Empirical Studies of the Therapeutic Hour

Edited by Robert F. Bornstein and Joseph M. Masling

American Psychological Association • Washington, DC

Chapter 7

Therapist Interventions and Patient Progress in Brief Psychodynamic Therapy: Single-Case Design

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In this chapter we describe a research program that was designed to explore the relationship between therapist interventions and patient (or client) responses in brief psychodynamically oriented psychotherapy. Note that we did not study psychoanalysis per se but brief psychotherapy that is based on the application of psychoanalytic or psychodynamic principles. As such, the therapies were insight based and broadly exploratory within the framework of a psychodynamic focus. This has the advantage of ecological validity because it represents the more typical current mode of practice, but it is at the expense of the kind of depth that psychoanalysis can offer. In presenting the research, we emphasize not only the results attained but also the process by which they were gathered. In this way we hope to remain true to both the difficulties and excitement of carrying out such a project and to demonstrate

iow this kind of research can be conducted in less-than-optimal circumstances with the hope that others will follow suit.

The Rutgers Psychotherapy Research Group (RPRG) consisted of graduate students from both the PsyD and PhD clinical psychology programs at Rutgers University, which included Stephen J. Holland. Stanley B. Messer headed the project. We were able to obtain some modest funds (about $7,000) from an internal Rutgers source, with few illusions about attaining funding for this kind of project from a national granting institute. We enlisted staff psychologists at the Rutgers College Counseling Center to audiotape cases that we all considered suitable for brief psychodynamic therapy (BPT) and that lasted, by design, about 15 sessions. The tapes were carefully transcribed by paid typists or students, providing an archive from which different kinds of cases could be drawn for study. We interviewed the clients before and after therapy and at 1-year follow-up, completed outcome forms and scales, and had clients and therapists do the same. In this way we were able to make an informed judgment about the relative success of the cases, which was important in validating our psychotherapy progress scale, which we describe below.

We had originally planned to conduct a randomized clinical trial of one of the BPT models (e.g., those of Mann, Malan, etc.; see Messer & Warren, 1995), but it quickly became clear that to do so would require a large budget and a setting that could accommodate such a trial, neither of which was available. Thus, of necessity, even if not by design, we switched to a single-subject research design. In doing so, we came to appreciate the virtues of this method of empirical study, which we now briefly describe.

Quantitative Single-Case Design

Single-case research is a type of intrasubject research in which there is an aggregation of data across cases; generality is established through replication, one case at a time (Hilliard, 1993). Intrasubject research design is concerned with the temporal unfolding of variables within individual participants and involves repeated measurement or observation of a variable over time. Quantitative techniques of analysis are used, such as time series analysis, sequential

analysis, or growth curve analysis, for analyzing the temporal unfolding of variables. These are applied to single cases without manipulating the variables studied. The quantitative analysis of single cases requires either ongoing access to the case so that one can administer questionnaires, or the availability of complete transcripts of sessions. The temporal unfolding of change is crucial in intrasubject research because it would make no more sense to sample one point in time in an intrasubject study than it would to sample one participant in an intersubject study.

The emphasis on time in intrasubject research also has important implications for the unit of statistical analysis used. In intrasubject research, the proper unit of analysis is a point in time, just as in intersubject research the unit of analysis is the individual (Hilliard, 1993). As Spence, Dahl, and Jones (1993) stated, from the viewpoint of statistical inference, single-case studies can be seen as providing data samples from a distribution or population that is defined by the individual being studied.

Single-subject design also has gained currency with the acknowledgment that group studies pose their own problems of generalizability. Data averaged across a group do not necessarily tell researchers about the performance of individuals; the average may in fact reflect a performance not achieved by any individual within the group. Thus, the question of whether group data can be generalized to individuals must be verified by examining data from individual cases.

Quantitative single-subject research can be undertaken either for the purpose of hypothesis testing (confirmatory analysis) or hypothesis generation (exploratory analysis). In his review and categorization of this kind of research, Hilliard (1993) encouraged investigators to engage in theory-based, question-driven, single-case research, which is precisely the method used in our project. The most prominent current example of single-case quantitative study in the psychoanalytic realm is the case of Mrs. C. (Jones & Windholz, 1990; Spence et al., 1993; Weiss & Sampson, 1986; see also chapters in this book). There is increasing recognition that, although control cannot be perfect in single-case research, threats to internal validity can be minimized, objective measures can be used, generalizability can be studied using replication, and hypotheses can be tested.

The initial goal of the project was to study psychodynamic therapy as it is taught and practiced, that is, how well therapists track clients' constantly shifting needs and how clients progress or stagnate in response. We chose two therapist variables to study, both of which are considered to be central in BPT: (a) the extent to which the therapist adheres to a psychodynamic focus and (b) the quality of the therapist's interventions. We also chose one client variable —the extent to which clients progressed or stagnated in therapy —to examine in connection with these two therapist variables. Before presenting the measures used and results attained, we describe some features of BPT that constitute the backdrop and broader context of this project.

Brief Psychodynamic Psychotherapy

What are the major features of brief *psychodynamic* therapy? Although any effort to specify its span of sessions is somewhat arbitrary, it can be said to range from 1 to 40 sessions, with 10–25 being typical. A time limit is usually established from the start, which places into motion a series of expectancies that has an effect on both the content of the material that clients bring to therapy and on the length of time they may be willing to remain. The major concepts of psychoanalytic theory are used to understand clients, such as the continuity of normality and psychopathology, waking and dream life, and childhood and adulthood. The major techniques of psychoanalytic therapy are used, such as clarification, interpretation, and confrontation of defenses, impulses, and interpersonal patterns. Unlike the practice in some traditional models of therapy, therapists tend to be relatively active in engaging clients in dialogue.

In BPT, a focus is set that is formulated in psychodynamic terms, such as the presence of pathogenic beliefs, conflicts, maladaptive interpersonal patterns, or negative feelings about oneself. The point is that not all of clients' difficulties can be taken up in a short time period; rather, there is a narrowing and focusing of the work. Goals are often set after the first few interviews (which may or may not be communicated directly to clients) that serve to guide the therapy. These might include a partial or even full resolution

of a conflict, a changed interpersonal pattern, or greater ease with recognition and expression of feeling as well as symptom reduction and an enhanced sense of well-being.

There also are criteria for client suitability for this modality (which are observed as much in the breach as in the practice currently because of the pressure brought by managed care to offer all clients only brief therapy). They include clients' ability to engage fairly rapidly and to disengage without being traumatized; the presence of significant ego strength, such as the ability to tolerate frustration; the willingness to participate actively in the treatment (good motivation); and psychological mindedness, or the capacity for insight. Excluded are those with more serious psychiatric disorders such as psychosis, major depression, and substance abuse as well as the more severe personality disorders.

There is extensive research supporting the value of BPT (e.g., Koss & Shiang, 1994), at least as measured in global terms. For example, the dose–effect studies (which track the percentage of clients improved or symptoms alleviated as a function of the number of sessions) suggest that time-limited therapy is helpful to a majority of clients (e.g., 60% improved by 13 sessions and 75% by 26 sessions; Howard, Kopta, Krause, & Orlinsky, 1986). (For a more complete review of the research literature on BPT, see Messer & Warren, 1995.)

There are several models of BPT. Those that derive primarily from drive and ego psychology tend to be focused on formulations that emphasize aggressive, sexual, and dependent impulses and defenses against them as well as oedipal conflicts (e.g., the brief therapies of Malan, Davanloo, and Sifneos). Others are based largely on object relations and interpersonal perspectives, which formulate problems in terms of (a) maladaptive interpersonal patterns (e.g., Levenson & Strupp, 1997); (b) client wishes, the responses of others, and the subsequent response of the self (Luborsky, 1997); (c) pathogenic beliefs and the way they are manifested relative to the therapist (Curtis & Silberschatz, 1997); and (d) schemas and role relationships (M. J. Horowitz & Eells, 1997). In addition to incorporating some of these theoretical approaches, Mann (1991) described a time-limited, 12-session therapy that also includes concepts from self psychology, particularly the use of empathy to heal clients' chronically endured pain. We now turn to

ıose elements of BPT that were incorporated into our research esign.

The Psychodynamic Focus

)ne of the important recent developments in psychoanalytic em-ırical research has been the effort to systematize case formulation uch that scientific standards of reliability and validity could be net (Barber & Crits-Christoph, 1993). There are now several such ıpproaches to case study. One, the Core Conflictual Relationship Theme method, extracts interpersonal relationship patterns from ɔsychotherapy transcripts (Luborsky & Crits-Christoph, 1990), in-:luding patients' wishes or needs, the expected or actual responses ɔf others, and the response of the self. A second, the idiographic conflict formulation method (Perry, 1997), assesses wishes, fears, the ways in which patients handle the ensuing conflicts including symptoms and inhibitions, and patients' best level of adaptation to the conflicts.

A third, the consensual response method (Horowitz & Rosenberg, 1994), has judges rate semistructured interviews broken into thought units. The units that have similar meaning across several judges are identified and integrated into a single narrative. Other approaches are the cyclical maladaptive pattern (Schacht & Henry, 1994), configuration analysis (M. J. Horowitz & Eells, 1997), plan analysis (Caspar, 1997), and the plan formulation method (PFM; Curtis & Silberschatz, 1997).

To measure therapists' adherence to a focus, the RPRG chose to use the Mt. Zion PFM in part because the Mt. Zion Psychotherapy Research Group (now known as the San Francisco Psychotherapy Research Group) conducted its research primarily using a single-subject design. The PFM is a procedure for developing reliable psychodynamic formulations on the basis of the material in the first two or three sessions of a case. Patients are said to enter therapy with a plan, partly conscious and partly unconscious, for overcoming their problems with the therapists' help (Curtis & Silberschatz, 1986). Four aspects of patients' expectations of, or beliefs about, the self or others are generated by the method: goals, obstacles (or pathogenic beliefs), tests, and insights, which together constitute the plan.

To elaborate, these include (a) goals, conscious or unconscious, that patients would like to achieve to rid themselves of their suffering; (b) obstacles, those irrational, pathogenic beliefs that prevent patients from becoming free to achieve their goals; (c) tests, the enactment within the therapeutic situation of patients' central conflicts in their effort to get the therapist to disconfirm their pathogenic beliefs; and (d) insights, which are said to help modify the pathogenic beliefs and attain the goals. Once the plan is developed, therapist interventions can be rated for the degree to which they adhere to it using the Plan Compatibility of Intervention Scale, described below.

Cognitive–Dynamic Theory

We found that the literature produced by the Mt. Zion research group did not by itself provide enough information to allow us to construct a plan. Furthermore, the diversity of psychoanalytic theoretical orientations among our group's raters led to low and disappointing interjudge reliability. Because the Mt. Zion group had just begun offering workshops in their method, five members of our research group accepted the invitation to attend. While studying protocols under the tutelage of the Mt. Zion researchers, we frequently disagreed about the "correct" formulation of the cases we were jointly examining. The Mt. Zion researchers' way of viewing the cases was based on Weiss's (1990) cognitive–dynamic theory, which emphasizes two chief motives: separation guilt and survivor guilt. "Separation guilt may develop in a child who wishes to become more independent of a parent but who infers that were he to do so, he would hurt the parent" (Weiss & Sampson, 1986, p. 49). Therefore, such people might be reluctant to separate from their parents lest the latter be harmed.

Survivor guilt is "the guilt of persons who assume they have fared better than their parents or siblings" (Weiss & Sampson, 1986, p. 52), a belief that can prevent them from succeeding too well. In both instances, in other words, people believe that they have harmed others and are to blame for others' unhappiness. According to Weissian theory, these are pathogenic beliefs limiting their

ndependence, life ambitions, or both. Weiss's ideas were based on Freud's later works on ego psychology, in which a larger role is given to children's inferences on the basis of their actual experiences.

Object Relations Theory

The RPRG, on the other hand, considered the same patients' problems to be based not on separation guilt but on unresolved, immature dependency wishes and consequent separation anxiety. This view, derived from an object relations perspective, especially that of Fairbairn (1946/1954), posits three stages of dependence: infantile, transitional, and mature. The infantile stage is characterized by "an attitude of oral incorporation towards, and an attitude of primary emotional identification with the object" (Fairbairn, 1946/1954, p. 145). In other words, there is a taking rather than a giving mode of interaction and a need to be too closely tied to the significant other. Mature dependency, by contrast, "is characterized by a capacity on the part of a differentiated individual for cooperative relationships with differentiated objects" (Fairbairn, 1946/1954, p. 145). Fairbairn emphasized that this is not an attitude of independence but one of "evenly matched giving and taking between two differentiated individuals who are mutually dependent, and between whom there is no disparity of dependence. Further, the relationship is characterized by an absence of primary identification and an absence of incorporation" (Fairbairn, 1946/1954, p. 145). The transitional stage is one of conflict and defense, of trying to deal with the earlier internalized objects—trying to get rid of them but at the same time not wanting to lose them.

In brief, the RPRG viewed separation difficulties, especially those of the patients we were studying jointly, as being caused primarily by unresolved, immature dependency wishes and anxiety rather than by guilt over separation or success. The difference between the two groups' outlooks led us to test whether adherence to a plan based on object relations theory would produce better predictions of in-session patient progress than adherence to a plan based on cognitive–dynamic theory. The first step, however, was to test empirically whether the Mt. Zion group and the RPRG would indeed formulate the same cases differently on the basis of their respective theoretical leanings and whether the PFM could be used in a different setting with good reliability and stability.

For her doctoral dissertation, Collins (1989) presented the initial transcribed interviews of two cases, one each from the archives of the Mt. Zion group and the RPRG, to both groups of researchers to create items for the plans relevant to the particular cases as required by the PFM procedure (see chap. 8 in this book). Intraclass correlations for the pooled judges' item ratings in each of the four segments of each of the two plans that were created separately by the RPRG and Mt. Zion group were high, ranging from .81 to .95 (Collins & Messer, 1991). This was a considerable improvement over the RPRG's initial efforts to achieve reliability and pointed to the importance of theoretical like-mindedness among judges in achieving good reliability (Messer, 1991). Furthermore, the stability of the ratings over a 3-month period ranged from .94 to .98, the first such test of the PFM's staying power.

The next question was whether the Mt. Zion and RPRG panels of judges would derive similar or different formulations of the two cases. The items constructed by both groups were pooled for each case and presented to both panels of judges. The results were striking: Each panel rated its own items much more highly than the items derived by the other group for the same two cases (see Figure 1; Collins & Messer, 1991). In other words, there was a Panel × Plan interaction, especially for the plan segments containing the obstructions and insight items, which are those most highly influenced by theory. Inspection of the items included in each plan revealed that the RPRG rated highly those items attributing the clients' difficulties to unresolved dependency wishes and rated lower those items related to separation or survivor guilt; the converse was true for the Mt. Zion group. That is, the Mt. Zion plan reflected its cognitive–dynamic emphasis, whereas the RPRG plan reflected its object relations emphasis.

The Epistemological Issue of "Accuracy" of the Focus

That two independent research groups using the same method produced two different dynamic assessments of the same participants

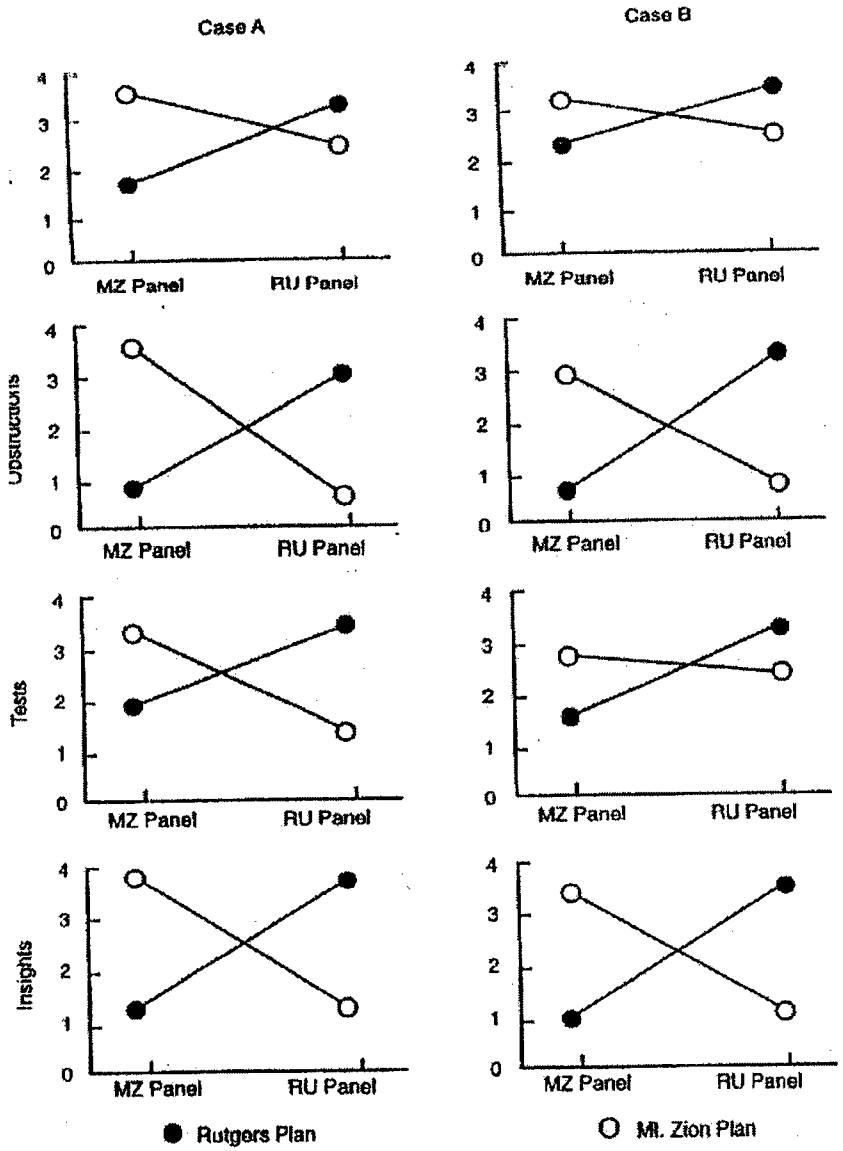

Figure 1. Plan formulation method. Two-way interactions (Plan × Panel) of scores of Rutgers (RU) and Mt. Zion (MZ) judging panels on Rutgers and Mt. Zion plan items. From "Extending the Plan Formulation Method to an Object Relations Perspective: Reliability, Stability, and Adaptability," by W. D. Collins and S. B. Messer, 1991, *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3*, pp. 75–81. Copyright 1991 by the American Psychological Association.

raises interesting epistemological questions (Messer, 1991). Does the case formulation derive largely from the patient's verbalizations, or is it more reliant on theory, which resides in the mind of the formulator? Does one discover the correct or accurate dynamic formulation as traditional psychoanalytic thinking suggests (e.g., Glover, 1931), or does one construct dynamic formulations on the basis of some mix of observation and theory, as others might claim (e.g., the authors listed in Messer, Sass, & Woolfolk, 1988; Schafer, 1992; Spence, 1982)?

The epistemological question, framed most broadly, is whether there is such a thing as objective knowledge in the social and psychological spheres. Freud believed, as did most of his contemporaries and followers, that there are actual events, memories, and meanings to be discovered. One could dig deeply into layers of the psyche and unearth important relics of the individual's past history that continued to affect the present in the form of symptoms and other behaviors. Interpretations that tallied with what was "real" were said to alleviate symptoms.

Once it became clear that there was no ready cause and effect, one-to-one relationship between specific interpretations and symptom remission, the door was open to the idea that more than one theory or meaning system could be "accurate" or curative. Within a postmodernist or constructivist approach, psychoanalytic accounts are not an unearthing of truth, but instead constitute a narrative unfolding that produces coherence and unity in the description of people's lives (Ricoeur, 1981). "What we discover in psychoanalysis are not pieces of personal history so much as meanings, filtered through memory and through language—that is, through the conversation of analyst and patient" (Woolfolk, Sass, & Messer, 1988, p. 10). The analyst's stories are retellings of the patient's stories (Edelson, 1992).

> The repeated revisions and elaborations of the stories told by both participants lead ideally to a shared, co-authored story that . . . [is] more complex, comprehensive, and complete. They bring to light previously hidden, implicit and conflicted elements that are present in a variety of single or partial stories [resulting in] what Edelson calls a "master story." (Messer & Wolitzky, 1997, p. 35)

However, alternate theoretical models with their different etiological emphases can shape different stories or, in the present language, different plans.

Having available two reliable but different plans (foci, or "stories"), we could now test (a) whether therapist interventions that adhered to a plan or focus would aid the therapeutic process and (b) whether therapist interventions that adhered to an object relations focus (or story) were more or less helpful than those that adhered to a cognitive–dynamic focus (or story).

Measures of Therapist and Patient Variables

Therapist Variables

Therapist adherence to the plan. To assess the extent to which the content of therapists' interventions were compatible with either plan, we used the Plan Compatibility of Intervention Scale (PCIS; Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988). It is a Likert scale ranging from −3 (*strongly antiplan*) to 3 (*strongly proplan*).

Quality of therapist interventions. As mentioned earlier, we also were interested in the relationship between the quality of therapist interventions and client progress. To explore the former required a measure of the extent to which therapists' interventions were responsive to patients' moment-to-moment needs. As part of her doctoral dissertation, Tishby (1991) developed the Rutgers Therapy Process Scale (RTPS) with the help of the RPRG. Although a number of process scales already existed, none was designed to capture the continuously evolving quality of all therapist interventions in individual cases.

An additional feature of our single-case research and the instruments we designed was to consider the context in which therapists' interventions and patient responses were made. The scale tapped three overlapping and interactive dimensions. One was *attunement to the patient* in both dynamic content and affective tone. It reflected the therapist's ability to stay close to patients' themes and current difficulties. A second aspect, *therapist competence*, emphasized the manner in which therapists' understanding was communicated. It assessed the skillful application of psychodynamic technique, including proper timing of interventions, addressing the therapeutic relationship, and the style and phrasing of interventions. *Interpersonal manner*, the third aspect, referred to the way in which therapists related to patients, including being accepting and supportive, inviting patients to collaborate, and striking a balance between observing and participating in the process.

The raters had to decide the following: Does this intervention facilitate the therapeutic process, and is it responsive to patients' needs at the moment or does it hinder the process? Each therapist turn-at-talk was given a single RTPS score using a Likert scale ranging from −3 (*impeding progress or nonresponsive*) to 3 (*facilitating progress or highly responsive*). Raters were given general guidelines and scoring examples for each point on the scale.

The Patient Variable

Turning to the patient variable, our research group searched in vain for a scale to measure shifts in patient process in response to therapist interventions. None of the existing scales, such as the Experiencing Scale (Klein, Mathieu-Coughlan, Gendlin, & Kiesler, 1986) or the Vanderbilt Psychotherapy Process Scale (Suh, Strupp, & O'Malley, 1986), was considered suitable for one or more reasons: They were not designed to measure progress as it is conceptualized within psychodynamic therapy; they measured only a single dimension of patient progress; they did not measure patient stagnation; and they were not designed to assess progress and stagnation on a moment-to-moment basis.

The Rutgers Psychotherapy Progress and Stagnation Scale (RPPSS), developed as part of Spillman's (1991) dissertation with the RPRG's participation, considers eight aspects of progress and stagnation on the basis of a review of the psychoanalytic literature. Each patient's turn-at-talk is assigned a single global score on a 7-point Likert scale ranging from −3 (*strong stagnation*) to 3 (*strong progress*). The scale can be found in Messer, Tishby, and Spillman (1992). A revised version, called the *Rutgers Psychotherapy Progress Scale* (RPPS), is discussed later in this chapter.

Relating Therapist Interventions to Patient Progress

The PCIS, RTPS, and RPPSS were used in two complete cases of BPT selected by mutual agreement of the RPRG and Mt. Zion group. One case (identified as Case 3-29), selected from a pool of patients treated at the Rutgers College Counseling Center, was a college junior, aged 20, who came to therapy because of mild depression and difficulty concentrating on her work. The other (identified as Diane), selected from a group of patients treated at the Mt. Zion Hospital and Medical Center in San Francisco, suffered from moderate depression and inhibitions about getting started in her profession. Both therapists had several years of postgraduate experience conducting psychotherapy.

For all three scales, raters read the first two sessions of each case to become familiar with the patient's history and initial presentation. In an effort to maximize reliability, after rating the third session the raters discussed the results to resolve any differences in their understanding and scoring of the dimensions. The raters then applied the scales independently to each therapist's or patient's turn at talking from Session 4 until the end of the therapy (15 or 16 sessions). Four raters were used for each scale.

In rating the RTPS and the PCIS, raters read both therapists' and patients' turn at talking. Each therapist's turn at talking was assigned a score on the therapist variables (RTPS and PCIS) before the rater read the patient's response. The patient's response was then read, followed by the next therapist's turn at talking, which would then be rated. By contrast, when scoring the patient variable on the RPPSS, the therapists' turns at talking were deleted from the transcripts, leaving raters with access only to the patients' turn at talking. Each patient's turn at talking was scored before the next one was read (Messer et al., 1992). Although it was recognized that deleting therapists' turns at talking meant some loss of context, it was deemed important to make this compromise so that raters would not be unduly influenced in rating the patient's progress or stagnation by their impression of the quality of the therapist's intervention that preceded it.

The first question asked was whether the scales could be rated reliably. For each scale, intraclass correlations were calculated for every session to assess the reliability of the mean of the scores assigned by the four raters. The intraclass correlation for the RPPSS for each session ranged from .58 to .86, with a mean of .73 for each case. For the RTPS, the mean intraclass correlation for Case 3-29 was .89 and .79 for Diane. For the PCIS, the mean intraclass correlation was .89 for Case 3-29 and .76 for Diane. (It was lower for Diane because the Mt. Zion group used fewer interventions that were relevant to an object relations plan.) Hence, the question of whether the scales were reliable was answered affirmatively.

The second question was whether adherence to the RPRG object relations plan and quality of therapist process would predict patient progress. Initial data analysis using each turn at talking indicated that patients' tendency to continue functioning at the same level of progress was stronger than the effects of therapist intervention, which, although significant, were modest in size. When the scales were correlated by aggregating the data over sessions on a session-by-session basis, we found that the significant correlations were not evenly distributed throughout the sessions. This led us to divide each session into two (to have enough data points) and each case into early, middle, and late phases of therapy, as is commonly used to describe many BPT models (e.g., Mann, Malan, and Sifneos).

The results showed significant relationships between plan compatibility of therapist interventions (the PCIS) and patient progress (the RPPSS) in the early and middle phases of therapy for both cases and between goodness of therapist process (the RTPS) and patient progress in the middle phase. Marmar (1990) and others have described these two phases as defining a focus and working through a focal conflict, which helps explain why the relationship between the therapist dynamic content variable (the plan or focus) and patient progress was strongest at these phases of therapy. Similarly, we view the therapist process variable as becoming most important when the focal conflict is being worked on, namely in the middle phase. We concluded that one cannot necessarily expect individual therapist interventions to have a major impact immediately in the next patient's turn at talking, but, when such data are aggregated in larger units, they indicate a positive impact of interventions that adhere to a focus and are good in process.

The next question was whether interventions compatible with the RPRG object relations plan would predict patient progress better than interventions compatible with the Mt. Zion cognitive–dynamic plan. As far as we know, this was the first study to compare the utility of two different theoretical formulations of the same case. Tishby and Messer (1995) applied the PCIS using the Mt. Zion plan to all therapist interventions in the same two patients described earlier. This scale was then correlated with patient progress on the RPPSS; and the correlations were compared with those found between the Rutgers PCIS and the RPPSS. Correlations were computed for the early, middle, and late phases of therapy. For Diane, interventions compatible with the RPRG plan predicted patient progress better than interventions compatible with the Mt. Zion plan in all three phases of therapy. For Case 3-29, the Rutgers PCIS predicted patient progress better in all but the final phase of therapy. In fact, the Mt. Zion plan was negatively correlated with the RPPSS for all three phases of Diane's therapy and for two of the three phases of Case 3-29's therapy.

Tishby and Messer (1995) concluded that the evidence supported the hypothesis that therapist interventions compatible with the object relations plan, emphasizing dependency issues, helped more than those compatible with the Mt. Zion cognitive–dynamic plan, emphasizing issues of guilt over causing harm to, or separating from, others. Thus, the RPRG plan appears to have been the more "accurate" or resonant formulation for the two patients studied. However, two factors may have influenced the results: First, interventions according to the Mt. Zion plan were rated by RPRG judges, who may have scored it differently than would have the Mt. Zion judges. Second, in their studies, the Mt. Zion group typically focus on interpretations alone or patient "tests" of the therapist, whereas we scored every therapist's turn at talking. The results may have been different had we rated only interpretations or key tests (see Silberschatz & Curtis, 1990).

The Rutgers Psychotherapy Progress Scale

Although the Rutgers Psychotherapy Progress Scale (RPPS) served the purpose of providing a global measure of patient progress, the problems with it led Roberts (1994) and Holland (1994) and the RPRG to make major revisions, resulting in the creation of the RPPS. The old scale required the rater to keep in mind eight different variables; the new one called for eight different judgments about a variety of aspects of in-session progress that would ultimately allow a more fine-grained approach to tracking progress.

The old scale assessed both progress and stagnation, but researchers found it difficult to rate degrees of stagnation and rarely used the lower numbers that indicated greater degrees of stagnation. Hence, the new scale collapsed stagnation, or lack of progress, into one point at one end of the 5-point scale, with the other 4 points gauging the degree of progress.

The old scale was designed to take into account every patient's turn at talking, which resulted in too much "noise"; that is, there were many patient statements that were brief, conveyed little of importance, and hence were difficult to score. Instead, the new scale used ratings based on sequential, 5-min blocks of the transcript, which gave raters more material on which to base their score and lessened the work considerably.

Because of the design of the initial study, it was important to remove therapist interventions to avoid biasing raters in making their judgments. In the present study using the RPPS, raters were given both therapist and patient material to read that preserved the full context. Raters were instructed to use the context by keeping in mind, for example, the patient's particular defensive style in determining whether a response was indicative of progress or stagnation.

Finally, we sharpened the criteria for each component of the scale and provided case examples from the transcripts for the 0–4 scoring points. The result was a 44-page manual containing scoring guidelines, scale point descriptions, and clinical examples that serve as anchors for each scale point.[1] We tried to produce a scale that did not divide each aspect into smaller components, stemming from our belief that too much of the meaning of complex constructs

[1]A copy of the Rutgers Psychotherapy Progress Scale and scoring manual may be obtained from Health and Psychosocial Instruments, P.O. Box 110287, Pittsburgh, Pennsylvania 15232-0787.

s lost in such an endeavor. Rather than being tied to a specific school, the scale is broadly psychodynamic in its conceptualization, which allows it to be used to compare progress in different types of psychodynamic therapy. It was designed to be used as a measure of intermediate outcome that could identify in-session changes in patient progress. We now provide brief descriptions of the newly revised scale items.

Scale Values

The following are the scale points: 0 = not present, 1 = slightly present, 2 = moderately present, 3 = very present, and 4 = extremely present.

Scale Items

Significant material refers to the expression of significant current events and memories that are related to important (frequently interpersonal) issues in the patients' lives, especially issues that they have brought to therapy.

Development of insight is new understanding on the part of the patients related to the issues that they are presenting in therapy.

Focus on emotion is the degree to which patients focus on and explore their emotional experience. The emotions discussed may have taken place in the past or are present during the session.

Direct reference to the therapist and therapy refers to patients' statements that involve the expression of feelings, fantasies, or thoughts about, or attitudes toward, the therapist, therapy, or both.

New behavior in the session is the emergence in the therapy session of a new way of behaving or a new way of interacting with the therapist.

Collaboration is the degree to which responses indicate that patients are working spontaneously, collaboratively, and actively on the task of therapy and the degree to which they appear to be actively involved and engaged in the treatment process.

Clarity and vividness of communication refers to the degree to which patients are communicating in a manner that is clear, understandable, vivid, and evocative.

Focus on the self is the degree to which patients are focusing directly on themselves, including their feelings, motivations, and actions relative to others, and are taking responsibility for them.

Raters must continually monitor the context in which clients' statements appear so that they can determine whether the material shows an increase or decrease in the various indicators of progress. The following is an example from the manual of the item "focus on the self," as just defined.

Criteria

Focus on the patient's own experience. The more patients focus on their own feelings, reactions, motivations, and actions in describing an interaction or situation, the higher the rating for this item. For example, patients who discuss fights that they used to witness their parents having would receive a low rating unless they directly discussed how those fights affected them and what they did in reaction to them.

Taking responsibility. To receive a high rating, patients must not only describe their personal experience but also take responsibility for that experience. For example, a patient who relates in detail her feelings about a fight with her boyfriend would not receive as high a rating on "focus on the self" as she would if she also explored her role in the fight, why the fight touched off in her the particular emotional reaction that it did, and the motivations involved in her own actions.

Additional Guidelines

Raters are asked to pay close attention to the specific wording of responses in assessing the degree of self-reference. For example, "I want people to understand me" is a better response than "What makes people understand each other . . . ."

The following includes scale point case examples as scored by actual raters ("yk" = you know, and a dot [.] represents a second of silence). More such examples are provided in the manual.

Scale Points

0 = *not focused on the self.* Patients discuss events or other material that do not directly involve them and without making clear any relevance of the material to the self.

1 = *slightly focused on the self.* Patients discuss events and others in a way that shows only an implied relevance to the self.

Example: One of my brothers has like severe problems dealing with other people and the other brother is like just totally out for himself.

2 = *moderately focused on the self.* Patients describe themselves, or how they typically act, in a certain situation or describe the roles they play.

Example: Um, I just, I would just do what they wanted me to do, I mean I just did that all along, I just always, you know (yk), tried to get good grades. I think in high school I did more of what I wanted to do . . . but still like . . . I still, yk, it became . . . even little judgments at home, yk, like when to come in and stuff—I didn't argue about it . . . and I never tested them, I never came in late (sigh).

3 = *very focused on the self.* Patients "own" their feelings or actions and take more responsibility for who they are or for their part in some interaction or dynamic.

Example: My mom does wife things. She lives vicariously almost, yk, in her husband and her children. Trying to find some fulfillment for herself in us. . . . I find myself like tending towards like doing things for Paul [her boyfriend] and stuff . . . and I can't do that. I have to do it for myself and not expect anything.

4 = *extremely focused on the self.* Patients accept responsibility for who they are and their actions. Patients are reflective and explore their motivations, reactions, choice of significant others or certain situations, and so on. Statements may take the form of "Why is it that I take this attitude with her?"

Example: I see now that I don't do much to assert myself when I'm on a date, that I just go along with him and just, like, hope that he likes me. But then I get mad that he doesn't treat me better and—it's confusing because I also see how I get mad at me when this happens. . . . It's like then I feel bad and like that maybe I deserve how I'm treated. Yk, I don't think I try to be more—yk, assert myself more because I don't want to be disliked and maybe dumped . . . (sigh), but I also somehow feel that I deserve not to be liked and so when I get treated bad it feels like it was supposed to happen.

The challenge of the current scale was to set criteria that would allow a reliable rating of complex constructs without reducing them to such narrow units that the meaning gets lost. As it has been constructed, the RPPS represents a midpoint between scales that tap constructs using several items requiring a low level of inference, such as the Vanderbilt Psychotherapy Process Scale (Suh et al., 1986), and scales that consist of a single rating, such as the original RPPSS or the Experiencing Scale (Klein et al., 1986). To achieve adequate reliability with this kind of scale, several raters (three or more) are typically required.

Reliability and Validity of the RPPS

Quantitative Analysis

Transcripts of two BPT cases that were conducted by an experienced therapist and that differed in outcome were chosen from our archive for study. The patients were 21- and 30-year-old women with anxiety and relationship difficulties. Each session of these 13- and 16-session therapies was divided into 10, roughly equal 5-min blocks of material. There were two sets of raters, each scoring every other block of material in order, on either the RPPS or on three subscales of the Vanderbilt Psychotherapy Process Scale—Patient Participation, Patient Exploration, and Patient Hostility—totaling 21 items. A composite score, Patient Involvement, was calculated by subtracting the z score for Patient Hostility from the z score for Patient Participation. Patient Participation, Patient Exploration, and Patient Involvement all have been found to be positively correlated with outcome, whereas Patient Hostility has been found to be negatively correlated with outcome (O'Malley, Suh, & Strupp, 1983; Suh et al., 1986).

Reliability. The interrater reliability for the RPPS Total Score was .80 for Case 2-45 and .74 for Case 2-9. Thus, raters were able

o apply the scale with adequate reliability. The item, "new behavior," however, had poor reliability for Case 2-9.

Internal consistency. All items except "reference to the therapist and therapy" were significantly related to the total score.

Predictive validity. Six of the eight items and the total score were significantly higher for the patient with the better outcome.

Concurrent validity. The eight items of the RPPS and its total score were correlated with the four subscales of the Vanderbilt scale. Twenty-three of the 36 correlations were significant, and 6 others approached significance, providing good support for the convergent and discriminant validity of the RPPS. The two items that did not correlate well with the Vanderbilt scale were "new behavior" and "reference to the therapist and therapy." We recommended that "new behavior" be dropped because raters had difficulty applying the item as intended, which led to low reliability and validity (Holland, Roberts, & Messer, 1998).

Qualitative Analysis

"Reference to therapist and therapy" posed an interesting problem. It had the highest reliability of any item on the scale, but, unexpectedly, it correlated negatively with other scale items and with the Vanderbilt subscales that correlated with good outcome. It also had a higher average score for the patient with the poorer outcome. This finding was not consistent with a central tenet of psychoanalytic therapy, namely that focusing on patients' transferential feelings should lead to in-session progress.

We conducted a qualitative analysis to better understand this anomalous finding. All blocks rated above zero on this item were read, along with preceding and subsequent blocks. We found that neither client spontaneously made reference to the therapist or the therapy and that the therapist initiated such discussions only when there was manifest resistance (Holland et al., 1998). Although the therapist's style was consistent with traditional approaches to psychoanalytic psychotherapy, it was not consistent with current brief psychodynamic approaches that emphasize active transference interpretation, which had influenced our thinking in constructing this item. Because there was client resistance present in blocks in which "reference to the therapist and therapy" was scored, judges

generally assigned lower-than-average ratings for the other RPPS and Vanderbilt items, resulting in the negative correlations between this item and the other measures of in-session progress.

In addition, because Case 2-9 showed considerably more resistance, the therapist had to deal with it more frequently than for Case 2-45, leading to higher ratings for this item in the poorer outcome case (Case 2-9). The following is a typical sequence for Case 2-9 (Session 5, Block 1):

THERAPIST: It seems that you don't know how to start (pause).

CLIENT: Yeah (pause). I'm afraid to start it I guess (pause).

THERAPIST: If that were the case, you'd be afraid of what?

THERAPIST: Uh (pause). I don't know (pause), uh, what you would say to whatever I said, I guess (silence).

THERAPIST: Like what?

CLIENT: Mmm (silence). I don't know, maybe that I'd be criticized for it, or whatever (silence).

THERAPIST: So if I were to tell you what to talk about, that would sort of take you off the hook.

CLIENT: Yeah, I guess, 'cause I don't know what you expect or whatever (silence).

Note that such discussions of Case 2-9's anxieties about opening up in therapy led to discussions of similar anxieties she had in other situations and to greater openness on her part. Inspection of the data revealed that the blocks immediately following transference discussions typically had higher-than-average ratings for the other RPPS and Vanderbilt scale indicators of progress. A good example of this sequence occurred in Session 8. In Block 1, the client started (as usual) by saying that she did not know what to talk about or what the therapist expected. She went on to say that she had been noticing that she blocked herself from being spontaneous in a number of other situations. This was followed by a long discussion of her experience in the day-care program where she worked, in which she had trouble interacting freely with the children. She also expressed anger at the teachers for not giving her enough guidance. This experience was then linked by the therapist to her having grown up with an alcoholic father who, she

elt, rarely made clear what was expected of her. The client's subsequent associations supported this interpretation.

The discussion of transference issues in Block 1 of this session and in other places appeared to have played a facilitative role for this patient. If one had looked only at the gross differences between the cases in the scores for "reference to the therapist and therapy" and at the correlations between "reference to the therapist and therapy" and the other variables, one might have mistakenly concluded that such discussions of the transference were harmful. We suggested that this item continue to be rated with the rest of the scale but examined separately before including it in the total score (Holland et al., 1998). In conducting this close reading of the material, we came to appreciate how single-subject research lends itself to fine-grained qualitative and quantitative analysis of data that can clarify the overall statistical findings in an important way.

In brief, there is good preliminary support for a six- (and possibly seven-) item version of the RPPS. Its most appropriate use is in microanalytic process research such as sequential analysis, or analysis of significant change events, in assessing in-session patient progress in psychodynamic psychotherapy.

Methodological and Clinical Implications of the Research

There are three methodological features of this research project that we want to highlight. The first is the fruitfulness of single-case design, which, in this project, included (a) single-case quantitative analysis in which patients' turns-at-talk or a block of psychotherapy material constituted the unit of analysis and (b) confirmatory case study. Although this particular single-case design does not constitute an experiment in which variables are manipulated, thus limiting conclusions about causality, it does include the testing of hypotheses that are subject to disconfirmation. Another feature of single-case design that we used and that we recommend to others is studying more than one case at a time. Doing so increases the likelihood of the results being generalizable and permits a comparison between two cases with different outcomes.

A second methodological feature that is important is the use of

context. The concepts measured by the scales are complex and require an understanding of the patient and the course of therapy. These are unlikely to be obtained from 10-min samples taken from sessions and scored in scrambled order. For example, to judge whether a statement by a patient represents insight or resistance requires knowledge of the patient's characteristic defenses, which comes from a familiarity with the presenting issues and what has come before the scoring point. Our belief in the importance of context, however, requires empirical testing.

A third methodological feature, and one we encourage other researchers to use, is combining quantitative and qualitative analysis. By examining each instance of reference to the therapy or therapist, we came to understand what triggered such discussion (i.e., resistance) and the salutary effect its exploration had on subsequent blocks of material. This kind of supplementary analysis can help to make sense of purely quantitative data. The sequential scoring of full transcripts of single cases made this possible in a way that large-sample, traditional research could not.

The results of this project have implications for practicing clinicians. One is the importance of recognizing the decisive role of theory in the way that clinicians formulate cases. Recall that two groups of researchers arrived at much different formulations of the same case on the basis of their different theoretical approaches. It behooves therapists to keep track of their own theoretical biases and to consider the value that a different understanding and approach may have, especially when therapy is not proceeding smoothly.

In this connection, it appears that not just any formulation can be expected to produce patient progress. That patients showed more in-session progress when therapist interventions were compatible with one but not the other plan suggests that there may be validity to the concept of "accuracy" of formulation. Clearly, much more research is required before firm conclusions can be reached on this controversial issue.

Our research attests to the value of therapists making interventions compatible with a well-formulated focus in BPT. In addition, the results confirm the importance of what is commonly thought of as good therapist process, which included attunement to patients in both dynamic content and affective tone, competent ap-

plication of psychodynamic technique, and an accepting and supportive interpersonal manner.

Finally, that the RPPS showed good initial reliability and validity suggests that the variables it includes could be profitably kept in mind by therapists in gauging their patients' in-session progress. In fact, while working on the development and testing of this scale, we and members of our research team found ourselves thinking in just this way. That is, knowledge of the RPPS helped us to focus on and consider whether our interventions were leading to progress or stagnation in the psychotherapies that we were conducting.

References

Barber, J. P., & Crits-Christoph, P. (1993). Advances in measures of psychodynamic formulations. *Journal of Consulting and Clinical Psychology, 61*, 574–585.

Caspar, F. (1997). Plan analysis. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 260–288). New York: Guilford Press.

Collins, W. D. (1989). *The reliability, stability, and theoretical adaptability of the Plan Diagnosis Method.* Unpublished doctoral dissertation, Rutgers University, New Brunswick, NJ.

Collins, W. D., & Messer, S. B. (1991). Extending the plan formulation method to an object relations perspective: Reliability, stability, and adaptability. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3*, 75–81.

Curtis, J. T., & Silberschatz, G. (1986). Clinical implications of research on brief dynamic psychotherapy: I. Formulating the patients' problems and goals. *Psychoanalytic Psychology, 3*, 13–25.

Curtis, J. T., & Silberschatz, G. (1997). The Plan Formulation Method. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 116–136). New York: Guilford Press.

Curtis, J. T., Silberschatz, G., Sampson, H., Weiss, J., & Rosenberg, S. (1988). Developing reliable psychodynamic case formulations: An illustration of the Plan Diagnosis Method. *Psychotherapy, 25*, 256–265.

Edelson, M. (1992). Telling and enacting stories in psychoanalysis. In J. Barron, M. Eagle, & D. M. Wolitzky (Eds.), *Interface of psychoanalysis and psychology* (pp. 99–124). Washington, DC: American Psychological Association.

Fairbairn, W. R. D. (1954). Object relations and dynamic structure. In W. R. D. Fairbairn (Ed.), *An object relations theory of the personality* (pp. 137–151). New York: Library of the Behavioral Sciences. (Original work published 1946)

Glover, E. (1931). The therapeutic effect of inexact interpretation: A contribution to the theory of suggestion. *International Journal of Psycho-Analysis, 12*, 397–411.

Hilliard, R. B. (1993). Single-case methodology in psychotherapy process and outcome research. *Journal of Consulting and Clinical Psychology, 61*, 373–380.

Holland, S. J. (1994). *Development and validation of a scale to assess patient progress in psychodynamic therapy.* Unpublished doctoral dissertation, Rutgers University, New Brunswick, NJ.

Holland, S. J., Roberts, N. E., & Messer, S. B. (1998). Reliability and validity of the Rutgers Psychotherapy Progress Scale. *Psychotherapy Research, 8*, 104–110.

Horowitz, L. M., & Rosenberg, S. E. (1994). The consensual response psychodynamic formulation: 1. Method and research results. *Psychotherapy Research, 4*, 222–233.

Horowitz, M. J., & Eells, T. D. (1997). Configurational analysis: States of mind, person schemas, and the control of ideas and affect. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 166–191). New York: Guilford Press.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose–effect relationship in psychotherapy. *American Psychologist, 41*, 159–164.

Jones, E. E., & Windholz, M. (1990). The psychoanalytic case study: Toward a method for systematic inquiry. *Journal of the American Psychoanalytic Association, 38*, 985–1015.

Klein, M. H., Mathieu-Coughlan, P., Gendlin, E. T., & Kiesler, D. J. (1986). The Experiencing Scales. In L. S. Greenberg & W. M. Pinsoff (Eds.), *The psychotherapeutic process* (pp. 21–71). New York: Guilford Press.

Koss, M. P., & Shiang, J. (1994). Research on brief psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 664–700). New York: Wiley.

Levenson, H., & Strupp, H. H. (1997). Cyclical maladaptive patterns: Case formulation in time-limited dynamic psychotherapy. In T. D. Eels (Ed.), *Handbook of psychotherapy case formulation* (pp. 84–115). New York: Guilford Press.

Luborsky, L. (1997). The Core Conflictual Relationship Theme: A basic case formulation method. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 58–83). New York: Guilford Press.

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method.* New York: Basic Books.

Mann, J. (1991). Time limited psychotherapy. In P. Crits-Christoph & J. P.

Barber (Eds.), *Handbook of short-term dynamic psychotherapy* (pp. 17–44). New York: Basic Books.

Marmar, C. R. (1990). Psychotherapy process research: Progress, dilemmas, and future directions. *Journal of Consulting and Clinical Psychology, 58,* 265–272.

Messer, S. B. (1991). The case formulation approach: Issues of reliability and validity. *American Psychologist, 46,* 1348–1350.

Messer, S. B., Sass, L. A., & Woolfolk, R. L. (Eds.). (1988). *Hermeneutics and psychological theory: Interpretive perspectives on personality, psychopathology, and psychotherapy.* New Brunswick, NJ: Rutgers University Press.

Messer, S. B., Tishby, O., & Spillman, A. (1992). Taking context seriously in psychotherapy research: Relating therapist interventions to patient progress in brief psychodynamic therapy. *Journal of Consulting and Clinical Psychology, 60,* 678–688.

Messer, S. B., & Warren, C. S. (1995). *Models of brief psychodynamic therapy: A comparative approach.* New York: Guilford Press.

Messer, S. B., & Wolitzky, D. L. (1997). The traditional psychoanalytic approach to case formulation. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 26–57). New York: Guilford Press.

O'Malley, S. S., Suh, C. S., & Strupp, H. H. (1983). The Vanderbilt Psychotherapy Process Scale: A report of the scale development and a process–outcome study. *Journal of Consulting and Clinical Psychology, 51,* 581–586.

Perry, J. C. (1997). The idiographic conflict formulation method. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 137–165). New York: Guilford Press.

Ricoeur, P. (1981). *Hermeneutics and the human sciences.* Cambridge, England: Cambridge University Press.

Roberts, N. E. (1994). *Reliability and factor analysis of the Rutgers Psychotherapy Progress Scale.* Unpublished doctoral dissertation, Rutgers University, New Brunswick, NJ.

Schacht, T. E., & Henry, W. P. (1994). Modeling recurrent patterns of interpersonal relationship with structural analysis of behavior. *Psychotherapy Research, 4,* 208–221.

Schafer, R. (1992). *Retelling a life: Narratives and dialogue in psychoanalysis.* New York: Basic Books.

Silberschatz, G., & Curtis, J. T. (1990, June). An empirical test of psychotherapy process predictions derived from alternate psychodynamic formulations. In J. T. Curtis (Chair), *Applications of a model for studying and comparing theories of psychotherapy.* Symposium conducted at the meeting of the Society for Psychotherapy Research, Wintergreen, VA.

Spence, D. P. (1982). *Narrative truth and historical truth.* New York: Norton.

Spence, D. P., Dahl, H., & Jones, E. E. (1993). Impact of interpretation on associative freedom. *Journal of Consulting and Clinical Psychology, 61,* 395–402.

Spillman, A. (1991). *The development of a scale for measuring patient progress and patient stagnation in psychodynamic psychotherapy.* Unpublished doctoral dissertation, Rutgers University, New Brunswick, NJ.

Suh, C. S., Strupp, H. H., & O'Malley, S. S. (1986). The Vanderbilt process measures: The Psychotherapy Process Scale (VPPS) and the Negative Indicators Scale (VNIS). In L. S. Greenberg & W. M. Pinsoff (Eds.), *The psychotherapeutic process* (pp. 285–323). New York: Guilford Press.

Tishby, O. (1991). *The effects of patient interventions on patient progress in brief psychodynamic therapy.* Unpublished doctoral dissertation, Rutgers University, New Brunswick, NJ.

Tishby, O., & Messer, S. B. (1995). The relationship between plan compatibility of therapist interventions and patient progress: A comparison of two plan formulations. *Psychotherapy Research, 5,* 76–88.

Weiss, J. (1990). Unconscious mental functioning. *Scientific American, 262,* 103–109.

Weiss, J., & Sampson, H. (1986). *The psychoanalytic process.* New York: Guilford Press.

Woolfolk, R. L., Sass, L. A., & Messer, S. B. (1988). Introduction to hermeneutics. In S. B. Messer, L. A. Sass, & R. L. Woolfolk (Eds.), *Hermeneutics and psychological theory: Interpretive perspectives on personality, psychopathology, and psychotherapy* (pp. 2–26). New Brunswick, NJ: Rutgers University Press.