved / or you know trying to - that wasn’t important to do that any more. /

Clinical Example 6V.2

/ I - it was just that I was feeling / that I was seeing everybody differently / and I was pleased about it. / And I have been pleased about it. / I’m not so desperately trying to impress them / or even trying to make them see me favourably - / or whatever it was I was trying to do in the past. /
Clinical Example 6V.3

/ Like we were talking last night / and she was telling me about a number of personal things / and I was telling her about some personal things about me. / And it was good / because I wasn’t telling her everything / because I’ve decided that’s something I shouldn’t do to somebody I don’t know very well / - tell them everything. /

Clinical Example 6V.4

/ Sunday I was out in the field flying kites. / And you know, doing crazy things that I’ve never done before / because I was, before I was always concerned about how will I look if I run with this kite / if I make it fly or something?! / Because it would be, you know, it wouldn’t be uh behaving according to protocol or something, / and uh (pause) it feels like a sort of freedom. /

Clinical Example 6V.5

/ Well I wanted to go out Sunday / and I called a few people to see who was busy / an’ I said ‘Hi, how’re you doing, so let’s go.’ / Usually I wait for others to call. /, It’s the first time I called and said ‘Let’s go.’ /
6W References To Self-Analysis

References to introspection, self-monitoring, internal dialogue with the self, carrying out psychotherapy of the self.

/I have thought all this through over the last week /
/This is my lay analysis of the situation /
/I have really sat down and thought about myself as a person /
/I talk to myself a lot now and find that this helps me /
/I thought about it carefully before I decided /
/I was thinking about it and a lot came out /

Clinical Example 6W.1

6V
/I have really learned since I have been coming to see you I think, / more than - well I think
6W
6V
I questioned things before anyway, / but now, I feel that I do so a lot more / and it’s - it’s
6V
6W
very helpful to me ya know, / I feel a lot more, ahm, I don-know, just, it makes my mind
6W
work more ya know, / I don’t just stagnate- stagnate ya know / because I - I really think
about things, /

Clinical Example 6W.2

/ He went way. / He went to Caracas for two weeks. / And for two weeks he was not around
6W
/ and I was sitting down thinking everything out. /

Clinical Example 6W.3

40
/I felt, I guess I felt that I should have acted more, ahh, positively with this kid, / more
6W
6W
aggressively than I did, / and you know this all came out when I was thinking about it. / I
6W
was trying to avoid / - but I was gonna, / I didn’t avoid thinking about it. / I said ‘Well, I’ll
6W
think about it anyway instead of holding it back.’ / I just kept on, I just thought about it : /
6U
And ah, it was better - I thought it was better that I did. /
Samples for Practice Scoring and Training of Judges

The following samples are for the training of clusers and judges in the use of the Mastery Scale. Prior to attempting this task the Mastery Manual should be thoroughly studied, with particular attention given to the clinical examples illustrating each code. It is recommended that each of the following examples is worked through in turn, from clousing through to scoring. The results of each trial should be then compared with the scored versions before moving onto the next example. The examples have been selected because each contrasts with the other in demonstrating various levels of Mastery. As a final part of the training it is recommended that mean mastery scores are derived for each sample. Discussions of the final four samples between the author and clinical researchers helped to shape form of the Mastery Scale, so these samples also have some small historical interest. They have also been used in the past to successfully train naive judges in the methods. These final samples are somewhat less typical than the ones appearing as examples in the Manual, so are useful in provoking discussion about coding issues and in thinking about the coding task. Discussions of the following samples between judges in training have been found to be a useful adjunct in the calibration of scorers.

Notes: T = Therapist. P = Patient. Comments in square brackets are made by the other speaker within the main speaker's statement.
Sample 1

P: One thing that, uh, sorta just hit me, and I guess it’s one of these delayed action things that - that seems to happen to me quite a bit. There’s this guy I was - lived with - lived with us for about a month during July and he’s uh, I mean we didn’t get along too well, and, uh, whenever he got into a conversation or anything, y’know, he uh - he’d immediately try to dominate it and things like that. He did a lot of things that irritated me and at the time I guess I just, y’know, I repressed everything and just sank back. And lately I’ve been sort of brooding about it, and y’know, I’ve been getting really worked up, pissed off over it, y’know, and then uh, uh, y’know, it’s as I said, I said, it’s a delayed action thing, I guess. It’s like he was - stepping on my toes a lot when I was there, you ... bluntly, crudely and uh, y’know, I think there ought to be a better way to handle it, but I’m not quite sure - y’know, how it’s gonna work. like uh - in - in one of the fantasies uh, y’know, as I was reliving this thing where he, uh - that, that incident I just described when he said, uh, “excuse me for interrupting” - at the I was dri - I was drinking a glass of water or something, and in this fantasy, I threw the water in his face, or something like that (pause 10 seconds, clears throat). I think I, I tend to get abnormally worked up and you know frightened, and angry at at people who - who do things like this.

Number of Scorable Clauses :
Sum of Mastery Scores :
Mastery Score this Sample =
Sample 2

P: I just never really ran up against anyone that I really felt dominated me to the extent that I couldn't fight back or that I couldn't, ya know, tell them a thing or two. Which is what I've done (laughs). And uh - I don't think I've ever - I've never really thought that I've made any enemies because of it, but - ya know yet I'm sure that I- I'm sure that people have felt, ya know that I've been (pause) a little too big for my britches sometimes. Even with my parents, um especially now that I've been away from home I go an' (pause) if they have arguments or something, and I don't agree with what they say, I'll just tell 'em what I think. And I feel good about myself, and I think that they respect me for it. I don't just jump in, I think carefully about what I am going to say first.

Number of Scorable Clauses:
Sum of Mastery Scores:
Mastery Score this Sample =
Sample 3

T: I get the feeling you’re really, you’re really trying to test me out right now - lately either you’re asking questions, or thinking about situations to provoke me in some way.

P: Well, perhaps that’s because I’m getting a little more, um, militant about, more militant about people responding to me. I get - trying to get back to the whole thing about me feeling that you’re a conspirator in this plan to destroy me. (pause) Boy I really think I must be crazy, I must be out of my mind. When I think of mysel- y’know, when I think of you, and I think, y’know, like you’re placing me as ‘this cat is out of his mind’ and, um, you know, it just, it, it, destroys me. The thing is, I don’t know you at all (pause), and yet I feel there’s something missing in you because there’s something that’s, that’s going wrong in me. It’s sorta like I can’t, um, (pause) y’know, I can’t really trust you.

Number of Scorable Clauses :
Sum of Mastery Scores :
Mastery Score this Sample =
Sample 4

P: I was just thinking about this the other day. oh, that, y'know, I just expect you to meet a girl and y'know, to immediately fall into a serious relationship - y'know, serious meaningful relationship, without uh, really getting to know her or anything like that. That's sort of what happened with this girl I was going with last year, uh, sort of neurotically we were just, she initiated it. But we just - y'know, immediately, y'know, the first night I, I went out with her, and we went through this heavy necking thing and the next weekend I was sleeping with her. And al' - y'know, even though I had, y'know talked to her - I had a couple of uh intimate discussions beforehand, I guess, but we didn't really know what we were about - I didn't know what she was about, she didn't know what I was about. And I sort of expect the same thing to happen again. I get the feeling that I didn't really learn anything from that relationship, uh - y'know it that, if I if maybe I was, well, then the way I broke it off just totally, completely. The way I reacted against it, against her finally. Uh, was, uh, really a regression - and y'know, I I don't know if I described to you the way it happened but briefly it was just that, uh, she had a lot of second thoughts about sleeping with me. Finally - and she decided that y'know to tone down the relationship, especially sexually. and I went along with it uh, and I guess I really didn't know what I felt at the time but uh, finally I I just uh, - what I felt I guess was like uh, I'd been really rejected. And so I just broke off the relationship completely - like y'know I just couldn't handle it. Y'know, it might have been, y'know uh, now that I look at it as the saner thing to do than to plunge into things the way we were.

Number of Scorable Clauses:
Sum of Mastery Scores:
Mastery Score this Sample =
Sample 5

T: And it is hard to comfort yourself when there are so many different problems [P: yeah] it’s hard to know where to get comfort from, and and who is there to look after you, it’s so hard.

Silence in seconds : thirty three [(cries hard)]

P: My husband, everyday he tries to (loud sniff), to make me happy but (breathes out) ...(pause) (cries) he is very worried about - [T: he is worried] (very quietly:) yeah ... (teary voice:) I know he is worried because, ts everyday I talk with him, and I said “the only thing I want to do is go to Italy” and he says - “what can I do ?” Um I plead to him everyday - I put pressure, pressure on him. ... And he doesn’t feel (breathes out) (unclear words) because sometimes I see that he is very very quiet and thinking about something. ... And I ask him ... and he says (sniffs) ts (very quietly:) “I am thinking - what can I do ? ... for you ? - If I can help you but ... you see now we are very ... and if I ask for another loan it will put more more pressure more” (loud sniff) and ... his job is no - it’s not enough, we have six people in our family. (breathes out) ... And it’s ... it’s very ... you know very ... difficult situation. Sometimes at the end of the (breathes out) ... fortnight we don’t have ... money to buy milk or something like that. ... And (sniffs) my husband says “don’t worry - tomorrow I will go to the bank” “Yeah but we have to pay for things for this and that - and the money is gone again !” ... (sniffs) ts It’s no ... , very (breathes out) hard to ... to to pay for everything (takes tissue) ... it’s very ...

Silence in seconds : sixteen (tears)

P: Especially when you have children, and everyday the children need something - they need some shoes or, um, from school they ask for money for this, money for that ... and your children and your (quickly:) children say “I need this !” but “I don’t have money” and they say (high pitched:) (loudly:)“go to the
bank!

T: So you feel that there is, that they have so many needs... it's hard to meet them

[P: yeah]... (very quietly:...) very hard to meet them and you want to be a good mother and [P: yeah] give them things.

P: Yeah because, that is the other thing that I have been thinking about... Um, when I was a girl, a little one, ts I didn't have toys, um, I didn't play. ... And I was always like this you see? (tears) And I always ts thought "if I get married, and I have children, I will never stop them playing - or if they want something - I will try to give it to them" [T: mm] and ... you know ... I don't know, I was thinking like that... and I know, I know when my children ask me for a car or a toy and I can't get, I feel bad!... And so my husband said "if you didn't have toys when you were a little girl it doesn't mean they have to be given all..."

T: (quietly:) So the needs of your children, when you can't meet them, reminds you again of the pain of when you were young, and what it was like not to have toys and not to be able to play...

Number of Scorable Clauses:
Sum of Mastery Scores:
Mastery Score this Sample =
Sample 6

P : ... on Friday after I came here, I went back to my place, and in the afternoon I tried to talk to my husband. I mean, at night, because he was working on the afternoon shift, and he came back very late on Friday. And we didn’t do it. And on Saturday morning everything started. Our conversation started with jokes and things like that, and then we started to talk seriously, and it was good. [T : mm] Um ... I thought he would not understand what I wanted to tell him. Because I didn’t know either! I knew the relation and connection here in therapy, and it was new for me, and new for him too.

T : So what did you talk about?

P : Well, we talked - ... (breathes out) (soft laugh) you know, the thing I said to him, um “do you know how my therapist thinks about you?” And he said “what does your therapist think about me?” “Not in you, it is the connection we found, we have found today” And he said “what is the connection?” And I said “I haven’t really been thinking about this, but today I have been seeing a new thing. My therapist and I talked, and my therapist told me - he made me see the connection - but this thing doesn’t mean you are that person - it is just what, the feeling that I have, for that reason.” And I, I, told him what was the connection that we saw.

T : Between him and your father?

P : Yeah. And ... he just put his head down and was thinking for a few seconds, or a few minutes, I don’t remember really. And then he said “what is your therapist doing?” And I said “doing what?” And he said “I thought he is trying to make you better” And I said, “that is what we are trying to do - feel better, and think in a different way, forget about everything” Then he said to me “OK I’m so sorry, maybe you are right, maybe you don’t -” Because, I didn’t know my reaction when I get angry with him is ... suddenly [T : mm] so ... he saw, he said
to me something like that "I know you can't control yourself now, but you have to do it, you have to learn to control yourself and and be more polite! (soft laugh) Not so angry, so irrational when you get angry - you explode! You don't know, and you don't see who is in front of you, who is getting your anger."

T : He said that?

P : Yeah. And...

T : And that is very much along the lines of what we were talking about.

P : Yeah. And then, well, we started talking, and then he said, he said to me "OK, from now on, you are the mother, you are the person who knows when the children need something, or when you need something, and. Make a list, and if we can't get the things this fortnight, we will the next fortnight... [narrative truncated here]... because if the children need it, we have to buy it, but, That is not the reason to get angry with me or, ... because I don't know if you don't tell me". I understood him, because that is my problem, I always wait until the last minute to tell him the children need this, that. So at that moment I saw a lot of things. I was wrong, and. And he was, um, different too. He saw everything, maybe, he was wrong, I don't know, or, but. That day, on Saturday morning, we fixed a lot of things. Everything was - like when you open a window and the sun comes inside, lights all of the house.

Number of Scorable Clauses:
Sum of Mastery Scores:

Mastery Score this Sample =
Sample 7

T: And the incident with Auntie Dee has compounded things

P: Oh um, we haven’t heard from her for a couple of days and Nan went around this morning and told her to come around and talk to me and get it sorted out. Because I didn’t want to go around there, because Janet was there ... probably (unclear words) flew off again ... so Auntie Dee came around and we had a bit of a talk but - it’s not, it’s not resolved really. It’s not back the way it was before we had the argument. But, we talked about it and ... she doesn’t like to talk about things, she just likes to forget about it. I, I do too, to a certain extent, but I can’t pretend that it never happened. She is the type of person - she hasn’t rung or come around since it has happened. She is the type of person that would leave it a fortnight and then come around as if nothing had happened.

T: This is what Janis said on Wednesday, isn’t it

P: Yeah yeah, so she hasn’t been around or rung. Rung anyone, not even the rest of the family. And Nan just went around there this morning, because she has been really worried and upset the last couple of days. So she went around and told her to come around. When she came around she just walked in and sat down. She didn’t want to say anything - I had to talk to her and I - and when I started she said “I’d rather just forget about it” and I said “I would too, I’d rather forget that thing happened but we sort of got to talk about it a bit, and then once we have talked about it then we can leave it”. That was very frustrating, not waiting these last couple of days - not knowing what was going on, what was happening. And I felt really, I don’t know, at loose ends I suppose.

T: You felt angry ?

P: Mm, angry, I was more upset at first but as ... the last few days have gone on, I’ve got more and more angry about it. ... I was cranky at her - for not coming
around and talking to me about it.

T: Not giving you the opportunity to say what you wanted to say

P: Yeah, yeah, I was getting madder at her, thinking - "she's she's got no right to ...
... to start something and then just - to start a fight and then walk away and leave it" and I was ... oh ... I didn't, when we had the fight I really didn't get to say anything because I was too upset. And those two were yelling. And, well I - even when the fight happened I didn't really say anything. And, she came around and had her say and I didn't really get to - to say my say, and the last ...

first I was upset because it happened and I just wanted to fix it and the last two days ... sh ... you know, her not coming around - it's sort of building up and building up and when she came around this morning, and she was gone, I was glad that we had done it. And got it over with. And now we can sort of ... just try and go on.

T: So what did you get over ? How did it help you ?

P: Well, I was scared about talking to her.

T: Because ?

P: I don't know, I just was ... I felt

T: That you would be rejected or was it - was that what it is ?

P: Well, a bit of that and bit of - that we'd have like another fight. And (unclear words) trying to smooth it over. And ... well I'm, I'm not really that type of person either. I don't like confrontations ... I'm a bit like Aunty Dee, and I can understand how she feels, sometimes I'd rather just forget about things ... but something that big you just can't leave. Otherwise things - well they just won't be the same. You have to ... I need to talk about things but I'm scared about doing it and I find it hard to do it ... I know myself - if I don't - if I didn't - ...
even though I was scared, I knew that it was ... I had to do it, and I had to make myself do it ...

T: So what were you scared that might happen ?
P: Well, that we would have another fight, or, or she wouldn't believe what I was saying ...

T: Wouldn't believe what I was saying, because she wasn't believing you last time, was she? [no] If people don't believe you, what do you feel?

P: (very quietly:) (pause) um, that like I am lying or (unclear words)

T: You feel that you are lying because -

P: - what they would think - that I was lying (spoken together with therapist)

T: - that you were lying yeah.

P: and ... I know that I wouldn't lie over something like that, with Auntie Dee, and ... just the fact that you are being really honest - and they, they don't believe you -

T: So what is the feeling you have, when you are in that situation?

P: Frustration. (pause) Upset, and just ... feel ... I don't know, like you can't ... can't cope or ... (pause)

T: Cope with what?

P: With her not believing me.

Number of Scorable Clauses:
Sum of Mastery Scores:

Mastery Score this Sample =
Sample 8

T: So it is hard to get that middle ground [mm]

P: I know because we have got someone living with us at the moment, David, ts and it's a very - he works with Greg, and a lot of our friends - they all work together. And, he's just started having, I don't know, an affair, what you could say, with one of the girls in the, in the like group - the group of friends. And, another one was always really attracted to David. And we found out, because he was living with us, well we didn't say anything because it wasn't our problem. And the other one that liked David - I was pretty close with. And just before I came, about - oh, three or four weeks before I came down here, she found out and it all blew up. And she wouldn't speak to me because - I, um, well I knew and I didn't tell her. And I tried to explain to her that it wasn't my place to tell her. And, that really hurt me and upset me, and Greg said "well - you should learn to forget about it - she's the one with the problem" and um "she's got to snap out of it, you can't do anything about it". And well it really hurt because I didn't think I'd done anything wrong. And that, sort of, I suppose knocks the wind out of me. Things like that. [mm] She's, she's come around now, but I don't know how to cope with, with things like that. And, Greg sort of says "oh well if she's not talking to me - fine - that's her problem" and he gets on with it I suppose and I - that sort of hurts a lot.

T: That's a bit like what happened when you were a kid - you got punished for doing nothing wrong. And then that gets into blaming yourself and feeling- "oh well, I'm not much good anyhow - I'm not really worthy of it or something like that". So Greg is telling you that it's the girl's problem - What are your feelings about her and the way she reacted?

P: Well, I was disappointed that she would be angry with me. Um and that she, she couldn't see that - I understood that she was hurt, but she wasn't talking to me
but she was talking to David. And I thought that, well, it should be the other way around. She should be cranky with David if she’s going to be cranky with someone. And ... (pause) um ... (pause) I’m not sure ...

T : So how do you interpret her behaviour like that?

P : I understood that she was hurt, but I thought she was being childish about it.
That I knew that she was hurt and that she wanted to sort of lash out at someone.
And, but I, I, was trying to be there for her. And, sort of be nice and help her.
But she didn’t - I suppose she didn’t want my help.

T : So does that make you wonder about your friendship with her?

P : Yes. Because I thought we were closer than that.

T : And what do you think of it now?

P : Well apparently Greg says she has been coming around to visit, and asks about me and everything, so hopefully when I go home I’ll be able to like be the same as we were before. I hope we can.

T : Do you think that’s a good thing?

P : ... well I think that the problem really wasn’t with us two, because with Dav - if it had been something that I’d done, or there was a problem that had caused it between us two, it probably would be different. But, I really like her and I think she’s a nice person, and it was probably her way of dealing with something hurtful.

T : So what do you think you need to do with that friendship with her?

P : ... (pause) I suppose, just, stand back and see how things go. Not fix it, just see what happens.

T : Can you also re-define the friendship, have different rules for behaviour in it?
So that she is treating you the way that you are treating her?

P : Yes. Now I realize that if someone wants to be like that - well - I’m not, I feel - I don’t know, whereas before I would be upset and it would really upset me - I’m not as strong as Greg in the sense that I can forget about it, I’m sort of a half
way.

T: Oh to say "forget about it" is very dismissive of your feelings.

P: I do look at her differently now, and I realize that I do have a lot of other friends if she wants to be like that - well she can. Um ... and and it won't worry me as much. I'll I'll let her go her own way. That sort of thing.

Number of Scorable Clauses:
Sum of Mastery Scores:

Mastery Score this Sample =
P: One thing that, uh, sorta just hit me, / and I guess it’s one of these delayed action things / that - that seems to happen to me quite a bit. / There’s this guy I was - lived with - / lived with us for about a month during July / and he’s uh, I mean we didn’t get along too well, / and, uh, whenever he got into a conversation or anything, y’know, / he uh - he’d immediately try to dominate it / and things like that. / He did a lot of things that irritated me / and at the time I guess I just, y’know, I repressed everything / and just sank back. / And lately I’ve been sort of brooding about it, / and y’know, I’ve been getting really worked up, / pissed off over it, y’know, / and then uh, uh, y’know, it’s as I said, I said, it’s a delayed action thing, I guess. / It’s like he was - stepping on my toes a lot when I was there, / you ... bluntly, crudely and uh, y’know, I think there ought to be a better way to handle it, / but I’m not quite sure - y’know, how it’s gonna work. / like uh - in - in one of the fantasies uh, y’know, as I was reliving this thing / where he, uh - that, that incident I just described / when he said, uh, “excuse me for interrupting” - / at the I was dri - I was drinking a glass of water or something, / and in this fantasy, I threw the water in his face, / or something like that (pause 10 seconds, clears throat). / I think I, I tend to get abnormally worked up / and you know frightened, / and angry at at people who - who do things like this. /
Sample 1 Distribution of Mastery Category Scores

Discussion

In this example, the patient is in the early stages of mastering his maladaptive interpersonal pattern of relating [5Q]. When confronted with a dominant person, his response is to 'repress' his true feelings and to act helpless [2I] whilst feeling resentful and angry [2F]. The anger is clearly symbolised in the impulsive [1B] fantasy to throw water in the person's face. Although blaming the other person [2F], he is also questioning his reactions, observing that 'I think there ought to be a better way to handle it' [40]. The patient is only just beginning to see that the problem resides within, when they state 'I tend to get abnormally worked up' [5Q].

Number of Scorable Clauses : 17  
Sum of Mastery Scores : 52  
Mastery Score this Sample = 3.1
Sample 2 (Scored Version)

P: / I just never really ran up against anyone / that I really felt dominated me / to the
extent that I couldn’t fight back / or that I couldn’t ya know, tell them a
5Q
thing or two. / Which is what I’ve done (laughs). / And uh - I don’t think I’ve ever -
4N
I’ve never really thought that I’ve made any enemies because of it, / but - ya know
yet I’m sure that I- I’m sure that people have felt, / ya know that I’ve been (pause) a
little too big for my britches sometimes. / Even with my parents, um / especially now
that I’ve been away from home I go an’ (pause) / if they have arguments or
4M 4P
something, / and I don’t agree with what they say, / I’ll just tell ’em what I think.
6U 4N 6U
/ And I feel good about myself, / and I think that they respect me for it. / I don’t just
6W
jump in, / I think carefully about what I am going to say first. /

Sample 2 Distribution of Mastery Category Scores

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<th>Mastery Categories</th>
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Discussion

In this sample, the patient is showing that she has both awareness [5Q] and control [6U]
over her interpersonal pattern of relating. She is both thoughtful [6W] and assertive
[4P].

Number of Scorable Clauses : 8
Sum of Mastery Scores : 39
Mastery Score this Sample = 4.9
Sample 3 (Scored Version)

T: I get the feeling you’re really, you’re really trying to test me out right now - lately either you’re asking questions, or thinking about situations to provoke me in some way.

P: Well, perhaps that’s because I’m getting a little more, um, militant about, more militant about people responding to me. / I get - trying to get back to the whole thing about me feeling that you’re a conspirator in this plan to destroy me. / (pause) Boy I really think I must be crazy, / I must be out of my mind. / When I think of myself- y’know, when I think of you, / and I think, y’know, like you’re placing me as ‘this cat is out of his mind’ / and, um, you know, it just, it, it, destroys me. / The thing is, I don’t know you at all (pause), / and yet I feel there’s something missing in you / because there’s something that’s, that’s going wrong in me. / It’s sorta like I can’t, um, (pause) y’know, I can’t really trust you. /
Sample 3 Distribution of Mastery Category Scores

Discussion

Here the patient is clearly paranoid [2G] and distressed [1A] about the interpersonal relations with his therapist. He is persecuted [2G] by the thought of what he is in the therapist’s mind, which ‘destroys’ [1A] him. He feels that he cannot trust the relationship because of a serious disorder in himself: ‘something’ is ‘going wrong in me’ [1D]. He has neither insight into the problem nor control over it, displaying very low mastery.

Number of Scorable Clauses: 10
Sum of Mastery Scores: 19

Mastery Score this Sample = 1.9
Sample 4 (Scored Version)

6W
P: / I was just thinking about this the other day. / oh, that, y'know, I just expect you
know to meet a girl and / y'know, to immediately fall into a serious relationship -
y'know, / serious meaningful relationship, without uh, really getting to know her or
anything like that. / That's sort of what happened with this girl I was going with last
year, uh, / sort of neurotically we were just, she initiated it. / But we just - y'know,
immediately, y'know, the first night I, I went out with her, / and we went through this
heavy necking thing / and the next weekend I was sleeping with her. / And al’ -
y'know, even though I had, y'know talked to her - / I had a couple of uh intimate
discussions beforehand, I guess, / but we didn’t really know what we were about - / I
didn’t know what she was about, / she didn’t know what I was about. / And I sort of
expect the same thing to happen again. / I get the feeling that I didn’t really learn
anything from that relationship, / uh - y'know it that, if I if maybe I was, well, then
the way I broke it off / just totally, completely. / The way I reacted against it, against
her finally. / Uh, was, uh, really a regression - / and y’know, I I don’t know if I
described to you the way it happened / but briefly it was just that, uh, she had a lot
of second thoughts about sleeping with me. / Finally - and she decided that y’know
to tone down the relationship, especially sexually. / and I went along with it uh, / and
I guess I really didn’t know what I felt at the time / but uh, finally I I just uh, - what
I felt I guess was like uh, I’d been really rejected. / And so I just broke off the
relationship completely - / like y’know I just couldn’t handle it. / Y’know, it might
have been, y’know uh, now that I look at it / as the saner thing to do than to plunge
into things the way we were. /
Discussion

In this sample, the client is working hard to understand a dysfunctional relationship so that he might be able to avoid falling into the same trap in the future. He describes aspects of the relationship in which his response was to withdraw [2H] and separate ‘completely’ [1B] after an intense and premature affair. He recognizes the position of the other person [4N] and realizes it was not dissimilar to his own [4O] in that ‘we didn’t really know what we were about’ [5T]. He carefully describes the maladaptive pattern of relating [5Q] and has some insight into how this pattern might be active in his life [5Q]. However, he does not show in this sample that he has resolved the problem.

Number of Scorable Clauses : 25
Sum of Mastery Scores : 90

Mastery Score this Sample = 3.6
Sample 5 (Scored Version)

T: And it is hard to comfort yourself when there are so many different problems [P: yeah] it’s hard to know where to get comfort from, and and who is there to look after you, it’s so hard.

Silence in seconds : thirty three [(cries hard)]

P: / My husband, everyday he tries to (loud sniff), to make me happy / but (breathes out)...(pause) (cries) he is very worried about - [T: he is worried] (very quietly:)

yeah ... (teary voice:) / I know he is worried / because, ts everyday I talk with him, 4N

/ and I said “the only thing I want to do is go to Italy” / and he says - “what can I do ?” / Um I plead to him everyday / - I put pressure, pressure on him. / ... And he doesn’t feel (breathes out) (unclear word/s) / because sometimes I see that he is very very quiet / and thinking about something. / ... And I ask him ... / and he says (sniffs) ts (very quietly:) “I am thinking - what can I do ? ... for you ? - / If I can help you / but ... you see now we are very ... / and if I ask for another loan it will put more more pressure more” (loud sniff) / and ... his job is no - it’s not enough, 2E

/ we have six people in our family. (breathes out) ... / And it’s ... it’s very ... you know very ... difficult situation. / Sometimes at the end of the (breathes out) ... fortnight we don’t have ... money to buy milk / or something like that. ... / And (sniffs) my husband says “don’t worry - tomorrow I will go to the bank” 2I

/ “Yeah but we have to pay for things for this and that - / and the money is gone again !” / ... (sniffs) ts It’s no ... , very (breathes out) hard to ... to to pay for everything (takes tissue) ... it’s very ...

Silence in seconds : sixteen (tears)

P: / Especially when you have children, / and everyday the children need something - / they need some shoes / or, um, from school they ask for money for this, money for that ... / and your children and your (quickly:) children say “I need this !” / but “I don’t have money” / and they say (high pitched:) (loudly:)“go to the
bank !". / That is the answer they give ... /

T : So you feel that there is, that they have so many needs ... it's hard to meet them

[P : yeah] ... (very quietly:) very hard to meet them and you want to be a good

mother and [P : yeah] give them things.

6W

P : / Yeah because, that is the other thing that I have been thinking about ... / Um, when I

was a girl, a little one, / ts I didn't have toys, / um, I didn't play. / ... And I was

always like this you see ? (tears) / And I always ts thought “if I get married, and

I have children, / I will never stop them playing - / or if they want something / - I

will try to give it to them” / [T : mm] and ... you know ... I don't know, / I was

thinking like that ... / and I know, I know when my children ask me for a car or a

toy / and I can't get, / I feel bad !... / And so my husband said “if you didn't have

toys when you were a little girl it doesn't mean they have to be given all ...” /

T : (quietly:) So the the needs of your children, when you can't meet them, reminds

you again of the pain of when you were young, and what it was like not to have

toys and not to be able to play ...
Sample 5 Distribution of Mastery Category Scores

Discussion

This client is clearly distressed by her problems [2E]. She wants to flee from her feelings [1B] and expresses a desire to escape to Italy [1B]. She is feeling guilty [2E] and helpless [2I] in not meeting the demands of her children, yet has some realization that the guilt is linked to feelings aroused by her own deprived childhood [5R]. She can observe the impact that her emotions are having on her husband [4N], yet remains desperate.

Number of Scorable Clauses : 14
Sum of Mastery Scores : 43

Mastery Score this Sample = 3.1
Sample 6 (Scored Version)

P: /... on Friday after I came here, / I went back to my place, / and in the afternoon I thought to talk to my husband. / I mean, at night, / because he was working on the afternoon shift, / and he came back very late on Friday. / And we didn’t do it. / And on Saturday morning everything started. / Our conversation started with jokes / and things like that, / and then we started to talk seriously, / and it was good. / [T : mm] / Um ... I thought he would not understand what I wanted to tell him. / Because I didn’t know either ! / I knew the relation / and connection here in therapy, / and it was new for me, / and new for him too. /

T : So what did you talk about ?

P: / Well, we talked - ... (breathes out) (soft laugh) you know, / the thing I said to him, um / “do you know how my therapist thinks about you ?” / And he said “what does your therapist think about me ?” / “Not in you, / it is the connection we found, we have found today” / And he said “what is the connection ?” / And I said “I haven’t really been thinking about this, / but today I have been seeing a new thing. / My therapist and I talked, / and my therapist told me - he made me see the connection - / but this thing doesn’t mean you are that person - / it is just what, the feeling that I have, / for that reason.” / And I, I, told him what was the connection that we saw. /

T : Between him and your father ?

P: / Yeah. / And ... he just put his head down and was thinking for a few seconds, / or a few minutes, / I don’t remember really. / And then he said “what is your therapist doing ?” / And I said “doing what ?” / And he said “I thought he is trying to make you better” / And I said, “that is what we are trying to do - feel better, / and think in a different way, / forget about everything” / Then he said to me “OK I’m so sorry, maybe you are right, maybe you don’t -” / Because, I didn’t know my reaction when I get angry with him is ... suddenly / [T : mm] so ... he saw, he said
to me something like that / “I know you can’t control yourself now, but you have to do it, you have to learn to control yourself / and and be more polite! (soft laugh) / Not so angry, / so irrational when you get angry - you explode! / You don’t know, / and you don’t see who is in front of you, / who is getting your anger.” 

T: He said that?

P: / Yeah. / And ...

T: And that is very much along the lines of what we were talking about.

P: / Yeah. / And then, well, we started talking, / and then he said, he said to me “OK, from now on, you are the mother, / you are the person who knows when the children need something, / or when you need something, and. / Make a list, / and if we can’t get the things this fortnight, / we will the next fortnight... [narrative truncated here]... / because if the children need it, / we have to buy it, / but, That is not the reason to get angry with me / or, ... because I don’t know if you don’t tell me”. / I understood him, / because that is my problem, / I always wait until the last minute to tell him the children need this, that. / So at that moment I saw a lot of things. / I was wrong, / and. And he was, um, different too. / He saw everything, maybe, he was wrong, / I don’t know, or, but. / That day, on Saturday morning, we fixed a lot of things. / Everything was - like when you open a window / and the sun comes inside, lights all of the house. /
Discussion

In this discussion the patient is reporting a significant therapeutic change in her life as a result of an insight gained through therapy. She has been reacting to her husband as if he was her father [5R]. This insight has led her to respond to her husband in a new way [6V]. The achievement of psychological mastery [6U] is experienced as 'when you open a window and the sun comes inside, lights all the house.'

Number of Scorable Clauses : 28
Sum of Mastery Scores : 129
Mastery Score this Sample = 4.6
Sample 7 (Scored Version)

T: And the incident with Auntie Dee has compounded things

P: / Oh um, we haven’t heard from her for a couple of days / and Nan went around
this morning / and told her to come around and talk to me / and get it sorted out. 2H
/Because I didn’t want to go around there, / because Janet was there ... probably
(unclear word/s) flew off again ... / so Auntie Dee came around / and we had a bit
of a talk / but - it’s not, it’s not resolved really. / It’s not back the way it was
before we had the argument. / But, we talked about it / and ... she doesn’t like to
talk about things, / she just likes to forget about it. / I, I do too, to a certain extent,
but I can’t pretend that it never happened. / She is the type of person - she
hasn’t rung / or come around since it has happened. / She is the type of person
that would leave it a fortnight / and then come around as if nothing had
happened. /

T: This is what Janis said on Wednesday, isn’t it

P: / Yeah yeah, / so she hasn’t been around or rung. / Rung anyone, not even the rest
of the family. / And Nan just went around there this morning, / because she has
been really worried / and upset the last couple of days. / So she went around and
told her to come around. / When she came around she just walked in and sat down. 4N
/ She didn’t want to say anything / - I had to talk to her / and I - and when I started
she said “I’d rather just forget about it” / and I said “I would too, I’d rather
forget that thing happened / but we sort of got to talk about it a bit, / and then once
we have talked about it then we can leave it”. / That was very frustrating, / not -
waiting these last couple of days / - not knowing what was going on, / what was
happening. / And I felt really, I don’t know, at loose ends I suppose. /

T: You felt angry ?

P: / Mm, angry, / I was more upset at first / but as ... the last few days have gone on,
/ I’ve got more and more angry about it. ... / I was cranky at her - for not coming
around / and talking to me about it. /

T : Not giving you the opportunity to say what you wanted to say

P : / Yeah, yeah, / I was getting madder at her, / thinking - "she's she's got no right to
... to start something / and then just - to start a fight and then walk away and leave it" / and I was ... oh ... I didn’t, when we had the fight / I really didn’t get to say anything / because I was too upset. / And those two were yelling. / And, well I -
even when the fight happened I didn’t really say anything. / And, she came around / and had her say / and I didn’t really get to - to say my say, / and the last ...

first I was upset because it happened / and I just wanted to fix it / and the last two days ... sh ... you know, her not coming around - / it's sort of building up and building up / and when she came around this morning, / and she was gone, / I was glad that we had done it. / And got it over with. / And now we can sort of ... just try and go on. /

T : So what did you get over ? How did it help you ?

P : / Well, I was scared about talking to her. /

T : Because ?

P : / I don’t know, / I just was ... I felt /

T : That you would be rejected or was it - was that what it is ?

P : / Well, a bit of that / and bit of - that we’d have like another fight. / And (unclear word/s) trying to smooth it over. / And ... well I’m, I'm not really that type of person either. / I don’t like confrontations ./. I’m a bit like Aunty Dee, / and I can understand how she feels, / sometimes I’d rather just forget about things ... / but something that big you just can’t leave. / Otherwise things - well they just won’t be the same. / You have to ... I need to talk about things / but I’m scared about doing it / and I find it hard to do it ... / I know myself - / if I don’t - if I didn’t - ...
even though I was scared, / I knew that it was ... I had to do it, / and I had to make myself do it ... /

T : So what were you scared that might happen ?
P: / Well, that we would have another fight, / or, or she wouldn’t believe what I was saying ... /

T: Wouldn’t believe what I was saying, because she wasn’t believing you last time, was she? [no] If people don’t believe you, what do you feel?

P: / (very quietly:) (pause) um, that like I am lying or (unclear word/s) /

T: You feel that you are lying because -

P: / - what they would think - / that I was lying (spoken together with therapist) /

T: - that you were lying yeah.

P: / and ... I know that I wouldn’t lie over something like that, with Auntie Dee, / and ... just the fact that you are being really honest - / and they, they don’t believe you - /

T: So what is the feeling you have, when you are in that situation?

P: / Frustration. / (pause) Upset, / and just ... feel ... I don’t know, / like you can’t ... can’t cope or ... (pause) /

T: Cope with what?

P: / With her not believing me. /
Discussion

The overall picture here is of the client struggling [3L] with her interpersonal tendency to avoid confrontations [2H] which so obviously distress [2E] her. She is angry [2F] at how the other person is avoiding the issues, but recognizes that she herself has a similar pattern of reacting to interpersonal difficulties [5Q]. Although having some insight into both her and the other person's pattern of relating [5T], she does not feel in control of the situation [1A]. She clearly struggles to master her feelings [3L], but nevertheless is persecuted by her perception that the other person harbours negative thoughts towards her [2G].

Number of Scorable Clauses : 53
Sum of Mastery Scores : 165
Mastery Score this Sample = 3.1
Sample 8 (Scored Version)

T: So it is hard to get that middle ground [mm]

P: / I know because we have got someone living with us at the moment, David, / ts and it's a very - he works with Greg, / and a lot of our friends - they all work together. / And, he’s just started having, I don’t know, an affair, / what you could say, with one of the girls in the, in the like group - the group of friends. / And, another one was always really attracted to David. / And we found out, / because he was living with us, / well we didn’t say anything / because it wasn’t our problem. / And the other one that liked David / - I was pretty close with. / And just before I came, / about - oh, three or four weeks before I came down here, / she found out / and it all blew up. / And she wouldn’t speak to me / because - I, um, well I knew / and I didn’t tell her. / And I tried to explain to her that it wasn’t my place to tell her. / And, that really hurt me / and upset me, / and Greg said “well - you should learn to forget about it - she’s the one with the problem” / and um “she’s got to snap out of it, / you can’t do anything about it”. / And well it really hurt / because I didn’t think I’d done anything wrong. / And that, sort of, I suppose knocks the wind out of me. / Things like that. / [mm] She’s, she’s come around now, / but I don’t know how to cope with, with things like that. / And, Greg sort of says “oh well if she’s not talking to me - fine - that’s her problem” / and he gets on with it I suppose / and I - that sort of hurts a lot. /

T: That’s a bit like what happened when you were a kid - you got punished for doing nothing wrong. And then that gets into blaming yourself and feeling- “oh well, I’m not much good anyhow - I’m not really worthy of it or something like that”. So Greg is telling you that it’s the girl’s problem - What are your feelings about her and the way she reacted?

P: / Well, I was disappointed that she would be angry with me. / Um and that she, she couldn’t see that / - I understood that she was hurt, / but she wasn’t talking to me
but she was talking to David. And I thought that, well, it should be the other way around. She should be cranky with David if she's going to be cranky with someone. And ... (pause) um ... (pause) I'm not sure ...

T: So how do you interpret her behaviour like that?

P: / I understood that she was hurt, but I thought she was being childish about it. That I knew that she was hurt and that she wanted to sort of lash out at someone. And, but I, I, was trying to be there for her. And, sort of be nice and help her. But she didn't - I suppose she didn't want my help. /

T: So does that make you wonder about your friendship with her?

P: / Yes. Because I thought we were closer than that. /

T: And what do you think of it now?

P: / Well apparently Greg says she has been coming around to visit, and asks about me and everything, so hopefully when I go home I'll be able to like be the same as we were before. I hope we can. /

T: Do you think that's a good thing?

P: / ... well I think that the problem really wasn't with us two, because with Dav - if it had been something that I'd done, or there was a problem that had caused it between us two, it probably would be different. But, I really like her and I think she's a nice person, and it was probably her way of dealing with something hurtful. /

T: So what do you need to do with that friendship with her?

P: / ... (pause) I suppose, just, stand back and see how things go. Not fix it, just see what happens. /

T: Can you also re-define the friendship, have different rules for behaviour in it?

So that she is treating you the way that you are treating her?

P: / Yes. Now I realize that if someone wants to be like that - well - I'm not, I feel - I don't know, whereas before I would be upset and it would really upset me - I'm
not as strong as Greg / in the sense that I can forget about it, / I'm sort of a half way. /

T : Oh to say “forget about it” is very dismissive of your feelings.

P : / I do look at her differently now, / and I realize that I do have a lot of other friends if she wants to be like that - / well she can. / Um ... and and it won't worry me as much. / I'll I'll let her go her own way. / That sort of thing. /

Sample 8 Distribution of Mastery Category Scores

Discussion

Here the patient has achieved a sense of control [6U] over the conflict with her girlfriend, by emotionally separating herself [6U] and putting into perspective the negative reactions expressed towards her [5T]. She is seeing how her own ways of reacting contribute to her feelings of distress [5Q]. Although the conflict has upset her [2E], she is now ‘sort of half way’ towards resolving her feelings [5Q]. She has achieved this by not only understanding [4N] and challenging [4M] the way that her girlfriend responded to the problem, but also by seeing that she can control her feelings and ‘look at her differently now’ [6V].

Number of Scorable Clauses : 36
Sum of Mastery Scores : 151
Mastery Score this Sample = 4.2
CODE OF ETHICS FOR RATERS OF PSYCHOTHERAPY TRANSCRIPTS

This research material has strict limits as to its use and distribution, for which you must sign the following agreement before undertaking any rating task.

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I agree to act as rater for this project and have read and agree to the above conditions.

________________________ ____________________ ____________
Signature Name Date
SAMPLE ONLY
This form is only a guide. For ethical approval to do research, consult your local Ethics committee and the guidelines set down by your State and National bodies and those of your profession.

INFORMED CONSENT FORM

Date: ____________________  Name of Patient: ________________________________

I, the undersigned, give ______________________________ (psychologist) permission to make an audio tape recording of my psychotherapeutic treatment, and to use the recordings for research. He has informed me that the recordings will be available only to him and to his research colleagues; and that in the event of any future scientific report or publication of the research, my anonymity is to be protected by deletion of identifying data.

I have been informed that my consent to have my psychotherapy recorded is not a requirement for receiving treatment.

I have been informed that at the completion of the research study I will be advised of the results of the project.

With these conditions, I willingly consent to participate in the study by allowing audio tape recordings of my psychotherapy. However, I reserve the right to withdraw my consent for participation in the study at any time without the necessity of giving a reason, and without prejudice for my continued treatment.

Date: ____________________  Signature: _______________________________

Date: ____________________  Witness: _______________________________
References


MASTERY SCALE I
A RESEARCH AND SCORING MANUAL

Brief Version

This brief version contains the complete Mastery Scale I with annotated examples of scored clauses. The full 100 page manual contains details about the background, reliability and validity, methods of scoring, explanations and examples for each Mastery Scale code, and practice and worked examples for training judges.

Note: Numbers in square brackets refers to the page number in the text of the manual which contains further explanation of the code. Citation of the Full Version (100 pages) is as follows:
Level 1

Lack of Impulse Control

1A Expressions of being Emotionally Overwhelmed (p.19)

Being globally emotionally overwhelmed and distressed. State dominates the person's state of mind.

/ I exploded /
/ It is extremely painful /
/ Nothing is easy /
/ I felt very bad /
/ Everything is black /
/ My sickness controls everything /

1B References To Immediacy of Impulses (21)

• Extreme loss of control in mind and actions
/ I was heavily intoxicated and reckless /
/ I have lost all control /
/ I couldn't stop laughing /

• Overwhelming urgency to gratify needs
/ I put pressure, pressure on him /
/ I would do anything at all to get it /
/ All I want is this /
/ I feel so guilty /

1C References To Blocking Defences (23)

Blockages in thinking and feeling
/ Denial
/ I'm OK / and I don't want to change anything /
/ I act normal /
/ It doesn't bother me /

• Forgetting
/ Oh, what was I saying? /
/ Something just slipped my mind /

• Numhness
/ I can't think /
/ I can't concentrate on anything /
/ I feel blank about this /

• Avoidance
/ I just ignored it all /
/ I pretend that it didn't happen /

1D References To Ego-Boundary Disorders (25)

Serious disorders of ego-functioning - fragmentations and ego-boundary ruptures, regression of the ego.

• Dependency, submission & masochistic passivity-aggression
/ I want my mummy and go home /
/ I need someone to tell me what to do /
/ I really had a love crush on him /
/ I am subservient to you /

• Identity instability
/ I don't have an identity /
/ I don't feel that I'm me /
/ I feel like a different person each time I arrive /

• Omnipotent narcissism
/ I deserve special treatment /
/ I live in my own world /
/ I know you think about me all day /

• Ego-boundary ruptures
/ He spoke to me in my dream / and commanded me to act this way /
/ She can read my mind /
/ The lecturer is always looking at me / and giving me secret love messages /
/ It is like they are an extension of me /

Level 2

Introduction and Projection of Negative Affects

2E Expressions Of Suffering From Internal Negative States (28)

References to the self suffering - anxieties, melancholia, mania, guilt, shame, jealousies.

/ I felt panicked /
/ I suffered a lot with depression /
/ I've been feeling hypnoticataive /
/ I feel so jealous and envious /
/ I started shaking /
/ I got mad at myself /
/ I am very upset about it /
/ I feel so guilty /

2F Expressions Indicative Of Negative Projection Onto Others (30)

Negative internal states directed toward others - anger and blame; cynicism and repressed rage; resentments and defiance; revengeful and sadistic feelings; domination and manipulation of others. Patients' negative emotions are intended to upset the others' feelings.

/ I got madder and madder at him /
/ I blamed him for all my problems /
/ I am not going to budge an inch /
/ I just stormed out of the room /
/ I screamed at him /
/ It's all his fault !

2G Expressions Indicative Of Negative Projection From Others (31)

Other is perceived to be punishing and rejecting self. Paranoid ideation about others' motives. Others may be unaware of distress, since the malevolent affects are a projection of the negative internal states of the patient.

/ I get the feeling a lot of people think I'm dumb /
/ They are not interested in me /
/ They are playing a game against me /
/ I felt she didn't care about me /
/ You are making this hard for me /
/ He uses me for his own ends /

Level 3

Difficulties in Understanding and Control

3J Expressions Of Cognitive Confusion (36)

Inability to predict or understand, things being left unresolved, uncertain, contorted.

/ I don't know /
/ I don't know why /
/ My dreams are very confused and mixed up /
/ I don't know why he changed the way he did /
/ I guess things haven't really been sorted out at all /
/ I wasn't sure what to do /

3K Expressions Of Cognitive Ambivalence (37)

Struggling to understand; partial awareness & hypothesizing; difficulties communicating or putting things into words; emerging contents of unconscious.

/ Well it was sort of like this /
/ It is hard to explain how it was /
/ I don't know whether to feel one way or the other /
/ I seem to be making sense of it / but I am unsure /
/ It might be beginning to come together in my mind now /
/ Sometimes I think that / but other times I don't /
/ I sort of said that /
/ I suppose that it was like this /
/ I don't seem to be able to say it very well /

3L References To Positive Struggle With Difficulties (39)

Expressions of struggling with difficulties, seeking change & control. References to effort, hope, engagement in struggle to get better and improve.

/ I am trying to get myself better and under control /
/ I had to face it instead of ignoring it /
/ I have to put up with it /
/ I want to get over this /
/ I can't pretend that it never happened /
/ I am always trying to be the best I can /
/ I know I had to do it /
/ Talking and thinking about these things is very painful and hard /
/ If I really want to do it I can /

3M Expressions Of Lack of Control (39)

Lack of control, helplessness, personal and social helplessnes. Regard for self's incapacity and helplessness.

/ There was nothing I could do /
/ I can't help it /
/ I don't care about anything /
/ I just shut up and didn't say anything /
/ I am going to give up /
/ These pills will cure me /
Standing up for self with confidence.

4P Expressions Of Interpersonal Self-Assertion [40]

Standing up for self with confidence.

4M References To Questioning
The Reactions Of Others [p. 41]

Probing, assessing and challenging others' reactions rather than blindly accepting them.

I asked him why he thought this / I don't agree with the way she is approaching it / I asked him to tell me what he thought instead of just shutting up / I told him to stop because he was disturbing the children / She shouldn't be cranky with me / Do you know what I am saying?

4N References To Considering
The Other's Point Of View [45]

Clear consideration of alternative perspectives; compassion and understanding towards another person; consideration of how the other may be viewing the self; listing qualities of the other.

He is sensitive about things like this / I can see from her point of view / Maybe he did this because of y / It could be that he reacted because of y / I wasn't sure if he would understand / I can understand how she feels / I know he doesn't mean it / because he is just a boy / I know he suffered / I can see she was jealous /

4O References To Questioning
The Reaction Of The Self [45]

Awareness of role of the self - one's own contribution to conflict or situation.

I wonder whether I do something to create conflict / I asked myself why I felt this about her / It was my fault really / I am seeing this in more of a negative way than it really is / I can see now that I caused this / and made her feel bad / I realized there are things that need to be dealt with here / I questioned my reaction in this situation / I think maybe I was the problem /

45 Expressions Of Interpersonal
Self-Understanding [48]

Insight into other people and the dynamics of their relationships with the self.

I see now that my parents had trouble with this / She is the type of person that will react in this way / I think at first we were both hung up with problems / I know I have the same problem as he does / He is as stubborn as I am / We rub each other the wrong way /
Appendix 3

Publications and conference presentations
during the term of candidature

(January 1991 - March 1996)

Note: References in bold refer to work specifically associated with this thesis
Appendix 3

Publications


* Project Team : Andrew Baillie, Brin Grenyer, Wayne Hall, Julie Hando, Tracey Jarvis, Jeffrey Ward, Pam Webster, & Richard Mattick (Director).

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* Project Team : Andrew Baillie, Brin Grenyer, Wayne Hall, Tracey Jarvis, Pam Webster, & Richard Mattick (Director).

Conference Papers


Grenyer, B.F.S. (1992) Relapse and Depression. Academic Mental Health Professorial Unit, Liverpool Hospital. (June)

