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Anaclitic-Introjective Personality Traits and Client Outcomes in Psychoanalysis

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Abstract

The symptom presentation of clinical diagnoses varies so much that individuals with the same diagnosis may only share one or two cardinal symptoms while still meeting criteria for the same diagnosis (Goodwin, 2015). Therefore, examining the underlying personality constructs and how each type best responds to treatment is particularly important. Two core personality constructs, anaclitic and introjective, have proven to be predictive of differential outcome patterns based on the treatment offered (Blatt, 1995; Luyten & Blatt, 2013). The current study evaluated how the anaclitic and introjective styles are related to therapeutic alliance, length of treatment, and treatment outcome using 27 audio recorded psychoanalyses from an archival sample. The analyses took place between 1968 and 2012 (participant's M_{age} = 33; 48% were female; all seven analysts were male). Participants who scored higher on the introjective scale tended to have shorter treatments despite treatment length moderating their positive treatment outcome. Additionally, those with greater anaclitic ratings had achieved greater initial levels of therapeutic alliance. Despite the fact that the measured alliance for the introjective participants was quite good and they stayed in treatment, on average, for 655 sessions, these data suggest that, when the introjective could stay in treatment longer, they profited more. This is believed to have occurred when they and the analyst had an affective bond and this, in turn, may have helped them establish adequate time for the introjective to trust their analyst enough to stay in treatment long enough to bring it to a proper close.

Keywords: anaclitic, introjective, psychoanalysis, therapeutic alliance

Anaclitic-Introjective Personality Traits and Client Outcomes in Psychoanalysis

Client variables have long been shown to be the best predictors of treatment outcome in various psychotherapies, including psychoanalysis (Bergin & Garfield, 1994). The anaclitic and introjective depressive styles described by Blatt (1974, 1992, 1995, 1998), as well as the working alliance between therapists and their clients, have consistently proven to be predictors of outcome in psychoanalyses and psychodynamic psychotherapies (Blatt, 1998; Blatt et al., 1998; Blatt, Besser, & Ford, 2007; Blatt, Shahar, & Zuroff, 2001; Safran & Muran, 1996; Werbart & Forsstrom, 2014; Werbart & Levander, 2016; Zuroff et al., 2000). The estimated amount of variance in the treatment outcome accounted for by the patient varies substantially. The treatments utilized may significantly impact the expected therapeutic outcome. Of all of the factors that influence treatment results, patient variables consistently account for more of the outcome variance than any other group of variables (Lambert, 1992; Orlinsky, Grawe, & Parks, 1994; Orlinsky, Rønnestadt, & Willutski, 2004; Shedler, 2010). Some of these patient variables, such as the way an individual connects to the world around them, better suit them for some forms of psychotherapy while other patients are better suited for other methods, such that there are interactions between patient variables and other groups of variables. The key, however, is that it is the patient that determines these differences (Norcross & Lambert, 2011).

Depression is a patient variable that describes symptom presentations so varied that individuals diagnosed may only share one or two cardinal symptoms and yet meet multiple criteria from the rest of the DSM-5 description without overlap (Goodwin, 2015). Such umbrella diagnoses become much more useful in predicting such things as reaction to treatment when they are elaborated with specifiers that capture the variety of ways one may be depressed or anxious

(Blatt, 1995). In an effort to better narrow the umbrella diagnosis of depression, Blatt divided depressive pathology into two subtypes, *anaclitic* and *introjective*, based on the attributional styles of the people who are depressed.

Blatt's (1974) close study of patients with depression revealed two divergent underlying personality styles characterized by different attributional styles, different object relations configurations, and different attachment styles in people receiving the same diagnosis. He later came to see these as central developmental arcs that describe differences in people whether they are depressed or not (Luyten & Blatt, 2013). He and his colleagues termed these two styles the anaclitic and the introjective; each has proven to be predictive of differential outcome patterns based on the type of treatment offered (Blatt, 1995; Luyten & Blatt, 2013).

Those with anaclitic psychopathologies tend to believe that others are the cause of their struggles and triumphs, transforming others into gatekeepers of their happiness. They tend to idealize others and are dependent on others for their psychological well-being, resulting in an identity fashioned through and defined by their relationships with others (Blatt, 1995; Blatt et al., 2001; Luyten & Blatt, 2013). Conversely, individuals with introjective psychopathologies tend to be self-critical, attributing their difficulties to their own failings. They believe that others are harsh and critical, and they have introjected (hence the name) that harsh and critical stance, becoming their own worst critics. Introjectives tend to be very self-reliant, not trusting in others – on the one hand because they believe that others will be harsh and critical, and on the other believing that others will not live up to their expectations and will disappoint them. Put simply, introjective individuals fashion their identity through their sense of self, whereas anaclitic individuals fashion their identity through how they relate to others.

Anaclitic Psychopathology

Those with anaclitic personality styles tend to fear being abandoned and yearn for the care, protection, and love of others. The confluence of abandonment fear and care yearning can result in feelings of helplessness, as the key to these individual's happiness resides in how others respond to them, not in how their own actions shape their world and thus their own level of happiness (Blatt & Schichman, 1983).

Anaclitic functioning, then, is seen by some theorists as underlying a variety of relationally determined personality disorders that also are characterized by feelings of hopelessness, including Dependent, Borderline, and Histrionic disorders (Ouimette, Klein, Anderson, Riso, & Lizardi, 1994). Within this constellation of engagement, a stable self-identity is difficult to maintain in part because external relationships change and in part because there is a focus on the external world rather than a focus on what is occurring within the person's own mind. With this external focus, these individuals may only take inventory of their mental state while experiencing extreme emotions as opposed to more consistently internally monitoring during the more mundane, baseline activities of daily life. So, at lower levels of stimulation, these individuals may not attend to feeling states that might help guide them, such things as mild irritation, but when emotionally pressed, they may have a hard time not feeling or sometimes not acting on their feelings because of how intensely they experience strong feeling states and how limited they are in managing those states.

Introjective Psychopathology

Blatt and Shichman (1983) described introjective pathologies as containing themes of aggression, identity, and self-control. With this focus on autonomy, self-mastery, and

establishing a stable identity, interpersonal relationships tend to be neglected. Self-identity is a key theme within the identity construct. Trouble emerges when these individuals do not live up to their envisioned identity; at these times, they tend to be overly self-critical and harsh with themselves, even rejecting as inferior what others would see as good quality work. Once activated, these thoughts are intrusive and tend to affect most daily functions. If one were to engage in an argument with an introjective individual, there would be a tendency for them to display a more hostile and critical style (Blatt, 2004); thus they can appear abrasive.

The Development of Anaclitic and Introjective Psychopathology

Interpersonal relatedness is believed to start developing in early infancy (Stern, 1985). During this time, it contributes to the development of the sense of self, allowing for greater understanding of the experiences of others, enhancing one's interpersonal relatedness, and creating a healthy developmental loop (Blatt, 2008). Despite the tendency to list anaclitic and introjective features as static symptoms or stable features embedded in one's personality, there are varieties of two-polarity models, which suggest that these qualities represent attempts to achieve developmental stability in what is, by nature, a fluid environment (Luyten & Blatt, 2013).

The styles, both of which are present in all of us to some extent, become psychopathologies when the individual over-relies on others (anaclitic) or over-relies on themselves (introjective) (Beebe et al., 2007; Luyten, Mayes, Target, & Fonagy, 2012). The dialectical development between these anaclitic and introjective features occurs through experiences of interpersonal relatedness, self-definition, and the interaction between the two (Blatt, 2008). In positive feedback loops, autonomous achievements are celebrated in

interactions, which support more autonomous functioning. A style involves preferring one mode or another, and when this becomes completely out of balance, it is likely to support pathology (e.g., depression).

Looking outside of the clinical population, the expansion of focusing on developing the sense of self (the introjective side) leads to increasingly mature levels of interpersonal relatedness in all healthy individuals (the anaclitic side). In normal development, gaining an increasing understanding of one's internal world leads to increased capacities to maturely interact with others. As someone gains a better sense of who it is that they are, they are more competent to articulate that and better able to understand where another person is coming from. It becomes apparent that introjective development facilitates anaclitic growth. In the same way, being able to engage with and understand others allows us to think differently about ourselves. Further, the confidence that comes from interpersonal competence feeds one's ability to engage in autonomous activity - individuals feel that it is likely that what they invest themselves in will reap rewards in their relationships with others, so they double down, so to speak, on what it is that they do well.

That is, by knowing ourselves we are better able to know where we stand compared to those around us. This changes over time but the dialectical development described facilitates growth and differentiation (Blatt, 2008; Luyten, Blatt, & Fonagy, 2013). A psychologically healthy individual balances a stable identity with some meaningful attachments, showing us how we are related, but also how we are different; the capacity to individuate and engage in intimate relationships are both aspects, then, of healthy psychological functioning.

The anaclitic and introjective "styles" are perhaps most visible when exaggerated while many of the attributes of the style are therefore pathologically tinged. They are also extreme versions of how to cope with a central human dilemma – are we primarily or essentially a member of a community or are we primarily or essentially an isolated individual. There are advantages and disadvantages to each position, and individuals tend to lean one way or another (and most of us can shift depending on the situation). From Blatt's perspective, people generally organize themselves based on the basic position they take in this dilemma, and thus this can be thought of as a dichotomous personality or style underlying all behavior.

Treatment

Blatt, Shahar & Zuroff (2001) put forward the idea that establishing a strong therapeutic alliance is particularly challenging with introjective individuals, as they tend to have harsh, punitive, representations of both themselves and others; therefore, they are likely to believe their therapist embodies these features as well. In other words, there is likely to be a long period in the treatment during which statements intended by the therapist to be constructive criticism are heard exclusively as criticism. It may take a long time for perfectionistic individuals to learn how to engage in a collaborative relationship.

Furthermore, Zuroff et al. (2000) proposed that introjective individuals are less able to cultivate open, more collaborative therapeutic relationships or they take more time to do so. Zuroff and colleagues reported that those with anaclitic styles experienced significant treatment improvement in briefer treatment, whereas their introjective counterparts did not experience such improvement. Previous research has indicated that introjective individuals report poorer and more fixed levels of therapeutic alliance, particularly when equated to those of more anaclitic

individuals (Blatt & Ford, 1994). Additionally, anaclitic individuals have been shown to achieve better treatment outcomes than their introjective counterparts in briefer treatments (Blatt et al., 1998).

Anaclitic individuals have been reported as being able to achieve a healthier balance between anaclitic and introjective functioning after engaging in psychoanalysis, which was attributed to the anaclitics being less initially guarded. On the other hand, introjectives were found to achieve reductions in their symptomatology, but they remained nearly as introjectively-dominated as they had been at the start of treatment (Werbart & Forsstrom, 2014).

Introjective patients frequently see minimal improvement unless the duration of therapy extends beyond 15 months (Blatt et al., 2001). Categorizing individuals' unique forms of distress based on these anaclitic and introjective traits can predict the effectiveness of brief versus long-term treatment, with longer treatments bringing greater benefit to the introjective group. Despite longer treatments producing better results among introjective individuals, they tend to have fewer positive outcomes overall than their anaclitic counterparts, regardless of the type or length of treatment (Blatt et al., 2001).

Therapeutic alliance. The therapeutic alliance is also likely an important factor in understanding the differential impact of treatment between the anaclitic and introjective patients.A primary difference between the two prototypical patients is the quality of the relationship they establish with their treatment providers as well as their response to treatment (Blatt, 1992; Blatt, 1995; Blatt & Ford, 1994). One of the cornerstone elements of the introjective style is interpersonal mistrust based on fear of being evaluated by others. Those in this position have more difficulty establishing a genuine therapeutic alliance with a treater than

those with an anaclitic style, which is founded in part on an interpersonal hunger and a predilection to view others, at least consciously, as benign or benevolent objects. Furthermore, introjective patients' style of interacting can invite empathic breaks. The rigid internal standards that they have set for themselves are likely to trump whatever alternative evaluative positions are offered (Zuroff et al., 2000).

Working from the perspective of the treatment alliance literature, Zilcha-Mano (2017) suggested that those patients who quickly feel attached and connected with their therapist and are eager to work on their issues will have their therapeutic improvements predicted by things like whether the analyst and patients share a vision of the treatment goals. Zilcha-Mano defineed those who quickly connect with their therapists as having *trait alliance*. This description of trait alliance fits nicely with the anaclitic prototype, as previous literature has indicated that anaclitic patients tend to achieve greater alliances with their therapists (Blatt et al., 2001; Blatt & Ford, 1994; Zuroff et al., 2000). It is believed that anaclitic patients whose alliance increases will fare better than for anaclitic patients for whom that is not the case. As previous literature has indicated, those with introjective styles traditionally have poorer trait alliance (Blatt & Ford, 1994; Zilcha-Mano, 2017). One key factor as to why lengthier treatments are necessary for introjectives is their difficulty of establishing a positive therapeutic alliance (Blatt et al., 2001; Blatt & Ford, 1994; Zuroff et al., 2000).

Current Study

Because the symptom presentation of clinical diagnoses varies so much that individuals with the same diagnosis may only share one or two cardinal symptoms while still meeting criteria for the same diagnosis (Goodwin, 2015), examining the underlying personality constructs and how each type best responds to treatment is particularly important. Specifically,

understanding how these personality constructs influence factors such as treatment length, therapeutic alliance, and treatment outcome may assist in determining which treatment modalities best suit an individual's therapeutic needs in order to maximize their treatment gains. Research has revealed two core personality constructs, anaclitic and introjective; each have proven to be predictive of differential outcome patterns based on the treatment offered (Blatt, 1995; Luyten & Blatt, 2013). For the introjective personality types, short-term treatment may often not address the core underlying concerns and/or may result in premature termination, primarily because of distrust of the treater, minimizing therapeutic gains (Blatt et al., 2001).

This study utilized various measures in order to rate the participant variables as well as the outcome variables. The Prototype Matching Scale (Werbart & Forsstram, 2014) was used to individually rate the participant's anaclitic and introjective functioning. An adapted version of the Working Alliance Inventory- Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) was utilized to rate the therapeutic alliance between the analyst and the patient. The outcome measures included the Global Assessment of Functioning (GAF; American Psychiatric Association, 2000), Personality Health Index (PHI; Westen & Shedler, 1999), and "diagnostic status." The GAF is a commonly used numeric scale that subjectively rates an individual's social, occupational, and psychological functioning. The PHI and "diagnostic status" measurements are both derivatives of the Shedler-Westen Assessment Procedure-200 (SWAP-200; Shedler & Westen, 2007). The SWAP-200 is a widely researched personality assessment instrument composed of 200 items that describe both healthy and pathological personality features (Shedler & Westen, 2007).

The purpose of the current study is to examine how anaclitic and introjective personality traits predict the outcomes of psychoanalysis through the examination of 27 audio recorded

psychoanalyses. The first set of hypotheses included those involving introjective personality constellations and treatment outcome (1a-1b).

Hypothesis 1a: Those patients with greater initial levels of the introjective style as measured by the Prototype Matching Scale (Werbart & Forsstram, 2014) will predict a greater number of treatment sessions before the termination of therapy.

Hypothesis 1b: The number of treatment sessions moderate the effect of initial introjective ratings as measured by the Prototype matching scale on treatment outcome as measured by the GAF (American Psychiatric Association, 2000), PHI (Westen & Shedler, 1999), and "diagnostic status."

The second set of hypotheses included those involving therapeutic alliance, anaclitic functioning, and treatment outcome (2a-2b).

Hypothesis 2a: Initial alliance ratings as measured by the adapted WAI-SR (Hatcher & Gillaspy, 2006) will predict greater early anaclitic levels as measured by the Prototype Matching Scale (Werbart & Forsstram, 2014).

Hypothesis 2b: Increases in alliance from the beginning to the end of treatment as measured by the WAI-SR (Hatcher & Gillaspy, 2006) will be related to increases in anaclitic levels across treatment as measured by the Prototype Matching Scale (Werbart & Forsstram, 2014).

Lastly, the third set of hypotheses included those involving therapeutic alliance, personality style, and treatment outcome (3a-3c).

Hypothesis 3a: Higher initial anaclitic ratings will be related to a greater balance between the anaclitic and introjective scores at the end of treatment as measured by the Prototype Matching Scale (Werbart & Forsstram, 2014).

Hypothesis 3b: Higher initial anaclitic scores as measured by the Prototype Matching Scale (Werbart & Forsstram, 2014) will predict better therapeutic outcomes at the end of treatment as measured by the GAF, PHI, and "diagnostic status" (American Psychiatric Association, 2000; Westen & Shedler, 1999).

Hypothesis 3c: Initial alliance ratings as measured by the WAI-SR (Hatcher & Gillaspy, 2006) will predict better treatment outcomes as measured by the GAF, PHI, and "diagnostic status" (American Psychiatric Association, 2000; Westen & Shedler, 1999).

Method

Participants

An archival sample from 27 outpatient psychoanalyses obtained from the Psychoanalytic Research Consortium was utilized for this study. The audio recorded psychoanalyses took place between 1968 and 2012. The patients entered treatment with varying presenting concerns, such as depression or social anxiety disorders. The average age of the patients was 33 years and 48% were female. The sample utilized was a convenience sample. In this sample, reasons for the termination of treatment included successful terminations, meeting desired treatment goals, and some interruptions, discontinuing treatment before achieving desired outcomes. The current research team had limited additional information regarding the participants as their information was deidentified to protect their identities. A group of analysts and patients agreed to tape record

their analyses. At the conclusion of the analysis, all those pairs who chose to donate their analyses formed the collection of the 27 analyses in the current study. There were seven analysts in the sample and all of them were male. Each seasoned analyst had completed their psychoanalytic training more than 5 years ago before seeing any of the patients used in this study. There was no additional information available about the analysts. The average length of treatment was 366 sessions, ranging from 120 to 2836 sessions.

Procedure

Xavier University IRB approval (see Appendix A) was obtained prior to completing the proposed study. Participants' names and personal information were omitted from any public documentation, and de-identified recordings and transcripts are stored on a secure server. Recordings and transcripts were downloaded and electronically distributed to raters through a secure Educational Server System (Canvas) on campus.

Although recordings were available for each session, 20 sessions have been transcribed for each client. The 20 sessions were split into three basic categories: eight near the beginning, four in the middle and eight near the end of treatment. This study involved actively rating eight of those sessions. For the beginning stage, the first four sessions or four sessions near the beginning of meeting four times a week were rated – in any case the earliest four recorded sessions. For the termination stage, four sessions from the sixth week (or so) before termination were rated. The current researchers coded the introjective and anaclitic functioning using Prototype Matching of Anaclitic and Introjective Personality Orientation (Werbart & Forsstram, 2014). Additionally, they rated the therapeutic relationship using the Working Alliance Inventory- Short Revised form (WAI-SR, Hatcher & Gillaspy, 2006). The WAI-SR was adapted to accommodate third party ratings. Previously, the eight sessions near the beginning of

treatment (including the four rated in the current study) and eight at the end of treatment (again including the four in the current study) had been rated by another team to assess treatment outcomes using the Shedler-Westen Assessment Procedure (SWAP; Shedler & Westen, 2007) and Global Assessment of Functioning scale (GAF; American Psychiatric Association, 2000) for each of the 27 patients (e.g., Gazzillo et al., 2014; Waldron et al., 2011).

The current research team composed of three advanced graduate students and a graduate analyst with more than five years of analytic experience rated the patients' Prototype Matching rating and the Alliance of the patient/therapist duo from the four selected sessions at the beginning or the end of treatment (the RF scale for another study was rated at the same time). It was not possible to disguise whether the treatment was at its beginning or end. To minimize bias, the beginning hours for a specific participant were rated at a time as far removed as possible from the ending hours (generally about four months), offering a buffer period in which other participants were rated. At least two raters rated each set of hours. The raters were randomized into different teams throughout the coding process. The recording of the first hour of each group of four was listened to by each rater while reading a transcript in order to get a sense of the cadences and rhythm of the patients. The subsequent three hours were read from a transcript without listening to the audio.

Researchers rated each session before going on to read the next. They also noted supporting evidence for the ratings they assigned. After rating four sessions, they met with the other raters to discuss how they rated those hours to prevent drift and to improve interrater reliability in subsequent ratings. During these meetings, no ratings were altered. Meetings to discuss ratings took place at the end of the week in which the ratings were completed. Initially this process was used as training for the raters using the middle four hours of random

participants. this process was repeated until an interrater reliability of at least .70 was established for each instrument. After reliability was established, coding began on the beginning and late hours of treatment.

Measures

Prototype Matching of Anaclitic and Introjective Personality Orientation. The Prototype Matching of Anaclitic and Introjective Personality Orientation Scale (Werbart & Forsstram, 2014) consists of two numeric scales: one of anaclitic and one of introjective personality features. To assess the personality configurations of the participants, a prototype matching method was utilized, generating categorical and dimensional valuations (DeFife et al., 2013; Westen, 2012). That is, patients were rated on binary scales of introjective and anaclitic functioning by measuring the 'fit' of each personality style with the prototype. Each participant was rated on a scale ranging from 1 (*little to no match*) to 5 (*very good match*) on each of the scales at the beginning of treatment and, at a different point and perhaps by different raters, at the end of treatment. Anaclitic clients were defined as those with a score of three or greater on the initial anaclitic scale of the Prototype matching scale (Werbart & Forsstram, 2014). There were 11 clients in the anaclitic group. Three clients within the anaclitic group presented with higher anaclitic ratings while also having a three on the introjective scale; therefore, three of those in the anacliticly dominant group might be considered a 'mixed' type. Introjective clients were defined as those with a score of three or greater on the initial introjective scale. There were 16 clients in the introjective group.

Prototype matching ratings were made independently by each of at least two judges to maintain and report interrater reliability. In previous research, interrater reliability for the Prototype Matching of Anaclitic and Introjective Personality Orientation Scale was satisfactory

but not strong (0.65; Werbart & Forsstram, 2014). In the current study, the interrater reliability for this prototype scale was 0.80, which is good.

Working Alliance Inventory-Short Revised (WAI-SR), Adapted. The Working Alliance Inventory-Short Revised (WAI-SR, Hatcher & Gillaspy, 2006) is a measure completed by both the therapist and client. It assesses three key aspects of the therapeutic alliance: agreement on the tasks of therapy, agreement on the goals of therapy, and the development of an affective bond. The WAI-SR is a 12-item measure that demonstrated good psychometric properties with a Cronbach's alpha of 0.91 and a test-retest reliability of 0.93 (Paap & Dijkstra, 2017). The original WAI-SR items use this response format: 1 = *seldom*, 2 = *sometimes*, 3 = *fairly often*, 4 = *very often*, 5 = *always*. Higher scores on the WAI-SR are associated with better treatment outcomes (Paap & Dijkstra, 2017).

There is a version of the WAI that was designed to be rated by third party observers, the Working Alliance Inventory – Observer Form (WAI-O, Darchuk et al., 2000). The 36 items on the measure use a Likert scale response format ranging from 1 = *very strong evidence against*, to 7 = *very strong evidence*. A shortened version of this observer rating variant did not yet exist, so it was created by the current research team. Therefore, the items from the WAI-SR were adapted with their corresponding items from the WAI-O to retain the measure's integrity while allowing for a more accommodating version of the WAI-O to be utilized, resulting in a 10-item measure. The same Likert scale 1 to 7 response format used in the WAI-O was used in the adapted version. Individual items in the measure were used to rate the three factors of working alliance: goal, task, and bond. Three unique items were used in the scoring of goal of treatment, four items were used to assess the agreement on the task of treatment, and three were used to rate the

therapeutic bond. In the current study, the adapted WAI-O ratings had a Cronbach's alpha coefficient of 0.82, indicating good interrater reliability.

Global Assessment of Functioning (GAF). The Global Assessment of Functioning (GAF; American Psychiatric Association, 2000) is a numeric scale that subjectively rates an individual's social, occupational, and psychological functioning, using a scale from 100 (*extremely high functioning*) to 1 *(severely impaired functioning*). The scale is rated by clinicians and researchers after exposure to diagnostic information gathered in a variety of formats. The rater determines what level of functioning is the best descriptor of the patient who has been assessed. Lower GAF scores, below 70, are regarded as falling into a clinical range, while those above 70 designate a nonclinical, healthy range. In the current study, individuals had an average GAF of 64 at the beginning stage of treatment and a 71 at the end of treatment. This means that the average participant started treatment in the "some or mild symptoms" category and finished treatment in the "transient and expectable" category (American Psychiatric Association, 2000).

The GAF demonstrates strong interrater reliability (0.81 to 0.85) and concurrent validity with other global symptom severity indices (Hilsenroth, Ackerman, Blagys et al., 2000; Vatnaland, T., Vatnaland, J., Friis, & Opjordsmoen, 2007). Although the GAF has established adequate reliability, it is important to note that psychiatric symptoms have a greater impact on GAF ratings than variables associated with social and occupational functioning, resulting in more inflated scores for those suffering from syndromes like depression, like some of the patients in our sample (Skodol et al., 1988). In the current study, the average change experienced between the GAF at the beginning and the end of treatment was an increase of 7 or 11.1%. Additionally, the GAF had a smaller effect size of 0.31.

Shedler-Westen Assessment Procedure-200 (SWAP). The Shedler-Westen Assessment Procedure-200 (SWAP-200) is a widely researched personality assessment instrument composed of 200 items that describe both healthy and pathological personality features (Shedler & Westen, 2007). This measure has had interrater reliability scores ranging from .75 to .89 (Martin-Avellan, McGauley, Campbell, & Fonagy, 2005; Shedler & Westen, 1998; Westen & Muderrisoglu, 2006). The current study used archival ratings on the SWAP-200 to assess changes in psychopathology over the course of treatment.

The SWAP-200 uses a Q-sort method which requires clinicians to rate the 200 items so that a fixed distribution is obtained (Block, 1978; Shedler & Westen, 2007; Westen & Shedler, 1999). The raters score each item on a scale of 0 = *not descriptive* to 7 = *most descriptive* according to how salient the item is to that person's functioning. Outcome measures discussed in the current results and discussion sections derived diagnoses based on the SWAP assessment, using its indicators of psychological health as opposed to true psychological diagnoses. Due to this, diagnostic criteria will be referred to using quotes. "Diagnostic" status had a medium effect size of 0.47.

Personality Health Index (PHI). The PHI is a global measure of psychological health and personality functioning which is calculated using items of the SWAP-200. The PHI scale has been normed on a sample of patients entering analysis (Westen & Shedler, 1999). PHI scores are reported as percentile figures. So, for example, an overall PHI score of 15% would state the individual is more ill or functioning less healthily than 85% of the normative sample.

The PHI uses items from the SWAP to produce the health/illness ratings. Clinicians rated SWAP items in order to create weightings from +3 to -5, depending on their salience to psychological health, with the positive items indicating health, negative items indicating

pathology, and the absolute value of the item indicating the strength of item. This allows for the tracking of psychological health at a specific point as well as across treatment. The PHI achieved an excellent interrater reliability rating of .87 (Waldron et al., 2011). In the current study, the average change between the PHI at the beginning and the end of treatment was an increase of 24.6 or 64.9%. Additionally, based on the PHI, there was a large effect size of 0.88.

Results

Of the 27 participants, 16 met "diagnostic" criteria at the start of treatment. Ten participants no longer met "diagnostic" criteria at the end of treatment. In the current study, the average change experienced between the PHI at the beginning and the end of treatment was an increase of 24.6 or 64.9%. The average PHI at the start of treatment was 37.9 and was 62.5 at the end. The average change experienced between GAF at the beginning and the end of treatment was an increase of 7 or 11.1%. The average GAF at the start of treatment was 64.1 and was 71.3 at the end.

Primary Analyses

The set of hypotheses regarding introjective personality constellations and treatment are reported first (1a-1b). Hypothesis 1a stated that those patients with greater initial levels of the introjective style have a greater number of treatment sessions before the termination of therapy. To assess whether greater initial levels of the introjective style predicted a higher number of treatment sessions before the termination of therapy, a linear regression was conducted between the initial introjective ratings and the number of treatment sessions. Contrary to the hypothesized findings, this regression revealed that greater initial levels of the introjective style

were significantly correlated to those patients having fewer treatment sessions before termination ($F(1,25) = 12.55$, $p < .001$, $R^2 = 0.06$).

Hypothesis 1b: a moderation analysis was conducted to assess if treatment duration moderated the relationship between initial introjective scores and the outcome measures (see Table 5). Essentially, this analysis investigated whether those with introjective features required a longer treatment to achieve positive outcomes. Therefore, individual moderation analyses were conducted for GAF, PHI, and "diagnostic" criteria. In order for moderation to be supported, two conditions must be met (Baron & Kenny, 1986). First, the causal predictor variable, initial introjective scores, must significantly predict GAF in the simple effects model (step 1). Secondly, the interaction model (step 3) must explain significantly more variance of GAF than the non-interaction model (step 2). If either of these conditions fail, moderation is not supported. These regressions were examined based on an alpha of 0.05.

Mean centering was used for initial introjective scores and treatment duration. In the first step, a simple effects model was created using linear regression with GAF as the outcome variable and initial introjective scores as the predictor variable. In the second step, a non-interaction model was created by adding treatment duration to the predictor in the linear model in step 1 (simple effects model). In the third step, an interaction model was created by adding the interaction between initial introjective scores and treatment duration to the predictors in the linear model in step 2 (non-interaction model). Assumptions for linear regression analysis were conducted for the step 3 model (interaction model). These steps were then repeated for the other outcome variables: PHI and "diagnostic" criteria.

Initial introjective scores significantly predicted GAF, $B = 2.05$, $t(25) = 3.10$, $p = .002$. Therefore, the first condition was met, and the second condition was checked. A partial *F*-test was conducted to determine if the interaction model explained more variance in GAF than the non-interaction model. The partial *F*-test, $F(1,25) = 19.76$, $p < .001$, indicated that the interaction model explained significantly more variance compared to the non-interaction model based on an alpha of 0.05. Therefore, the second condition was met. Since initial introjective scores significantly predicted GAF in the simple effects model (condition 1) and the interaction model explained significantly more variance of GAF than the non-interaction model (condition 2), then moderation is supported.

Treatment duration significantly moderated the effect initial introjective scores had on GAF based on an alpha of 0.05, $B = 0.01$, $t(25) = 4.45$, $R^2 = 0.13$, $p < .001$. This indicates that on average, a one-unit increase of treatment duration will cause a 0.01 increase in the slope of GAF on initial introjective scores. In order to visualize the moderation analysis, treatment duration was dichotomized into High and Low categories using a median split. The High category indicates all observations of treatment duration above the median, and the Low category specifies all observations of treatment duration below the median. Figure 1 shows the regression lines for GAF predicted by initial introjective scores for the High and Low categories of treatment duration. The results of the simple, non-interaction, and interaction models are presented in Table 1. Table 2 presents a comparison of the non-interaction and interaction models.

As was the case when GAF was the dependent variable, when PHI was the dependent variable and the moderation hypothesis was tested, the first regression was significant (*B* =

6.64, $t(25) = 2.47$, $R^2 = 0.20$, $p = .014$), and the partial F-test indicated that the interaction model explained significantly more variance compared to the non-interaction model condition ($F(1,25) = 43.77$, $p < .001$). Therefore, both conditions were met, and moderation was supported.

The results of the simple, non-interaction, and interaction models are presented in Table 3. Table 4 presents a comparison of the non-interaction and interaction models. Treatment duration significantly moderated the effect initial introjective scores had on PHI based on an alpha of 0.05, $B = 0.03$, $t(25) = 6.62$, $p < .001$. Therefore, a one-unit increase of treatment duration will cause a 0.03 increase in the slope of PHI on initial introjective scores. Figure 2 shows the regression lines for PHI predicted by initial introjective scores for the High and Low categories of treatment duration.

As was the case when GAF and PHI were the dependent variables, when the absence of "diagnostic" criteria at the end of treatment was the dependent variable and the moderation hypothesis was tested, the first regression was significant ($B = -0.43$, $t(25) = -3.65$, $p < .001$). However, the partial F-test indicated that the interaction model did not explain significantly more variance than the non-interaction model. Therefore, the second condition was not met, and moderation was not supported and could not be continued.

It is notable that when this research was initially proposed, the researcher had decided to conduct a moderation analysis as opposed to the mediation analysis that was just described. This was proposed with the intention of seeing if the strength of the relationship between initial introjective scores and the outcome variables was further enhanced when accounting for treatment duration. Although this mediation analysis could be and was carried out with significance for both GAF ($F(1, 25) = 5.47$, $p = .005$) and PHI ($F(1, 25) = 4.34$, $p = .014$), it did not provide a clear illustration as to what occurred between the three variables. Introjectives

simply need more time to establish a trusting relationship with a treater as they expect a treater to be harsh, distant and judgmental – much the way they are with themselves and presumably the way that they have experienced others as having been in their past. The moderation model is a straightforward way of evaluating to what effect that relationship is enhanced.

The mediation analysis suggests that the relationship between the introjective style and the treatment effect is only present when additional sessions are factored into the equation. In short, the mediation captures that there is a relationship between the independent variables in predicting the dependent variables. However, it does not speak to how the third variable, treatment duration, impacts the relationship between the introjective style and the outcome measures. Ultimately, the moderation provided additional clarity that treatment duration was related to improved functioning among introjectives consistent with the hypothesis.

The set of hypotheses regarding therapeutic alliance, anaclitic functioning, and treatment outcome are reported second (2a-2b). Hypothesis 2a: to test whether stronger therapeutic alliances at the beginning of treatment, trait alliance, predicted early initial features of the anaclitic style, a linear regression was calculated between the initial anaclitic values and initial trait alliance. The results showed that a significant predictive relationship between early alliance ratings and initial anaclitic ratings was present ($F(1,25) = 12.02$, $p < .001$, $R^2 = 0.05$).

Hypothesis 2b: to assess whether improved therapeutic alliances at the end of treatment were associated with increases in anaclitic functioning at the end of treatment, a Pearson correlation between the change in alliance (WAI-SR Time 2 – WAI-SR Time 1) and change in anaclitic levels (Anaclitic Score Time 2 – Anaclitic Score Time 1) was conducted. Based on the analyses, no significant correlation was found between the variables, ($r_p = -0.04$, $p = .592$).

The set of hypotheses regarding therapeutic alliance, personality style, and treatment outcome are reported third (3a-3c). Hypothesis 3a: in order to examine whether higher initial anaclitic features were predictive of a smaller difference between anaclitic and introjective scores at the end of treatment, a Pearson correlation of initial anaclitic functioning was compared to the absolute value of final anaclitic minus introjective functioning. Though it was predicted that higher initial anaclitic ratings would predict lower differences between the anaclitic and introjective scores at the end of treatment, results of the Pearson correlation analysis revealed no significant correlation between patient's initial anaclitic functioning and their level of integration between anaclitic and introjective features at the end of treatment (r = .12, p = .54).

Hypothesis 3b: to evaluate whether higher initial anaclitic scores were predictive of better therapeutic outcomes at the end of treatment (higher GAF, higher PHI, and fewer "diagnostic" criteria met), initial anaclitic functioning was regressed against final scores on the GAF, PHI, and absence of "diagnosable" criteria. A standard regression revealed initial anaclitic functioning did not predict greater levels of positive change in GAF scores at the end of treatment (β = -2.18, t = -.68, p = .51). Similarly, the regression model was not significant between initial anaclitic ratings and the PHI scores at the end of treatment (β = -.10, t = -.32, p = .10). A logistical regression was performed to determine whether initial anaclitic scores were related to fewer "diagnostic" criteria met at the end of treatment; the regression revealed no significant relation between the variables ($\chi^2(1) = 0.59$, p = .442).

Hypothesis 3c: in order to assess whether initial alliance ratings predicted better treatment outcome as measured by the GAF, PHI, and the presentation of fewer "diagnostic" criteria at termination, two standard regressions (for GAF, PHI) and one logistic regression (for "diagnostic" criteria) were completed. Initial therapeutic alliance ratings were compared to

treatment outcomes. Regarding the GAF scores, the results of the regression model were not significant, (β = .44, t = .75, p = .46), indicating early alliance ratings did not explain a significant proportion of variance in GAF. For PHI, the results of the linear regression model were not significant, (β = 2.80, t = 1.18, p = .24), indicating early alliance ratings did not explain a significant proportion of variance in PHI. The logistic regression model, $\chi^2(1) = 6.10$, p = .01, to assess whether initial alliance ratings predicted "diagnostic" status at the end of treatment was significant, indicating that early alliance ratings predicted the absence of "diagnostic" criteria at the end of treatment.

Discussion

Based on the literature supporting a relationship between personality styles and treatment outcome (Blatt et al., 2001; Blatt & Ford, 1994; Blatt & Schichman, 1983; Zuroff et al., 2000), a series of predictions about introjective functioning were supported, though most of the predictions about anaclitic functioning were not. The hypotheses related to introjective functioning are reviewed first, followed by those related to therapeutic alliance. Lastly, a deeper exploration as to why the anaclitic hypotheses were not supported are conducted.

The first of the introjective hypotheses was hypothesis 1a, which was based on the expectation that those with greater initial introjective ratings would have longer treatments (Blatt et al., 2001; Blatt, 2004; Zuroff et al., 2000). Although the results were significant, they were opposite to the predicted direction. Those with greater initial introjective ratings were more likely to have fewer sessions. Hypothesis 1b provides some hints that may help to explain the directionality observed in hypothesis 1a. Hypothesis 1b assumed that treatment duration directly moderated the positive outcomes for those with greater initial introjective ratings. These

significant findings were supported for two of the three outcome measures (GAF & PHI), whereas the moderation was not supported when applied to “diagnostic” criteria.

In hypothesis 1b, the moderator can be thought of as a ‘multiplying force’ towards positive treatment outcomes. So, if treatment duration is our multiplier, then the more of it we have (the longer treatment extends), the greater the treatment outcomes for introjectives. However, there is a limit to this effect, such that it would not continue indefinitely. Additionally, in the sample, introjectives might be thought of as having a lower base value than their anaclitic counterparts. But this lower base value comes with the ability to be multiplied with additional treatment, granting them tremendous potential for therapeutic gain. In the introjective population, improvement is believed to occur when the client and the analyst achieve a shared vision of the treatment goals and establish adequate time for the client to trust their analyst. The lower base value might make it difficult to feel that change is possible, all the while engaging in an innately difficult task, perhaps resulting in earlier termination rates that were observed in Hypothesis 1a.

Taken together then, hypotheses 1a and 1b provide a fuller picture that greater initial introjective features were associated with shorter treatments; better treatment outcome required lengthier treatments. In other words, and consistent with Blatt’s understanding of the constructs (Blatt et al., 2001; Blatt, 2004; Zuroff et al., 2000), patients with introjective features want to leave treatment as soon as they can. However, these earlier terminations may occur before optimal work is achieved, even in longer term treatments like psychoanalysis. These individuals may have been in treatment for a long period of time relative to psychotherapy or perhaps to what they imagined would be useful to them.

To assess the exploratory, post-hoc hypothesis that was formulated from analyzing the data for hypotheses 1a and 1b that a lack of therapeutic alliance would be related to an earlier or more 'premature' termination, a Pearson correlation was conducted between treatment length and therapeutic alliance at the end of treatment for introjective clients. Introjective clients were defined as those with a score of three or greater on the initial introjective scale of the Prototype matching scale (Werbart & Forsstram, 2014). There were 16 clients in this group.

The correlation between treatment length and alliance at the end of treatment for this group of 16 introjective clients was significant though small ($r = 0.21$, $p = .01$). Therapeutic alliance ratings were comprised of three individual ratings between the analysis and patient on the therapeutic bond, task, and agreement. The average of these three ratings makes up the overall alliance rating. The relationship between the therapeutic bond subscale at the end of treatment and length of treatment was also significant ($r = 0.17$, $p = .044$).

The first of the hypotheses regarding therapeutic alliance, anaclitic functioning, and treatment outcome was Hypothesis 2a. It assumed that anaclitic personality features would predict greater levels of therapeutic alliance at the start of treatment. This hypothesis was supported. As expected, individuals who are more focused on seeking out relationships were rated as working more closely with their treaters at the beginning of the relationship.

Hypothesis 2b was based on the expectation that as a client's anaclitic scores change across treatment so would their therapeutic alliance. This did not turn out to be the case. Upon reflection, it is likely this finding was insignificant due to the likely interaction being more complex than the hypothesis gives it credit. It seems more likely that for anaclitic clients, the alliance would actually worsen as they approached the middle of treatment as their default stances of agreeableness are challenged. That is, in a successful analysis, the style of interacting

would come under question, and as this reliance on others, and specifically the analyst, becomes more fluid, various complex transference experiences might emerge that the style was intended to protect against. In the course of a long-term treatment, the alliance and the anaclitic scores may fluctuate in a complex rather than in a simple linear fashion.

Hypothesis 3a was based on an expectation that, in a psychoanalysis, anaclitic patients would become more introjective by the end of treatment while retaining their anaclitic proclivities (Werbart & Forsstram, 2014). Put another way, these anaclitic individuals were expected to achieve a healthier balance. However, there was no evidence to support this.

Next, hypothesis 3b assumed that the presence of anaclitic features at the start of treatment would be related to better treatment outcomes. As with hypothesis 3a, this did not turn out to be the case. Both hypotheses possess strong empirical backing (Blatt et al., 2001; Blatt & Ford, 1994; Luyten & Blatt, 2013; Werbart & Forsstram, 2014); however, one notable difference between our sample and those of previously cited research involves the length of treatment and the idea of a "natural" termination of treatment. This will be better understood after the discussion of hypothesis 3c.

Additionally, hypothesis 3c was based on the expectation that initial early indicators of therapeutic alliance would be related to positive therapeutic outcome. These alliance ratings were significantly related to the client endorsing fewer "diagnostic" criteria at the end of treatment; however, the other indicators of psychological health, GAF and PHI, were not significant. This outcome was expected to be significant due to the therapist and patient agreeing on the tasks and goals at hand while having a strong enough bond to work through various difficulties. Though initial alliance might be significantly related to outcome in a relatively short treatment (those studies reviewed by Zilcha-Mano (2017) ranged from 10-30 sessions;

average=17), in order for a longer term treatment to take place (the lowest number of sessions in this sample is 120), a treatment alliance needs to be established at some point.

As a whole, we are left with the question as to why all but one of the anaclitic hypotheses were not supported. A couple of considerations include the length and style of treatment. The anaclitic scale at the beginning of treatment was associated with higher alliance at the beginning of treatment. In this sample in which all the protocols come from analyses of over 120 sessions, some level of treatment alliance was established. Psychoanalysis is a treatment that is probably designed by introjectives and frankly designed for introjectives. We all have some introjective issues – but the anaclitic aspects of ourselves may not always serve us well – or another way of saying that, they may not be as responsive to the analytic process. Being in a relationship with a therapist over a long period of time addresses our anaclitic wishes, but it does not become the primary focus of treatment. However, it is the healthy anaclitic parts of ourselves that allow for increasingly mature levels of interpersonal relatedness to others, such as therapists.

Blatt (1992) highlighted the therapeutic gains on anaclitic individuals, which were notable in both psychoanalysis and psychotherapy. However, in Blatt's sample, anaclitic individuals in psychotherapy as opposed to psychoanalysis experienced significantly more therapeutic gains. The notion that psychoanalysis is best suited for introjective individuals has been supported by numerous works by Blatt; however, that is not to say that psychoanalysis does not benefit anaclitics (e.g., Blatt 1992; 1998; Blatt & Ford, 1994, Zuroff et al., 2000).

It is helpful to understand why these hypotheses stating that anaclitic individuals were more likely to experience therapeutic gains were put forth in the first place. They were chosen based on an inference made from the empirical literature – that anaclitics would achieve greater therapeutic gains than introjectives. This was primarily based on several key studies that

reported anaclitic individuals as achieving greater outcomes than introjectives in side by side comparisons (Blatt et al., 1998; Blatt, Shahar & Zuroff, 2001; Zuroff et al., 2000 Blatt et al., 1998; Blatt, Shahar & Zuroff, 2001; Zuroff et al., 2000; Werbart & Forsstrom 2014; Werbart, Aldén, & Diedrichs, 2017). Once it was assumed that anaclitics would consistently outperform introjectives, additional support for this claim was gathered. However, some of the empirical literature highlighting introjective individuals achieving greater success than anaclitics in longer-term treatments was undervalued (Blatt et al., 2001; Blatt & Ford, 1994). This assumption of 'truth' was likely made prematurely. Additionally, the sample used in the current study differed in important ways, notably treatment length, from several of the samples studied and an assumption was made that the results would be similar (e.g., Blatt, 1998; Blatt, Shahar & Zuroff, 2001; Zuroff et al., 2000).

It is less clear why the hypotheses about those with anaclitic features achieving a balance or an 'evening of the legs' were not supported. Werbart and Forsstrom (2014) highlighted how anaclitic clients achieved a greater balance between matters of self-definition and how they relate to others. In their sample, the clients engaged in psychoanalysis for an average of 61 months. A follow-up study with a larger sample found similar results (Werbart, Aldén, & Diedrichs, 2017). In a similar sample that excluded dropouts, it remains unclear as to why the current results did not match previous findings.

Lastly, one of the interesting contributions of this research was not related to the hypotheses. We were able to improve the reliability of the Prototype Matching of Anaclitic and Introjective Personality Orientation Scale (Werbart & Forsstram, 2014). The published scale has an interrater reliability of 0.65, whereas our study's adapted methodology increased the interrater reliability to 0.80. The methodology we used of reviewing and not changing scores after scoring

four sessions appears to have been responsible for this and should allow future research to investigate these complex personality constellations with greater confidence.

Limitations and Future Directions

A challenge throughout our research process was determining how many sessions were needed to achieve a clear snapshot of client variables. Direct observational access to therapist and client interaction to achieve adequate ratings on the client's anaclitic and introjective ratings, therapeutic alliance, and treatment outcome is difficult. Throughout the coding process, it became clear that taking one or two sessions out of context does not provide stable ratings for the assessed variables. Instead, the four sessions reviewed at the beginning and then again at the end of treatment felt necessary to accurately rate the client variables.

A broad limitation for this study was the limited data available regarding the analysts and the patients. There were no subjective ratings performed by the analyst or the patient regarding key variables, such as alliance. Additionally, all the analysts being male likely influenced the process and result of treatment. The analyses conducted took place between 1968 and 2012. Therefore, many gender and cultural differences could have influenced treatment during this large timeframe with each analyst being male. Using post-hoc analyses, the researchers investigated and found no significant relationship between gender and personality style. Another area of limited information included not having access to the reasons for termination between the clients and analysts.

An additional limitation for this study was the used of adapted measures. The internal reliability between the four members of the research group was good for the Prototype Matching of Anaclitic and Introjective Personality Orientation Scale (0.80; Werbart & Forsstram, 2014) as

well as the adapted WAI-SR (0.82; Hatcher & Gillaspy, 2006). However, both measures were adapted in some way. Stricter methodology was added to the Prototype Matching scale by having researchers meet and discuss their rationale for their ratings while the WAI-SR was combined with the WAI-O (Darchuk et al., 2000). This combination was performed to have access to a shorter alliance inventory that could be completed by an observer. Further reliability and validity testing could be conducted in the future on these adapted methodologies and measures.

This research was made possible due to the notable efforts of previous researchers, who recorded, transcribed, and coded numerous variables regarding these clients. We appreciate their efforts, as it would be incredibly demanding for us to engage in all these steps on our own. Furthermore, the rating of outcomes by a different research team allowed for the limitation of bias and unintentional shaping of results based on hypotheses. Additionally, when glancing at the sample utilized, it feels natural to state that the research had quite a limited sample size. When comparing it to other studies of its kind cited previously, it becomes clear that this criticism is applicable to this area of study as a whole.

A natural extension of the current research would be to explore the personality style of the analyst at the beginning and end of treatment to determine if there is a match/contrast with treatment outcome. Understanding the client and therapist qualities that best support positive treatment outcomes is a worthy treatment goal to pursue. Additionally, it would be helpful to further explore and assess the current accepted paradigm that healthy functioning requires fairly equal levels of introjective and anaclitic features (Werbart, Aldén, & Diedrichs, 2017; Werbart & Forsstram, 2014). For instance, it seems possible for someone firmly rooted in their style to become ‘better’ at it. This was something observed in the work of Werbart and Forsstram

(2014), where introjective individuals were reported as achieving positive outcomes while remaining unbalanced. For an anaclitic individual, they may still base their well-being on the quality of their relationships, but they may be better able to choose healthier relationships to engage in.

Conclusion

The current study suggests that individuals who scored higher on the introjective scale tended to have shorter treatments despite greater treatment length increasing likelihood of a positive treatment outcome. Additionally, those with greater anaclitic ratings had achieved greater initial levels of therapeutic alliance. These anaclitic features appear to mimic that of trait alliance, suggesting that those with anaclitic traits are more easily able to form connections with others while agreeing on a task at-hand. Another contribution of this research process is its notable improvement to the interrater reliability of a personality constellation scale from 0.65 to 0.80.

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Table 1

GAF Predicted by Early Introjective Scores Moderated by Treatment Duration

Predictor	*B*	*SE*	β	*t*	*p*
Step 1: Simple Effects Model					
(Intercept)	65.58	1.81		36.32	< .001
Initial Introjective Scores	2.05	0.66	0.21	3.10	.002
Step 2: Non-Interaction Model					
(Intercept)	64.41	2.08		31.04	< .001
Initial Introjective Scores	2.24	0.68	0.23	3.29	.001
Treatment Duration	0.00	0.00	0.08	1.14	.256
Step 3: Interaction Model					
(Intercept)	71.51	0.49		147.18	< .001
Initial Introjective Scores	2.54	0.66	0.26	3.87	< .001
Treatment Duration	0.00	0.00	0.16	2.35	.020
Initial Introjective Scores: Treatment Duration	0.01	0.00	0.30	4.45	< .001

Table 2

Linear Model Comparison Between GAF and Introjective Scores Interaction Model

Model	R^2	F	df	p
Non-Interaction	0.05			
Interaction	0.13	19.76	1	< .001

Table 3

PHI Predicted by Early Introjective Scores Moderated by Treatment Duration

Predictor	*B*	*SE*	β	*t*	*p*
Step 1: Simple Effects Model					
(Intercept)	45.09	7.32		6.16	< .001
Initial Introjective Scores	6.64	2.69	0.17	2.47	.014
Step 2: Non-Interaction Model					
(Intercept)	51.67	8.39		6.16	< .001
Initial Introjective Scores	5.61	2.75	0.14	2.04	.043
Treatment Duration	-0.01	0.00	-0.11	-1.59	.114
Step 3: Interaction Model					
(Intercept)	65.61	1.87		35.09	< .001
Initial Introjective Scores	7.36	2.53	0.19	2.91	.004
Treatment Duration	0.00	0.00	0.01	0.11	.910
Initial Introjective Scores: Treatment Duration	0.03	0.00	0.42	6.62	< .001

Table 4

Linear Model Comparison Between PHI and Introjective Scores Interaction Model

Model	R^2	F	df	p
Non-Interaction	0.04			
Interaction	0.20	43.77	1	< .001

Table 5

Moderation between Introjective Ratings and Treatment Outcome Visual Aid

Independent Variable	Moderator	Dependent Variables
Introjective Ratings	Treatment Duration	GAF
		PHI
		"Diagnostic Criteria"

Figure 1

Regression lines for GAF: Initial Introjective Scores for Treatment Duration

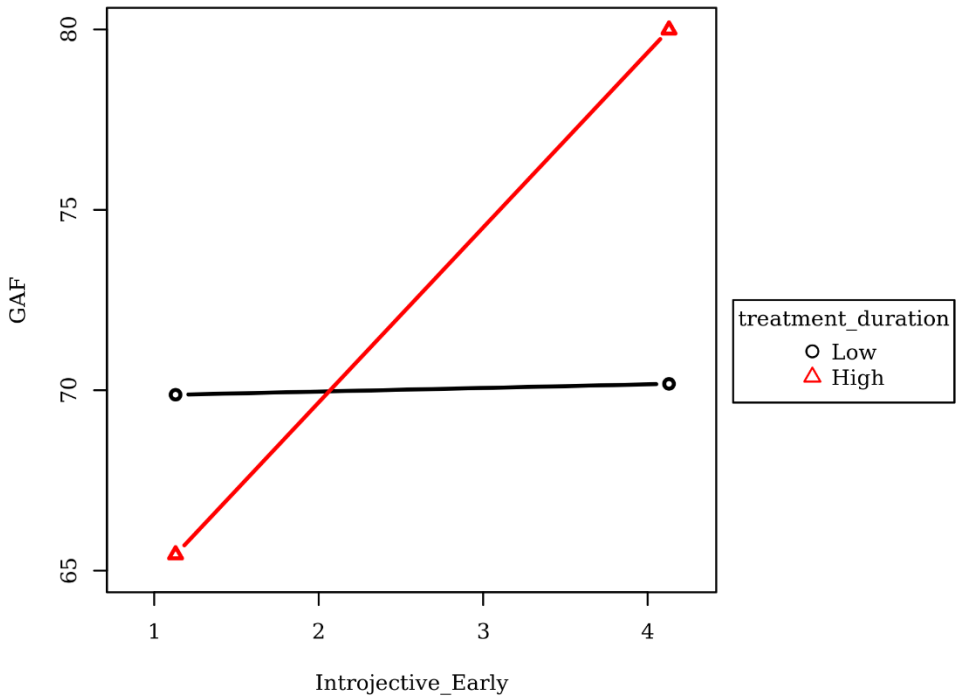
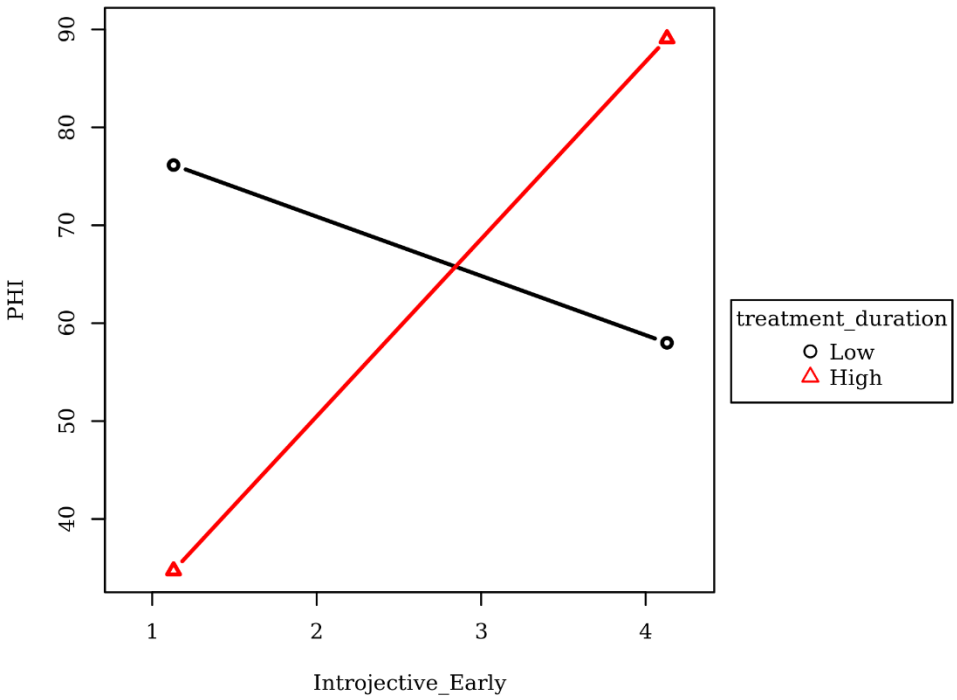


Figure 2

Regression lines for PHI: Initial Introjective Scores for Treatment Duration



Appendix A
Institutional Review Board Agreement

Luke Bieber
3607 Fallsburg Road
Newark, OH 43055

Re: Protocol #19-110, *Anaclitic-Introjective Personality Traits and Client Outcomes in Psychoanalytic Treatment*

Dear Mr. Bieber:

The IRB has reviewed the materials regarding your study, referenced above, and has determined that it meets the criteria for the Exempt from Review category under Federal Regulation 45CFR46. Your protocol is approved as exempt research, and therefore requires no further oversight by the IRB. We appreciate your thorough treatment of the issues raised and your timely response.

If you wish to modify your study, including the addition of data collection sites, it will be necessary to obtain IRB approval prior to implementing the modification. If any adverse events occur, please notify the IRB immediately.

Please contact our office if you have any questions. We wish you success with your project!

Sincerely,

Signature hidden at the
request of Dr. Mullins

Morrie Mullins, Ph.D.

Summary

Title: Anaclitic-Introjective Personality Traits and Client Outcomes in Psychoanalysis

Problem. Because the symptom presentation of clinical diagnoses varies so much that individuals with the same diagnosis may only share one or two cardinal symptoms while still meeting criteria for the same diagnosis (Goodwin, 2015), examining the underlying personality constructs and how each type best responds to treatment is particularly important. Specifically, understanding how these personality constructs influence factors such as treatment length, therapeutic alliance, and treatment outcome may assist in determining which treatment modalities best suit an individual's therapeutic needs in order to maximize their treatment gains. Research has revealed two core personality constructs, anaclitic and introjective; each have proven to be predictive of differential outcome patterns based on the treatment offered (Blatt, 1995; Luyten & Blatt, 2013).

Method. The current study evaluated how the anaclitic and introjective styles are related to therapeutic alliance, length of treatment, and treatment outcome using twenty-seven audio recorded psychoanalyses from an archival sample (participant's M_{age} = 33; 48% were female; all seven analysts were male). Four sessions near the beginning as well as the end of treatment were rated by three advanced graduate students and a graduate analyst. The current researchers coded the introjective and anaclitic functioning using Prototype Matching of Anaclitic and Introjective Personality Orientation (Werbart & Forsstram, 2014) and the therapeutic relationship using an adapted version of the Working Alliance Inventory- Short Revised form (WAI-SR, Hatcher & Gillaspy, 2006). The outcome measures (Global Assessment of Functioning (GAF; American Psychiatric Association, 2000), the Personality Health Index (PHI; Westen & Shedler, 1999), and an evaluation of "diagnostic criteria" derived from the Shedler-Westen Assessment Procedure-200 (SWAP-200; Shedler & Westen, 2007)) had been previously rated by another research team.

Findings. Participants who scored higher on the introjective scale tended to have shorter treatments despite treatment length moderating their positive treatment outcome. Additionally, those with greater anaclitic ratings had achieved greater initial levels of therapeutic alliance. Despite the fact that the measured alliance for the introjective participants was quite good and they stayed in treatment, on average, for 655 sessions, these data suggest that, when the introjective could stay in treatment longer, they profited more. This is believed to have occurred when they and the analyst had an affective bond and this, in turn, may have helped them establish adequate time for the introjective to trust their analyst enough to stay in treatment long enough to bring it to a proper close.

Implications. The current study suggests that individuals who scored higher on the introjective scale tended to have shorter treatments despite greater treatment length increasing likelihood of a positive treatment outcome. Additionally, those with greater anaclitic ratings had achieved greater initial levels of therapeutic alliance. These anaclitic features appear to mimic that of trait alliance, suggesting that those with anaclitic traits are more easily able to form connections with others while agreeing on a task at-hand. Another contribution of this research process is its

notable improvement to the reliability of a personality constellation scale from 0.65 to 0.80.