QUALITY OF OBJECT RELATIONS, SECURITY OF ATTACHMENT, 
AND INTERPERSONAL STYLE AS PREDICTORS OF 
THE EARLY THERAPEUTIC ALLIANCE

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Gregory A. Goldman

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This thesis entitled
QUALITY OF OBJECT RELATIONS, SECURITY OF ATTACHMENT,
AND INTERPERSONAL STYLE AS PREDICTORS OF
THE EARLY THERAPEUTIC ALLIANCE

by

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The therapeutic alliance is consistently related to treatment outcome, and therefore represents an important aspect of how and why psychotherapy is effective. In the present study, security of attachment, quality of object relations, and interpersonal style were measured as predictors of the alliance early in treatment. Forty-eight individual psychotherapy clients were administered the Revised Adult Attachment Scale (AAS), the Bell Object Relations and Reality Testing Inventory (BORRTI), and the Interpersonal Adjective Scales-Revised (IAS-R) prior to their initial therapy session. Participants completed the Working Alliance Inventory (WAI) following their first, second, and third sessions. Security of attachment and quality of object relations were related to the alliance at session one, while quality of object relations was no longer related to the alliance at session two, and none of the predictors were related to the alliance at session three. Early therapeutic alliance appears to be influenced by interpersonal attachment and object relations.

Approved:

Timothy Anderson
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Dedication

This thesis is dedicated to my parents,
who worked to make it possible for me to pursue this
and every other endeavor I have chosen;
to my brother Erik,
who was willing to provide influence and be
influenced by me and my “soft science”;
to my friends,
who helped me enjoy this
and everything else I have gone through;
and most importantly, to Liz,
who chose to love me and be loved by me for life.
These have been my true therapeutic alliances.
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I would like to acknowledge the indispensable guidance and tutelage of my advisor, Tim Anderson; my committee members, Ben Ogles and John Garske; Nancy Collins and Brent Mallinckrodt, who were kind enough to humor my requests for information; Kim Lassiter and the CPS clinical staff, who supported and encouraged this work; and finally, Margie Wolfe, Amy Gould, and Jill Well, who literally made this study happen.
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Introduction

Increased attention has been paid to the role of the therapeutic alliance in psychotherapy as an agent of change. Numerous studies have found a moderate but consistent relationship between the alliance and outcome of psychotherapy (for reviews of this literature, see Horvath & Symonds, 1991, and Martin, Garske, & Davis, 2000). What is the alliance? How does it affect the course of psychotherapy? And most importantly, if it is so important to positive outcome, how does one go about fostering its formation? Following is a broad review of the alliance and its numerous correlates in the area of client pretreatment factors, ultimately leading up to an argument for a correlational study (such as the present study) bringing together some of the best predictors.

History of the Alliance Construct

The concept of the alliance dates back to Freud (1913/1958) who proposed early in his writings that successful analysis requires, among other things, attachment of the patient to the therapist. Freud later (1937/1962) developed this idea, referring to a collaboration between the therapist and patient, with the unified goal of undermining the patients’ neuroses. Freud’s propositions set in motion numerous debates over the therapeutic relationship, including questions about its nature and significance. The term “therapeutic alliance” was coined by Zetzel (1956), who saw the formation of the alliance as the task of both therapist and patient; and that the lack thereof would preclude maximum benefit of the therapist’s services by the patient. Greenson (1965) later introduced the working alliance, defined as the aspect of the therapeutic relationship
involving the patient’s ability to work purposefully in treatment. Working alliance was differentiated from the bond between therapist and client, which he referred to as the therapeutic alliance.

Luborsky (1984) divided the alliance into Type I and Type II alliances. Type I alliances “are those in which the patient perceives the therapist as being capable of helping him or her” (Saketopoulou, 1999, p. 330), whereas Type II alliances are those in which the therapist’s and patient’s skills and resources are aligned to help the patient.

Bordin’s (1979) view of the alliance, which was the first to cut across theoretical orientations, consists of three elements: a) client and therapist agreement on goals of treatment (or at least the groundwork of such goals), b) a vivid link between the tasks of therapy and the patient’s goals for change, and c) development of bonds of trust and attachment between the client and the therapist. While there is growing acceptance of this definition of the alliance, there is currently no gold standard of definition of the alliance, and clarification of the alliance construct is still needed (Andrusyna, Zang, DeRubeis, & Luborsky, 2001). For example, there is disagreement as to the relative importance of the affective (bond) aspect and the collaborative working aspects (tasks, goals) of the alliance.

Though the alliance has its roots in psychoanalytic thought, the construct has gained acceptance in other orientations as well. For example, research has investigated the impact of the alliance in cognitive and cognitive-behavioral therapy (e.g., Newman, 1998; Overholser, 2000; Raue, Goldfried, & Barkham, 1997; Rector, Zuroff, & Segal, 1999), as well as behavioral approaches such as functional analytic psychotherapy.
and multimodal behavioral therapy (Oejehagen, Berglund, & Hansson, 1997). In fact, a focus on the therapeutic alliance is one of the key elements that define dialectical behavior therapy (Robbins & Koons, 2000). One panel discussion concluded that psychodynamic, cognitive-behavioral, and experiential approaches all emphasize the importance of the alliance; however, it is conceptualized differently in each of these orientations (Gaston, Goldfried, Greenberg, Horvath, et al., 1995). For example, the cognitive-behavioral view of the alliance is often more or less synonymous with compliance, the implication being that it will expedite the process of therapy, whereas more psychodynamic and humanistic orientations tend to view the alliance as an end in itself with therapeutic effects. The alliance appears to be related to outcome regardless of theoretical orientation (Horvath & Symonds, 1991; Martin et al., 2000).

The present review will explore a number of the client pretreatment characteristics that have been investigated as possible predictors for the formation and maintenance of a healthy therapeutic alliance. Some of the most pertinent findings are summarized in Table 1. While many of the variables reviewed have been individually shown to represent promising leads in the effort to understand how the alliance works, there is a strong need for research that compares the relative contributions of some of these variables in one design. The present study fills this gap in the research by comparing three variables that are thought to provide promising leads in the understanding of interpersonal factors affecting the alliance.
Table 1

Summary of Selected Studies

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Pretreatment Factors and the Alliance

Therapist Variables. Basic personal attributes of the therapist such as empathy, non-possessive warmth, and genuineness have long been suggested to be necessary characteristics for proper alliance formation (e.g., Mitchell, Bozarth, & Krauft, 1977). Early researchers in psychotherapy process and outcome proposed that objectivity, honesty, capacity for relatedness, emotional freedom, security, integrity, humanity, intuitiveness, patience, perceptiveness, empathy, creativity, and imaginativeness were all highly desirable therapist characteristics (Krasner, 1962; Slavson, 1964; Swensen, 1971). A subset of these concepts have since been empirically tested, while most, if not all, remain on a veritable “wish list” of traits to which psychotherapists aspire.

Therapists’ perceived expertise, attractiveness, and the extent to which they are regarded by patients as trustable have been found to be associated with the alliance (Horvath & Greenberg, 1994). As one might expect, therapists’ skills in negotiating a positive alliance have been found to correlate with the quality of the alliance (Yeomans et al., 1994).

Much of the work in understanding how psychotherapist traits affect the alliance remains to be done. Suggestions of the necessity for such research have been made; for example, Mutén (1991) notes that knowledge of both patient and therapist personality profiles may enable clinicians to better understand and maintain a positive alliance. Miller (1991) suggests that personality traits can help “elucidate the personality of the therapist…its interaction with the personality of the client, and the consequent transference and countertransference phenomena” (p. 432). Similarly, Bishop and Fish
(1999) call for more in-depth investigation of therapist personality characteristics. Regrettably, little of this research exists to date.

Patient Variables. Research on patient variables indicates that there may be a variety of pretreatment factors that can influence the formation and maintenance of a positive therapeutic alliance. Severity of impairment at intake is one factor that has received attention in the literature. Much of this research finds the alliance to be negatively correlated with severity of pathology; however, it is not clear that the relationship can be characterized this simply. Level of patient disturbance was found to be negatively associated with the alliance by Eaton, Abeles, and Gutfreund (1988), Gaston, Marmar, Thompson, and Gallagher (1988), Kivlighan and Schmitz (1992), and Luborsky et al. (1993). However, Kokotovic and Tracey (1990) found that the alliance was not related to client presenting concerns, and Raue, Castonguay, and Goldfried (1993) found a negative relationship between alliance and symptom distress within psychodynamic treatment but not cognitive-behavioral therapy. Petry and Bickel (1999) found that the alliance acted as a moderating variable between symptom severity and treatment completion. Horvath (2001) reviewed much of the literature on client factors impacting the strength of the alliance, finding “a convergence of data suggesting that there is an interaction among the therapist’s level of experience, severity of impairment, and quality of alliance” (p. 368). Types of pathology may differ in their influence on the alliance. In a sample of adult survivors of child abuse, Paivio and Patterson (1999) found that severity of childhood trauma and the presence of personality pathology were associated with early alliance difficulties. Two specific types of patient pathologies that
have been shown to negatively influence the alliance are borderline personality disorder (Gunderson, Najavits, Leonhard, Sullivan, & Sabo, 1997; Horowitz et al., 1996) and antisocial personality disorder (Saketopoulou, 1999). It appears that there may be a negative relationship between patient level of disturbance and the alliance; however, this finding is inconsistent within the literature, and further work is needed to examine how this relationship works.

Patient motivation in therapy has been found to be associated with formation of the alliance (Horvath, 1994; Stiles, Shapiro, & Elliott, 1986), and accordingly, patient self-disclosure has been shown to aid in the formation of the alliance (Svartberg, 1993). Motivation, however, is partially dependent on patient expectations, a variable that has received a lot of attention in the literature (Luborsky, 1994). Setting high (or low) expectations for therapy leads patients to feel disappointed in the therapist, thereby harming the alliance (Stiles et al., 1986). Patient expectations have been found by several researchers to influence the alliance, psychotherapy process, and outcome (Al-Darmaki & Kivlighan, 1993; Hartley & Strupp, 1983; Joyce & Piper, 1998; Strupp, 1993).

What patients expect from therapy may be in some ways influenced by what they expect of themselves. Thus, patient self-efficacy is a pretreatment factor that may have some bearing on the alliance. DiGiuseppe, Tafrate and Eckhardt (1994) found that aggressive patients who tend to attribute their problems to external factors had difficulties establishing a working alliance. Patients will need to take control of their therapy by self-disclosing important information, and accordingly, Svartberg (1993) and Strassberg, Roback, D’Antonio, and Gable (1977) have found patient self-disclosure to influence the
formation of the alliance. Indeed, the climate of therapy is largely determined by the client’s behavior. For example, Alpher, Henry and Strupp (1990) identified poor impulse control and poor judgment as factors that may compromise the interpersonal climate of therapy.

*Five-Factor Personality Traits.* One area that has received a modest amount of attention in alliance research has been patient personality traits. The Five Factor Model, or Big Five (McCrae & Costa, 1987) is a common framework for conceptualizing personality, consisting of the following independent dimensional traits: openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism. This being a major area in personality theory, some of this research literature is summarized below.

Miller (1991) discusses implications of each of the five factors in the psychotherapy process. Clients with high levels of extraversion, for example, tend to appear enthusiastic about treatment, and engage in the treatment process without much need for therapist prompting. Miller notes that high extraversion patients may appear to exhibit deceptively strong alliances through their eagerness to participate, but he warns that “they also disclose their thoughts and fantasies to passing acquaintances and strangers” (p. 423). Thus, their eagerness to participate may not be indicative of a strong relationship per say, but rather of a general tendency to self-disclose. Conversely, low extraversion (introverted) clients may pose difficulties in establishing an alliance as well; they are by definition uncomfortable with social contact, and have difficulties in engaging in interpersonal relationships. Accordingly, Miller found that extraversion was positively associated with treatment outcome.
Patient openness may have a positive influence on the alliance. Miller (1991) notes that patients high on openness are more likely to accept interventions and are more engaging to talk with; while patients low on openness appear resistant to interpretations and similar interventions and may be perceived by therapists as less interesting or even frustrating to treat. Miller did not find an effect on treatment outcome for openness; however, Keijser, Schaap, and Hoogduin (2000) found an association between patient openness and outcome, and Svartberg (1993) asserts that openness and the alliance are the two most consistent predictors of outcome. Miller’s (1991) predictions about openness and the alliance have yet to be empirically tested.

Agreeableness is also hypothesized to affect formation of the alliance. Miller (1991) notes that highly agreeable patients are exceedingly willing to form an alliance, while less agreeable clients are skeptical and slow to develop an alliance. Similarly, highly conscientious clients are likely to engage in the treatment process with resolve and determination, while patients low on conscientiousness tend to be resistant to treatment, and may be especially low on the task component of the alliance. Miller did find a correlation between conscientiousness and treatment outcome.

Neuroticism has been found to be negatively associated with treatment outcome (Miller, 1991; Ogrodniczuk, Piper, Joyce, McCallum, & Rosie, 2003), and Miller (1991) found that neuroticism was positively associated with severity of pathology, especially in the case of borderline pathology. As discussed above, level of severity is often negatively associated with the alliance, especially with regard to borderline pathology (Gaston et al., 1988; Gunderson et al., 1997; Horvath, 2001; Horwitz et al., 1996;
Kivlighan & Schmitz, 1992; Luborsky, 1994; Luborsky et al., 1993). Although studies specifically linking neuroticism to the alliance are lacking in the literature, its negative relationship to outcome and positive relationship to symptom severity suggest a negative relationship with the alliance.

One personality factor that is related to neuroticism and has consistently been linked to alliance formation is perfectionism. Zuroff et al. (2000) found that not only did perfectionistic patients have less increases in the alliance over the course of treatment, but a negative relationship between perfectionism and outcome was mediated by alliance formation. Blatt (1999) found that pretreatment perfectionism had a negative impact on development of the alliance and outcome in brief treatment for depression, independent of treatment modality.

Based on the above findings, it appears that the personality characteristics openness, agreeableness, neuroticism, and perfectionism may be especially salient to the patient’s contribution to the therapeutic alliance. Further research is needed to establish the unique role each of these characteristics may play in formation and maintenance of the alliance.

Interpersonal Style. Koss and Shiang (1994) point out that patient interpersonal variables such as coping style and capacity to form relationships may exert a large influence on treatment decisions. For example, Beutler et al. (1991) found that patients with externalizing coping styles responded best to behavioral and symptom-focused techniques. Such an approach could equally be applied to predicting the alliance. Saunders (2001) found that interpersonal difficulties such as troubles being close and
emotionally open with others (detachment) were indicative of lower ratings on the bond component of the alliance. Hardy et al. (2001) found that an underinvolved interpersonal style was predictive of treatment outcome, and that this relationship was mediated by the alliance. Similarly, Colson et al. (1988) posit that collaborative interpersonal style is associated with alliance formation and maintenance. Moras and Strupp (1982) found that patient interpersonal relations were more predictive of the alliance than pre-therapy assessments of psychological health. Curiously, Gaston, Marmar, Thompson, and Gallagher (1988) failed to find an association between pretreatment quality of interpersonal relationships and patient contribution to the alliance in behavioral, cognitive, and psychodynamic treatment. However, this may be due to the fact that the sample included only patients suffering from depression, not interpersonal or characterological problems.

*Interpersonal Circumplex Model.* The circumplex model is one that recognizes the relational, co-created nature of the alliance, and allows researchers to examine interpersonal processes in a more dynamic, integrated way using a circular structure. Early circumplex work (Freedman, Ossario, & Coffey, 1951; LaForge & Suczek, 1955; Leary, 1957; Lorr & McNair, 1963, 1965) explored the notion that two bipolar traits can be arranged to form a circular function; such that the origin of the circle lies at the midpoint of each of the two traits (where they intersect), and any given position on the perimeter of the circle establishes a specific value for each axis. The structure provided by this technique, when fitted with appropriate variables, has been helpful in
conceptualizing many aspects of individual psychology; including emotions, personality traits, personality disorders, and ego defenses (Plutchik, 1997).

Leary (1957) proposed what has now become a commonly seen circumplex structure; with the dimension of dominant-submissive set perpendicular to friendly-hostile (see Figure 1). This structure can be compared to a compass, with the direction that corresponds to north representing dominance and south representing submission, while east represents friendliness and west represents hostility. The midpoints between these (e.g., northwest) are simply combinations of the original four characteristics (e.g., hostile-dominant). Each place on the circle has its corresponding interpersonal trait. Andrews (1989) outlines how additional subdivisions can be created in the interpersonal circle, and values can be added to each subdivision corresponding to the types of responses a person who falls in that place on the circle provokes from others. For example, a hostile-submissive person can either be rebellious-distrustful or self-effacing-masochistic. If he or she is rebellious-distrustful, on the positive side he/she will have a realistic outlook in terms of wariness and skepticism, but on the negative side he/she might act hurt or suspicious and be distrustful. This personality type provokes rejection from others when embodied to the extreme. This interpersonal circumplex has been shown to be a valid model for conceptualizing interpersonal processes, and converges well with the extraversion and agreeableness dimensions of McCrae and Costa’s (1987) Five Factor Model (Lorr, 1997).

The interpersonal circumplex model has yielded findings regarding patient interpersonal style and its contribution to therapy process (including alliance) and
outcome. Higher patient scores on the affiliative dimension of the interpersonal circumplex have been found to be positively related to treatment outcome (Schauenburg, Kuda, Sammet, & Strack, 2000). Paivio and Bahr (1998) found that patient hostility, coldness, social avoidance, and nonassertiveness were all predictive of a poorer alliance, with the social-emotional avoidance domain being more salient than the control-hostility domain. Connolly Gibbons et al. (2003) found that hostile-dominant patients had significantly poorer alliances.

Two studies that concentrate on patient interpersonal functioning as it relates to the alliance are particularly germane to the present research. Muran, Segal, Samstag and Crawford (1994) assessed the alliance and interpersonal style in 32 patients in manualized individual cognitive psychotherapy for depression and anxiety. The Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988) was used to measure interpersonal style at intake. The IIP contains 127 items, falling into six subscales, that can be factor analyzed to represent the octants of the circumplex model (IIP-CX). The full client version of the WAI was used to measure alliance after session three. Partial correlation coefficients were calculated for all possible relationships between subscales and full scale scores, controlling for symptom severity.

Problems of over-nurturance (friendliness on the circumplex) were associated with better agreement on goals and tasks as well as total alliance (correlations ranged from .40 to .44). Exploitability (friendly-submissive on the circumplex) was associated with agreement on tasks (r = .48, p < .01), and was also related to agreement on goals and total alliance (.43 and .41, respectively). Nonassertiveness (submissiveness on the
circumplex) was associated with task and goal agreement (.45 and .43, respectively), and social avoidance (hostile-submissive on the circumplex) was associated with task agreement ($r = .39$, $p < .05$). It is hardly surprising that none of the IIP-CX subscales were correlated with the bond dimension of the WAI, given that the IIP-CX was measuring interpersonal problems and was therefore less sensitive to interpersonal strengths that may contribute to an affective bond. Overall, however, the findings of this study seem to indicate that friendly and submissive interpersonal styles may be related to better alliances.
The second study, Samstag, Batchelder, Muran, Safran and Winston (1998), measured the alliance in 73 patients and 47 therapists in brief psychotherapy, using the 12-item version of the WAI for brevity (WAI-12; Tracy & Kokotovic, 1989). Among the predictor variables, the Friendliness and Hostility subscales of a short form (IAS-S; Muran & Safran, 1989) of the Interpersonal Adjective Scales measured these two aspects of patients’ and therapists’ interpersonal styles. It should be noted that while friendliness and hostility are typically treated as opposing poles of the friendliness dimension of the circumplex, they were separated and treated as distinct dimensions in this study. The authors also measured therapeutic outcome with pre-post ratings from the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1983) and the Inventory of Interpersonal Problems.

Three outcome groups were identified based upon reliable change scores: good, poor, and dropout. When therapists rated their patients, strength of alliance significantly varied by outcome as expected: goals, tasks, and bond as well as total alliance were all highest in good outcome cases, followed by poor outcome cases, and lowest in dropouts (F’s ranged from 7.33 to 8.46, all p’s < .001). While client friendliness (rated by therapists) did not significantly differ by outcome group, client hostility followed the predicted pattern among outcome groups, with dropouts most hostile, followed by poor outcome cases, and with good outcome cases being rated least hostile (F = 3.05, p < .05). Interestingly, while patient-rated alliance varied by outcome group much the same way as therapist-rated alliance, patient ratings of therapist hostility did not differ significantly by outcome group, while patient ratings of therapist friendliness did show significant
differences by outcome. Thus, it appears that when patients rate their therapists, friendliness serves as a predictor of outcome; whereas when therapists rate their patients, hostility serves as a better predictor of outcome. Unfortunately, the authors do not report what the direct relationships were between alliance and interpersonal style, but the directionalities of their findings (alliance was highest in good outcome cases, which is when patient hostility was lowest and therapist friendliness was highest) suggest a relationship between the friendliness-hostility dimension of the interpersonal circumplex and the strength of the alliance.

While the findings of these two studies suggest a relationship between the friendlinessSubmission quadrant of the circumplex and the alliance, direct relationships between friendliness and submission as interpersonal styles and the alliance were not established. In the first study, interpersonal functioning was considered in terms of interpersonal problems rather than a more general interpersonal style, while in the second study explicit relationships between clients’ interpersonal styles and the alliance were not reported. A study clearly exploring relationships between interpersonal styles and the alliance appears to be needed.

A circumplex model of interpersonal style is utilized in the present study as a predictor of the alliance for several reasons. First, the alliance itself is essentially an interpersonal process: it is a type of relationship that develops between people in a therapeutic situation. An interpersonal process does not only consist of the observable events that transpire between parties, but is also highly dependent upon each person’s tendencies to react in specific ways. These reactive patterns seem likely to bear strongly
upon the ways that each individual client approaches, receives, negotiates, and maintains
the alliance. Secondly, the circumplex model can provide an especially useful framework
for understanding how interpersonal processes may affect the alliance, and has become a
dominant force in the interpersonal process literature (see Plutchik & Conte, 1997).
Finally, prior research regarding the dominance and affiliation dimensions of the
interpersonal circumplex suggests that they may be helpful predictors of the therapeutic
alliance (e.g., Hersoug et al., 2001; Muran et al., 1994), but this link has not been clearly
established for clients in a correlational model such as the present one. Given the
importance of interpersonal styles in the development and maintenance of the alliance,
the usefulness of the circumplex model in conceptualizing interpersonal style, and the
prior research concerning interpersonal dominance and affiliation, it is believed that
dominance and affiliation are excellently suited as predictor variables in the present
study.

Quality of Object Relations. One way that interpersonal and intrapersonal
processes can be understood is through the use of object representations, or object
relations. Westen and Gabbard (1999) describe object relations broadly as enduring
patterns within interpersonal functioning, occurring in the context of intimate
relationships. Furthermore, object representations can be said to affect interpersonal
functioning through fantasies and fears attached to the self and others (Westen, 1991).
These fantasies and fears are simply internalizations of patterns of interaction between
the self and external objects (people, places, things, constructs) that begin in infancy.
They are believed to be built upon throughout subsequent development and adulthood.
Destructive interpersonal patterns in early childhood are hypothesized to be at the root of maladaptive interpersonal styles in adulthood (Westen, 1996). Thus, object relations reflect not only those interpersonal processes that occur and are internalized, but also the effects of these internalizations on subsequent interpersonal interactions.

On the one hand, object representations can help support and guide one’s actions, such that one may benefit from drawing upon past interactions to help understand and navigate current situations. If one consistently benefits from and is supported and guided by their past interactions, it may be said that the quality of one’s object relations is good. On the other hand, some object representations may evoke uncomfortable or maladaptive thoughts and feelings, either internally or in the context of present interpersonal interactions. These difficulties, when experienced in a recurrent pattern, form the basis of many of the problems with which patients present for therapy. Assessing quality of object relations can help therapists understand their patients’ level of functioning. Piper and Duncan (1999) state that quality of object relations “considers affect regulation, self-esteem regulation, use of fantasy and defenses, as well as relationship patterns” (p. 670).

In a discussion of various views of the therapeutic alliance, Shane (2000) describes patient change in therapy as a “new object experience” (p. 109). Alpher, Henry and Strupp (1990) made the following statement pertaining to patients’ object representations:

A prevalent view is that the greater the degree of early character pathology, the more likely it is that traditional analytic techniques will require modification in order to prevent a negative therapeutic reaction from developing. Character
pathology rooted in early development is regarded as compromising the
individual’s capacity for ‘full object relations.’ In other words, the person is
unable to relate consistently to others in a realistic way… (p. 351)

This view summarizes the powerful effect that deficits in a patient’s object relations can
have upon the therapeutic relationship. In the same publication, those authors found that
two aspects of object relations, differentiation and articulation (derived from Rorschach
data), served as valuable predictors of outcome. It is interesting to note that outcome was
assessed in this study using change in another object relational component, introject.

In fact, clients’ quality of object relations (QOR) has been shown to be a predictor
of psychotherapy process (including alliance) and outcome (Saketopoulou, 1999).
Henry, Strupp, Schacht, and Gaston (1994) point out that quality of object relations can
be seen as a reliable predictor of outcome, the alliance being an intermediate step.

A string of studies by Piper and colleagues (Piper, Azim, McCallum, & Joyce,
1990; Piper et al., 1991, 1995; Joyce & Piper, 1996, 1998; Ogrodniczuk, Piper, Joyce, &
McCallum, 1999; Joyce, McCallum, Piper, and Ogrodniczuk, 2000; Piper, McCallum,
Joyce, Rosie, & Ogrodniczuk, 2001) have investigated the role of quality of object
relations in psychotherapy process and outcome. Their findings indicate that patient
QOR (their measurement of which is described below within the discussion of Piper et
al., 1991), powerfully influence the process and outcome of psychotherapy, in terms of
benefit, improvement, and the alliance.

Piper, Azim, McCallum, and Joyce (1990) administered a comprehensive set of
outcome measures at five-month intervals as well as a follow-up assessment. They found
that the most improved patients were those that were described as high quality of object relations, while the least improved were those described as low quality of object relations. Piper et al. (1995) investigated patterns of alliance change across 20 sessions in low QOR and high QOR patients. For low-QOR patients, increasing alliance (therapist-rated) was directly related to better outcome. For high-QOR patients, there was no such relationship. They concluded that quality of object relations may be an important mediating variable between patterns of alliance change and outcome. Joyce, McCallum, Piper, and Ogrodniczuk (2000) re-analyzed these data, this time considering expectancies of in-session behavior on the part of both therapist and client from both participants’ perspective. They found that patients had varying expectancies by level of QOR, and that these expectancies were related to changes in the alliance. High-QOR patients in fact were found to have more widely varying patterns of alliance change, while variations in patterns of alliance change for low-QOR patients were negligible. However, mean slopes for improvements in the alliance were higher in the high-QOR group. Joyce and Piper (1998) studied patient QOR in time-limited dynamic therapy. They assessed QOR over two 1-hour interviews, and alliance was assessed using six 7-point items. They found that overall, QOR accounted for a significant amount (7%) of the variation in the quality of the therapeutic alliance.

Possibly the most relevant of these studies was reported by Piper et al. (1991). They measured alliance, quality of object relations, and interpersonal functioning (as in the present study) in 64 outpatients in brief (mean = 18.8 sessions) dynamic psychotherapy. Therapists rated QOR using the Quality of Object Relations Scale
(QORS; Azim et al., 1991), a system developed by one of the authors for rating unstructured interviews. Raters using this system attend to patient data such as behavioral manifestations, regulation of affect, regulation of self-esteem, and historical antecedents.

Patients underwent a two-hour, unstructured interview prior to therapy, performed by a senior clinician other than the therapist. At the conclusion of this procedure, the interviewer assigned a score between 1 and 9, corresponding to the patient’s overall quality of object relations (QOR). Scores of 5 and higher were considered to be high (mature) QOR, defined as when the patient “enjoys equitable relationships characterized by love, tenderness and concern for objects of both sexes,” with a “capacity to mourn and tolerate unobtainable relationships” (p. 434). Scores of 4.5 and lower given by the interviewer were classified as low (primitive) QOR, which is present when “the person reacts to perceived separation or loss of the object, or disapproval or rejection by the object, with intense anxiety and affect. There is inordinate dependence on the object, who provides a sense of identity for the person” (p. 434). This method of QOR assessment was adequately reliable; agreement between the interviewer and an independent rater was obtained for 50 cases and was found to be 76% agreement for high-low distinctions, and the intraclass correlation coefficient for the 9-point rating was .50. QOR was established to be distinct from health-sickness and psychiatric disturbance.

The therapeutic alliance was measured after every session with four 7-point Likert-type items (immediate impression rating), as well as with two additional, more
general 7-point items after sessions 7, 14, and 20 (reflective impression) by both therapists and clients. This pool of items was factor analyzed, yielding one patient alliance factor combining immediate and reflective impressions and accounting for 77% of the variance in patient items, and two therapist factors (immediate and reflective) accounting for 63% and 22% of the variance in therapist items. These three factors served as measures of the alliance.

The emotional reliance subscale of the Interpersonal Dependency Scale (Hirschfield, Klerman, & Gough, 1977), the present functioning subscale of the Interpersonal Behavior Scale (Piper, Debbane, & Garant, 1977), and the six subscales (work, social, family, partner, parental, and sexual) comprising the Social Adjustment Scale (SAS; Weissman et al., 1971) were all assessed prior to therapy. These eight subscales were used as predictor variables, assessing aspects of recent (past 1 to 3 months) interpersonal functioning.

Correlation coefficients between the predictor variables, (QOR and recent interpersonal functioning) and each of the three alliance factors revealed a significant correlation between QOR and patient-rated alliance ($r = .29$, $p < .05$), and between QOR and reflective therapist-rated alliance ($r = .28$, $p < .05$). In addition, the partner subscale of the SAS was found to be related to immediate therapist-rated alliance ($r = .35$, $p < .05$). No other relationships were found. QOR was the only one of the nine predictor variables related to both therapist and patient ratings of the alliance, while only one aspect of interpersonal functioning was related to the alliance. In addition, the authors found that QOR was significantly related to outcome on a variety of subscales, and also related to
the partner and sexual subscales of interpersonal functioning. Finally, the alliance was highly related to outcome on a variety of subscales.

The results of this study provide evidence that a) the alliance is related to outcome, b) QOR can be used to predict the alliance, and c) QOR may predict alliance better than other measurements of interpersonal functioning. However, these findings are difficult to replicate, given that the laboratory-created measures that were used to measure the alliance are not published in the literature.

One study using more replicable methods was initially published by Mallinckrodt, Gantt, and Coble (1995) as the development and validation of the Client Attachment to Therapist Scale (CATS). In this study, 138 clients in individual therapy in four different treatment settings completed a battery of measures including the Bell Object Relations and Reality Testing Inventory (BORRTI; Bell, 1991) and the full client version of the WAI. The BORRTI is a 45-item, self-report, true-false inventory designed to assess object relations and reality testing in adult populations of varying pathology. Higher scores on the BORRTI indicate greater pathology and poorer QOR. Only the four object relations subscales (Alienation, Insecure Attachment, Egocentricity, and Social Incompetence) were analyzed in this study.

Items from all of the measures administered were factor analyzed to create the subscales of the CATS. Then, to establish convergent validity, associations between the CATS and each of the source measures were reported. While the authors reported that both the BORRTI and the WAI were correlated with the CATS, they did not directly report the correlations between the BORRTI and the WAI. However, in a recent re-
analysis of these data (Mallinckrodt, Porter, & Kivlighan, 2005), data from 44 of the participants were re-examined with closer attention to object relations deficits as they relate to alliance and attachment to the therapist. The BORRTI, which had been scored in the earlier study using a hand-scoring method, was re-scored using a newer computerized scoring program.

The authors report correlations between the BORRTI and the WAI in this re-analysis. They found that the BORRTI subscale Insecure Attachment was negatively related to agreement on tasks ($r = -.40$, $p < .01$), and the BORRTI subscale Social Incompetence was negatively related to agreement on tasks ($r = -.38$, $p < .05$) and total alliance ($r = -.32$, $p < .05$). No other BORRTI subscales were related to the alliance. Thus, it appears that some deficits in object relations (poorer QOR), when measured using this self-report methodology, may be inversely related to the alliance.

Object relations theory provides a useful framework for understanding how interpersonal relationships are experienced internally, and how these internalizations may affect future relationships. If one’s object relations are maladaptive, a relationship that is charged with emotion (like the therapeutic relationship) is almost certain to be affected. Like interpersonal style, one carries one’s object representations into every interpersonal situation, and this aspect of the self profoundly shapes the formation and maintenance of relationships.

The quality of one’s object relations thus has tremendous bearing upon the therapeutic relationship (Joyce & Piper, 1998), and has even been suggested to be of more predictive value than other interpersonal variables such as recent interpersonal
functioning (Piper et al., 1991). Object relations also provide unique information about interpersonal functioning beyond what is covered by interpersonal style. Quality of object relations incorporates the intrapersonal experiences (trust, hope, sensitivity, etc.) awakened by recurring interpersonal themes, an aspect untouched by interpersonal style, which concentrates more upon observable reactions and behaviors (dominance, affiliation). Unfortunately, findings regarding quality of object relations and the alliance are largely relegated to one research laboratory, and are difficult to replicate given the nature of the measures used. It is therefore presently uncertain whether patient QOR is indeed the best predictor of the therapeutic alliance. However, evidence from one recent study (Mallinckrodt, Porter, & Kivlighan, 2005) suggests that object relations measured using self-report methodology may be related to the quality of the alliance. For all of these reasons, in an investigation of relational patterns that affect the alliance it is vital that one take into account the client’s quality of object relations.

Attachment Style. Attachment style is an aspect of interpersonal functioning that is formed in childhood based on experiences of significant others’ reliable presence and care. Pioneered by John Bowlby (1969, 1980), the ideas of attachment theory were first researched by Mary Ainsworth (1967), then later by Mary Main (Main & Cassidy, 1988; Main, Kaplan, & Cassidy, 1985; Main & Solomon, 1986) and have now become a mainstay of contemporary psychology. Thanks partly to the work of the aforementioned researchers, attachment style in adulthood can now be assessed reliably, and psychotherapy process and outcome research has made good use of this construct.
One issue in the use of attachment style as a variable in psychotherapy process and outcome research is the frequent overlap between attachment style and quality of object relations. Steele and Steele (1998) note that three main assumptions of attachment theory are founded in object relations theory: a) parents’ behavior profoundly influences personality and social development of children; b) interactions with caregivers are represented by children in mental models of others, and these models later influence expectations, feelings, and behavior with others; and c) these internal models are shaped by, and later activated by, separation from or loss of attachment figures.

One fine distinction that has been made between these approaches concerns their underlying motivating forces. Object relations theory is rooted in psychoanalytic theory, which assumes the presence of innate creation and destruction drives. Attachment theory, on the other hand, circumvents the need for such drives by taking a more behavioral and ethological approach that focuses on attachment behaviors as an evolutionarily adaptive mechanism (Steele & Steele, 1998). Furthermore, attachment theory focuses more exclusively on actual experiences of loss and separation from an attachment figure, whereas object relations focus more on the internal experience of loss, whether based in reality or not. Attachment theorists such as Bowlby regard the “experiences and fantasies of relationships and loss as epiphenomena;” far less relevant than “the concrete, the actual physical absence or presence of the mother” (Greenberg & Mitchell, 1983, p. 186). Also, object relations theory appears to be somewhat broader in scope than attachment theory, in that it considers interactions between the self and all
kinds of objects, whereas attachment theory focuses exclusively on the mother-infant relationship.

One useful approach to integrating these two theories was proposed by Bartholomew (1990) in an effort to better explain avoidant attachment as displayed by adults. This author considers working models of the self as they combine with working models of others, and the attachment styles that are indicated by each combination. For example, one who generally views the self negatively while generally viewing others positively would be mapped as bad-self, good-others. This corresponds to an attachment style that Bartholomew terms Preoccupied attachment (Main also uses this term, while Hazan and Shaver, 1987, call it Ambivalent attachment), which is characterized by over-dependence on others. There are four combinations of self- and other-representations, each corresponding to an attachment style.

There are several terms that attachment theorists have developed to describe attachment styles, including avoidant, secure, ambivalent, disorganized/disoriented, preoccupied, dismissing, and unresolved (Goldberg, Muir, & Kerr, 1995). Many of these attachment styles can be grouped into the three basic patterns of attachment identified by Ainsworth, Blehar, Waters, and Wall (1978), each with subtypes. Type A (avoidant) infants appear detached from the mother, pay little attention to her, and ignore her return from a departure. Type B (secure) infants tend to use their mother as a “secure base for exploration” (Goldberg et al., 1995, p. 3). They attend to her whereabouts, but are nevertheless able to be separate from her enough to engage in exploration of the environment. One way to distinguish among secure subtypes is by the level of distress
exhibited upon separation from the primary caregiver. Finally, Type C (ambivalent or resistant) infants are distressed by the idea of separation from their primary caregiver, whether it might be to explore the surrounding environment or because of her absence. Main and Solomon (1986) later identified a Type D (disorganized/disoriented), in which infants appear as if they are either confused or frightened by the caregiver. Today, most research utilizes four classifications for attachment: avoidant, secure, resistant, and disorganized (Goldberg et al., 1995).

Mallinckrodt (2000) discusses how attachment style can be seen as a pattern of social competencies, and that these competencies are required for the establishment of a therapeutic relationship. Thus, deficits in attachment style (and thus social competencies) will interfere with the therapeutic alliance and must be addressed in therapy. Similarly, London (1983) comments that a successful therapeutic change process involves both attachment to the therapist and the therapeutic alliance.

Progress in therapy and the alliance, then, may be measured by changes in attachment style. Travis, Bliwise, Binder, and Horne-Moyer (2001) found that a significant number of patients with successful outcomes were described as having changed from insecure to secure attachment styles, and that changes in attachment style were related to overall improvement. Horowitz, Rosenberg, and Bartholomew (1993) point out that patients’ attachment styles correspond closely to their types of interpersonal problems. In the course of developing the Inventory of Interpersonal Problems (IIP), these authors administered questionnaires and interviews to 77 participants and one close friend each of the same sex. The data were used to determine which of four attachment
styles each person fit best (secure, preoccupied, dismissing, fearful). Each person also completed the IIP. The authors found that areas of interpersonal problems corresponded conceptually with attachment style; for example, the secure group’s IIP profile clustered on the warm side of interpersonal space (but without any extreme elevations), the dismissing group’s profile was elevated on the hostile side of the interpersonal space, and so on. To date, no published studies have used these methods to compare attachment style and interpersonal problems as they might affect the alliance.

Rubino, Barker, Roth, and Fearon (2000) found that therapists tended to respond more empathically to fearful and preoccupied patients than to dismissing and secure patients. Thus, certain attachment styles may affect the therapeutic alliance by pulling for more empathy from the therapist. Hardy et al. (1999) found that preoccupied patient attachment styles frequently pulled for increases in reflection as a response mode, while dismissive attachment styles pulled for increases in interpretation as a response mode. As discussed above, it has been found that high concentrations of one type of interpretations, transference interpretations, are related to poorer therapist-rated alliances (Ackerman & Hilsenroth, 2001). Thus, it could be hypothesized that there is a negative, indirect relationship between dismissive patient attachment style and the alliance.

Attachment style has been investigated as a direct predictor of the therapeutic alliance in a number of studies. Meyer and Pilkonis (2001) reviewed three studies that investigated client attachment style and the alliance, and reported that a positive relationship existed in all three studies between secure attachment and the alliance. They comment that attachment style can be seen as a determinant of whether patients will be
confident, fearful, or defensive in the therapeutic relationship. In a review of developments within the alliance literature, Horvath (2001) comments that “there appears to be a confluence of data suggesting that the quality of the alliance, as reported by the client in the early phases of therapy, is impacted by the quality of the attachment style” (p. 368). Particularly, he notes that fearful, anxious, dismissive, and preoccupied styles are predictive of poor initial alliances (Eames & Roth, 2000; Ogrodniczk et al., 2000; Rubino, Baker, Roth, & Fearon, 2000; Tyrrell, Dozier, Teague, & Fallot, 1999).

One oft-cited study investigating attachment style and alliance was published by Eames and Roth (2000), who administered the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994) at intake and the WAI-12 (at sessions 2, 3, 4, and 5) to 30 patients undergoing several different modes of therapy (CBT, psychodynamic, cognitive analytic, and eclectic). The RSQ is a self-report measure derived from Hazan and Shaver’s (1987) Adult Attachment Styles measure and Collins and Read’s (1990) Adult Attachment Scale, and consists of 30 statements about behavior in close relationships rated on a 5-point Likert scale. Four subscales are derived, corresponding to Bartholomew’s (1990) four attachment styles: secure, fearful, preoccupied, and dismissing. The RSQ shows somewhat disappointing psychometric properties, having weak convergent validity, variable internal consistency, and moderate test-retest reliability (Eames & Roth, 2000).

The authors found that when considering patient-rated alliance, fearful attachment was negatively related to agreement on tasks at session 3, and negatively related to tasks, goals, and total WAI at session 5 (correlations range from -.46 to -.52, all p’s < .05).
Interestingly, dismissing attachment was positively related to agreement on goals at session 3 ($r = .45, p < .05$). When considering therapist-rated alliance, the authors found that fearful attachment was related to agreement on goals at session 2 ($r = -.40, p < .05$), while secure attachment was related to bond and global WAI at session 5 ($r’s = .44$ and $.42$ respectively, both $p’s < .05$). Given that the authors calculated 128 correlations, it is not surprising that seven of them came out significant; this is roughly 5% of the total number. Nevertheless, especially in the area of fearful attachment, there is some evidence to suggest that patient attachment style may be related to the quality of the alliance. It should be noted that nearly all of the associations with alliance, whether significant or not, were in the correct direction for secure, fearful, and preoccupied attachment.

Mallinckrodt, Gantt, and Coble (1995) looked at attachment styles, object relations, and the alliance (three of the variables included in the present study) in the development of the Client Attachment to Therapist Scale (CATS). One hundred and thirty-eight clients in individual therapy in four different treatment settings completed the Adult Attachment Scale (AAS; Collins & Read, 1990), the Self-Efficacy Scale (SES; Sherer et al., 1982), the four object relations subscales of the Bell Object Relations and Reality Testing Inventory (BORRTI; Bell, 1991), and the full client version of the WAI. All items from all measures were pooled and factor analyzed (minus 25 of the items with the lowest relationships to the pool) resulting in three factors representing styles of client attachment to their therapists: Secure, Avoidant-Fearful, and Preoccupied-Merger.
Of these three resulting client attachment to therapist styles, Secure was positively correlated with agreement on tasks ($r = .80, p < .01$), agreement on goals ($r = .77, p < .01$), bond ($r = .77, p < .01$), and total alliance ($r = .82, p < .01$). Avoidant-Fearful was negatively correlated with bond ($r = -.71, p < .01$), agreement on tasks ($r = -.62, p < .01$), agreement on goals ($r = -.57, p < .01$), and total alliance ($r = -.56, p < .01$). Preoccupied-Merger was related to the bond component of the alliance only ($r = .19, p < .05$). Thus, secure attachment was a good predictor of positive alliance, fearful attachment was a good predictor of poor alliance, and preoccupied attachment did not reliably predict quality of the alliance.

It should be noted that high correlations between CATS subscales and WAI subscales may be attributable to the fact that the CATS was in part derived from items on the WAI. However, the Adult Attachment Scale also served as a source of items for the CATS, and this attachment measure did not correlate well with the CATS ($r$’s range from .01 to .18). Therefore, it is possible that the CATS and the AAS measure different constructs, or different aspects of the attachment construct, while the CATS and the WAI may be tapping into similar constructs. It is interesting to note that there is a good deal of correspondence between the three attachment factors of the CATS and the subscales of the BORRTI: CATS Secure attachment to therapist correlated negatively with all four BORRTI object relations subscales ($r$’s ranged from -.23 to -.29, all $p$’s < .05 or smaller), while Fearful-Avoidant attachment to therapist correlated positively with BORRTI Alienation ($r = .42, p < .01$), Egocentricity ($r = .36, p < .01$), and Social Incompetence ($r = .46, p < .01$), and Preoccupied-Merger attachment to therapist was correlated with
BORRTI Insecure Attachment ($r = .28, p < .05$). Once again, the distinction between object relations and attachment style is found to be tenuous, and efforts to tease these two variables apart are needed.

A study by Satterfield and Lyddon (1995) has particular relevance to the present study. These authors administered the AAS (at intake) and the WAI (at session 3) to 60 first-time clients at a university-based counseling center, in an effort to predict the quality of the alliance from attachment style. The AAS is a self-report measure containing 18 items rated on a 5-point Likert scale. It yields three subscales, Close (the extent to which individuals are comfortable with closeness and intimacy), Depend (the extent to which individuals trust others and depend on their availability when needed), and Anxiety (the extent to which individuals fear being abandoned or not being loved).

These authors found that the AAS Close and Depend subscales were highly intercorrelated ($r = .45, p < .01$), and that the AAS Depend and Anxiety subscales were negatively correlated ($r = -.29, p < .05$). However, alliance was only predicted by the Depend subscale ($r = .31, p < .05$). This would seem to indicate that clients who depend on their therapists tend to form stronger alliances, independent of how anxious they are about being abandoned or how comfortable they are with closeness. However, it seems likely that interactions between the three AAS subscales might yield more promising findings with regard to predicting the alliance, since the subscales are not meant to be considered independently, and they were found to be correlated in this study. Unfortunately, the authors did not report any such interactions.
Another study of particular relevance, by Kivlighan, Patton, and Foote (1998), investigated attachment and alliance in 40 counselor-client dyads at two university-based counseling centers. The AAS was administered at intake, and the WAI was administered after the third session. Correlations between the AAS subscales and the WAI total score, as well as a hierarchical regression analysis predicting alliance from the AAS subscales and other measures, were calculated and presented. The authors found that AAS Close and Depend scores were positively correlated with the total WAI ($r = .35$ and $r = .38$, respectively; both $p$’s < .05), whereas AAS Anxiety was not related to the alliance. In the regression analysis, the authors found that the AAS accounted for 33% of the variance in alliance, with the largest effect for the subscale Close ($\beta = .43; p < .01$). Clearly, in this study client security of attachment as measured by the AAS was a valuable predictor of the early alliance.

The interpersonal patterns that result from the earliest experiences of the primary caregiver are clearly integral to the formation of a relationship that is close, emotionally arousing, and likely to bear some similarity to the parent-child relationship, as is often the case with the therapeutic relationship. Attachment style speaks to the ways that real relationship experiences have affected one’s interpersonal viewpoints, and therefore represent an indispensable source of data untapped by interpersonal style, although the two constructs are related (Horowitz, Rosenberg, & Bartholomew, 1993). For these reasons, attachment theory appears to make an important and unique contribution to the understanding of interpersonal functioning as it affects the alliance.
However, there is some question as to the distinctness of attachment from object relations (Greenberg & Mitchell, 1983). In a review of self-report measures for assessing attachment, Lyddon, Bradford, and Nelson (1993) include the BORRTI, a quality of object relations measure. This same measure in fact contains a subscale referring to insecurity of attachment. Mallinckrodt et al. (1995) created an attachment measure from factor analysis of the BORRTI and other measures, and found the resulting attachment measure to correlate with the BORRTI. In order to establish whether object relations and attachment are separate or the same, it is necessary to include both variables in a single study, so that they may be compared and contrasted in the ways that they affect a single relationship. To date, no such study is known to exist. The present study incorporates attachment style and quality of object relations into a single correlational model, directly answering this question.

The Present Study

Rationale. The present literature review has focused on how numerous variables relate to the therapeutic alliance. On the one hand, it is noteworthy that the alliance is related to an extremely broad set of pretreatment variables, including the Five Factor Model of personality, symptom severity, motivation, expectations, locus of control, social support, perfectionism, and coping style, to name but a few. Given the breadth of this list, it might be argued that there is no single coherent set of variables that best predict the therapeutic alliance. On the other hand, there are a large number of interpersonal relationship variables that appear to be particularly germane to the alliance. As (hopefully) demonstrated in the present review, the weight of these interpersonal
relationship variables is considerable. It has been argued above that even though there have been numerous studies that relate interpersonal relationship variables to the alliance, it is striking that there are very few studies known which examine multiple domains of interpersonal functioning simultaneously in relation to the alliance.

The three domains reviewed (interpersonal style, adult attachment, and quality of object relations) are important, and at least theoretically, separate contributors to actual interpersonal phenomena such as the therapeutic alliance. The relative approaches to interpersonal functioning that these three variables adopt each have conceptual similarities and differences. For example, the circumplex model focuses more upon the “real,” external manifestations of interpersonal style and functioning (e.g., person tends to behave in friendly-dominant ways with others), whereas object relations theory focuses more upon the ways that one internalizes objects and relates to them (e.g., person experiences object as hostile and blaming, and reacts with intense affect). All domains of interpersonal functioning may not be synonymous. Yet, as reviewed above, research has suggested that each of these three variables may be particularly salient in relation to the alliance. This study will explore the contributions of these three domains of interpersonal relating (i.e., at the internalized object level, the attachment level, and the interpersonal circumplex level) to the alliance.

Research concentrating upon interpersonal style from the circumplex perspective has suggested that this aspect of interpersonal functioning may have implications for the alliance (Muran et al., 1994; Samstag et al., 1998). However, these studies do not establish a direct connection between interpersonal style and the alliance, in that one
study utilized a measure specific to interpersonal problems (not interpersonal style), and
the other used outcome as a dependent variable, rather than the alliance. A concise,
replicable investigation of interpersonal style as it relates to the alliance is needed,
preferably within the framework of the circumplex model. The present study achieves
this, using an appropriate and widely accessible measure (Interpersonal Adjective Scales-
Revised; Wiggins et al., 1988). Prior research suggests a positive relationship between
affiliation and alliance, such that higher (friendlier) scores are associated with better
alliances, while lower (more hostile) scores are associated with poorer alliances
(Connolly Gibbons et al., 2003; Muran et al., 1994; Paivio & Bahr, 1998; Samstag et al.,
1998; Schauenburg et al., 2000). For dominance, prior research offers somewhat less
clear guidance. Some studies suggest that low patient dominance (i.e., submissiveness)
can be detrimental to the alliance (e.g., Paivio & Bahr 1998), while other studies suggest
the opposite: that high dominance can detract from the alliance while submissiveness is
associated with better alliances (Connolly Gibbons et al., 2003; Muran et al., 1994). The
latter two studies are more similar in approach to the present study, thus it is possible that
these findings may be more applicable to the present study.

Interpersonal experiences that are internalized as objects continue to exert
powerful influence upon one’s interpersonal world throughout life. The object relations
approach to interpersonal functioning takes into consideration relationships that are of
particular importance in the interpersonal framework, moving beyond general external
trends to consider possible sources and expressions of these trends. Instruments
measuring quality of object relations (such as the Bell Object Relations Inventory; Bell,
Billington, & Becker, 1986) provide a unique and useful view of interpersonal functioning, delving beyond action-reaction patterns into internal experiences awakened by interpersonal interactions. Past research in quality of object relations has suggested that high patient QOR may be associated with stronger alliances, while low QOR may be predictive of poorer alliances (Joyce and Piper, 1998; Piper et al., 1991). Also, some suggestion has been made that QOR can potentially predict the alliance even more strongly than interpersonal style (Piper et al., 1991). However, findings regarding QOR and the alliance are largely limited to a string of studies emerging from one research laboratory and with low replicability. Thus, there is suggestion that QOR can be helpful in predicting the alliance, but this hypothesis continues to need support.

Similarly, adult attachment comprises a domain of the interpersonal world that has a clear relationship to the past; an interpersonal pattern that has a beginning in the real infant-caregiver relationship. But attachment also represents an internalized pattern that has observable effects upon interpersonal functioning. The effect of attachment upon a relationship such as the alliance may be profound, when the therapist is a close other who represents guidance and understanding. Past research has shown that more secure patient attachment may be associated with stronger alliances (Eames & Roth, 2000; Kivlighan et al., 1998; Mallinckrodt et al., 1995; Satterfield & Lyddon, 1995), and it is believed that such a relationship will be found in the present study. Adult attachment can easily be assessed in a short, dimensional, self-report measure such as the Adult Attachment Scale (AAS; Collins & Read, 1990).
The independence of quality of object relations and adult attachment is somewhat tenuous as there is some evidence in the literature that the two constructs may be closely related (Mallinckrodt et al., 1995). Some researchers use the terms interchangeably (e.g., Lyddon et al., 1993; Mallinckrodt et al., 1995), while others maintain a distinction between them. Attachment theory draws upon real relationships in infancy, while object relations theory focuses on relationships with imagined others (e.g., the mother-object). Both have been found to have predictive power for the alliance, but relatively little work has explored their combined contributions to the therapeutic alliance.

The three basic interpersonal frameworks reviewed (object relations, attachment, and circumplex theories) all have distinct theoretical perspectives and all yield separate research measures. Hence, each of these frameworks could measure a different component of the relational aspect of the therapeutic alliance: object relational measures approach interpersonal phenomena as internalized, imagined, past relationships; attachment theory being similar but based on an attachment “style” acquired through the concrete presence or absence of nurturance; interpersonal circumplex measures through the more general acquisition of interpersonal patterns with a wide range of others. And as noted in the review, each of these measures has shown promise in past research and have been related to the therapeutic alliance. However, their combined value in predicting the alliance has not been explored, which is a primary purpose of the present study.

Another question concerns the independence of the three approaches. For example, is there in fact a time when one relates to others without the influence of
internal working models, without the biases created in past relationships (e.g., attachment
and especially object relations measures)? Based on the research reviewed above, it
seems likely that some overlap necessarily exists between the empirical measurement of
“real” and “unreal” relationship variables (Henry et al., 1990; Hersoug et al., 2001;
Horowitz et al., 1993; Piper et al., 1991). Psychoanalytic theorists might ask whether
there is such a thing as a “real relationship,” or whether all interactions are in some way
influenced by internalized objects. It is noteworthy that Freud wrestled with this very
issue in his conception of the alliance, at one time envisioning it as “admissible”
transference, at another time defining it as the real, non-transferential part of the

It has been shown that interpersonal style, defined in terms of the interpersonal
circumplex, taps into the observation of how one acts in interpersonal situations. This is
essentially a real-relationship, external, and observable approach to understanding
interpersonal functioning. By contrast, quality of object relations focuses more on the
internalized, imagined relationships between the self and others. At a midpoint in
between sits attachment, in which here-and-now interactions are guided by internal
expectations of others, which were themselves created by real experiences with the
caregiver. The question of whether these three variables simply represent alternate
approaches to the same basic construct, or whether they are in fact separate (but related)
components can be addressed by measuring the extent to which they overlap in the
prediction of another variable.
The present study considers this issue in the context of the therapeutic relationship. It is believed that interpersonal style, quality of object relations, and security of attachment are not truly unique variables, in the sense that they will overlap to some extent in their power to predict the quality of the alliance. Partial support for this proposition comes from inspection of the subscales included in the present measures. The BORRTI, which assesses QOR, contains a subscale called insecurity of attachment, which seems likely to be associated with the security of attachment dimension measured by the AAS. The BORRTI also has a subscale partially assessing the ability to attain closeness, which has a counterpart in a closeness subscale of the AAS, and also bears similarity to the affiliation dimension of the interpersonal circumplex. Similarly, the BORRTI has items relating to shyness, a concept similar to the submissive sector of the interpersonal circumplex.

However, to answer this question more definitively, the unique contribution of these variables to the alliance is measured, in terms of variance explained. If each of these three variables contributes a significant amount of unique variance explained in the alliance, it might be concluded that they do in fact measure unique aspects of interpersonal functioning. However, if these three variables overlap considerably in the amount of variance explained in the alliance, it may be that they simply represent three approaches to the same basic construct.

**Hypotheses.** The following hypotheses were made in regard to the zero-order relationships of the variables:

I. Interpersonal affiliation will be positively related to the therapeutic alliance.
II. A moderate, but significant, negative relationship will be found between dominance and the alliance.

III. Lower scores on the BORRTI (i.e., higher QOR) will be associated with stronger alliances.

IV. Security of attachment as measured using the AAS will be positively associated with strength of alliance.

The following hypothesis is made in regard to the combined effect of the variables:

V. Each of the four predictor variables (security of attachment, quality of object relations, dominance, and affiliation) will contribute a significant amount of unique variance accounted for in the alliance (represented by significant partial correlations for all predictors).

Method

Participants

Patients were recruited to participate in the present study from two university-based outpatient treatment centers. The only exclusionary criteria were if the clients were less than 18 years of age, or if a judgment of severe distress was made by the reception staff. Forty-eight clients returned initial packets with predictor variables, but only 43 of them returned packets containing the criterion measure after their first session, and this number decreased at the following two sessions. Thus, most analyses only contain 43 participants or less.

Between the two data collection sites, important differences exist with regard to client participation. The main data collection site was a counseling center serving
university undergraduate and graduate students who are enrolled full-time. During the
data collection period, 1,038 clients were seen at this site. Some (321) of these clients
were already enrolled in therapy at the start of data collection, and were therefore
ineligible to participate in the present study. Of the remaining 717 clients, approximately
half were not recruited for various reasons, most notably when clients were in acute crisis
(e.g., recent sexual assault). This judgment was made by the reception staff as they
distributed the intake paperwork, and as such no exact record of how many clients were
disqualified for this reason exists. Of the remaining clients, 43 agreed to participate in
the present study, resulting in a participation rate of roughly 12%. The second data
collection site was a training clinic housed within the department of psychology, which
serves students and community members. During the data collection period, 36 adult
clients presented for treatment, including some (the precise number is unknown) who had
received an intake interview elsewhere and were thus exempt from the present study. Of
the remaining clients only five chose to participate in the present study. Thus, the
participation rate was higher at the training clinic than at the university counseling center.

Descriptive statistics for the total present sample are presented in Table 2, with
the counseling center population percentages for comparison at the far right. As the table
shows, participants in this study were predominantly female (89.6%), their mean age was
21.77 (S.D. = 6.77), and they were predominantly Caucasian (83.3%). Of all clients seen
at the university counseling center during the data collection period (right-hand column in
Table 2), 54.15% were female, 61.56% were Caucasian, and the average age was 20.5
Table 2

Demographic Characteristics of Study Participants and Counseling Center Population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (S.D.)</th>
<th>Freq.</th>
<th>Sample %</th>
<th>Pop. %</th>
</tr>
</thead>
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<tr>
<td>Age</td>
<td>21.77 (6.77)</td>
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<td></td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
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<td>5</td>
<td>10.4</td>
<td>45.66</td>
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<td>Females</td>
<td></td>
<td>43</td>
<td>89.6</td>
<td>54.15</td>
</tr>
<tr>
<td>Race:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td></td>
<td>40</td>
<td>83.3</td>
<td>61.56</td>
</tr>
<tr>
<td>African-American</td>
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<td>4</td>
<td>8.3</td>
<td>2.89</td>
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<td>2.1</td>
<td>1.35</td>
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<td>Asian-American</td>
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<td>2</td>
<td>4.2</td>
<td>0.48</td>
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<td></td>
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<td>68.8</td>
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<td>19.56</td>
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<tr>
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<td>2</td>
<td>4.2</td>
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<tr>
<td>Previous Therapy:</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>28</td>
<td>58.3</td>
<td>N/A</td>
</tr>
<tr>
<td>Some Previous</td>
<td></td>
<td>20</td>
<td>41.7</td>
<td>N/A</td>
</tr>
<tr>
<td>Length of Therapy*</td>
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<td></td>
<td></td>
</tr>
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<td>How Long Ago*</td>
<td>34.84 (47.62)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Distress†</td>
<td>6.48 (1.81)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Length of therapy in months
†Note: Distress rated on 1-10 Likert scale; 1 = most at ease possible, 10 = most distress possible
years. Thus, the present sample was disproportionately female and Caucasian. All but 4.2% of the present sample reported having had at least a high school diploma (it is unclear what education level was held by these 4.2%), and the majority had had some college (68.8%). 41.7% had been in some form of previous therapy, with an average length of 14.95 months (S.D. = 22.15), and occurring an average of 2.9 years before their intake (S.D. = 47.62 months). On a 1 to 10 Likert scale of distress, 1 representing the most at ease one could possibly feel, and 10 representing the most distressed one could possibly feel, the present sample had an average distress level of 6.48 (S.D. = 1.81).

A number of clients did not continue to participate past their first and second sessions. There are at least two reasons for this. Two clients were transferred to another agency following their initial appointment and were thus ineligible to continue in the study. Two additional clients were transferred to other clinicians in the same agency, and again were ineligible to continue in the study. A number of clients did not return for their second appointment, and a portion of those who returned for their second appointment did not return for a third. Indeed; the mean total number of sessions completed by clients who participated in the present study was 5.35 (S.D. = 5.25), which exemplifies the brief and erratic nature of therapy attendance at university-based treatment centers such as the present data collection sites. Dropout in the present study is defined as a failure to complete the WAI at each of the first three sessions of therapy. Ten people dropped out after session one, and four more people dropped out after session two. Thus, total dropout in the present study equals 14.
Of those who dropped out after their first session, the mean age was 22.0, 88.9% were female, 88.9% were Caucasian, 44.4% had previous therapy, and the mean level of distress was 6.94. Thus, those who dropped out after their first session were not different from the rest of the sample in any discernable way. Of those who dropped out after their second session, the mean age was 19.4, 80% were female, 100% were Caucasian, 60% had previous therapy, and the mean level of distress was 6.60. Thus, those who dropped out after session two were slightly younger than the rest of the sample, more likely to be male, and had more prior experience with therapy than the rest of the sample.

Eleven of the therapists who were seen by the above clients consented to provide information about their demographic status. Eight of them were female, and three were male. Eight were Caucasian, one was Latina, and two were Asian-American. Three (27.3%) held a Ph.D., seven (63.6%) held a Masters degree, and one (9.1%) was working towards a Masters degree. In terms of clinical experience, one therapist (9.1%) had less than a year, six therapists (54.5%) had between one and five years, one (9.1%) had between 10 and 20 years, and three (27.3%) had more than 20 years of clinical experience. Most of the therapists (54.5%) identified their therapeutic orientation as eclectic, two (18.2%) were predominantly cognitive-behavioral, and three (27.3%) were of some therapeutic orientation other than cognitive-behavioral, psychodynamic, humanistic, behavioral, or eclectic.

Measures

*Working Alliance Inventory (WAI).* The WAI (Horvath, 1981) consists of 36 self-report items, based on Bordin’s (1979) tripartite conception of the alliance. Three
versions exist, allowing for patient, therapist, and observer ratings. In the present study, only patient ratings were used. There are three subscales: agreement on goals, agreement on tasks, and bond; each containing 12 items and scored on a seven-point Likert scale (1 = never, 7 = always). Subscale scores have a possible range of 12 to 84, and total scores range from 36 to 252.

Tichenor and Hill (1989) report high internal consistency for the total WAI-client version (alpha coefficient of .96), and alpha coefficients for the three subscales range from .85 to .88 (Horvath & Greenberg, 1989). The goal and task scales of the WAI display high convergent and discriminant validity, though the convergent validity of the bond subscale is more tenuous (Greenberg & Pinsof, 1986; Horvath & Greenberg, 1989). Client ratings on the WAI show high predictive validity, correlating with multiple measures of outcome (Horvath & Greenberg, 1989).

Interpersonal Adjective Scales-Revised (IAS-R). The Interpersonal Adjective Scales were originally designed by Wiggins (1979) as a 128-item, self-report measure for assessing a full range of interpersonal traits. The measure was revised and shortened to form the current version, the IAS-R (Wiggins, Trapnell, & Phillips, 1988). The IAS-R is comprised of 64 adjectives that are rated for applicability to the self (though the IAS-R can be used to rate others as well) on an 8-point likert scale ranging from “extremely inaccurate” to “extremely accurate.” The adjectives are grouped into eight scales that span the circumference of the interpersonal circle, ordered around the typical dimensions of affiliation (friendliness) and control (dominance). These octants contain eight items each, with scores ranging from 8 to 64. The octant scores are averaged and converted to
z-scores based on normative data provided in the scoring manual (Wiggins, 1995). These octant z-scores can then be computed into DOM and LOV values using an equation provided in the scoring manual, representing placement on axes of dominance and nurturance (also called affiliation). The two dimensions DOM and LOV are used in the present study, rather than all eight octant scores. Although it is not necessary in the present study, angular location and vector length of DOM and LOV can also be calculated from z-scores.

Internal consistency of the IAS octant scales ranges from .733 to .865 in adult and college student populations (Wiggins, 1995). The structural validity of the IAS system has been fairly well established, and the circumplex structure of the IAS and the IAS-R have been repeatedly confirmed by Wiggins and other researchers (e.g., Acton & Revelle, 2002; Gurtman & Pincus, 2000; Wiggins, 1979; 1995; Wiggins, Phillips, & Trapnell, 1989; Wiggins, Trapnell, & Phillips, 1988). The convergence of the IAS system with other systems measuring interpersonal functioning is excellent, including but not limited to the IIP system (Wiggins, 1995). The IAS has been well validated in a variety of clinical and experimental uses. Normalization of the IAS-R based on over 4,000 administrations of the measure revealed two potential weaknesses: first, there appears to be evidence of desirability bias; and second, gender differences may account for up to 13% of the variance in IAS scores. However, on the whole, the IAS system is structurally and psychometrically valid.

In the present study, octant z-scores are entered into an equation defined by Wiggins (1995) to derive normalized scores for the DOM and LOV dimensions. These
were the two scores entered into the regression formula, representing the variables interpersonal dominance and interpersonal affiliation, along with the other two predictor variables. Although reliabilities of the total DOM and LOV dimensions are not available, these dimensions are derived from octant scores, which show adequate reliability (see above).

*Bell Object Relations and Reality Testing Inventory (BORRTI).* The BORRTI (Bell, 1995) is a 90-item self-report questionnaire designed to assess quality of object relations and ego functioning, though only the 45 true-false items separately comprising the Bell Object Relations Inventory (BORI; Bell, Billington, & Becker, 1986) are used in the present study. Quality of object relations is determined via four subscales that assess object relations deficits: Alienation, Insecure Attachment, Egocentricity, and Social Incompetence. Alienation refers to a basic lack of trust in relationships, inability to attain closeness, and hopelessness about achieving intimacy with others. Insecure Attachment refers to painful interpersonal relations, sensitivity to rejection, and overemphasis on acceptance by others. Egocentricity is comprised of mistrust of others, regarding others only in relation to the self, and manipulation of others. Social Incompetence, as the name suggests, refers to shyness, uncertainty about interpersonal relations (especially with the opposite sex), and inability to form relationships. The four subscales can be summed to create a composite quality of object relations score.

Lower scores on the BORRTI represent healthier responses, while higher scores are more pathological. Raw subscale scores are converted to T-scores based on a reference sample of 934 individuals from university and community non-clinical settings.
Based on these normative data, Bell (1995) recommends a diagnostic cutoff score (T-value above 60), indicating when a score is in the pathological range. The BORRTI has displayed adequate test-retest reliability (r’s range between .58 and .90 for object relations subscales at 4 weeks, and between .65 and .81 at 13 weeks) as well as freedom from response bias due to age, sex, or social desirability (Bell, 1995). Chronbach’s alphas range between .79 and .90 for object relations subscales, while Spearman split-half reliabilities range from .78 to .90 (Bell, 1995). The BORRTI discriminated between several criterion groups, including Borderline pathology and other Axis II disorders, schizophrenics, affective disorders, and other Axis I pathology, and students and community samples (Bell, 1995). Engelman (1985) found correlations of BORRTI object relations subscale scores with other measures of therapeutic outcome.

Bell (1995) reports correlations between the object relations subscales of the BORRTI and the Brief Psychiatric Rating Scale (r’s ranged from .16 to .25 for total BPRS scores), the Positive and Negative Syndrome Scale (r’s ranged from .21 to .29 for total PANSS scores), the Symptom Checklist-90-Revised (r’s ranged from .10 to .56 for global SCL-90-R scores), the MMPI (some r’s as high as .75 and .67), the Millon Clinical Multiaxial Inventory (r’s as high as .59 and .55 for Clinical Syndrome Scales, but nonsignificant for Personality Disorder Scales), and physiological measures (highest r’s were .25 for serum total testosterone and .27 for urinary free cortisol).

For the present study, BORRTI responses were converted to T-scores using a hand-scoring method. This method of scoring weights items based on their eigenvalue in a factor analysis by the author (Bell, 1991). Some items, when endorsed in a pathological
direction, may load on more than one of the BORRTI subscales. The weighted item
scores are summed to form raw subscale scores, and these subscale scores are then
converted to T-scores for each subscale. There is a newer computerized scoring method
available, which produces a full interpretive report for each test-taker, including scores on
each subscale and their implications for pathology and treatment. This method utilizes
over 800 calculations and weights each item in accordance with population norms.
However, this method of scoring is also highly cost-prohibitive and impractical for
research applications. Bell (1991) reports high correlations between the two scoring
methods (r’s range from .94 to .98). In the present study, T-scores from the four object
relations subscales of the BORRTI were summed to create a composite score
representing quality of object relations (higher composite scores = poorer QOR).

Revised Adult Attachment Scale (AAS). The theoretical foundation for the AAS
(Collins & Read, 1990) was drawn directly from Ainsworth’s tripartite conception of
attachment (Ainsworth, Blehar, Waters, & Wall, 1978), and partially based on Hazan and
Shaver’s (1987) adult attachment descriptions. The AAS consists of 18 items, scored by
the participant on a 5-point Likert scale ranging from “not at all characteristic of me” to
“very characteristic of me.” An original pool of 21 items were factor analyzed, yielding
three attachment factors: Depend, Close, and Anxiety. Depend refers to the extent one
trusts and relies on others. Close refers to comfort with intimacy and emotional
closeness. Anxiety refers to fears of abandonment. After discarding 3 items that did not
load well on any of the three factors, the authors were left with 18 items, 6 on each
subscale, with subscale scores ranging from 6 to 30. Collins and Read (1990) report that
for 400 undergraduates, the totals and standard deviations for the Depend, Anxiety, and Close subscales were 18.3 (SD = 4.7), 16.2 (SD = 5.1), and 21.2 (SD = 4.8), respectively. Cluster analysis confirmed a three-factor solution for the AAS. The present study utilizes an updated form of the AAS (Revised AAS; Collins, 1996), in which items were reordered and some were slightly reworded.

Collins and Read (1990) found that test-retest reliability (2-month interval) was .68 for Close, .71 for Depend, and .52 for Anxiety. They also report that internal consistency coefficient alphas were above .58, whereas Sperling, Foelsch, and Grace (1996) report AAS internal consistency coefficient alphas between .71 and .80. The latter authors report excellent convergent validity of the AAS with the Attachment Style Measure (ASM; Simpson, 1990), and adequate convergent validity with four other measures of attachment (Hazan-Shaver Attachment Self Report, Attachment Style Inventory, Reciprocal Attachment Questionnaire, and Anxious Romantic Attachment Scale). Collins and Read (1990) found the AAS subscales to correspond closely to the attachment categories utilized by Hazan and Shaver’s (1987) measure. They also found convergence of the AAS with measures assessing working models of the self, working models of the social world, working models of love, and attachment history, further validating the framework of the AAS. Lyddon and Satterfield (1994) measured attachment style in a clinical population using the AAS and found that clients’ security of attachment was related to therapists’ assessment of severity. The authors concluded that the AAS is a viable measure for assessing adult attachment in clinical practice.
It is important to note that the AAS subscales are *not* considered categorical attachment styles, but rather dimensions that relate to adult attachment. This represents an innovative approach to adult attachment, which breaks away from the traditional categorical conceptualization. However, cluster analysis can be used to produce the attachment styles secure, avoidant, and preoccupied (Collins, 1996). AAS scores can also be used to categorize test-takers into Bartholomew’s (1990) attachment styles of secure, preoccupied, fearful, and dismissive (N. L. Collins, personal communication, January 13, 2004).

Based on the AAS system, Collins and Read (1990) describe a securely attached person as comfortable with closeness, able to depend on others, and not worried about being abandoned or unloved. Thus, secure attachment in the AAS system is described by relatively high Close and Depend subscale scores and relatively low Anxiety scores. Allen, Huntoon, and Evans (1999) derived a measure of security of attachment from Close and Depend, minus Anxiety. Following this model, the present study derives a single dimension, security of attachment, by summing Close and Depend and subtracting Anxiety. Although reliability for this summed score is not available, the reliability data available concerning the individual subscales (reported above) provide overall support for the use of this measure.

*Procedures*

An invitation to participate in the present study was placed within the standard intake paperwork for new clients at each counseling center, and it was attached to a sealed packet of initial measures (see Appendix A for invitation to participate). The
invitation to participate explains the purpose of the study, its procedures, and
requirements.

If a new client chose to participate, he or she was instructed to open the sealed
packet to find consent forms (see Appendix B) and a questionnaire packet (see Appendix
C) containing a demographic information form, the Revised Adult Attachment Scale, the
Bell Object Relations Inventory, and the Interpersonal Adjective Scales-Revised. Also
included in the packet was a copy of the Working Alliance Inventory (see Appendix D),
which they were instructed to retain and complete after their first session. Once they
completed the consent form and questionnaire packet, participants returned all materials
to the receptionist with their intake paperwork, retaining the WAI for after their first
session. Upon completion and return (to the receptionist) of the session one WAI,
participants were given a sealed envelope containing $5.00 and instructions for
continuing participation.

Session two WAI s were placed in clients’ therapy charts, and therapists were
asked to hand these to the client after their second session, to be completed immediately
after the session in the waiting room. The same procedure was employed for session
three. Clients returned completed WAI s to the receptionist, and upon returning their third
(and final) WAI, they were given another sealed envelope containing an additional $5.00
compensation for their time, along with instructions for receiving information about the
results of the present research, if they so desired.

All materials, with the exception of the consent forms, were labeled only with the
participant’s identification number. They were returned to the agency receptionist, and
subsequently collected by the principal investigator. Consent forms were kept in a separate, locked location so that identification numbers could not be connected with identifying information.

Results

Results of the present study are presented in three parts. First, data entry and scoring procedures are briefly described. Then, descriptive information about each of the measures is summarized, including means, standard deviations, and scale and subscale intercorrelations. The third section summarizes the results of various tests of the present study’s hypotheses. Finally, a number of post-hoc analyses are presented.

Plan of Analysis

All data from all measures were entered by hand into SPSS for Windows, a computerized statistical analysis package. Measures were scored by creating formulas within SPSS based on standard scoring procedures for each measure. For example, the BORRTI was scored by entering responses, computing weighted variables within SPSS based on hand-scoring templates provided by the test manufacturer, summing these variables for each subscale, and then converting raw scores to T-scores within SPSS based on materials provided by the test manufacturer. In this way, all data entry, scoring, and analysis could be managed within a single program, SPSS.

The WAI, which served as a criterion measure in the present study, exhibited ceiling effects: responses were restricted to the upper range of the measure’s scale (see Tables 4 and 5). This is problematic because without a full range of responses, fluctuations are more difficult to detect and therefore correlations may be artificially low.
In an effort to counteract this problem, WAI scores were standardized (converted to Z-scores) by subtracting subscale and total scores from the sample means, and dividing by the sample standard deviations. This procedure was repeated for each session. All hypotheses were tested using the standardized WAI scores.

Final predictor variables used in the present analysis include security of attachment (AAS Close plus Depend, minus Anxiety), QOR (sum of BORRTI subscale T-scores), interpersonal dominance (DOM derived from IAS-R octant scores), and interpersonal affiliation (LOV derived from IAS-R octant scores). Correlation matrices were produced for all measures and their subscales. The four predictor variables were also entered into a linear regression, with total standardized WAI at session one being the criterion variable. Zero-order and partial correlations were computed to determine each predictor’s relative and unique contribution to the alliance.

Since WAI data were also available from sessions two and three, change in alliance over time was computed using residualized gain scores (unstandardized) and entered into a separate regression analysis as the criterion variable, with the same four predictor variables from above. This analysis focused on the changes in alliance across time that could be predicted from security of attachment, QOR, dominance, and affiliation. Since fewer participants returned all three usable WAIs, only 26 participants are included in this analysis. An alpha level of .05 was used for all statistical tests, which were one-tailed when hypotheses were specific to directionality, and two-tailed for exploratory tests.
Means and standard deviations for predictor measures and their subscales are presented in Table 3, followed by means and standard deviations for the dependent measure and its subscales at sessions one, two, and three in Table 4. As Table 3 shows, ratings on the Revised Adult Attachment Scale clustered around the midpoint of the scale. Ratings on the Bell Object Relations and Reality Testing Inventory yielded T-scores roughly half of a standard deviation above the normative non-patient means. Interpersonal Adjective Scales-Revised dominance and nurturance scores indicate that on average, the present sample tended slightly towards submissiveness and nurturance as general interpersonal qualities. However, variance within each IAS-R dimension was greater than either dimension’s departure from normal population means.

As Table 4 shows, Working Alliance Inventory ratings indicate that in general, participants indicated feelings of attachment and intimacy (bond) with the therapist, agreement on the goals of therapy, and agreement on the tasks of therapy, in the “often” to “very often” range. A repeated measures (across sessions) analysis of variance (ANOVA) was conducted using unstandardized WAI scores in order to detect increases in the alliance over time. It was found that total alliance significantly increased across the three sessions, \( F(2, 54) = 8.077, p = .003 \).

In order to show the degree to which self-report responses in the present sample were comparable with those found in previous research, means found in the present sample are compared with means from published studies in Table 5. Adult Attachment Scale subscale means from the present study are shown next to those found by Collins.
Table 3
Means and Standard Deviations For Predictor Variables and Their Subscales

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AAS (n = 48)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close</td>
<td>3.48</td>
<td>.86</td>
</tr>
<tr>
<td>Depend</td>
<td>2.96</td>
<td>.78</td>
</tr>
<tr>
<td>Anxiety</td>
<td>3.05</td>
<td>.94</td>
</tr>
<tr>
<td>Security of Attachment</td>
<td>3.39</td>
<td>2.11</td>
</tr>
<tr>
<td><strong>BORRTI (n = 48)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alienation</td>
<td>56.06</td>
<td>9.68</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>55.94</td>
<td>9.95</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>53.65</td>
<td>8.83</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>51.50</td>
<td>8.58</td>
</tr>
<tr>
<td>Total Score</td>
<td>217.15</td>
<td>30.60</td>
</tr>
<tr>
<td><strong>IAS (n = 45)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominance</td>
<td>-.57</td>
<td>1.30</td>
</tr>
<tr>
<td>Nurturance</td>
<td>.53</td>
<td>1.24</td>
</tr>
</tbody>
</table>

Note: AAS = Adult Attachment Scale, BORRTI = Bell Object Relations and Reality Testing Inventory, IAS = Interpersonal Adjective Scales.
Table 4

Means and Standard Deviations For Working Alliance Inventory and Subscales At All Sessions

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Session One</th>
<th>Session Two</th>
<th>Session Three</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 43)</td>
<td>(n = 33)</td>
<td>(n = 29)</td>
</tr>
<tr>
<td>Bond</td>
<td>68.92 (9.64)</td>
<td>72.03 (11.24)</td>
<td>73.62 (6.82)</td>
</tr>
<tr>
<td>Task</td>
<td>71.64 (10.43)</td>
<td>73.85 (9.96)</td>
<td>75.90 (8.44)</td>
</tr>
<tr>
<td>Goal</td>
<td>68.23 (12.07)</td>
<td>71.18 (11.44)</td>
<td>74.28 (9.44)</td>
</tr>
<tr>
<td>Total</td>
<td>208.79 (30.34)</td>
<td>217.06 (31.09)</td>
<td>223.79 (22.39)</td>
</tr>
</tbody>
</table>
Table 5
Subscale Means in Present Study Versus Published Studies

<table>
<thead>
<tr>
<th>Sample</th>
<th>Present Sample</th>
<th>Published</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAS</td>
<td>(n = 48)</td>
<td>(n = 400)</td>
</tr>
<tr>
<td>Close</td>
<td>3.48</td>
<td>3.53</td>
</tr>
<tr>
<td>Depend</td>
<td>2.96</td>
<td>3.05</td>
</tr>
<tr>
<td>Anxiety</td>
<td>3.05</td>
<td>2.70</td>
</tr>
<tr>
<td>BORRTI</td>
<td>(n = 48)</td>
<td>(n = 145)</td>
</tr>
<tr>
<td>Alienation</td>
<td>56.06</td>
<td>53</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>55.94</td>
<td>51</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>53.65</td>
<td>51</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>51.50</td>
<td>51</td>
</tr>
<tr>
<td>IAS</td>
<td>(n = 45)</td>
<td>(n = 941)</td>
</tr>
<tr>
<td>DOM</td>
<td>-.57</td>
<td>.14</td>
</tr>
<tr>
<td>LOV</td>
<td>.53</td>
<td>-.16</td>
</tr>
<tr>
<td>WAI (session three)</td>
<td>(n = 29)</td>
<td>(n = 54)</td>
</tr>
<tr>
<td>Goals</td>
<td>6.19</td>
<td>5.80</td>
</tr>
<tr>
<td>Tasks</td>
<td>6.33</td>
<td>5.92</td>
</tr>
<tr>
<td>Bond</td>
<td>6.14</td>
<td>5.94</td>
</tr>
</tbody>
</table>

Note: AAS = Adult Attachment Scale; BORRTI = Bell Object Relations and Reality Testing Inventory; IAS = Interpersonal Adjective Scales-Revised; WAI = Working Alliance Inventory.
and Read (1990) in a sample of 400 undergraduates. As the table shows, the present sample appears to have provided very similar AAS ratings to the larger published sample. BORRTI T-score means are compared with a sample of 145 undergraduates (Bell, 1991). Again, the mean T-score for each subscale corresponds closely to that found in the literature. Interpersonal Adjective Scales-Revised ratings are compared to values reported by Trapnell and Wiggins (1990) for 941 undergraduates. Participants in the present sample were less dominant and more nurturing than those in a much larger sample of undergraduates. This may be evidence of social desirability bias in present sample IAS-R ratings. However, it should be noted that there was considerable variability within both of these dimensions in the present sample (see Table 3).

Means and standard deviations for the Working Alliance Inventory are seldom reported in the literature, neither by the authors of the measure nor by subsequent researchers. However, one recent study was located (Busseri & Tyler, 2003) in which a sample of 54 individual psychotherapy clients at two university-based counseling centers were administered the WAI, much like in the present study. These authors found that at session four, the average WAI item rating was 5.89. This is a very similar item rating mean to the one found at session one in the present study, 5.80. However, session one responses and session four responses may not be adequately comparable. Therefore, Table 5 compares mean WAI item responses from session three in the present study to those reported by Busseri and Tyler (2003). As the table shows, mean responses in the present study were somewhat higher than those reported in the literature. This is
evidence of the ceiling effect in the present study’s WAI data, possibly resulting from response bias.

As Table 6 shows, there were strong correlations among most of the predictor variables, particularly between security of attachment, quality of object relations, and interpersonal dominance. This indicates some degree of collinearity between predictor variables. Regarding subscale correlations within measures, Table 7 shows that each of the AAS subscales was significantly related to each other, and most of the BORRTI subscales were significantly related to each other. IAS-R DOM and LOV were not found to be significantly correlated. Regarding subscale correlations between measures, Table 7 shows that a number of subscales were significantly correlated with subscales of other predictor measures. Particularly notable are the AAS subscale Close and the BORRTI subscale Alienation, which are each significantly correlated with every subscale of every predictor measure.

_Hypothesized Relationships_

The following are tests of the present study’s hypotheses. Since direction of relationship (positive, negative) was specified in Hypotheses I through IV, 1-tailed tests of significance were used for these hypotheses. Standardized WAI scores were used for all hypothesis testing.

Hypothesis I, that interpersonal affiliation would be positively related to the alliance at session one, was not supported, \( r = .176, p = .139, n = 40 \). Hypothesis II, that interpersonal dominance would be negatively related to the alliance, also was not supported, \( r = .196, p = .113, n = 40 \).
Table 6

Correlation Matrix of Predictor Variables

<table>
<thead>
<tr>
<th></th>
<th>Security</th>
<th>QOR</th>
<th>DOM</th>
<th>LOV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment Security</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>QOR</td>
<td>-</td>
<td>-.632***</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dominance (DOM)</td>
<td>.446**</td>
<td>-.632***</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Nurturance (LOV)</td>
<td>.266</td>
<td>-.269</td>
<td>.022</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: Security = security of attachment, QOR = quality of object relations, DOM = interpersonal dominance, LOV = interpersonal nurturance

**p<.01, ***p<.001 (2-tailed); n = 48
Table 7

Correlation Matrix of Predictor Variables’ Subscales

<table>
<thead>
<tr>
<th></th>
<th>Dep</th>
<th>Anx</th>
<th>AN</th>
<th>IA</th>
<th>EG</th>
<th>SI</th>
<th>DOM</th>
<th>LOV</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAS Close</td>
<td>.612***</td>
<td>- .416**</td>
<td>-.655***</td>
<td>-.407**</td>
<td>-.415**</td>
<td>-.374**</td>
<td>.379*</td>
<td>.421**</td>
</tr>
<tr>
<td>AAS Dep</td>
<td></td>
<td>- - .484***</td>
<td>-.627***</td>
<td>-.341*</td>
<td>-.412**</td>
<td>-.127</td>
<td>-.385**</td>
<td>.137</td>
</tr>
<tr>
<td>AAS Anx</td>
<td></td>
<td></td>
<td>.488***</td>
<td>.587***</td>
<td>.416**</td>
<td>.179</td>
<td>-.334*</td>
<td>-.095</td>
</tr>
<tr>
<td>BORI AN</td>
<td></td>
<td></td>
<td></td>
<td>.720***</td>
<td>.712***</td>
<td>.513***</td>
<td>-.586***</td>
<td>-.312*</td>
</tr>
<tr>
<td>BORI IA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.694***</td>
<td>.453**</td>
<td>-.444**</td>
<td>-.151</td>
</tr>
<tr>
<td>BORI EG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.313*</td>
<td>-.488**</td>
<td>-.206</td>
</tr>
<tr>
<td>BORI SI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.601***</td>
<td>-.232</td>
</tr>
<tr>
<td>IAS DOM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.022</td>
</tr>
<tr>
<td>IAS LOV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: AAS = Adult Attachment Scale, BORI = Bell Object Relations and Reality Testing Inventory, IAS = Interpersonal Adjective Scales, Dep = Depend, Anx = Anxiety, AN = Alienation, IA = Insecure Attachment, EG = Egocentricity, SI = Social Incompetence, DOM = interpersonal dominance, LOV = interpersonal nurturance.
*p<.05, **p<.01, ***p<.001 (2-tailed); n = 48
Hypothesis III, that quality of object relations would be positively related to the alliance at session one (signified by a negative relationship since the BORRTI is reverse-scored), was supported, \( r = -0.256, p = 0.049, n = 43 \). Hypothesis IV was that security of attachment would be positively related to the alliance at session one. This hypothesis was supported, \( r = 0.393, p = 0.005, n = 43 \).

Hypothesis V was that each of the four predictor variables (security of attachment, quality of object relations, dominance, and affiliation) would contribute a significant amount of unique variance accounted for in the alliance, as represented by significant partial correlations for all predictors. This hypothesis was not supported: with all four predictors in the model, there was not significant variance accounted for in the alliance, \( R^2 = 0.144, F(4, 39) = 1.47, p = 0.233 \). This lack of significance may be due to evidence of collinearity among the predictor variables, as evidenced by the fact that several zero-order correlations were significant, but the combined R was too small to reach significance.

Since alliance was also measured at sessions two and three, correlations between the predictor variables and the alliance at sessions two and three are provided in Tables 8 and 9. As Table 9 shows, the only predictor variable significantly correlated with the alliance at session two was security of attachment, \( r = 0.375, p = 0.03, n = 33 \). The strength of this relationship is cut in half by session three as shown in Table 10, so that none of the predictors is associated with any component of the alliance at session three.
Table 8
Correlations of Predictor Variables With Standardized Session 1 Therapeutic Alliance Scores

<table>
<thead>
<tr>
<th>Predictor</th>
<th>WAI Bond</th>
<th>WAI Task</th>
<th>WAI Goal</th>
<th>WAI Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AAS (n = 43)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close</td>
<td>.300</td>
<td>.330*</td>
<td>.361**</td>
<td>.353*</td>
</tr>
<tr>
<td>Depend</td>
<td>.238</td>
<td>.342*</td>
<td>.289*</td>
<td>.308*</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.198</td>
<td>-.300*</td>
<td>-.266*</td>
<td>-.272*</td>
</tr>
<tr>
<td>Security</td>
<td>.310*</td>
<td>.409**</td>
<td>.387**</td>
<td>.393**</td>
</tr>
<tr>
<td><strong>BORRTI (n = 43)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alienation</td>
<td>-.296*</td>
<td>-.367**</td>
<td>-.293*</td>
<td>-.337*</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>-.162</td>
<td>-.186</td>
<td>-.195</td>
<td>-.193</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>-.019</td>
<td>-.059</td>
<td>-.014</td>
<td>-.032</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>-.292*</td>
<td>-.224</td>
<td>-.214</td>
<td>-.255*</td>
</tr>
<tr>
<td>QOR</td>
<td>-.239</td>
<td>-.261*</td>
<td>-.225</td>
<td>-.256*</td>
</tr>
<tr>
<td><strong>IAS (n = 40)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominance</td>
<td>.245</td>
<td>.150</td>
<td>.166</td>
<td>.196</td>
</tr>
<tr>
<td>Nurturance</td>
<td>.177</td>
<td>.228</td>
<td>.106</td>
<td>.176</td>
</tr>
</tbody>
</table>

Note: Bolded values indicate hypothesized relationships. WAI = Working Alliance Inventory, AAS = Adult Attachment Scale, BORRTI = Bell Object Relations and Reality Testing Inventory, IAS = Interpersonal Adjective Scales. *p<.05, **p<.01 (1-tailed)
Table 9

Correlations of Predictor Variables With Standardized Session 2 Therapeutic Alliance Scores

<table>
<thead>
<tr>
<th>Predictor</th>
<th>WAI Bond</th>
<th>WAI Task</th>
<th>WAI Goal</th>
<th>WAI Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AAS (n = 33)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close</td>
<td>.285</td>
<td>.277</td>
<td>.281</td>
<td>.295*</td>
</tr>
<tr>
<td>Depend</td>
<td>.129</td>
<td>.269</td>
<td>.275</td>
<td>.234</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.308*</td>
<td>-.301*</td>
<td>-.321*</td>
<td>-.326*</td>
</tr>
<tr>
<td>Security</td>
<td>.321*</td>
<td>.369*</td>
<td>.382*</td>
<td>.375*</td>
</tr>
<tr>
<td><strong>BORRTI (n = 33)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alienation</td>
<td>-.212</td>
<td>-.250</td>
<td>-.238</td>
<td>-.244</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>-.178</td>
<td>-.129</td>
<td>-.180</td>
<td>-.172</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>-.020</td>
<td>-.002</td>
<td>-.023</td>
<td>-.015</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>-.137</td>
<td>-.072</td>
<td>-.019</td>
<td>-.066</td>
</tr>
<tr>
<td>QOR</td>
<td>-.172</td>
<td>-.143</td>
<td>-.139</td>
<td>-.159</td>
</tr>
<tr>
<td><strong>IAS (n = 31)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominance</td>
<td>.065</td>
<td>-.047</td>
<td>-.034</td>
<td>-.003</td>
</tr>
<tr>
<td>Nurturance</td>
<td>.019</td>
<td>.066</td>
<td>-.066</td>
<td>.004</td>
</tr>
</tbody>
</table>

Note: WAI = Working Alliance Inventory, AAS = Adult Attachment Scale, BORRTI = Bell Object Relations and Reality Testing Inventory, IAS = Interpersonal Adjective Scales. *p<.05 (1-tailed)
Table 10

Correlations of Predictor Variables With Standardized Session 3 Therapeutic Alliance Scores

<table>
<thead>
<tr>
<th>Predictor</th>
<th>WAI Bond</th>
<th>WAI Task</th>
<th>WAI Goal</th>
<th>WAI Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAS (n = 29)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close</td>
<td>-.135</td>
<td>-.087</td>
<td>.077</td>
<td>-.041</td>
</tr>
<tr>
<td>Depend</td>
<td>-.055</td>
<td>.222</td>
<td>.325*</td>
<td>.204</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.305</td>
<td>-.227</td>
<td>-.198</td>
<td>-.262</td>
</tr>
<tr>
<td>Security</td>
<td>.059</td>
<td>.156</td>
<td>.258</td>
<td>.186</td>
</tr>
<tr>
<td>BORRTI (n = 29)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alienation</td>
<td>-.075</td>
<td>-.158</td>
<td>-.219</td>
<td>-.174</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>-.149</td>
<td>-.073</td>
<td>-.135</td>
<td>-.129</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>-.074</td>
<td>-.040</td>
<td>-.032</td>
<td>-.006</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>-.107</td>
<td>-.081</td>
<td>-.140</td>
<td>-.122</td>
</tr>
<tr>
<td>QOR</td>
<td>-.124</td>
<td>-.084</td>
<td>-.143</td>
<td>-.130</td>
</tr>
<tr>
<td>IAS (n = 28)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominance</td>
<td>-.127</td>
<td>-.123</td>
<td>-.009</td>
<td>-.091</td>
</tr>
<tr>
<td>Nurturance</td>
<td>.195</td>
<td>-.044</td>
<td>.013</td>
<td>.048</td>
</tr>
</tbody>
</table>

Note: WAI = Working Alliance Inventory, AAS = Adult Attachment Scale, BORRTI = Bell Object Relations and Reality Testing Inventory, IAS = Interpersonal Adjective Scales. * p<.05 (1-tailed)
Post-Hoc Analyses

Because in the present analysis alliance was found to increase over time, a post-hoc analysis was performed to see if any of the predictor variables accounted for significant amounts of variance in change in alliance over time. Change in alliance was calculated from unstandardized WAI responses using residualized gain scores from session one to session three. This regression analysis found that the four predictors did not account for significant amounts of variance in alliance change over time, $R^2 = .113$, $F(4, 39) = .732$, $p = .58$.

There are several other post-hoc analyses that will be explained further in the Discussion section. First, the BORRTI subscale Egocentricity was removed from total QOR scores, and a correlation was computed between this modified QOR score and alliance at session one. This relationship was significant, $r = -.315$, $p = .04$, $n = 43$.

Second, a correlation was computed between unmodified QOR and patients’ stated level of distress at intake. This relationship was significant, $r = .301$, $p < .05$, $n = 43$. A correlation was computed between level of distress and alliance at session one, and this relationship was not significant, $r = -.158$, $p = .04$, $n = 43$.

A separate regression analysis was also run to predict alliance from security of attachment, dominance, and nurturance only. In the absence of QOR, security of attachment, dominance, and nurturance remained unable to account for significant amounts of variance in the alliance, $R^2 = .144$, $F(3, 40) = 2.01$, $p = .13$.

Several interaction terms were computed post-hoc. QOR and security of attachment were multiplied together to create an interaction term, and a significant
relationship was found between this interaction and the alliance, \( r = .362, p = .02, n = 43 \).

An interaction term was computed for security of attachment by interpersonal dominance, and this interaction was not significantly related to the alliance, \( r = .094, p = .57, n = 40 \).

A final QOR by interpersonal dominance interaction term was computed, and was not significantly related to the alliance, \( r = .205, p = .21, n = 40 \).

The final post-hoc analysis was a principal components analysis of the predictor measure subscales. Using no rotation method, three factors were extracted with eigenvalues greater than 1.0. The first accounted for 55.30% of the total variance, the second accounted for an additional 12.79% of variance, and the third accounted for 9.93% of variance. Subscales loading on the first factor include all subscales of the AAS and BORRTI as well as IAS DOM. Subscales loading most strongly on the second component include AAS Depend and BORRTI Social Incompetence. The only subscale to load strongly on the third factor was IAS LOV. These factors will be discussed more fully in the Discussion section.

Factor one was significantly correlated with total alliance at session 1, \( r = .330, p = .04, n = 43 \), as well as level of distress, \( r = .297, p = .05, n = 43 \).

Discussion

The main purpose of the present study was to determine if certain aspects of client interpersonal functioning could predict clients’ early impressions of the therapeutic alliance, and to determine the extent to which these aspects of interpersonal functioning overlap in their ability to predict the early alliance. Forty-eight psychotherapy clients completed self-report inventories of the alliance and interpersonal functioning. Security of attachment and quality of object relations (QOR) were significantly correlated with
alliance at session one; however, interpersonal dominance and interpersonal nurturance were not related to initial impressions of the alliance. The relationship between security of attachment and early alliance suggests an attachment component to clients’ initial impressions of the alliance, consistent with the ideas of previous authors (Mallinckrodt, 1991; Pistole, 1989). The inability of interpersonal style to predict early alliance suggests that initial alliance may be resilient to certain deficits in interpersonal functioning.

Overview of Findings

The present study had several hypotheses regarding the strength of the therapeutic alliance at session one. First, it was hypothesized that patient interpersonal affiliation would be positively related to quality of the initial alliance, such that greater amounts of affiliation would be associated with stronger alliances, and less affiliation would be related to worse alliances. No such relationship was found in the present analysis. Although interpersonal affiliation was related to comfort with intimacy and emotional closeness (AAS Close), it did not predict strength of the alliance. This was surprising given that there is evidence in the literature that such a relationship may exist (Connolly Gibbons et al., 2003; Muran et al., 1994; Paivio & Bahr, 1998; Samstag et al., 1998; Schauenburg et al., 2000). However, as noted above, many of these studies provide indirect evidence of such a relationship, and the use of the circumplex model to link patient interpersonal style and the alliance is still a relatively new development in the literature. It is possible that such a relationship existed within the present sample, but that there was not sufficient statistical power to detect it. Another statistical reason may
be that there was a large amount of variability in trait-level nurturance, while alliance was narrowly distributed at the upper end of its scale.

Second, it was hypothesized that interpersonal dominance would be inversely related to the alliance, such that more dominant clients would have poorer alliances, and less dominance would be associated with stronger alliances, and it was further hypothesized that this effect would be significant but moderate. Such a relationship was not found, and in fact greater levels of dominance were related to more adaptive interpersonal functioning in the areas of attachment security and quality of object relations. Given the fact that prior research has yielded mixed findings regarding interpersonal dominance and the alliance, it is hardly surprising that support for such a relationship was not garnered in the present study. Nevertheless, the present findings suggest that trait-level interpersonal dominance may be indicative of better interpersonal functioning in other areas (attachment and object relations).

The third hypothesis of the present study was that better quality of object relations would be associated with stronger alliance. This hypothesis was supported, consistent with evidence in the literature that such a relationship exists (Mallinckrodt, Porter, & Kivlighan, 2005; Joyce and Piper, 1998; Piper et al., 1991). Piper et al. (1991) found a correlation coefficient of QOR with alliance of $r = .29$, which is very similar to the level of relationship found in the present study ($r = .256$). It should be noted that studies by Joyce and Piper (1998) and Piper et al. (1991) utilized an interview method for measuring QOR and a laboratory-created measure of the alliance, yet found similar relationships to those in the present study. However, Mallinckrodt, Porter, and Kivlighan
(2005) used the same measures as those used in the present study, and found negative correlations between agreement on tasks and BORRTI Social Incompetence and BORRTI Insecure Attachment. No such relationships were found in the present study; however, a number of other relationships were found between facets of QOR and alliance. One particularly strong relationship was between alienation and early alliance. Alienation, as measured on the BORRTI, refers to a client’s ability to establish trust, closeness, and intimacy in relationships. It is not surprising that clients who were lacking in this area had poorer agreement on tasks and goals and poorer emotional bonds with their therapists at their first session.

The fourth hypothesis of the present study was that clients with more secure attachment would have stronger initial alliances, while less securely attached clients would experience poorer initial alliances. This hypothesis was supported: security of attachment was related to each component of the initial alliance as well as total scores at session one. As discussed above, security of attachment in the AAS system is attained when one is comfortable with closeness (Close), able to depend on others (Depend), and not overly worried about being abandoned or unloved (Anxiety). Analysis of these subscales provides a fuller understanding of how security of attachment relates to the alliance.

Comfort with intimacy and closeness, when isolated from other components of attachment, was significantly related to every component of the alliance at session one. This makes sense from a substantive standpoint: the more comfortable a client was with intimacy and closeness in general, the more likely that client was to agree with their
therapist and feel a sense of bond with him or her. This indicates that a strong initial connection between therapist and client partially rests on the client’s capacity for such intimacy. Ability to trust and rely on others, when isolated from other aspects of attachment, was related more specifically to agreement on the tasks of therapy. This, too makes sense from a substantive standpoint: clients who were more able to look to another for guidance and nurturance were more likely to feel that what their therapist was doing with them in their first session was positive and therapeutic. Both measures tap into a general sense of confidence clients had in the therapist’s guidance. When worries about abandonment and rejection are removed from these other aspects of attachment, it is hardly surprising that the relationship between attachment and the initial alliance is strengthened: what remains is a sense of confidence, intimacy, and trust regarding close others such as a therapist. Such qualities practically define strong alliances.

The significant relationship between security of attachment and strength of initial alliance found in the present study adds to the “confluence of data suggesting that the quality of the alliance, as reported by the client in the early phases of therapy, is impacted by the quality of the attachment style” (Horvath, 2001, p. 368). Specifically, Kivlighan, Patton, and Foote (1998) found correlations between the alliance and the AAS subscales Close and Depend that were of nearly identical value to those found in the present study. These authors found no relationship between Anxiety and the alliance, a finding not replicated in the present study. They did not calculate security of attachment. Similarly, Satterfield and Lyddon (1995) found a relationship between AAS Depend and the alliance of nearly identical value to that found in the present study, and found no
relationship between AAS Anxiety and alliance, unlike in the present study. These authors found no relationship between AAS Close and the alliance, a finding that differs from the results of the present study and those of Kivlighan, Patton, and Foote (1998). Again, these authors did not calculate a security of attachment dimension.

Eames and Roth (2000) found relationships between secure attachment (as measured using the Relationship Scales Questionnaire) and therapist-rated WAI bond and global alliance at session five. Fearful attachment was negatively related to patient-rated bond, tasks, and goals at session five as well as tasks at session three. Thus, more secure attachment was related to stronger alliances, and less secure attachment was related to weaker alliances. The findings of the present study with regard to security of attachment and strength of initial alliance are consistent with findings in the literature.

One curious finding with regard to security of attachment and alliance was the drastic reduction in the relationship between these two variables at session three (compare Tables 8 and 9). One might argue that this reduction could be attributed to attrition and the consequent loss of power. However, the greatest reduction in sample size occurred between sessions one and two (43 to 33), and this drop was not accompanied by a notable decrease in the relationship between attachment and alliance. Only four participants were lost between sessions two and three; therefore, loss of power is not a viable explanation for this substantial drop in correlation. As discussed below, this may be a reflection of the changing nature of the alliance as it moves past initial impressions into a more reality-based relationship.
The fifth and final hypothesis of the present study pertained to the degree to which security of attachment, QOR, interpersonal dominance, and interpersonal nurturance made overlapping predictions with regard to the alliance. Given the theoretical relationships between each of these constructs, it was believed that to some degree, they would make similar predictions about the quality of the alliance. However, it was hypothesized that the constructs measured by these predictors were unique enough that even when one removes the areas in which they overlap, each would retain a significant amount of power to predict the quality of the alliance. In other words, it was hypothesized that each predictor would be able to account for variations in the alliance above and beyond their shared ability to do so. This hypothesis was not supported in the present study. Results of the regression analysis showed that when all four predictor variables were included together, they could not adequately predict variations in the alliance, neither together nor individually.

Collinearity

The regression analysis in the present study did not yield significant results, possibly due to collinearity among the predictors and weak associations of QOR and interpersonal style with the alliance. Collinearity occurs when predictor variables are so strongly correlated with each other that minor fluctuations in the sample such as measurement error and sampling error have inflated impact upon predictors’ beta weights. This makes regression coefficients much more difficult to estimate, and as a result there is a loss of power. Put simply, collinearity indicates redundancy or overlap
between the predictor variables. Evidence of this redundancy is present in the strength of
correlations between the predictor variables (see Table 5).

Security of attachment and (to a lesser extent) QOR were related to the alliance at
a zero-order level, but interpersonal dominance and affiliation were not. However, when
these predictors were entered into a regression model together, the combined R was not
large enough to reach statistical significance. The predictor that was most strongly
correlated with other predictors is QOR. As a means of investigating the extent to which
QOR was responsible for the collinearity, the linear regression was re-run without QOR
(see Post-Hoc Analyses). The regression analysis remained nonsignificant; thus,
collinearity remains an issue even when the most redundant variable, QOR, is removed.
This renders the relationship between security of attachment and early alliance tenuous,
though it is very predictive of initial impressions of the alliance in isolation.

Conceptually, the presence of collinearity has applicability to the question of
distinctness between attachment and object relations. As operationalized in the present
study, security of attachment and quality of object relations appear to be highly related
constructs. It is informative to consider what the subscales of the AAS and BORRTI are
designed to measure: themes such as trust, reliance, intimacy, and fear of rejection are
evident in both measures. When one considers the theoretical backgrounds of attachment
and object relations, such themes are indeed predominant in both theories.

Attachment and Object Relations

At a basic level, both attachment and object relations focus upon separation or
loss and how individuals withstand or tolerate it. Put another way, both theories focus
upon the development of a certain emotional object constancy during childhood. The individual in early life is charged with the task of individuating or differentiating the self, while simultaneously developing trust and reliance on others (even in the face of failures or absences on the part of these close others). In object relational terms, a psychic structure of the self is etched out and differentiated from others, and inconsistencies in the self and in others are regarded with increasing levels of acceptance and toleration as object relations mature. In attachment terms, the individual begins to differentiate by literally venturing away from others, and greater security is achieved as the absence of others is met with less and less distress. The thrust of each of these theorized processes is towards trust, reliance, and confidence. Interruptions or hindrances to the process result in fear, mistrust, and lack of closeness or intimacy. Whether one focuses upon psychic structures or behaviors, the processes described by each of these theories are guided by the same basic themes.

Considering these themes as they arose in the present study, the capacity for trust in relationships was tapped by BORRTI Alienation and AAS Depend. Reliance on others was tapped by BORRTI Egocentricity and AAS Depend, and confidence in relationships was tapped by BORRTI Alienation and AAS Anxiety. Each of these pairs of subscales was found to be closely correlated. Similarly but in negative terms, fear of rejection was tapped by BORRTI Insecure Attachment and AAS Anxiety, basic mistrust of others was tapped by BORRTI Alienation and AAS Depend, and lack of closeness or intimacy was tapped by BORRTI Alienation and AAS Close. Each of these pairs of subscales was
highly correlated. Thus, the AAS and the BORRTI converged in their ability to assess these basic relational themes.

**Interpersonal Style and the Other Predictors**

One surprising finding in the present study is the convergence of interpersonal dominance with both security of attachment and QOR. In an attempt to better understand the role of interpersonal dominance in the present analysis, dominance by QOR and dominance by security of attachment interactions were investigated (see *Post-Hoc Analyses*). Interpersonal dominance did not interact with either of these other variables to predict the alliance. This means that although dominance was related to security of attachment and QOR, its lack of relationship with the alliance was unchanged by variations in security of attachment and quality of object relations. In other words, no further understanding of the relationship between alliance and interpersonal dominance can be gleaned from the other predictors.

The convergence of QOR and security of attachment with dominance, but not with nurturance, comes as somewhat of a surprise given the meaning of these dimensions in circumplex theory. Dominance refers to the social status consequences of dyadic interactions, whereas nurturance refers to the emotional consequences of such interactions (Wiggins, Trapnell, & Phillips, 1988). One would expect that nurturance would have more pertinence than dominance to the ability to attain interpersonal closeness and reliance without being overwhelmed by anxiety. Similarly, object relational functioning, which pertains to the complexity and flexibility with which one views others, seems more relevant to nurturance than to dominance. Nevertheless, some
tentative interpretations of the present study’s findings with regard to dominance are given.

It is possible that the relationship between dominance and security of attachment may represent the behavioral result of an emotional disposition. When one feels confident in one’s ability to attain closeness with others (with relatively little fear of rejection) one is “freed up” to act in a more assertive manner. This effect is evident in the positive correlation between AAS Close and IAS DOM, and the negative correlation between AAS Anxiety and IAS DOM (i.e., closeness and intimacy predicted assertiveness, while anxiety about rejection predicted submissiveness). Interestingly, AAS Depend is negatively, as opposed to positively, associated with IAS DOM. Thus, the extent to which participants trusted others and depended on their availability was related to participants’ interpersonal submissiveness. This highlights the relevance of the individuation process to interpersonal dominance. This tentative conceptualization of the present study’s findings regards interpersonal dominance as one behavioral indicator of the underlying individuation process that lies at the core of attachment security.

Following this same line of reasoning for QOR, those who rated themselves as highly assertive in the present sample were likely to have better quality of object relations. Bell (1995), in a discussion of the theoretical background of the BORRTI, refers to healthy object relations as “more complex, differentiated, and flexible” (p. 47). In this sense, as individuals are more able to recognize and integrate inconsistencies in others, differentiate the self from others, and adjust views of others based on new information, their object relational functioning can be said to move into the healthier
range. In the present study, individuals in this healthier range of object relations were also more likely to be interpersonally assertive. It is possible that one leads to the other: poorer object relational functioning encumbers individuals with abilities, doubts, and fears. Those unencumbered individuals who enjoy healthier object relational functioning are freer and more confident in interpersonal transactions, and this is evident in their assertiveness. In this interpretation of the present study’s findings, the internal state of healthier object relations is expressed in more dominant interpersonal transactions. However, it is again noted that these ideas represent a speculative attempt to understand how the present study’s findings run counter to the predictions of circumplex theory, and are tentative at best.

The Initial Therapeutic Alliance

The present findings suggest that interpersonal style is unable to predict the quality of the initial therapeutic alliance. While this finding runs contrary to the study’s hypotheses, it nevertheless provides important information about the nature of the alliance. Initial alliances were generally strong in the present sample regardless of clients’ interpersonal style. In other words, clients with highly varied interpersonal styles formed equally favorable initial impressions of the alliance. One might expect that certain interpersonal styles characterized by high levels of hostility would be less conducive to the establishment of a strong early alliance. The results of the present study suggest that this was not the case: interpersonally hostile individuals were equally likely to experience strong initial alliances as affiliative individuals. Given the importance of the alliance as a predictor of treatment outcome (Martin, Garske, & Davis, 2000), it is of
great consequence initial impressions of the alliance are not contingent upon a particular interpersonal style.

The relationship between security of attachment and early alliance has important theoretical implications for the therapeutic alliance construct. Bordin (1979) talks about the bond between therapist and patient in terms of trust and attachment, noting that agreement on goals and tasks is intimately linked to the strength of this “human relationship” between therapist and patient. There is some question as to the role of transference in this trust and attachment. Does the bond between therapist and client reflect a connection between two human beings as they relate to one another in the moment, independent of past experiences? Or do the patient’s early experiences in life establish interpersonal patterns and working models that at least in part influence every subsequent interpersonal transaction of the patient’s life, including (and especially) those between the patient and therapist?

This important consideration with regards to transference in the alliance dates back to Freud, whose most oft-cited view of the alliance is one of “unobjectionable positive transference”: transference on the part of the patient that should not be analyzed, but rather used as a vehicle for therapeutic progress (Freud, 1913/1958). Divergent lines of theory sprung from Freud’s ideas about the alliance, including a more transferential view of the alliance held by object relations theorists, and a real-relationship view of the alliance held by ego psychologists (for a review of these theoretical developments, see Safran & Muran, 2000). A notable attempt to merge the two notions was made by Greenson (1971), who recognized the separate yet interrelated notions of the transference
configuration and the real relationship. Zetzel (1966) argued that the patient’s capacity to form trusting and stable relationships, developed in early childhood, is a key factor in the development of an alliance. This capacity is analogous to the construct measured in the present study as security of attachment. Thus, the present study’s findings support this aspect of Zetzel’s (1966) conceptualization of the alliance.

A more explicit connection between security of attachment and the alliance may be found in the work of Pistole (1989) and Mallinckrodt (1991), who conceptualize the therapist as an attachment figure and the alliance as an attachment bond. In this view, the therapist fulfills the functions of security and sensitivity that were initially sought from the primary caregiver. Arrests in the development of a sense of the caregiver as a “secure base” for exploration are worked through as the therapist takes on this role. The therapist, more so than other attachment figures in adult life (e.g., romantic partners), replaces distorted perceptions of attachment relationships with realistic and adaptive ones. Therapy, then, is for many clients a process of developing a much-needed secure base. In this context, it is not surprising that increases in the alliance over time have been found to predict treatment success better than average alliance (Hartley & Strupp, 1983; Kivlighan & Shaughnessy, 1995). This is because clients are developing secure attachment to the therapist, and thereby healing disturbed attachment patterns.

Mallinckrodt, Gantt, and Coble (1995), in an effort to assess client feelings and attitudes toward the therapist from an attachment perspective, developed the Client Attachment to Therapist Scale (CATS). They found that clients who rated their therapeutic relationship as secure on the CATS were relatively free from object relations
deficits and reported positive working alliances. In this way, they showed that the therapeutic relationship can be effectively measured from an attachment perspective. The findings of the present study are well aligned with findings from the CATS, suggesting that initial impressions of the therapeutic relationship may indeed be a function of secure attachment. Mallinckrodt, Gantt, and Coble (1995) suggest that “Perhaps the process of therapeutic change itself could be tracked as changes over the course of therapy in a client’s attachment patterns and flexibility of working models” (p. 316). Using the framework from the present study, this process could be operationalized as increases in clients’ security of attachment ratings.

It is curious, then, that the relationship between security of attachment and the alliance decreases over time in the present study. Specifically, between sessions two and three, the relationship between security of attachment and alliance is cut in half, and this finding is not attributable to loss of power. It may be that initial impressions of the alliance gleaned at the first session or two are more heavily influenced by attachment patterns than the more real-relationship alliance that develops as therapy progresses. In this view, the experienced interactions between client and therapist within the first couple of sessions quickly replace the client’s a priori expectations and fantasies about the therapist, and either a relationship is formed with the therapist based on this real-life experience, or the therapist is found to be too different from expectations and dropout occurs. Thus, attachment style influences the initial development of the therapeutic alliance, but the real-relationship alliance soon takes over and renders the relationship between attachment and alliance immaterial.
It is noteworthy that in the present study, security of attachment was more strongly associated with goals and tasks than with bond, whereas in the above discussion of the history of the alliance, bond and security are conceptualized as analogous. This may be a function of the lower variance of the bond component at session one. Alternatively, it may be that there is some functional difference between the kind of attachment measured by the AAS and attachment to the therapist as measured on the bond component of the WAI. Indeed, Mallinckrodt et al. (1995) found no relationships between the CATS and the AAS, implying that attachment is somehow different when placed in the therapeutic context. This is echoed in Mallinckrodt’s (1991) definition of the alliance as a “specialized type of attachment bond” (p. 407). Ratings on the AAS are made with romantic relationships in mind, rather than therapeutic relationships; therefore, AAS ratings might be expected to diverge from ratings of the therapeutic bond somewhat. Whatever the case, attachment appears to be an important aspect of the earliest impressions of the alliance, with regard to Bordin’s (1979) conceptualization of the alliance, the findings of Mallinckrodt et al. (1995), and the findings of the present study.

Speculative Comments and Post-Hoc Analyses

QOR and the Alliance. Although quality of object relations was related to session one alliance in the present study, this relationship was not strong and ceased being statistically significant at sessions two and three. Given the strength of the relationship between security of attachment, a closely related construct, and initial alliance, it is surprising that QOR did not yield stronger results. Examining the correlations by
subscale (see Table 8), it is striking how much smaller the correlations are between BORRTI Egocentricity and the alliance, as compared to the other BORRTI subscales. Indeed, when Egocentricity is removed from BORRTI totals, the relationship between QOR and session one alliance strengthens considerably (see Post-Hoc Analyses in Results). It is unclear why this subscale was problematic in the present analysis. Egocentricity as defined by the BORRTI refers to regarding others with mistrust or only as instruments of one’s own will. It is possible that individuals with moderate to high levels of this characteristic may not be adept at rating relationships, and were less able to reflect on the therapeutic relationship in the way that the WAI requires. However, this explanation is speculative at best.

Another possible explanation for the weaker relationship between QOR and early alliance might be related to the constructs measured by the BORRTI. Although the items on the BORRTI were derived from clinical wisdom concerning object relations deficits, the test may not converge fully with alternative measurements of quality of object relations as well as it does with measures of distress. For example, the manual for the BORRTI (Bell, 1995) does not report convergent validity of the BORRTI with projective tests such as the Rorschach or the Thematic Apperception Test, nor with the interview method used in the majority of the studies focusing on QOR, the Quality of Object Relations Scale (QORS; Azim et al., 1991). However, the manual does report convergence of the BORRTI with more general measures of pathology such as the Symptom Checklist – 90 – Revised (SCL-90-R), the Positive and Negative Syndrome Scale (PANSS), the Brief Psychiatric Rating Scale (BPRS), the Millon Clinical
Multiaxial Inventory (MCMI), and the Minnesota Multiphasic Personality Inventory (MMPI). Given the BORRTI’s convergence with measures of pathology, it is possible that the test in fact measures a construct that is more closely related to pathology than to quality of object relations. Indeed, a post-hoc analysis (see Results) confirms that QOR was significantly related to level of distress in the present sample, providing support for the hypothesis that the BORRTI may be measuring some aspect of impairment. Prior research has yielded mixed findings with regard to level of pathology at intake and the alliance, with a trend toward a negative relationship (e.g., Connolly Gibbons et al., 2003; Constantino, Arnow, Blasey, & Agras, 2005; Eaton, Abeles, & Gutfreund, 1988; Kokotovic & Tracey, 1990; McCabe & Priebe, 2003; Raue, Castonguay, & Goldfried, 1993; Saunders, 2001). No relationship was found between level of distress and initial alliance in the present study (see Post-Hoc Analyses).

Assuming that the BORRTI adequately measures the QOR construct, another possible explanation for the weaker relationship between QOR and early alliance involves the nature of work with object representations in therapy. Patients beginning therapy behave in ways that may be influenced by their quality of object relations, but it is possible that the relationship between patients’ object relational themes and the therapeutic relationship is most explicit later in treatment.

In the initial stages of therapy, a basic sense of trust and support is established, goals of treatment are formulated, and patients begin to become acquainted with the therapeutic process. All of this, of course, occurs while the therapist gathers sufficient information to begin making hypotheses and conceptualizing the case. It seems unlikely,
in this early phase, for transference to be a focus of discussion, or for other enactments of object relational themes to be processed within the relationship. These events, more than other processes in therapy, connect the patient’s object relational world directly to the therapeutic relationship. Furthermore, the therapeutic alliance serves as a springboard for such therapeutic tasks. For example, only in the presence of a strong alliance is a transference interpretation of any real therapeutic value. Such an intervention superimposes object relational themes directly onto the therapeutic relationship, something that requires somewhat of a history shared by therapist and patient. Thus, it seems likely that in later stages of treatment, the relationship between QOR and the alliance may be more robust, whereas in the earliest phase of treatment (the focus of the present study) this relationship is less directly evidenced.

While this explanation contradicts the speculation presented earlier to account for the rapid disappearance of a relationship between attachment and alliance at session three, the two ideas are not viewed as incompatible. It may well be that transference patterns are relevant early in treatment as the client attempts to place this new relationship in the context of relationships across the lifespan, then are replaced by real-relationship interactions, only to resurface again later in treatment as the therapist begins to note transference and comment upon it. While data from later stages of treatment are not available for analysis in the present study, clinical experience suggests that such a pattern is not unlikely nor uncommon.

Security of Attachment and QOR. One way to approach the relationship between security of attachment and quality of object relations is in terms of mediator effects.
Quality of object relations was correlated with session one alliance, but this correlation was reduced to nearly zero when security of attachment was included in the model. This suggests a mediation effect of security of attachment upon QOR. Following recommendations by Baron and Kenny (1986) for testing mediation between variables, three conditions must hold: QOR must be significantly related to security of attachment, QOR must be significantly related to the alliance, and security of attachment must be significantly related to the alliance. Each of these conditions has been met. Baron and Kenny (1986) go on to stipulate that if the above conditions are met, then the effect of QOR on the alliance must be reduced (ideally to zero) when security of attachment is included in the model. This was indeed the case. Thus, security of attachment qualifies as a mediator between quality of object relations and strength of the alliance.

A final way to elucidate the relationship between QOR and security of attachment in the present study was to test these two variables’ interaction in predicting the alliance. As can be seen in Post-Hoc Analyses, the security of attachment by QOR interaction term was significantly related to the alliance at session one. Since this interaction was weaker than the main effect for security of attachment, but stronger than the main effect for QOR, it can be said that security of attachment adds to our understanding of the relationship between QOR and the alliance: at high levels of security of attachment, QOR exhibits a stronger relationship with the alliance. Once again, secure attachment appears to be a precondition for object relational functioning to impact the alliance. This is because variability in QOR increases as attachment security increases.
Inspection of a scatterplot (see Figure 2) helps to elucidate this point. As the figure shows, at low levels of attachment security, there are no BORRTI scores below 200, indicating moderate to high levels of impairment in object relational functioning. At high levels of attachment security, QOR impairment is highly varied, with BORRTI scores ranging from 152 (the least impaired QOR in the sample) to 269 (the most impaired QOR in the sample). Thus, when attachment security was low, strong object relational functioning was not possible, but when attachment was secure, object relational functioning varied from good to poor. This conditionality further elucidates the function of security of attachment in the present analysis: not only was it related to early alliance, but it also specified the conditions under which QOR was related to early alliance.

Principal Components Analysis. While collinearity masks the ability of the predictors to account for variability in the alliance, it also provides evidence that an implicit assumption of Hypothesis V was correct: to a large degree, the predictor variables made similar predictions about the initial formation of the alliance. Such statistical redundancy gives evidence of a conceptual overlap between these variables. This assumption was further explored using a principal components analysis (see Post-Hoc Analyses in Results) on each subscale of each predictor measure. Three factors were found, the first of which accounted for more than half of the variance in subscale scores. This first factor, which includes attachment, QOR, and dominance, appears to be a single dimension of interpersonal functioning that cuts across each of these constructs. It may be conceptualized as an overall index of interpersonal functioning, and it is correlated both with alliance at session one and level of distress at intake. Thus, it may be that
interpersonal functioning is best conceptualized as a unidimensional construct, which can be measured using the AAS, the BORRTI, or the IAS dominance dimension. However, given that this principal components analysis had a small variable-to-factor ratio, this explanation should be considered very speculative at this time.
Locating QOR and Security of Attachment on the Interpersonal Circumplex. One way to make sense of the conceptual relationships between attachment, object relations, and the circumplex model would be to place security of attachment and QOR within the context of the circumplex model. Utilizing procedures outlined by Wiggins and Broughton (1991), a measure of any interpersonal construct can be placed within the circumplex model by administering a circumplex measure (such as the IAS) along with the measure of interest. Correlations between the measure of interest and the DOM and LOV factor scores are regarded as the measure’s $x$ and $y$ axis coordinates on the circumplex.

When one follows this procedure for the AAS, security of attachment appears to be located loosely within the gregarious-extraverted octant of the interpersonal circumplex (see Figure 3 for graphical representation). Therefore, the construct of security of attachment, measured using the AAS in the present study, falls somewhere within the gregarious-extraverted range of the circumplex model. This implies that those who score highly on security of attachment may be likely to exhibit gregarious or extraverted behaviors in dyadic interpersonal transactions. Security of attachment, then, is a dimension that taps into the extraversion and gregariousness with which one approaches interpersonal interactions.

Plotting the BORRTI on the interpersonal circumplex (see Figure 3), its strong negative correlation with dominance and moderate negative correlation with nurturance places it somewhere within the aloof-introverted octant. Thus, high scores on the
Figure 3

AAS and BORRTI Placed Within the Interpersonal Circumplex

Note: Adapted from Trapnell & Wiggins (1990)

BORRTI imply aloof or introverted behavior in dyadic interpersonal transactions. It should be noted that low BORRTI scores, or better quality of object relations, are loosely located within the assured-dominant octant of the interpersonal circumplex. The construct measured by the BORRTI, then, is more specific to dominance (and less specific to nurturance) than the security of attachment construct measured by the AAS. Good quality of object relations could be seen as being evidenced by a tendency to approach interpersonal interactions with assuredness and assertiveness. It should be noted that these descriptions of where the AAS and the BORRTI fall on the interpersonal
circumplex should not be confused with descriptions of the present sample’s average circumplex location. Indeed, the present sample is generally located within the unassuming-ingenuous octant of the circumplex. Rather, the above descriptions pertain to the circumplex locations of the variables used in the present study: it is an attempt to place the attachment and object relations constructs within a circumplex perspective.

Limitations

The present study is subject to a number of methodological limitations. First, the size of the present sample may not have been adequate to detect existent relationships between variables. Particularly with regard to the problem of collinearity, an increased sample size may have resulted in more stable partial regression coefficients, allowing for more accurate estimations of the contribution of each predictor. This may help explain why the regression analysis did not yield significant findings. Furthermore, it appears likely that some bivariate correlations may have reached statistical significance in a sample of more traditionally acceptable size. For example, the correlation between QOR and alliance ($r = -.256$), which was statistically significant using a one-tailed test but not a two-tailed test, would be considered statistically significant using a two-tailed test in a sample of 111 participants, rather than the 43 participants surveyed in the present study.

Another issue with regard to the present sample is its limited ability to represent a larger population. Participants in the present study were predominantly Caucasian females with some college education. As such, results of the present study may have limited application to males, individuals of minority status, older adults and younger children and adolescents, and those within a socioeconomic bracket that precludes a
college education. This problem may have been exasperated by the poor response rate; only clients who voluntarily participated are represented. Furthermore, clients at the two data collection sites were largely heterogeneous in terms of pathology; diagnoses at these treatment centers include a wide variety of Axis I and Axis II pathology. While this makes the results of the present study more generalizable, they are less applicable to the treatment of any particular disorder.

One way to evaluate the representation of the present sample might be to compare ratings provided by participants in the present study with those provided by participants in larger-sample studies. Mean item ratings on the AAS in the present study are very similar to those found by Collins and Read (1990) for 400 undergraduates. Likewise, BORRTI subscale means in the present study are very similar to mean scores reported by Bell (1991) for 145 undergraduates. Thus, the present sample appears to be very similar to larger samples of undergraduates with respect to AAS and BORRTI ratings. However, participants in the present sample were less dominant and more nurturing than those in a sample of 941 undergraduates reported by Trapnell and Wiggins (1990). Therefore, the present sample appears to be representative of the undergraduate population with respect to security of attachment and QOR, but not with respect to interpersonal style.

Although the findings of the present study have bearing upon the formation of initial impressions of the alliance, only tentative conclusions can be made with regard to the effect of the predictors upon the outcome of therapy. Alliance has been consistently found to be related to treatment outcome (Martin, Garske, & Davis, 2000); however, it is not clear what the relationship might be between the present predictor variables, the
alliance, and outcome. Inclusion of an outcome measure would establish a connection between these elements. Furthermore, analyses in the present study were correlational in nature; thus, it is impossible to determine whether relationships between the predictors and the alliance may have been influenced by an unknown variable. However, it is clear that early alliance did not influence the measurement of interpersonal functioning, because interpersonal functioning measures were administered prior to the first session.

Another potential limitation of the present study is the use of self-report ratings for security of attachment, quality of object relations, interpersonal style, and strength of early alliance. Correlations may have resulted from response-set or common-method variance, rather than the presence of genuine relationships between constructs. Self-report bias can also pose significant problems in such an analysis. For example, Jackson and Helmes (1979) have argued that the IAS may be subject to serious limitations due to response bias. Similarly, while client ratings of the alliance have been found to be more strongly related to treatment outcome than therapist ratings (Martin, Garske, & Davis, 2000), the use of multiple rating sources may have provided a more accurate view of the quality of the therapeutic relationship from both perspectives. This is particularly important in light of the ceiling effect found in the present study; alliance ratings were negatively skewed and may have been influenced by demand characteristics.

As discussed above, collinearity was an issue in the present study, indicating problems in the selection of the predictor variables. Ideally, predictors in a linear regression analysis should be orthogonal; that is, unrelated to each other. Selection of predictors for the present study followed theoretical, but not statistical, considerations.
As a result, no effort was made to ensure the orthogonality of predictor variables. More accurate predictions of the strength of the alliance could have been made using a set of interpersonal functioning variables with fewer theoretical commonalities.

There are some questions regarding the construct validity of the BORRTI. Convergence with several measures of pathology is presented in the manual (Bell, 1995), but no convergence with measures of object relations is reported. An unpublished doctoral dissertation (Miripol, 1982) compared various projective objective relations measures with an early version of the BORRTI, finding that the BORRTI was the most reliable and valid. However, this dissertation could not be located for the present discussion. Bell, Billington, and Becker (1986) administered the BORRTI to psychiatric inpatients and also scored their earliest memories (obtained during clinical interview) for object relations using a procedure developed by the BORRTI’s author (Ryan & Bell, 1984). These authors found a correlation between object relations scores from early memories and BORRTI Egocentricity subscale scores only. Limited inquiries have been made subsequent to the publication of the BORRTI manual (Bell, 1995) into the BORRTI as a Rorschach correlate (e.g., Burns & Viglione, 1996; Hansen, 2000); however, these do not overwhelmingly support the BORRTI as an equally valid measure of object relations.

Based on the dearth of available data to suggest that the BORRTI uniquely measures object relations deficits, and the considerable data to suggest that the BORRTI adequately measures pathology, it is possible that the BORRTI may more accurately be described as a measure of pathology than a measure of quality of object relations. Given
the mixed findings in the literature regarding the relationship between pathology and the alliance (e.g., Eaton, Abeles, & Gutfreund, 1988; Kokotovic & Tracey, 1990; Raue, Castonguay, & Goldfried, 1993), it is not surprising that the relationship between the BORRTI and early alliance was unstable in the present study.

Similarly, there is some question as to the construct validity of the AAS. Although items on the AAS were adapted from a categorical conceptualization of attachment style (Hazan & Shaver, 1987), the AAS itself takes a dimensional approach to attachment. Hazan and Shaver (1987) concede that a categorical approach to adult attachment may oversimplify the complexities involved. Nevertheless, it is a leap to move from a categorical to a dimensional approach, especially considering that throughout its history, attachment theory has overwhelmingly focused on styles rather than dimensions. Furthermore, the present study collapsed the dimensions of the AAS into a single dimension called security of attachment. This construct, although useful (Allen, Huntoon, & Evans, 1999), may be an oversimplification of attachment processes. For example, it is difficult to differentiate where an individual with a fearful attachment style would fall on the security of attachment dimension, as compared with where a preoccupied individual might fall on this dimension. Nevertheless, the strong relationship between security of attachment and quality of object relations indicates that this dimension has some relevance with regard to interpersonal functioning, and the relationship between security of attachment and working alliance establishes it as a potentially useful predictor of the alliance.
The alliance itself leaves much to be desired as a construct, especially in the earliest phases of treatment. Definitions of the alliance vary drastically, and it is unclear whether it is a single factor or a conglomeration of a number of interrelated constructs (Gaston, 1990; Henry & Strupp, 1994). Its overlap with outcome measures (Luborsky, 1994) both establish it as a powerful predictor of outcome and call into question its independence. Questions exist as to whether the alliance is a state, a process, or a set of behaviors (e.g., Henry & Strupp, 1994). Conditions and behaviors that influence its development are numerous (e.g., Ackerman & Hilsenroth, 2001; 2003). Although the WAI shows adequate convergence with other alliance measures, it is unclear what exactly this and other alliance scales are actually measuring. Nevertheless, the WAI has been shown to predict outcome on a relatively consistent basis, and is the most highly recommended scale for alliance measurement in research applications (Martin, Garske, & Davis, 2000). Whatever the WAI is measuring, it appears to be an important aspect of the process and outcome of psychotherapy.

**Future Directions**

Despite its limitations, the present study suggests that clients’ security of attachment and quality of object relations may influence their ability to form strong alliances in the earliest phases of treatment. Although prior research supports this link (Kivlighan, Patton, & Foote, 1998; Satterfield & Lyddon, 1995), it is unclear how security of attachment and quality of object relations may influence the outcome of therapy. Future research may benefit from the use of the alliance as a moderator between these predictors and outcome, as well as the use of security of attachment and quality of
object relations as two of a number of predictors of outcome. Another area that remains unclear is how client and therapist security of attachment and QOR interact to affect the alliance and outcome. It is possible that more secure therapists are better suited to work with less secure clients, or perhaps that it is optimal for both to be highly secure. Such questions provide important directions in our understanding of this construct as it affects psychotherapy process and outcome.

Collinearity in the present study resulted from the use of measures that tapped overlapping constructs. Future research can eradicate this problem by selecting constructs and measures that are less similar. In this way, predictors will be truly independent and can better compete with each other for predictive ability. In a related point, the interaction between security of attachment and QOR as they predict early alliance represents a promising direction. Future research could test the hypothesis that QOR and the alliance are most strongly related in the presence of secure attachment.

Another question concerns client and therapist interpersonal styles. Although interpersonal dominance and nurturance did not predict the alliance in the present study, it is possible that this is the result of the use of client ratings only. Future research involving interpersonal style as a predictor of the alliance may make use of interpersonal complementarity between therapist and client. Interpersonal complementarity can be defined as “an interpersonal situation in which two participants’ interpersonal behaviors endorse and confirm each other’s self-presentation in regard to both control and affiliation” (Kiesler & Watkins, 1989). For example, interpersonal dominance “pulls for” submission (and vice-versa); while friendliness “pulls for” friendliness and hostility
“pulls for” hostility. These processes may have particular relevance to the therapeutic relationship: “To say that one behavior invites a particular reaction implies an implicit communication between partners, a communication about the sender’s wishes” (Horowitz, Dryer, and Krasnoperova, 1997, pp. 356-357). To what extent does complementarity of the interpersonal styles of the therapist and client create conditions conducive to alliance development? Kiesler and Watkins (1989) found positive associations between patient-therapist interpersonal complementarity and both patients’ and therapists’ perceptions of the alliance. Thus, it may be that complementarity of interpersonal style, rather than patient interpersonal style alone, predicts the strength of the alliance. Future research utilizing both client and therapist ratings is necessary to understand this distinction.

As noted above, the use of the BORRTI for measurement of object relations is questionable, although it appears to be a useful measure of pathology. Future research would benefit greatly from investigation of the relationship between the deficits in interpersonal functioning measured with the BORRTI and the specific object relational components of ego functioning tapped by traditional projective and interview methods. Furthermore, the BORRTI’s strong relationships both with security of attachment and interpersonal dominance suggest that it may represent something of a link between these two constructs. Finally, the relationship between security of attachment and quality of object relations in the present study provides preliminary evidence that these two constructs may be similar or the same. Future research may benefit from a more in-depth
investigation of the uniqueness of these two constructs using multiple measurement methods and viewpoints.

The therapeutic alliance remains an elusive variable in psychotherapy research. However, the present study helps to fill the gaps in our understanding of how this construct develops. Strong initial impressions of the alliance appear to be possible even in the face of deficits in certain aspects of interpersonal functioning. This implies that therapeutic dyads are somehow able to overcome clients’ maladaptive interpersonal processes to forge a healing relationship. The therapeutic alliance research draws ever closer to an understanding of how this central aspect of change is possible.
References


Bell, M.D. (1991). An introduction to the Bell Object Relations Reality Testing Inventory. Unpublished manuscript. (Available from Morris Bell, Department of Psychiatry, Veterans Administration Hospital, West Spring Street, West Haven, CT 06516).


Appendix A

Invitation to Participate

As long as you are filling out paperwork, why not fill out a little more and be paid for your time?

This is an invitation to participate in a research project. It is optional, and there is no penalty of any kind if you should choose not to participate. If you choose to participate, you will be:

- Helping researchers better understand how psychotherapy can be as effective as possible
- Taking an opportunity to clarify your thoughts about what you are like as a person, and how you experience others
- Getting a chance to think about your relationship with your therapist, what you like about it, and what needs improvement
- Paid for your time!

This study involves the filling out of questionnaires only. It will require you to:

1. Fill out the attached questionnaire packet and return it to the receptionist
2. Fill out a post-session questionnaire immediately after each of your first three sessions

That’s it! You will receive $5.00 after your first session and $5.00 after your third session, just for taking the time to participate.

Remember, if you choose to participate YOUR RESPONSES WILL BE KEPT CONFIDENTIAL. NEITHER YOUR THERAPIST NOR THE AGENCY WILL RECEIVE INFORMATION ABOUT YOUR RESPONSES.

Thanks for taking the time to read about this study.

IF YOU WOULD LIKE TO PARTICIPATE, please OPEN the ATTACHED ENVELOPE and FILL OUT the CONSENT FORMS, making sure to TAKE A COPY FOR YOURSELF. Then BEGIN FILLING OUT the BIGGER, WHITE QUESTIONNAIRE PACKET.

DO NOT FILL OUT the BLUE QUESTIONNAIRE yet. KEEP IT for AFTER YOUR FIRST SESSION.
Appendix B

Consent Forms

Project: Interpersonal Variables Affecting the Therapeutic Alliance
Principal Investigator: Gregory A. Goldman
Co-Investigator: Timothy Anderson, Ph.D.
Department: Psychology, Ohio University, Athens, Ohio

Federal and university regulations require signed consent for participation in research involving human subjects. After reading the statements below, please indicate your consent by signing this form.

Explanation of Study
This study is designed to help researchers better understand how certain qualities that people have may affect the relationships they form in therapy. More specifically, this study focuses on tendencies to react to others in certain ways, and how these tendencies affect the therapist-client relationship.

If you consent to participate, you will be required to fill out questionnaires at your first therapy session having to do with your own experiences and feelings. This will take approximately 15-20 minutes. Additionally, you will be asked to fill out a questionnaire about your relationship with your therapist immediately after your first, second, and third sessions. Each of these will take approximately 10 minutes.

Some therapists are also participating in this study, possibly including your own therapist. However, your therapist will never be given any information about your responses on these questionnaires, nor will you ever receive information about your therapist’s responses. In order for the investigators to know which therapist you are seeing, it will be necessary for you to provide written consent for this information to be released. There is a separate consent form included for that purpose.

Once you complete all the questionnaires at your first session, you will be compensated for your time with a cash reward. Additionally, once you complete the questionnaire after your third session, you will be given an additional monetary reward for your time investment. Your participation in this study is complete once you have completed the questionnaire after your third session. If you wish to withdraw from the study at any time for any reason whatsoever, you may do so without being penalized in any way.

Risks and Discomforts
There is no risk associated with participation in this study. Some of the questions you will answer are very personal in nature, and may require you to provide honest feedback about yourself and about your feelings toward your therapist. However, this is the extent of discomfort you will experience as a participant in this study.
**Benefits**
As a participant in this study, you may benefit from the opportunity to think about your relationship with your therapist in a logical, coherent way. It is possible that answering some of the questions on these questionnaires will help you clarify in your own mind how you understand yourself and how you are affected by your relationships with others and with your therapist.

**Confidentiality and Records**
Once you agree to participate, you will be assigned an identification number, which will be the only identifying information on any of the materials you use. The only forms that will contain your name are this consent form and the release of information, which will each be locked in special rooms with restricted access.

In order for the investigators to use your responses in conjunction with the responses your therapist gives, it will be necessary for them to know which therapist you are seeing. This information will be obtained from the reception personnel in charge of your clinical records, and will not be shared with anyone other than the principle investigator. Once this information is gained, it too will be converted to identification numbers and will stay in this format for the remainder of the study. Any report generated from this study will not include any identifying information.

**Compensation**
As mentioned, you will be compensated for the time you spend filling out questionnaires. After your first session, you will be given $5.00 upon turning in the completed questionnaires (including the one you will fill out immediately after the session). You will then be compensated for your additional time spent on the last two questionnaires with $5.00 more, which you will receive upon turning in the last questionnaire.

**Contact Information**
If you have any questions regarding this study, please contact the Principal Investigator, Gregory A. Goldman, or his faculty advisor, Timothy Anderson, Ph.D., by phone at (740)593-9110.

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of
any benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me.

Signature ___________________________________________ Date _____________

Printed Name ___________________________________________
AUTHORIZATION for RELEASE of CONFIDENTIAL INFORMATION

Client Name: ___________________________________ Date of Birth: _____________
                        (first)        (middle initial) (last)

Social Security Number: _____________________________________

I authorize the Ohio University Counseling and Psychological Services to release to
Gregory A. Goldman, Principle Investigator of “Interpersonal Variables Affecting the
Therapeutic Alliance,” the following information:

NAME OF THERAPIST SEEN AT CPS/PSWC

The purpose of such disclosure is research.

I understand that my records are confidential and cannot be disclosed without a written
consent. I also understand that I may revoke this consent at any time and that in any
event this consent expires automatically in 90 days. The specific information released,
the date of release, to whom it was released, and the signature of the person releasing the
information will be noted in my clinical record. Any information received or sent by this
agency may not be released to a third party without an additional release.

 Executed this _____ day of ________, 20____. Expiration date: ___________
                        (6 months from date signed)

Client signature: __________________________________________________

Staff Signature: ___________________________________________________

Staff Name: ______________________________________________________

TO THE RECEIVER OF INFORMATION: This information has been disclosed to you from
records whose confidentiality is protected by federal and state law and by standards of
professional ethics. Further disclosure of it without specific written consent of the person to
whom it pertains is prohibited, unless otherwise permitted by state and federal regulations. A
general authorization for release of medical or other information is not sufficient for this purpose.

REVOCATION OF CONSENT: I hereby revoke the above consent for release of information.
Upon revocation of consent, further release of specified information shall cease immediately,
except otherwise allowed by law.

Signature of Person Revoking Consent: __________________________ Date: ___________
Appendix C
Questionnaire Packet

ID#: ___________________
Client

QUESTIONNAIRE PACKET

Thank You For Agreeing To Participate In This Study!

This Packet Contains 3 Different Activities.
Please Take Your Time
And Read The Directions Carefully For Each Activity.
Try To Give The Most Honest, Objective Answers You Can.

THIS PACKET SHOULD ONLY TAKE
ABOUT 15-20 MINUTES TO COMPLETE.

When You Are Done:
Please Put This Packet
And The Consent Form
Back In The Envelope Provided
And Give It To The Receptionist.

IMPORTANT:
MAKE SURE TO KEEP THE BLUE PAGES
AND FILL THEM OUT
AFTER YOUR SESSION!

Thank You Once Again For Participating.
You May Open The Packet And Begin Now.
Before you begin your three activities, please help us by providing some demographic information:

1. Age: ___________

2. Gender (circle one): male female

3. Race (circle one): Caucasian African-American Hispanic/Latino Native American Other (please specify): ________________

4. Education level: High School Diploma Some College Associates Bachelors Degree Masters Ph.D. Other: __________________

5. Have you ever been in therapy before? Yes No

   If yes, for how long? ________________
   How long ago? ________________

6. On a scale of 1 to 10, with 10 being the most distressed you could possibly feel and 1 being the most at ease you could possibly feel, how would you rate your average level of distress over the last couple weeks? (circle a number)

   1  2  3  4  5  6  7  8  9  10
ACTIVITY 1

**Directions:** Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel.

Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

<table>
<thead>
<tr>
<th></th>
<th>Not at all characteristic of me</th>
<th>Very characteristic of me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I find it relatively easy to get close to people.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I find it difficult to allow myself to depend on others.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I often worry that romantic partners don't really love me.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I find that others are reluctant to get as close as I would like.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I am comfortable depending on others.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I don’t worry about people getting too close to me.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I find that people are never there when you need them.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I am somewhat uncomfortable being close to others.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I often worry that romantic partners won’t want to stay with me.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>When I show my feelings for others, I'm afraid they will not feel the same about me.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I often wonder whether romantic partners really care about me.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I am comfortable developing close relationships with others.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I am uncomfortable when anyone gets too emotionally close to me.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I know that people will be there when I need them.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I want to get close to people, but I worry about being hurt.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I find it difficult to trust others completely.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Romantic partners often want me to be emotionally closer than I feel comfortable being.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>I am not sure that I can always depend on people to be there when I need them.</td>
<td></td>
</tr>
</tbody>
</table>
ACTIVITY 2

Directions: Next you will see 64 words. Please rate how accurately each of the words describes you as a person by circling the appropriate number. Use the following scale:

1 = Extremely Inaccurate
2 = Very Inaccurate
3 = Quite Inaccurate
4 = Slightly Inaccurate
5 = Slightly Accurate
6 = Quite Accurate
7 = Very Accurate
8 = Extremely Accurate

For example, consider the word “Bold.” How accurately does that word describe you as a person? If you think this is a quite accurate description of you, you would circle the number “6.”

Please be sure to circle an answer for every word. If you are uncertain of the meaning of a word, consult the definitions provided in the glossary on pages 5 and 6 of this packet.

1. Self-assured
   1 2 3 4 5 6 7 8
2. Wily
   1 2 3 4 5 6 7 8
3. Uncharitable
   1 2 3 4 5 6 7 8
4. Uncheery
   1 2 3 4 5 6 7 8
5. Timid
   1 2 3 4 5 6 7 8
6. Unargumentative
   1 2 3 4 5 6 7 8
7. Softhearted
   1 2 3 4 5 6 7 8
8. Cheerful
   1 2 3 4 5 6 7 8
9. Self-confident
   1 2 3 4 5 6 7 8
10. Crafty
    1 2 3 4 5 6 7 8
11. Ironhearted
    1 2 3 4 5 6 7 8
12. Unneighborly
    1 2 3 4 5 6 7 8
13. Bashful
    1 2 3 4 5 6 7 8
14. Undemanding
    1 2 3 4 5 6 7 8
15. Accommodating
    1 2 3 4 5 6 7 8
16. Friendly
    1 2 3 4 5 6 7 8
17. Assertive
    1 2 3 4 5 6 7 8
18. Boastful
    1 2 3 4 5 6 7 8
19. Unsympathetic
    1 2 3 4 5 6 7 8
20. Distant
    1 2 3 4 5 6 7 8
21. Shy
    1 2 3 4 5 6 7 8
22. Uncalculating
    1 2 3 4 5 6 7 8
23. Gentlehearted
    1 2 3 4 5 6 7 8
24. Neighborly
    1 2 3 4 5 6 7 8
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<th>Persistent</th>
<th></th>
<th>Cunning</th>
<th></th>
<th>Ruthless</th>
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<td>1 2 3 4 5 6 7 8</td>
<td></td>
<td>1 2 3 4 5 6 7 8</td>
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<td>25</td>
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<td>26</td>
<td>Meek</td>
<td>27</td>
<td>Uncrafty</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>1 2 3 4 5 6 7 8</td>
<td></td>
<td>1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>28</td>
<td>Tenderhearted</td>
<td>29</td>
<td>Extraverted</td>
<td>30</td>
<td>Firm</td>
</tr>
<tr>
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<td>1 2 3 4 5 6 7 8</td>
<td></td>
<td>1 2 3 4 5 6 7 8</td>
</tr>
<tr>
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<td>32</td>
<td>Coldhearted</td>
<td>33</td>
<td>Unsocial</td>
</tr>
<tr>
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<td></td>
<td>1 2 3 4 5 6 7 8</td>
<td></td>
<td>1 2 3 4 5 6 7 8</td>
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<td>Boastless</td>
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<td></td>
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<td>37</td>
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<td>Dominant</td>
<td>39</td>
<td>Sly</td>
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<td>1 2 3 4 5 6 7 8</td>
<td></td>
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<tr>
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<tr>
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<td>1 2 3 4 5 6 7 8</td>
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<td></td>
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<tr>
<td>43</td>
<td>Unwily</td>
<td>44</td>
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<td>Perky</td>
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<td>Uncunning</td>
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<td>56</td>
<td>Warmthless</td>
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<td>58</td>
<td>Unaggressive</td>
<td>59</td>
<td>Introverted</td>
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<td>Jovial</td>
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<td>Unsly</td>
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<td>Kind</td>
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</tr>
</tbody>
</table>
Word Glossary for Activity 2:

1. **Self-assured**: confident, secure, and sure of oneself
2. **Wily**: dishonest, sneaky, and underhanded
3. **Uncharitable**: intolerant in judging others, does not feel mercy or offer help
4. **Uncheery**: sober, solemn, not happy or sociable
5. **Timid**: shy, retiring, and fearful
6. **Unargumentative**: avoids arguments, not willing to disagree
7. **Softhearted**: not strict, full of compassion and tenderness
8. **Cheerful**: happy, pleasant, optimistic, and joyful
9. **Self-confident**: secure and poised, certain of oneself around others
10. **Crafty**: misleads, deceives, and manipulates others
11. **Ironhearted**: strict, harsh, and cruel
12. **Unneighborly**: unfriendly, not hospitable or sociable with others
13. **Bashful**: self-conscious and easily embarrassed
14. **Undemanding**: does not require or expect much time, effort, or attention from others
15. **Accommodating**: considerate and obliging, eager to please
16. **Friendly**: pleasant, accepting, and warm around others
17. **Assertive**: bold, forceful, and outspoken
18. **Boastful**: proud, vain, and conceited; tends to brag
19. **Unsympathetic**: indifferent, insensitive, and uncaring; not interested or concerned about others’ feelings or problems
20. **Distant**: aloof, cool, detached, reserved, and withdrawn around others
21. **Shy**: reserved and inhibited, tends to be uncomfortable in social situations
22. **Uncalculating**: treats people in a straightforward, undeceptive way; does not use cunning or scheming in order to get own way
23. **Gentlehearted**: warm, kind, and lenient; does not act in harsh or stern ways toward others
24. **Neighborly**: friendly, hospitable, and generous toward others
25. **Persistent**: determined and insistent; does not give up easily
26. **Cunning**: crafty and good at manipulating others
27. **Ruthless**: heartless and merciless, pursues own interest regardless of the effect on others
28. **Dissocial**: withdrawn, avoidant, and not friendly around others
29. **Meek**: submissive and weak, lacks self-confidence
30. **Uncrafty**: not tricky or sly when dealing with others
31. **Tenderhearted**: compassionate, kind, and loving toward others
32. **Extraverted**: outgoing, talkative, and lively; enjoys being around others
33. **Firm**: unbending and un摇erring toward others, does not compromise or give
   in easily
34. **Cocky**: conceited and arrogant; acts superior to others
35. **Coldhearted**: heartless and unkind, unfeeling toward others
36. **Unsociable**: does not enjoy meeting people or being in the company of others
37. **Unbold**: cautious, hesitant, and doubtful
38. **Boastless**: humble and modest around others, unlikely to brag or show off
39. **Charitable**: generous and benevolent, likes to help others
40. **Enthusiastic**: eager, spirited, and optimistic; lively interest in other people and
   activities
41. **Dominant**: assertive in social situations; tends to “take charge”
42. **Sly**: sneaky, shift), and secretive around others
43. **Cruel**: mean and unloving, able to cause pain and suffering in others
44. **Antisocial**: unfriendly, does not like to associate with others
45. **Unauthoritative**: not decisive or commanding, does not persuade or influence
   others
46. **Unwily**: deals honestly with others, not sneaky or underhanded
47. **Tender**: warm, compassionate, and supportive of others
48. **Outgoing**: gregarious, talkative, and animated; enjoys meeting and being around
   others
49. **Forceful**: powerful, convincing, and influential; tends to assert control
50. **Tricky**: deceptive and devious, able to fool others
51. **Hardhearted**: cold and callous, unconcerned about feelings of others
52. **Unsparkling**: dull, not lively or entertaining around others
53. **Forceless**: powerless and passive, not vigorous or assertive
54. **Uncunning**: straightforward with others, not deceptive or manipulative
55. **Sympathetic**: understanding and sensitive to the feelings and problems of others
56. **Perky**: cheerful, light-hearted, and lively around others
57. **Domineering**: commanding and overbearing, tends to control others
58. **Calculating**: selfishly scheming, tends to take advantage of others
59. **Warmthless**: insensitive and unfeeling, not sympathetic to others
60. **Introverted**: not outgoing or lively, avoids the company of others
61. **Unaggressive**: not assertive, tends to be a follower  
62. **Unsly**: genuine, sincere, and truthful  
63. **Kind**: thoughtful, helpful, and forgiving  
64. **Jovial**: hearty, joyful, and humorous
ACTIVITY 3

Directions: On the following page there is a test form, with instructions at the top. Please fill in the bubbles for True or False to indicate whether the statement is generally true for you. Try to be as honest as you can.

Note: Due to licensing restrictions, a BORRTI Form O Answer Sheet cannot be included in this document. Instead, a list of the items is presented on the following page.
<table>
<thead>
<tr>
<th>Item #</th>
<th>Item description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have at least one stable and satisfying relationship</td>
</tr>
<tr>
<td>2</td>
<td>If someone dislikes me, I will always try harder to be nice to that person</td>
</tr>
<tr>
<td>3</td>
<td>I would like to be a hermit forever</td>
</tr>
<tr>
<td>4</td>
<td>I may withdraw and not speak to anyone for weeks at a time</td>
</tr>
<tr>
<td>5</td>
<td>I usually end up hurting those closest to me</td>
</tr>
<tr>
<td>6</td>
<td>My people treat me more like a child than an adult</td>
</tr>
<tr>
<td>7</td>
<td>If someone whom I have known well goes away, I may miss that person</td>
</tr>
<tr>
<td>8</td>
<td>I can deal with disagreements at home without disturbing family relationships</td>
</tr>
<tr>
<td>9</td>
<td>I am extremely sensitive to criticism</td>
</tr>
<tr>
<td>10</td>
<td>Exercising power over other people is a secret pleasure of mine</td>
</tr>
<tr>
<td>11</td>
<td>At times I will do almost anything to get my way</td>
</tr>
<tr>
<td>12</td>
<td>When a person close to me is not giving me his or her full attention, I often feel hurt or rejected</td>
</tr>
<tr>
<td>13</td>
<td>If I become close with someone and he or she proves untrustworthy, I may hate myself for the way things turned out</td>
</tr>
<tr>
<td>14</td>
<td>It is hard for me to get close to anyone</td>
</tr>
<tr>
<td>15</td>
<td>My sex life is satisfactory</td>
</tr>
<tr>
<td>16</td>
<td>I tend to be what others expect me to be</td>
</tr>
<tr>
<td>17</td>
<td>No matter how bad a relationship may get, I will hold onto it</td>
</tr>
<tr>
<td>18</td>
<td>I have no influence on anyone around me</td>
</tr>
<tr>
<td>19</td>
<td>People do not exist when I do not see them</td>
</tr>
<tr>
<td>20</td>
<td>I've been hurt a lot in life</td>
</tr>
<tr>
<td>21</td>
<td>I have someone with whom I can share my innermost feelings and who shares such feelings with me</td>
</tr>
<tr>
<td>22</td>
<td>No matter how hard I try to avoid them, the same difficulties crop up in my most important relationships</td>
</tr>
</tbody>
</table>
I yearn to be completely "at one" with someone

In relationships, I am not satisfied unless I am with the other person all the time

I am a very good judge of other people

Relationships with people of the opposite sex always turn out the same way with me

Others frequently try to humiliate me

I generally rely on others to make my decisions for me

I am usually sorry that I trusted someone

When I am angry with someone close to me, I am able to talk it through

Manipulating others is the best way to get what I want

I often feel nervous when I am around members of the opposite sex

I often worry that I will be left out of things

I feel that I have to please everyone or else they might reject me

I shut myself up and don't see anyone for months at a time

I am sensitive to possible rejection by important people in my life

Making friends is not a problem for me

I do not know how to meet or talk with members of the opposite sex

When I cannot make someone close to me do what I want, I feel hurt or angry

It is my fate to lead a lonely life

People are never honest with each other

I put a lot into relationships and get a lot back

I feel shy about meeting or talking with members of the opposite sex

The most important thing to me in a relationship is to exercise power over the other person

I believe that a good mother should always please her children
You have finished this questionnaire packet!
What now?

You are done with the big packet.
Next, fill out the blue post-session questionnaire after today’s session.
Then, fill out two more post-session questionnaires, and you are done!

PLEASE REMEMBER TO
TAKE THE BLUE QUESTIONNAIRE WITH YOU!
You will need to fill it out after your session.
POST-SESSION QUESTIONNAIRE

Thanks again for participating!

This questionnaire should be filled out immediately after your session.

Directions: Following are sentences that describe some of the different ways a person might think or feel about his or her therapist (counselor). As you read the sentences, mentally insert the name of your therapist (counselor) in place of _____ in the text.

Below each statement there is a seven point scale:

1  2  3  4  5  6  7
Never Rarely Occasionally Sometimes Often Very Often Always

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL: neither your therapist nor the agency will see your answers.

Work fast; your first impressions are the ones we would like to see. Please don’t forget to respond to every item.

You may start now.

Please be sure to read the directions at the end of the questionnaire.
1. I feel uncomfortable with _____.
   
   1 2 3 4 5 6 7

2. _____ and I agree about the things I will need to do in therapy to help improve my situation.

   1 2 3 4 5 6 7

3. I am concerned about the outcome of my sessions.

   1 2 3 4 5 6 7

4. What I am doing in therapy gives me new ways of looking at my problem.

   1 2 3 4 5 6 7

5. _____ and I understand each other.

   1 2 3 4 5 6 7

6. _____ perceives accurately what my goals are.

   1 2 3 4 5 6 7

7. I find what I am doing in therapy confusing.

   1 2 3 4 5 6 7

8. I believe _____ likes me.

   1 2 3 4 5 6 7

9. I wish _____ and I could clarify the purpose of our sessions.

   1 2 3 4 5 6 7
10. I disagree with _____ about what I ought to get out of therapy.

1 2 3 4 5 6 7

11. I believe the time _____ and I are spending together is not spent efficiently.

1 2 3 4 5 6 7

12. _____ does not understand what I am trying to accomplish in therapy.

1 2 3 4 5 6 7

13. I am clear on what my responsibilities are in therapy.

1 2 3 4 5 6 7

14. The goals of these sessions are important for me.

1 2 3 4 5 6 7

15. I find what _____ and I are doing in therapy is unrelated to my concerns.

1 2 3 4 5 6 7

16. I feel that the things I do in therapy will help me accomplish the changes that I want.

1 2 3 4 5 6 7

17. I believe _____ is genuinely concerned for my welfare.

1 2 3 4 5 6 7
18. I am clear as to what _____ wants me to do in these sessions.

1 2 3 4 5 6 7

19. _____ and I respect each other.

1 2 3 4 5 6 7

20. I feel that _____ is not totally honest about his/her feelings toward me.

1 2 3 4 5 6 7

21. I am confident in _____’s ability to help me.

1 2 3 4 5 6 7

22. _____ and I are working towards mutually agreed upon goals.

1 2 3 4 5 6 7

23. I feel that _____ appreciates me.

1 2 3 4 5 6 7

24. We agree on what is important for me to work on.

1 2 3 4 5 6 7

25. As a result of these sessions I am clear as to how I might be able to change.

1 2 3 4 5 6 7

26. _____ and I trust one another.

1 2 3 4 5 6 7
27. _____ and I have different ideas on what my problems are.

28. My relationship with _____ is very important to me.

29. I have the feeling that if I say or do the wrong things, _____ will stop working with me.

30. _____ and I collaborate on setting goals for my therapy.

31. I am frustrated by the things I am doing in therapy.

32. We have established a good understanding of the kind of changes that would be good for me.

33. The things that _____ is asking me to do don’t make sense.

34. I don’t know what to expect as the result of my therapy.
35. I believe the way we are working with my problem is correct.

1 2 3 4 5 6 7

36. I feel _____ cares about me even when I do things that he/she does not approve of.

1 2 3 4 5 6 7
You are finished with this post-session questionnaire. 
Please return it to the receptionist before you leave.

If this is your first or third session, 
you may collect $5.00 from the receptionist when you turn in this form.

If this is your second session, 
you only have one more questionnaire to complete 
(after your next session).

If this is your third session, 
Thank you once more for participating. 
You have played a part in helping researchers 
understand how therapy can be maximally helpful. 
When you receive your $5.00, you will also be given 
information about how you can be informed of the results 
of this study once it is complete, if you desire.