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## The power of subtle interpersonal hostility in psychodynamic psychotherapy: A speech acts analysis

TIMOTHY ANDERSON<sup>1</sup>, LYNNE M. KNOBLOCH-FEDDERS<sup>2</sup>, WILLIAM B. STILES<sup>3</sup>,  
TATIANA ORDOÑEZ<sup>1</sup>, & BERNADETTE D. HECKMAN<sup>1</sup>

<sup>1</sup>Psychology, Ohio University, Athens, OH, USA; <sup>2</sup>The Family Institute at Northwestern University, Evanston, IL, USA &

<sup>3</sup>Psychology, Miami University, Oxford, OH, USA

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### Abstract

This study compared participants' speech acts in low-hostile versus moderate-hostile interpersonal episodes in time-limited psychodynamic psychotherapy. Sixty-two cases from the Vanderbilt II psychotherapy project were categorized as low or moderate in interpersonal hostility based on ratings of interpersonal process using Structural Analysis of Social Behavior (Benjamin, 1996). Representative episodes were coded using a taxonomy of speech acts (Stiles, 1992), and speech acts were compared across low- and moderate-hostile episodes. Therapists in moderate-hostility episodes used more interpretations and edifications, and fewer questions and reflections. Patients in moderate-hostility episodes used more disclosures and fewer edifications. Content coding showed that therapist interpretations with a self/intrapsychic self focus were more characteristic of moderate-hostility than low-hostility episodes, whereas the two types of episodes contained similar levels of interpretations focused on the patient's interpersonal relationships and the therapeutic relationship.

**Keywords:** brief psychotherapy; emotion in therapy; process research; psychoanalytic/psychodynamic therapy

Whereas the absence of a negative interpersonal process may not be sufficient for therapeutic change, the presence of even relatively low levels of negative therapist behavior may be sufficient to prevent change. Why should this be so?

Henry, Schacht, and Strupp (1990), p. 773

Successful psychotherapy seems to require a strong, positive therapist-patient relationship (Norcross, 2011). Psychotherapy process marked by interpersonal hostility—even in small amounts—predicts poorer outcome (Coady, 1991a, 1991b; Henry, Schacht, & Strupp, 1986; Jørgensen, Hougaard, Rosenbaum, Valbak, & Rehfeld, 2000). Thus, understanding exactly how hostility is expressed within therapy sessions is important, especially because low frequency or subtle hostility appears to be easily overlooked by all concerned—patients, therapists, supervisors, and researchers alike (Binder & Strupp, 1997).

Successful psychotherapy seems to contain very little hostility (Coady, 1991a, 1991b; Critchfield, Henry, Castonguay, & Borkovec, 2007; Henry et al.,

1986, 1990), with estimates of hostility consistently averaging between 0 and 1% of total patient and therapist utterances, as assessed using the Structural Analysis of Social Behavior observational coding system (SASB; Benjamin, 1978, 1987, 1996), explained in detail later. In contrast, unsuccessful therapy has been associated with relatively greater degrees of hostility, although estimates vary by study. On the high end, Henry et al. (1986) found rates of hostility as high as 20% for patient utterances and 19% for therapist utterances in poor outcome cases of time-limited dynamic psychotherapy. On the low end, Critchfield et al. (2007) found therapist and patient hostility levels averaged 4–8% in poor outcome cases in their study of cognitive-behavior therapy for generalized anxiety disorder.

Intensive case study suggests hostility need not be frequent or overt to be detrimental to the psychotherapy process. For example, Strupp, Schacht, Henry, and Binder (1992) analyzed a patient's premature termination and found that the therapist's hostility was often subtle, such that “the pejorative connotation of the therapist's communication was often indirect, implicit, and/or embedded in

messages carrying double meanings" (p. 204). Non-verbal communication (tone of voice, body language, etc.) may also heighten the interpersonal impact of subtle verbal hostility. Overt hostility may thus be a rare and transient expression within a more enduring problematic interpersonal pattern. In this study, our strategy was to examine the verbal context surrounding observer-identified hostile moments in order to distinguish such patterns.

### Interpersonal Hostility in the Context of Psychotherapy

The subtle but observable behaviors of interpersonal hostility are thought to involve both verbal and nonverbal expressions that have been assumed to significantly influence psychotherapy processes. A further inference is that these behaviors are not confined to the internal states of the patient or the therapist; rather, interpersonal hostility appears to involve both parties in an interacting system. Moreover, interpersonal hostility expressed within the dyad of therapist-patient is particularly problematic, and should be distinguished from hostility patients express regarding other people or circumstances in their lives. In their review, Binder and Strupp (1997) concluded that both patient and therapist contribute to what they called "negative process" by covert or overt manifestations of hostile behavior (including criticism, blame, withdrawal, and disengagement), which in turn is associated with outcome, though the relation is not necessarily causal (e.g., difficult clients or unresponsive therapists may produce negative process and poorer outcomes). Even if the relationship is causal, expressions of hostility may not necessarily be caused by the immediately preceding utterance, but rather unfold in the relationship over time in a pattern of mutual responsiveness (Stiles, Honos-Webb, & Surko, 1998). In their study of good- and poor-outcome cases, Henry et al. (1986) observed therapist and patient behavior using a sophisticated circumplex model of interpersonal behavior, Structural Analysis of Social Behavior (SASB; Benjamin, 1978, 1987, 1996). In comparison with interpersonal process in good outcome cases, they found therapists in poor outcome cases were less likely to focus on the patient using friendly-autonomous (affirming and understanding) and friendly-dominant (helping and protecting) behaviors, but were more likely to engage in hostile dominance (belittling and blaming). In contrast, patients were less likely to show self-focused friendly, autonomy-taking behavior (disclosing and expressing), and were more likely to engage in friendly-submissive (trusting and relying) and hostile-autonomous (walling off and avoiding) behavior.

Hostile complementarity (behavior patterns marked by reciprocal hostility from both patient and therapist) was more frequent in poor outcome cases. In a follow-up study, Henry et al. (1990) found that therapists' hostile and controlling behavior was correlated with patients' self-blaming statements.

Recognizing that even subtle forms of patient and therapist hostility can be problematic, Strupp and Binder (1984) developed their time-limited dynamic psychotherapy (TLDP) treatment manual specifically to help therapists reduce interpersonally hostile processes. The rationale for increasing transference interpretations early in treatment was based, in part, on clinical theory combined with prior observations of the context in which therapists became mired in transference-based hostile enactments. They noted that many patients "behaved in such a way as to actually elicit overt and covert responses" from the therapist (p. 145), which, when combined with the therapist's counter-transference and other aspects of the therapeutic relationship, generated hostile interpersonal processes. As the risks for therapists' early entry into enactment of patients' maladaptive patterns became apparent, the early introduction of interpretation of these patterns (both within and outside the therapeutic relationship) was proposed as a reasonable solution. Early and sensitively crafted identification of these interpersonal patterns was designed as one key element in assisting therapist-patient dyads from becoming hopelessly entrenched in poor interpersonal process. Sensible as this sounded, when the manual was implemented in the Vanderbilt II study (Strupp, 1993), the training had virtually no effect on outcomes (Bein et al., 2000). Unfortunately, learning to adhere to the treatment manual may have even enhanced some problematic therapist behaviors and negative processes, including less therapist support and optimism and greater defensiveness and authoritarian behaviors (Henry, Strupp, Butler, Schacht, & Binder, 1993).

Because TLDP was specifically designed to alter problematic patterns of interaction between the therapist and patient (Strupp & Binder, 1984), interpersonal hostility was of particular interest in the Vanderbilt II study, and was carefully measured by observer-based ratings of the therapeutic process using the SASB coding system. In the present study, we drew on these SASB codes to select episodes varying in interpersonal hostility, and we compared participants' *speech acts* within these episodes.

Speech acts describe an aspect of verbal communication that concerns what people *do* when they speak, rather than the content of what they say (Austin, 1975; Searle, 1969). Speech act categories may include typical types of therapist interventions, such as interpretations and questions, as well as

typical types of patient responses, such as self-disclosures. We used a taxonomy of verbal response modes (VRMs; Stiles, 1992) to classify participants' speech acts exhaustively. Thus, we cast a broad net seeking correlates of SASB-defined hostility. We were particularly interested in the role of therapist interpretations within moderate-hostile episodes, because previous empirical and theoretical literature has emphasized potential problems associated with therapist interpretation. Converging evidence from several sources suggests that transference interpretations are negatively correlated with alliance and outcome (Binder & Strupp, 1997; Piper, Azim, Joyce, & McCallum, 1991; Strupp & Anderson, 1997). Theorists have also cautioned against the accelerated use of interpretations in short-term psychodynamic treatments (e.g., Gill, 1979) in favor of a focus on positive interpersonal dynamics and alliance-building activities (Frances & Perry, 1983). More contemporary approaches to psychodynamic interpretation have attempted to enhance the interpretive focus on helping clients understand the interpersonal context of their lives, with relatively less focus on the patient's intrapersonal traits and characteristics (Safran & Muran, 2003; Strupp & Binder, 1984). In the present study, we attempted to understand the relative hostility of VRM therapist interpretations by further categorizing the extent to which the interpretations were solely focused on the client's intrapersonal processes and traits versus the extent to which they were relational in nature.

In summary, we compared participants' speech acts in low-hostility versus moderate-hostility interpersonal episodes in time-limited psychodynamic psychotherapy. Since VRM indexes are generally sensitive to differences in interpersonal relationships (Stiles, 1992), we expected to find that therapist and patient VRM profiles differed in these contrasting episodes. We also correlated VRM codes with SASB interpersonal process variables across episodes. Our goal was a careful description of speech acts in subtly hostile episodes of dynamic psychotherapy, in order to inform theory regarding successful therapeutic intervention.

### Method

We used data drawn from the Vanderbilt II Psychotherapy Research Project, a study of the effects of manualized training in time-limited dynamic psychotherapy (TLDP; Bein et al., 2000; Strupp, 1993). The larger study examined therapy offered by 16 therapists to three cohorts of patients: (a) a pre-training cohort in which each therapist treated two patients using his or her typical therapeutic practices, (b) a training cohort in which each

therapist had one training case and attended supervised training seminars in TLDP, and (c) a post-training cohort in which therapists were encouraged to apply TLDP to two additional cases.

### Patients

The present sample included 62 patients who were divided equally between the pre- and post-training cohorts. Full data were not collected from the 16 patients treated in the training phase, and this cohort has not been used in previous analyses (e.g., Henry et al., 1986, 1993; Bein et al., 2000). Of the 64 patients in the pre- and post-training cohorts, one patient was excluded because of refusal to be audio- or video-recorded, and one patient was not included because original SASB codes were unavailable. The present sample of patients averaged 42.3 years old (range: 24–64 years). Forty-eight (77%) were female, and all but one were Caucasian (98%). Patients were diagnostically heterogeneous. The most common diagnoses, using the third edition of the NIMH Diagnostic Interview Schedule, were Axis II personality disorders (65.4%), as well as Axis I depressive disorders (56.4%) or anxiety disorders (19.2%); 19.2% were diagnosed with a variety of other Axis I disorders (totals exceed 100% because of multiple diagnoses). A total of 92% met criteria for at least one Axis I disorder. For Axis II disorders, the most common diagnoses were Other or Mixed Personality Disorder (38.5%), followed by Avoidant (14.1%) and Dependent (9%). Patients were offered up to 25 sessions through the project and were seen for an average of 22 sessions.

### Therapists

The 16 licensed therapists included eight clinical psychologists and eight psychiatrists; ten were women and all were Caucasian. All therapists had at least 2 years of post-doctoral internship or post-residency clinical experience. Following the design, each therapist saw four patients, two pre-training and two post-training cases (except for the two cases not included in this sample; see above).

### Treatment and Training

Throughout the training year of the project, the 16 therapists were trained in time-limited dynamic psychotherapy (TLDP; Strupp & Binder, 1984). TLDP was developed as a response to clinical and empirical observation that therapists often struggle to appropriately manage hostile interpersonal processes. This treatment approach emphasizes (a) early engagement in transference and negotiation of the

therapeutic relationship; and (b) conceptualization of the patient's basic pattern of interpersonal problems, referred to by Strupp and Binder (1984) as the cyclical maladaptive pattern. TLDP attempts to help therapists avoid the pitfalls of enacting the patient's cyclical maladaptive pattern by exploring how patient-therapist communication problems may fit the patient's cyclical maladaptive pattern.

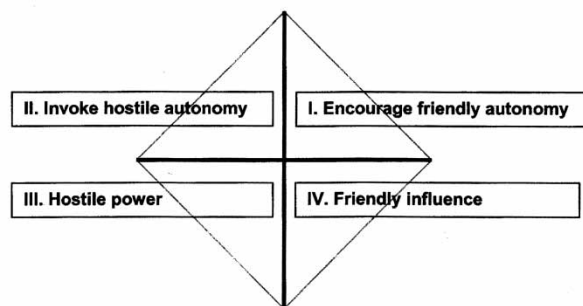
## Measures

**Hostility.** Hostility was measured using Structural Analysis of Social Behavior (SASB; Benjamin, 1978, 1987, 1996), an observer-based coding system that measures moment-to-moment interpersonal communication. SASB is a sophisticated, three-surface circumplex model built around two dimensions,

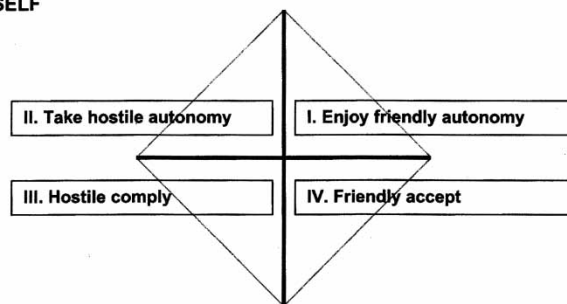
*affiliation* (the  $x$ -axis) and *interdependence* (the  $y$ -axis), and also takes into account the interpersonal *focus* of behavior (see Benjamin (1996) for a more comprehensive description of the SASB model).

SASB identifies the focus of the interaction on three separate surfaces (focus on other, focus on self, and focus turned inward; see Figure 1). *Focus on other* is transitive, describing behavior done to, for, or about another person (e.g., "he controls her" or "she protects him"). *Focus on self* is intransitive, describing behavior done to, for, or about the self in relation to the other person (e.g., "she submits to him" or "he trusts her"). *Focus turned inward* is drawn from Sullivan's (1953) concept of *introject*, or the incorporation into one's own personality of the tendency to treat oneself as one has been treated by others. In SASB language, focus turned inward describes

### FOCUS ON OTHER



### FOCUS ON SELF



### INTROJECTED FOCUS

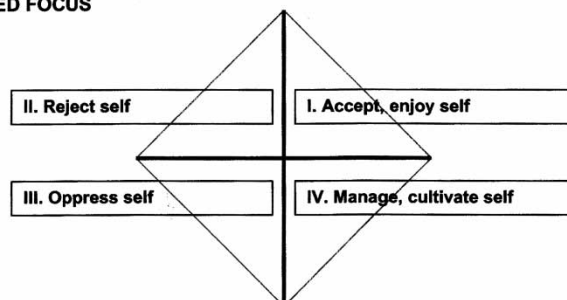


Figure 1. Combined quadrant and cluster SASB models. From Benjamin, L.S. (2000). *SASB Intrex user's manual for short, medium and long form questionnaires*. Copyright University of Utah. Reprinted by permission.

transitive action directed towards the self, or what the self is doing to, for, or about the self (e.g., "he attacks himself" or "she affirms herself").

SASB's two dimensions of affiliation and interdependence are designed to measure the complete array of interpersonal behavior, including the "primitive basics" of sexuality, aggression and hostility, and dominance-submission territorial behaviors (Benjamin & Cushing, 2000, p. 2). For example, SASB's affiliation dimension (x-axis; see Figure 1) ranges from intense hostility (murder) to intense love (sexuality). While pure forms of these primitive basics, including hostility, are not typically displayed in psychotherapy sessions, use of SASB allows the assessment of hostility in more mild or moderate forms.

SASB's interdependence dimension (y-axis; see Figure 1) is separated into two different axes: dominance to autonomy-granting, and submission to autonomy-taking. Because of this, SASB measures a wide range of interdependence-related behaviors, ranging from the absence of control (separation or differentiation) to intense control (fusion or enmeshment). Finally, SASB also contains the ability to measure *complex* communication, which is defined as interpersonal behaviors that cannot be fully described without using two or more SASB codes. Complex communication has been theoretically and empirically linked with various forms of psychopathology and negative interpersonal processes (Bateson, Jackson, Haley & Weakland, 1956; Humphrey, 1989; Ratti, Humphrey, & Lyons, 1996).

**SASB coding procedures.** The middle 15 minutes of each patient's third therapy session were coded according to the original version of the SASB manual (see Benjamin & Cushing, 2000) by two teams of graduate student coders, who had been given didactic instruction supplemented by examples of SASB codes. According to SASB's "pond water theory," coding a small sample of interpersonal behavior (at least 10 minutes in real time) typically results in a representative sample of interpersonal patterns (Benjamin & Cushing, 2000). Choosing the middle 15 minutes of the session, though somewhat arbitrary, was intended to sample therapeutic work while avoiding the clerical (e.g., scheduling) and casual conversations that sometimes occupied beginning and ending segments. As described by Henry et al. (1993), SASB coders were not aware of the hypothesis of the study.

Coders worked from both written transcripts and videotapes, and were encouraged to use both verbal and nonverbal cues to make their coding judgments. Coding proceeded in three steps. First, the written

transcripts were segmented into *thought units* (typically, a sentence or independent clause which expresses a complete thought). Second, the focus of the interaction was identified on one of the three surfaces (Other, Self, or Introject). Third, affiliation and interdependence ratings were made on a bipolar -9 to +9 scale; lower ratings described greater hostility and enmeshment, respectively. Finally, these ratings were used to place each speech act into Euclidian space by assigning it to the appropriate cluster in the SASB model (see Figure 1). Thus, interpersonal communications that were coded as "blaming and belittling," "attacking and rejecting," and "ignoring and neglecting" are examples of hostility in the SASB system (i.e., all codes falling to the left of the vertical axes in Figure 1).

Two teams of two coders each rated the segments; disagreements were resolved through consensus. One-third of the cases were randomly coded by two separate teams in order to establish reliability. As reported by Henry et al. (1993), reliability of coders was based on agreement of the SASB cluster codes (a more specific and conservative standard for reliability) and was acceptable (unweighted kappa of .75).

### Verbal Response Modes

The VRM system (Stiles, 1992) is a general-purpose taxonomy of speech acts. VRM codes are assigned according to three *principles of classification*, each of which can take the value of *other* or *speaker*:

1. *source of experience*: whether the utterance's topic is information held by the other or by the speaker,
2. *frame of reference*: whether the utterance is expressed from a point of view shared with the other or from the speaker's own point of view, and
3. *presumption*: whether the speaker presumes knowledge of what the other's experience or frame of reference is, was, will be, or should be (other) or instead uses knowledge only of his or her own experience and frame of reference (speaker).

As shown in Table I, these three forced choices place every utterance into one of the eight mutually exclusive categories, which are exhaustive in the sense that every comprehensible utterance can be coded. The eight categories are reflection, acknowledgment, interpretation, question, confirmation, edification, advisement, and disclosure. The designation *uncodable* is used only for utterances that are incomprehensible.

Table I. Taxonomy of verbal response modes

Source of experience	Frame of reference	Presumption	
		Other	Speaker
Other	Speaker	INTERPRETATION Explains or labels the other; judgments or evaluations of other's experience or behavior.	QUESTION Requests information or guidance.
Other	Other	REFLECTION Puts other's experience into words; repetitions, restatements, clarifications.	ACKNOWLEDGMENT Conveys receipt of, or receptiveness to, other's communication; simple acceptance, salutations.
Speaker	Speaker	ADVISEMENT Attempts to guide behavior; suggestions, commands, permission, prohibition.	DISCLOSURE Reveals thoughts, feelings, wishes, perceptions, or intentions.
Speaker	Other	CONFIRMATION Compares speaker's experience with other's; agreement, disagreement, shared experience or belief.	EDIFICATION States objective information.

A published manual (Stiles, 1992) describes the theoretical derivation of these categories and gives detailed coding instructions. For example, "I have pain when I move my legs" would be coded as disclosure intent (because it reveals subjective experience). Alternatively, "I went to the emergency room last week" would be coded as edification intent (because it transmits objective information). The VRM system also classifies the grammatical form of utterances into eight categories parallel to the eight intent categories shown here. For simplicity, the form classifications were not used in this study; because mixed VRM modes are rare, they were coded in their intent form only for the sake of parsimony.

The VRM system categorizes speech units at the *utterance* level, which is approximately the same size unit as the SASB *thought unit*. For consistency, SASB thought units were used in coding all VRMs in the present study (e.g., even brief utterances like "Mm-hm" were segmented for SASB, which was necessary for identifying VRM acknowledgement codes).

#### Relationship focus of VRM interpretations.

Because therapist interpretation was of specific interest in this study, we further distinguished VRM therapist interpretation codes according to their *relationship focus*. Although all VRM therapist interpretations are about the patient's experience from the therapist's frame of reference, there can be great variation in the extent to which those client experiences are framed in interpersonal terms. In order to study this, an additional code was added to categorize each VRM interpretation. The three relationship focus categories, which were mutually exclusive, included the following: (a) *self/intrapsychic interpretations*, or interpretations which focused exclusively on the patient's traits, acts of self, or

intrapsychic dynamics without reference to relationships with others or the therapist; (b) *interpersonal/non-transferential interpretations*, or interpretations focused on the patient's relationships with others, excluding the therapeutic relationship; and (c) *transference interpretations*, or interpretations containing any allusion to the patient's relationship with the therapist. For each patient-therapist dyad, these variables were expressed as a percentage of the total thought units. Reliability for each of these relationship focus ratings was high (see Table II).

#### Procedure

**Classification of low-hostility and moderate-hostility episodes.** Classification of hostility was defined as SASB thought units in which (a) the focus was on the Other, and (b) the affiliation rating was less than zero, placing the behavior anywhere in the hostile half of the SASB circumplex (i.e., the left side of the axis in Figure 1). While recognizing that self-directed hostility also occurs within an interpersonal context, for classification purposes we were most interested in forms of hostility that were clearly directed toward the other participant in the dialogue. We counted therapist- and patient-initiated hostile thought units equally in assessing the dyad's interpersonal hostility because hostility is conceptually a product of both participants' communication within the interpersonal model. Further, the overall frequency of SASB hostility was relatively low.

Patient-therapist dyads were classified as low or moderate in hostility using a median split based on the total number of combined therapist and patient hostile thought units contained in the SASB-coded 15 minutes of the third session. SASB hostility codes were relatively rare in these segments (see Henry et al., 1990); patient-therapist dyads averaged only 2.6

Table II. Mean therapist and patient VRM percentage for hostility level and training cohort

	Alpha	Hostility median split Low hostility Training cohort				Moderate hostility Training cohort				Total		<i>F</i> from ANOVA		
		Pretraining		Posttraining		Pretraining		Posttraining				SASB	Training cohort	Hospitality × cohort
		Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD			
Therapist														
Th Disclosure	0.82	3.25	8.81	6.44	6.37	9.12	8.59	3.87	4.77	5.60	7.51	0.78	0.31	5.15*
Th Advisement	0.97	1.79	7.14	2.50	5.06	4.26	8.13	3.48	5.32	2.99	6.44	1.08	0.00	0.21
Th Question	0.97	29.43	21.50	15.08	10.55	15.29	11.33	14.15	9.84	18.59	15.30	4.34*	4.59*	3.33
Th Interpretation	0.89	12.43	14.67	10.06	12.45	27.75	19.09	21.03	14.47	17.78	16.52	11.8***	1.36	0.31
Intrapersonal	0.95	1.85	3.77	2.90	4.24	15.12	15.68	5.19	7.88	6.18	10.34	11.21***	3.65	5.59*
Interpersonal	0.95	8.09	13.97	2.16	3.71	6.61	9.79	6.15	7.25	5.80	9.54	0.27	1.75	1.28
P-T Relationship	0.95	2.47	8.38	4.99	9.58	6.02	13.96	9.69	12.90	5.80	11.45	2.02	1.14	0.04
Th Edification	0.71	0.27	1.09	3.41	5.52	14.70	18.72	3.97	4.38	5.48	11.05	8.95**	2.30	7.65**
Th Confirmation	0.35	0.27	1.09	0.69	1.27	1.16	2.86	1.16	2.71	0.82	2.12			
Th Acknowledgment	0.97	23.33	25.29	42.82	25.69	16.10	9.24	35.11	19.75	29.34	23.02	1.94	12.86***	0.00
Th Reflection	0.74	25.42	19.73	16.82	13.74	9.08	9.23	14.85	10.96	16.66	14.94	6.57**	0.16	4.03
Th Uncodable		3.28	8.65	2.19	3.78	2.55	2.89	2.39	2.95	2.61	5.09			
Patient														
Pt Disclosure	0.73	40.05	18.23	43.21	16.06	47.40	16.21	55.76	16.22	46.65	17.38	5.48*	1.83	0.38
Pt Advisement	0.66	0.00	0.00	0.07	0.28	1.03	1.71	0.00	0.00	0.27	0.94			
Pt Question	0.97	0.74	1.47	1.16	1.61	1.95	2.19	0.61	1.13	1.10	1.68	0.64	1.20	4.52*
Pt Interpretation	0.90	0.21	0.65	1.77	5.77	0.47	1.80	0.58	1.60	0.74	3.08			
Pt Edification	0.79	50.93	18.91	39.80	21.03	33.73	17.88	26.06	18.10	37.66	20.73	10.27**	3.79	0.13
Pt Confirmation	0.45	4.09	4.47	4.57	4.61	5.55	4.45	6.89	4.69	5.28	4.58			
Pt Acknowledgment	0.94	3.12	4.21	7.60	8.14	6.27	6.36	5.97	8.61	5.70	7.06	0.18	1.36	1.79
Pt Reflection	0.5	0.00	0.00	0.00	0.00	0.48	1.30	0.61	1.33	0.27	0.95			
Pt Uncodable		0.85	1.43	1.82	4.66	3.11	2.83	3.52	4.25	2.32	3.59			

Note: \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ . Inferential tests were only when the eight coded VRM categories were at least 1% of the total talk. Alphas are the intraclass correlations of the four coders.



hostile thought units out of an average of 239.9 total thought units in a 15-minute segment. Because the distribution of hostile thought units was positively skewed, the median split left a very low concentration of hostile codes (ranging from 0 to 2 thought units) in the low-hostility group (31 cases). The moderate-hostility group (also 31 cases) contained between 3 and 10 hostile thought units. Although 13 of the 31 low-hostility cases had 1 or 2 hostile thought units included within the target episode, we believed these represented a sufficient contrast with the moderate-hostility cases to justify our comparisons.

**Selection of target hostility episodes for VRM coding.** To locate the highest frequency of hostility codes in each segment, each 15-minute psychotherapy episode was partitioned into segments of 10 thought units each. For dyads that contained hostility codes, histograms were created by summing the frequency of SASB-rated hostile thought units within each 10-thought-unit segment; the location with the greatest frequency of SASB hostile thought units was identified. We then excerpted all thought units located within the 250 words preceding or 250 words following the location of greatest hostility and considered these 500-word passages (approximately two double-spaced pages, representing approximately 5 minutes of dialogue) as target episodes; these were coded using the VRM system. For the 18 cases in the low-hostility group which contained zero SASB hostility codes, we selected the target episode by first matching that case with a randomly selected moderate-hostility case, and then selecting a 500-word passage from the corresponding location in the transcript by dividing the episode's beginning thought unit by the total number of thought units in the episode.

**VRM coding.** Four clinical psychology doctoral students (entirely separate from the SASB coding teams) served as VRM coders. The coders trained for a total of 40 hours through weekly didactic instruction and homework assignments over a 10-week period. They coded example transcripts and exercises provided in a computer-assisted VRM training program (Stiles, 1992). Once acceptable levels of reliability were established, coders applied the VRM system to transcripts of the selected episodes (inter-observer reliability for all VRM codes at the thought unit level was acceptable,  $\kappa = .65$ ). All four coders rated each episode. Two coders further classified each VRM therapist interpretation code according to its relationship focus. Video and audiotapes were made available for the coders' ratings but were rarely used; instead,

coders tended to rely on written transcripts (VRM coding, because it does not seek to assess affect, makes less use of non-verbal cues than SASB). Coders met twice weekly to discuss coding issues and to minimize drift. The VRM coders had no knowledge about SASB, the study hypotheses, how the transcripts had been selected and partitioned, or any other information about the patients or therapists.

A total of 4,193 thought units were coded, with a mean of 67.6 per dyad. Percentages were calculated for each VRM category by each speaker. This was done by dividing the frequency of each response mode by that speaker's total number of thought units and multiplying by 100. When disagreement existed among coders, the VRM code for which the majority (three out of four) coders agreed was assigned. When fewer than three coders agreed, final codes were chosen based on consensus after discussion.

## Results

As can be seen by comparing each speaker's relative percentages of VRMs in Table II, patient and therapist VRM percentages differed markedly in ways that were consistent with patient and therapist roles. Therapists used more questions, acknowledgments, and reflections, while patients used more disclosures and edifications.

As in prior VRM research (Stiles & Shapiro, 1995), VRM categories were not analyzed when they accounted for less than 1% of the speaker's thought units. Thus, therapist confirmation, along with patient advisement, interpretation, and reflection, were not included in analyses due to low frequency. Intraclass alphas for the percentage of VRMs among the four coders were generally high (see Table II). However, low frequency VRM categories also had low reliability. Because patient confirmation had low reliability, it was also removed from analyses even though the percentage of patient confirmation (5.2%) was slightly higher than the 1% criterion.

## Speech Acts in Low- and Moderate-Hostility Episodes

To compare the frequency of VRMs for low- versus moderate-hostility episodes, we performed a series of one-way ANOVAs, using SASB hostility level as the independent variable and percent frequency of VRM categories as dependent variables. Patient and therapist speech acts were analyzed in separate ANOVAs. Because VRM percentages are ipsative, higher rates in one category must be compensated by lower rates in the other categories; thus, the ANOVAs were not

independent of each other. Therefore, we conducted separate ANOVAs for each of the VRM categories that met the two criteria described earlier: (a) greater than 1% frequency in the sample, and (b) acceptable reliability.

Therapist communication in the moderate-hostile episodes was marked by significantly higher use of interpretation and edification and less reflection and questioning, relative to the low-hostility episodes (see Table II).

Training in TLDP also influenced therapists' VRMs (Table II). From pre-training to post-training, therapists tended to increase their use of acknowledgement and decrease their use of questions. Variations in the percentages of therapist disclosure, edification, and reflection depended on the interaction of hostility and training cohort. Specifically, the hostility  $\times$  cohort interaction on therapist disclosure in Table II is primarily from decreased therapist disclosures after training, but only in the moderate-hostile episodes,  $F(1, 29) = 4.50$ ,  $p < .05$ ,  $\eta^2 = .15$ .

Patients in the moderate-hostility episodes tended to use more disclosure and less edification than patients in the low-hostility episodes (see Table II). Also, a significant hostility  $\times$  training cohort interaction for patient questions emerged. This interaction was largely accounted for by a decrease in patients' use of questions in the post-training cohort within the moderate-hostility group,  $F(1, 29) = 4.66$ ,  $p < .05$ ,  $\eta^2 = .14$ .

### Therapist Interpretation in Low- and Moderate-Hostility Episodes

Analyses for type of therapist interpretation (self/intrapsychic, interpersonal/non-transferential, or transferential) were conducted using the same ANOVA strategy used for the other VRM analyses. Compared with low-hostility episodes, therapists in moderate-hostility episodes used more self/intrapsychic interpretations (see Table II). However, this relationship was conditional on a hostility  $\times$  training cohort interaction. For dyads within the moderate-hostile group, training in TLDP was associated with significant reductions in self-focused interpretations,  $F(1, 29) = 5.06$ ,  $p < .05$ ,  $\eta^2 = .15$ . Low-hostility episodes did not differ from moderate-hostility episodes in the frequency of therapist interpretations that were interpersonal/non-transferential or transferential in focus.

### Associations Between VRMs and SASB Variables

In our exploratory analyses, we correlated speech content and interpersonal process variables. VRM

categories' percentages were correlated with SASB quadrant scores and complex codes for therapists and patients separately, averaged across episodes. SASB codes in which therapist focused on self or the patient focused on other were eliminated from these correlational analyses because of sample size constraints (i.e., the vast majority of psychotherapy speech involves patient's focus on self and therapist's focus on other). Due to the relatively large number of comparisons remaining, however, results should be evaluated for both theoretical coherence and statistical significance.

Table III shows which VRMs were associated with various forms of positive and negative SASB-measured interpersonal process. Therapist disclosure was associated with problematic interpersonal process (i.e., complex communication and an absence of friendly influence). Therapist question and edification were associated with less friendly influence and more encouragement of friendly autonomy. Therapist interpretation was both negatively associated with friendly influence and positively associated with granting hostile autonomy (i.e., SASB positive interdependence and hostility). Finally, therapist acknowledgment was linked with positive interpersonal processes via its positive correlation with friendly influence and negative correlation with hostile autonomy-granting, but was also negatively associated with friendly autonomy-granting.

Although there were several significant relationships of SASB process variables with therapist VRMs, only a few such relationships existed for patient VRMs. Contrary to our expectations, patient disclosure was associated with problematic interpersonal processes (hostile comply behavior and complex communications), and patient edification was negatively associated with complex communication.

### Discussion

Both therapists and patients tended to use different patterns of speech acts in moderate-hostile episodes compared with low-hostility episodes. This finding supports our initial inference that interpersonal hostility is most properly thought of as a joint state of the therapist-patient dyad, rather than an individual attribute of either the patient alone or the therapist alone.

In contrast to low-hostility episodes, therapists in moderate-hostility episodes used nearly four times the rate of edifications and self/intrapsychic interpretations, with compensating lower rates of reflections and questions (Tables I and II). This suggests that, in moderate-hostility episodes, therapists took an interpretive, information-giving stance—or *telling* rather than *listening*.

Table III. Correlations between SASB quadrants and therapist and patient VRMs

Therapist: SASB focus on other	SASB friendly influence	SASB friendly autonomy-granting	SASB hostile power	SASB hostile autonomy-granting	SASB complex communication
Disclosure	-0.35**	0.00	0.10	0.23	0.45***
Advisement	-0.15	0.24	-0.09	0.07	-0.18
Question	-0.29*	0.40**	-0.01	0.04	-0.21
Interpretation	-0.51***	0.25*	0.07	0.33**	0.22
Interpretations: acts of self	-0.26*	0.03	0.12	0.15	0.11
Interpretations: interpersonal	-0.34**	0.37**	0.02	0.17	-0.09
Interpretation: transference	-0.22	0.03	-0.02	0.20	0.31*
Edification	-0.26*	0.29*	0.03	-0.12	0.13
Confirmation	0.14	-0.12	0.10	0.05	-0.07
Acknowledgment	0.84***	-0.65***	-0.07	-0.30*	-0.12
Reflection	0.06	-0.08	-0.08	0.01	-0.11
Patient: SASB focus on self	SASB friendly autonomy	SASB friendly accept	SASB hostile comply	SASB take hostile autonomy	
Disclosure	-0.14	-0.10	0.03	0.27*	0.32**
Advisement	-0.20	0.20	0.05	0.05	-0.01
Question	-0.23	0.18	0.04	-0.15	0.19
Interpretation	-0.09	0.14	-0.07	-0.09	0.05
Edification	0.17	0.06	-0.12	-0.11	-0.42***
Confirmation	0.04	-0.06	0.25	-0.11	-0.04
Acknowledgment	-0.03	0.00	0.19	-0.19	0.26*
Reflection	-0.07	0.00	-0.09	0.09	0.12

Results limited to SASB focus on self (Surface 2) codes for patients, and SASB focus on other (Surface 1) codes for therapists.

Patients' VRM use was also different in the moderate-hostility versus low-hostility episodes. Replicating previous findings (e.g., Stiles, Shapiro, & Firth-Cozens, 1988), the vast majority of patient utterances were disclosure and edification, but whereas the ratio of these two modes was only .91:1 in the low-hostility episodes, it was 1.73:1 in the moderate-hostility episodes (see Table I). In other words, patients averaged 24% more disclosures and 35% fewer edifications in the moderate-hostility episodes. Hence, it appears that while therapists in the moderate-hostile episodes were adopting an interpretive, information-giving stance, patients were focused on internal, subjective experience. We hasten to add that since we studied dialogue from relatively early in treatment (the third session), future work should assess whether the same patterns characterize late-treatment process.

Insofar as VRMs are coded without reference to affective valence (for example, interpretations can be either positive or negative; see Stiles, 1992, p. 91, for a discussion), the associations of VRM categories with hostility are not an artifact of coding criteria, but instead represent a pattern of verbal relating linked with interpersonal hostility in the context of psychotherapy. That is, the *telling-rather-than-listening* pattern may be indicative of subtle hostility within the therapeutic dialogue.

The following portion of a moderate-hostility episode illustrates the *telling-rather-than-listening* pattern of therapist speech followed by patient focus

on internal, subjective experience. Nearly half of the therapist's thought units were interpretations, and approximately three-fourths of the patient's thought units were disclosures. The therapist's interpretations were primarily focused on the patient's self/intrapsychic content. VRM and interpretation focus codes are indicated in square brackets.

T: Gee, that sounds more like ... self-criticism than, than a statement about yourself—

[Interpretation: Self/Intrapsychic]

says you feel lousy about yourself. [Interpretation: Self/Intrapsychic]

P: Uh, I guess I do feel lousy about myself.

[Disclosure]

But maybe because ... it seemed that at one time in my life ... I had everything anybody could ever want. Everything. [Disclosure]

And now, I have nothing hardly. [Disclosure]

And it's got to be mostly my fault that I've come from there to here ... [Disclosure]

I had a beautiful home... a husband who I loved and loved me ... [Edification]

Children ... friends ... family, my mother, my father,

my mother was still alive ... [Edification]

I had a future. [Edification]

And now all those, one by one, is gone.

[Edification]

Is that ... is this just self-pity? [Disclosure]

Is that what I'm doing? Am I wallowing in

self-pity? [Disclosure]

T: ... Well, I think self-pity is a, you know, an unflattering way of describing depression.

[Disclosure]

You know, everything you say about yourself is unflattering, self-critical. [Interpretation: Self/Intrapsychic]

What I would say is that you're depressed.

[Interpretation: Self/Intrapsychic]

I think you seem to prefer something that sounds more negative, like self-pity. [Interpretation: Self/Intrapsychic]

P: Wel .... [Acknowledgment]

I guess there's really nothing wrong with feeling sorry for yourself sometimes. [Disclosure]

You feel sorry for other people. [Edification]

So, why shouldn't I? [Disclosure]

If I have the capacity to feel sorry for other people, or compassion, why shouldn't I for myself?

[Disclosure]

T: I think that's very well put. [Interpretation: Self/Intrapsychic]

P: And right now I'm hurting. [Disclosure]

And so why ... I guess I wouldn't even be human if I didn't. [Disclosure]

To us, the therapist's interpretations seemed to indirectly blame the patient. As was true with many of the SASB hostility codes, the overt interpersonal hostility was subtle and appeared within the therapist's comments about how the patient seems to "prefer" negative, self-effacing labels. The hostility was even more evident from the therapist's nonverbal cues (tone of voice, posture, etc.) than it appears from the transcription. While mild, the therapist's blame may be significant within a relationship that requires vulnerability, trust, and consistency to be effective. In response, the patient's disclosures expressed self-blame and an affective tone of self-pity.

In contrast, the following passage from a low-hostility case provides an example of therapist listening-rather-than-telling, characterized by therapist reflections and questions, with a roughly even mixture of patient edifications and disclosures. The patient had been discussing how she often became intensely angry and easily lost control:

P: And when I get that mad, I just want to ... I'm to the point ... you know how mad I get ...

[Disclosure]

And I'm to the point right now ... "don't, don't push me any further." [Disclosure]

Because I just, I just, I get ... just blind mad.

[Disclosure]

I just, I can't. (I) totally lose control. [Disclosure]

T: Lose control. [Reflection]

P: Oh, screaming, hollering, or wanting to throw something or ... [Edification]

T: You have a fit. [Reflection]

P: Oh, yeah. [Confirmation]

I just have a fit. [Edification]

And then just feel terrible and so upset about it.

[Disclosure]

I was so upset that I cried all day long, in the house by myself. [Disclosure]

I was so upset. [Disclosure]

And when she came home I told her I was sorry [Edification]

and I realized that the problem was really with the girl who didn't come to pick her up. [Disclosure]

I just told her that I was sorry that that had happened. [Edification]

Cause she's always wanting to leave or run away or do something like that. [Edification]

T: Your sixteen year-old? [Question]

P: Um Hmm. [Edification]

T: Has she ever run away? [Question]

In this passage, the therapist actively tracked the patient's experiences but did not go so far as to reframe or make interpretations (although asking "You have a fit?" comes close to an interpretation). Coincidentally, the topic of the discussion was the patient's anger; however, interpersonal hostility was not directed at either the therapist or patient. While we believe these two examples are representative of the data, we chose them for illustrative purposes and we applied no formal qualitative methods in making our selections.

The speech act differences found in this study seemed to reflect a mutually-responsive interpersonal pattern. It could be that therapists' interpretive stance led patients to express feelings (including anger) which would be coded as VRM disclosures. Conversely, angry, attacking, and blaming patients may entice therapists into subtly hostile interpersonal exchanges (e.g., Henry et al., 1990; Safran & Muran, 1996). Patients who express interpersonal hostility may elicit therapists' attempts to interpret and explain patients' painful feelings, especially within the context of psychodynamic treatments. Of course, therapist interpretations delivered in the midst of patient attack and blame are prone to becoming hostile retorts in their own right. In this view, therapists' *telling-rather-than-listening* stance during moderate-hostility episodes may be as much a response to patients' distressing emotional expressions as a deliberate treatment strategy.

Significantly, almost all of the training cohort effects were limited to changes in therapist speech. In terms of main effects for training cohort, the finding of increased use of therapist questioning and

acknowledgments in the TLDP cohort might be viewed as positive within some treatment models. However, there was little plausible reason that we could identify for this finding in TLDP. Before training in TLDP, therapists in moderate-hostility dyads used more disclosure and edification and less reflection, relative to those in the low-hostility dyads. After TLDP training for moderate-hostility dyads, therapists' use of disclosure and edification decreased and their use of reflection increased to approximately the levels observed in low-hostility dyads.

### Interpretations and Hostility

It is important to note that many of the therapist interpretations in the moderate-hostility episodes were non-blaming (or even affirming): for example, inviting the patient to reframe their self-accusations in more positive terms. Thus, it would be incorrect to infer from our findings that interpretations themselves are hostile or that we found specific micro-links between VRM codes and SASB ratings. Instead, the hostility identified by SASB coders might reflect a more general presumptuousness by the therapist. Alternatively, to reverse the directionality, some interpretations might be reactions to moderate-hostile processes, representing therapists' attempts to pull their patients out of negative affective states via reframing.

Our exploratory correlational analyses (Table III) provide some clues regarding the links between verbal response modes and interpersonal process and supply further evidence to support the potential harmful effects of the therapist *telling-rather-than-listening* pattern. Therapists who employed more frequent disclosures and interpretations were more likely to engage in problematic interpersonal process (i.e., complex communication; an absence of friendly influence; and, in the case of interpretations, more hostile autonomy-granting). In the VRM system, interpretations are described as interpersonally *directive* (the speaker is guiding the conversation using his or her own frame of reference; see Table I) and *presumptuous* (the speaker presumes knowledge of the other, which is associated with higher relative status; Stiles, 1992). However, acknowledgments do the opposite: they are *acquiescent* (acceding to the other's frame of reference) and *unassuming* (displaying lower status and deference). Therapist acknowledgment was associated with positive interpersonal processes (friendly influence and the absence of hostile autonomy-granting) but also was associated with the absence of friendly autonomy-granting. As always, appropriate responsiveness is everything

(Stiles et al., 1998)—therapist acknowledgement and affirmation has been linked with poorer outcome if it is frequently expressed in response to maladaptive patient content (Karpiak & Benjamin, 2004). In our study, we speculate that perhaps therapists' frequent use of acknowledgments served to prevent the development of struggles for power and control between therapist and patient, but this idea is speculative and warrants further investigation.

Our finding that patient disclosure was associated with negative interpersonal processes (hostile submission and complex communication) seemed to contradict previous findings that patient disclosure is positively associated with outcome (Critchfield et al., 2007; Henry et al., 1986). However, our result converges with descriptions by patients, therapists, and external raters that sessions high in patient VRM disclosures are relatively rough, difficult, and uncomfortable (Reynolds et al., 1996; Stiles, 1984). This apparent contradiction in findings might reflect differences in the definition of *disclosure* in the VRM taxonomy as compared with the SASB system. Or, perhaps the rough, uncomfortable process containing SASB-coded hostility and VRM-coded disclosures is (sometimes) a manifestation of difficult material being confronted in psychodynamically oriented therapy (Reynolds et al., 1996).

Of course, causation should not be inferred from our correlational results. Therapist interventions, including interpretations, cannot be abstracted from the responsive interpersonal context in which they are delivered (Kiesler, 1996; Stiles et al., 1998). For example, Gabbard et al. (1994) found that transference interpretations produced noticeable increases or decreases in patient collaboration depending on the context. In their analysis of three long-term psychodynamic treatments of patients with borderline personality disorder, they found that effective transference interpretations were typically preceded by a series of supportive interventions. They speculate that the supportive interventions may have functioned to enhance patient receptivity to the therapist's confrontational transference interpretation.

In an innovative experimental study, Høglend, Johansson, Marble, Bøgwald and Amlo (2007) randomized patients to dynamic therapy with or without transference interpretations. Although no main effect of treatment on outcome was found, patients with more interpersonal problems, more severe symptoms, or poorer quality of life responded better to therapy with transference interpretations (typically, 1–3 delivered per session) than to therapy without such interpretations. However, transference interpretations were negatively associated with

outcome for patients with less severe problems and more resources. Drapeau et al. (2008) reported a lag-sequential analysis of therapists' interventions in relation to patients' defensive functioning in which one of several stable therapist patterns involved an extended series of interpretations; however, this sequence was not associated with any change in level of patient defensiveness.

These results suggest therapist interpretation is not always harmful, but may be used in harmful ways. VRM-defined interpretation is a broader construct than the sort of interpretations used in TLDP or psychodynamic therapy more generally, though both are speech acts in which the speaker/therapist imposes a frame of reference on the other/patient. Note that we did not assess the quality, accuracy, or timing of these interpretations, so our findings do not necessarily contradict the importance attributed to interpretation by psychodynamic theorists, who have long held that interpretations must be used sparingly, skillfully, and within the context of a positive alliance to be helpful (e.g., Bibring, 1954; Frances & Perry, 1983; Spence, 1992). Research findings have also suggested that an interpretation's benefit depends on its accuracy and relevance (Crits-Christoph, Barber, & Kurcias, 1993; Silberschatz, Fretter, & Curtis, 1986), timing (Bauer & Mills, 1989), and tailoring to the quality of the patient's object relations (Piper et al., 1999; Ogrodniczuk, Piper, Joyce, & McCallum, 1999). Further, these caveats are also true within TLDP's technique and treatment principles. While transference interpretation is a primary intervention within TLDP, it is construed as "the product of a collaborative inquiry in which the patient and therapist learn together about the patient's conflicts. Accordingly, interpretation per se is not the linchpin of treatment. Rather, it is one important activity in a process of understanding the transactions between patient and therapist, and the manner in which their relationship reflects episodes in a fixed scenario" (Strupp & Binder, 1984, p. 165).

The TLDP manual (Strupp & Binder, 1984) emphasized early interpretation of transference, resistance, and cyclical maladaptive patterns. It is tempting to conclude that the manual encouraged therapists to use interpretation prematurely, in which case the problem might be addressed by decreasing this emphasis. Indeed, Connolly, Crits-Christoph, Shappell, Barber, Luborsky and Shaffer (1999) found that a high proportion of transference interpretations early in supportive-expressive therapy were negatively associated with outcome for patients with interpersonal problems. In a small sample of patients with avoidant personality disorder, Schut

et al. (2005) also found a negative relationship between interpretations and both interpersonal hostility and outcome. On the other hand, the absence of pre- versus post-training cohort effects for interpretation in the present study suggests that therapists had the same tendency to take an interpretive stance before training as they did after training. More likely, as others have speculated (Strupp, 1989), compressing dynamic therapy into tight session limits may tend to accelerate therapists' use of interpretation, which may lead to problematic interpersonal processes for some patient-therapist dyads.

Identification of the interpersonal relationship context (e.g., types of therapy, close interpersonal relationships, physician-patient relationships) within which speech acts, like interpretation, become linked with certain interpersonal processes, like subtle interpersonal hostility, is a promising area for continued research. Micro-level observational research, especially across time, could facilitate theory-building regarding how macro-level processes (such as global level of empathy, or the therapeutic alliance) develop and thrive, or fail to thrive. Qualitative research, particularly narrative analyses comparing hostile versus non-hostile psychotherapy episodes, would be a valuable next step in contextualizing our quantitative results within clinical theory. Given the sometimes subtle nature of hostility in psychotherapy, more research is clearly needed to identify the conditions under which negative process in psychotherapy is generated and maintained. In our view, therapists' recognition of the *telling-rather-than-listening* pattern is a first step toward preventing its possible negative effects.

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