

Interpersonal communication in psychotherapy

A process-outcome study

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Abstract

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Title: Interpersonal communication in psychotherapy: a process-outcome study.

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Introduction: Research shows that psychotherapy is an effective treatment for many patients seeking help. What we know less about is what makes the way the therapist and patient communicate helpful or less helpful?

Aim: The present study aims to investigate what characterizes this communication across time with two groups of patients that either had very good effect of a specific treatment technique or had less effect of the same treatment technique. We wanted to examine the general way of communicating, as well as differences between the subgroups.

Method: This study is based on data from the First Experimental Study of Transference interpretations (FEST) study, a dismantling randomized controlled trial, where 100 patients received 1 year of psychodynamic therapy with or without transference work (TW). The main finding was that there was no difference between treatment groups. However, there was a moderated effect of Quality of object relations (QOR) and gender. Men with high QOR (N=21) showed a negative effect of transference work and women with low QOR (N=21) showed a large positive effect of transference work. The psychotherapy process of these two groups was coded using the Structural Analysis of Social Behavior (SASB) by the FEST researcher group. In the present study, two-way ANOVAs was conducted to investigate differences between SASB cluster scores between men with high QOR in TW/non-TW group and women with low QOR in TW/non-TW group. Multilevel modelling was used to assess the relation between a therapist variable and outcome in men and women, respectively.

Results: The results indicated that the communication as measured with SASB cluster scores, predominantly was seen as the therapist Protecting, and patient Trusting, the therapist

Affirming and patient Disclosing, or therapist Controlling and patient Submitting. In addition, we aimed to investigate whether SASB cluster scores could explain differences in outcome on Psychodynamic Functioning Scale (PFS). Limited differences were found between patient-therapist, between groups and over time. However, therapist “Control” was found to be more present in the transference work group (including both genders) compared to the non-transference work group (including both genders). Therapist Control was not found to be a clear predictor of outcome in this study and there were found no significant or strong effects. However, therapist Control seemed to be of relevance for the women in the study, indicating a negative effect of Control on outcome, especially for the TW-group. The present study has several limitations, including a small sample size.

Conclusion: Results from the present study indicate that SASB does not indicate substantial differences in the general way of communicating between the subgroups, between patient and therapist or across time. The differences detected in communication between the treatment groups do not seem to significantly predict outcome. Yet, therapist Control seemed to have negative impact on outcome for women, especially in the TW-group. However, the small sample size (N=42) and the complete confounding of the subgroup characteristics (gender and QOR) limit the possibility to draw a clear conclusion from this study.

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Table of contents

1	Introduction	12
1.1	History of psychotherapy research.....	12
1.1.1	Common factors and specific techniques.....	13
1.1.2	Psychotherapy process-outcome research.....	15
1.1.3	Research on psychodynamic therapy	16
1.2	Theoretical background.....	17
1.2.1	Psychodynamic therapy.....	17
1.2.2	Object relations theory	18
1.2.3	Transference	20
1.2.4	Transference interpretations.....	20
1.2.5	Countertransference	21
1.3	Structural Analysis of Social Behavior (SASB)	23
1.3.1	Background	23
1.3.2	Description	23
1.3.3	Coding	24
1.3.4	Theory	25
1.3.5	Studies using SASB	26
1.4	First Experimental Study of Transference interpretations (FEST)	27
2	Research questions	32
3	Methods.....	33
3.1.1	Patients	33
3.1.2	SASB.....	34
3.1.3	Outcome measures	34
3.1.4	Statistical analysis	35
4	Results.....	38
4.1	Research questions and results.....	38
4.1.1	Line charts	38
4.1.2	ANOVA	42
4.1.3	Multilevel Models	44
5	Discussion	47
5.1	Main findings	47
5.2	Methodological discussion.....	53
5.2.1	Strengths and limitations.....	54
5.3	Future research	55
6	Conclusion.....	56

1 Introduction

Key questions in psychotherapy research have been 1) *does psychotherapy work and, if so, 2) how does psychotherapy work and 3) what works for whom*. It is by now well established that psychotherapy is effective (Lambert, 2013; Smith & Glass, 1977; Wampold & Imel, 2015). However, uncertainty still exists concerning what are the active, and most important ingredients, that make psychotherapy effective (Kazdin, 2009). Subsequently, there are many possible explanations to what makes psychotherapy work. According to Wampold and Imel (2015), these are best characterized by a debate between proponents of evidence-based treatments/specific factors and proponents of common-factors (Wampold & Imel, 2015).

1.1 History of psychotherapy research

Early precursors of psychotherapy and psychotherapy research emerged as a part of medicine in the late 19th century. The introduction of “mind cures” and “talk therapies” was for the most part not well received in medical circles (Wampold & Imel, 2015). At the beginning of the 20th century, psychoanalysis largely dominated the field of psychotherapy, but it later came to be comprised of various methods. Due to various historical and contextual factors and consumer demand, the field expanded. As a result, there was an increasing pool of patients that seemed to need distinct treatments, and disagreement among practitioners what these treatments should comprise and how future therapists should be trained. New therapy orientations, such as humanistic-experiential, cognitive-behavioral, and couple and family therapy, gained a more central role in the coming years (Cautin, 2011). After the development of various theoretical orientations and as psychotherapy became more widespread and established, a need for evidence became more urgent (Wampold & Imel, 2015). A great part of the empirical basis of psychotherapy was drawn from studies on single cases, and a common criticism was a lack of objective verification of outcomes. Eysenck (1952, 1961, 1966) published several works pointing out this weakness, claiming that psychotherapy was no more curative than spontaneous remission. To address these shortfalls, medical methods, such as randomized design and placebo design, were applied to psychotherapy to demonstrate effect (Wampold & Imel, 2015). In 1977, Smith and Glass (1977), published a meta-analysis of all studies comparing a control group and psychotherapy. Their findings disputed Eysenck’s claims. As a result of an increasing amount of studies indicating that therapy is effective, the focus of psychotherapy research gradually

shifted to what aspects make therapy are effective, and whether some forms of psychotherapy are more effective for a particular issue or disorder than others (Wampold & Imel, 2015). This ongoing debate over what makes psychotherapy effective is elaborated upon in the upcoming section on common factors and specific techniques in psychotherapy practice and research.

1.1.1 Common factors and specific techniques

The concept of common factors was introduced by Rosenzweig in 1936. He considered all forms of psychotherapy to be equally effective because they all share factors that are essential in order for change to happen in therapy (Rosenzweig, 1936). Common factors are those factors that all therapies are considered to have in common and are also referred to as nonspecific or universal factors. They include therapist variables as well as client variables, the therapeutic relationship, and transtheoretical change principles, which include processes that promote important change mechanisms such as motivation, corrective experiences and hope (Cuijpers, Reijnders, & Huibers, 2019; Wampold & Imel, 2015). Alliance is the most researched common factor and is, in a common definition, composed of three components: the bond, the agreement about the goals of therapy, and the agreement about the tasks of therapy (Bordin, 1979; Wampold, 2015). A long standing finding from psychotherapy research is that different therapeutic approaches produce approximately identical clinical results due to the importance of common factors (Wampold & Imel, 2015).

At the other end of the scale, the focus is on specific factors. When investigating this, research is usually limited to one therapeutic tradition and to investigating which specific techniques that are effective. This is also termed *empirically supported treatments* (ESTs) (Wampold & Imel, 2015; Weinberger, 2014). A specific technique in psychotherapy can be understood as a defines tool or method used by a therapist to promote effective therapy or positive change in the patient (Harper & Bruce-Sanford, 1989). In the 80s, numerous meta-analyses comparing different therapeutic traditions were published (Dobson, 1989; Miller & Berman, 1983). When differences were found they often showed an advantage for cognitive and behavioral methods over traditional relationship-oriented traditions. When differences were found they often showed an advantage for cognitive and behavioral methods over

traditional relationship-oriented traditions. The differences were small, but consistent (Lambert, 2013).

Examples of specific factors in different forms of therapy can be found in Blagys and Hilsenroth's (2000) study of differences between activities in cognitive-behavioral (CB) and psychodynamic-interpersonal (PI) therapies. They identified certain differences between the two therapies. PI therapists focused more on affect and the expression of this in the session, emphasized past experiences, and explored dreams, fantasies and wishes. CB was for instance more characterized by homework assignments, activities outside sessions, teaching of skills, and focusing on client's future experience. One way to determine the importance of a specific ingredient is through a dismantling design, which is a type of component study where a critical ingredient is removed or added to an existing treatment. Based upon this method, the researchers are able to determine whether the efficacy of the treatment is weakened or strengthened. Such a result would provide evidence for specific effects (Wampold & Imel, 2015). Research examining specific factors have contributed to scientific and clinical advances in our understanding and application of specific psychotherapies (Weinberger, 2014).

The disagreements within the debate regarding which constituents of psychotherapy that are most important for the outcome has been, and is still to some degree, characterized by a dichotomy (Barber, 2009; Wampold & Imel, 2015). In spite of this, the debate has been somewhat nuanced by more recent discussions and studies of specific and common factors. While some authors claim CBT to be the gold standard of psychotherapy (David, Cristea, & Hofmann, 2018), other recent publications convey a critical view on the premise of a "gold standard" in psychotherapy and problematize the concept of ESTs (Leichsenring et al., 2018; Leichsenring & Steinert, 2017). In a recent article, de Felice et al. (2019) criticize the assumption that common and specific factors are independent of each other, which is a fundamental assumption in most studies investigating the role of common and specific factors in outcome variance. They claim this to be both statistically and conceptually unsound. There is a growing consensus in clinical psychology that common and specific factors both shape therapeutic outcomes (Hofmann & Barlow, 2014; Laska, Gurman, & Wampold, 2014), and many researchers stress the importance of an integrating perspective on specific techniques and common factors (Nissen-Lie, 2013). Studies indicate important interactions between specific and common factors in psychotherapy and relevant uses and implementations of

specific factors have been explored (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath, Del Re, Fluckiger, & Symonds, 2011; Wampold & Imel, 2015).

1.1.2 Psychotherapy process-outcome research

Psychotherapy process-outcome research examines both common factors and key theoretical aspects of specific psychotherapies (Wampold & Imel, 2015). More specifically, process-outcome research studies the relation between a measure on process and a measure on psychotherapy outcome. One of the strongest conclusions that can be drawn from the existing process-outcome studies is that alliance between therapist and patient is important to psychotherapy outcome across many forms of psychotherapy (Flückiger et al., 2012; Horvath et al., 2011). Other process-outcome studies investigate specific effects, and a robust finding that increased insight as a result of interpretations in psychodynamic therapy process leads to a change in symptoms. The term *insight* refers to an understanding that patients gain during therapy, which can alter maladaptive ways of functioning and relating to others. Self-understanding is a related term (Lambert, 2013).

Tools examining psychotherapy process and outcome

Psychotherapy process and outcome can be investigated in a number of ways. *The Psychotherapy Process Q-set (PQS)* is a tool designed to describe psychotherapy process at the level of an individual psychotherapy session (Price & Jones, 1998). It consists of 100 items describing therapist behaviors, patient behaviors and therapist-patient interactions. Uninvolved observers rate therapy sessions (from transcripts, video- or audiotapes) and are instructed to sort the items into 9 different categories and range them from least characteristic to most characteristic of this particular session. Opposed to other process measures which typically examine segments of the session, the PQS uses an entire hour as the unit of analysis. This may facilitate a more representative view of the session (Smith-Hansen, Levy, Seybert, Erhardt, & Ablon, 2012). Another way of measuring aspects of the psychotherapy process is using the *Vanderbilt Psychotherapy process scale (VPPS)* (Suh, 1989). The first version of the VPPS was constructed by Strupp (1974). The VPPS is an instrument designed to be rated by independent clinical observers, from the actual therapy, video recordings or audio recordings of the sessions. It consists of 80 items to be rated from 1, “not at all” to 5, a “great deal”. Three of the items concern the 1 of the therapeutic relationship, overall productivity

and the patient's level of function, respectively. The remaining items deals with therapist and patient behavior and adjectives describing each participant. In this thesis, process is measured by Structural Analysis of Social Behavior (SASB), which will be presented in section 1.3.

SCL-90-R is a self-report instrument developed by Derogatis (1977). It includes 90 items evaluating a broad range of symptoms of psychopathology. The instructions include asking the patient to consider experienced symptoms during his/her last week. The primary symptom dimensions are somatization, obsessive-compulsive, anxiety, phobic anxiety, depression, hostility, interpersonal sensitivity, paranoid ideation and psychoticism. *The Inventory of Interpersonal Problems (IIP)* is a self-report inventory initially developed by Horowitz. et al. (1988). The questionnaire seek to identify a person's most salient interpersonal difficulties. Items are grouped into eight subscales; domineering/controlling, vindictive/self-centered, cold/distant, socially inhibited, non-assertive, overly accommodating, self-sacrificing, and intrusive/needy. In this thesis, outcome is measured by *Psychodynamic Functioning Scale (PFS)* (Bøgwald & Dahlbender, 2004; Høglend et al., 2000) which will be presented in section 1.4.

Methodological issues

According to Crits-Christoph et al. (2013) there are a wide range of methodological and design issues that might influence both the nature and interpretation of findings from psychotherapy process-outcome studies. These issues include, among others, topics such as 1) training and reliability of observers who make ratings of material from psychotherapy sessions 2) the unit of therapy sampled (e.g. therapist or patient statement; segment of a session or whole sessions) and 3) perspective of evaluation (patient report, therapist report, independent observer ratings).

1.1.3 Research on psychodynamic therapy

Research focusing on manualized, short term therapies, such as cognitive-behavioral treatments, has been extensive compared to the relative scarce amount on outcome of humanistic and psychodynamic or psychoanalytic therapy (Gabbard, 2010). Psychoanalysis largely dominated the field of psychotherapy for the first part of the 20th century (Cautin, 2011), however, psychoanalytic therapy research has historically been limited by various factors. There has been a belief that clinical experience can determine its effectiveness, a

conviction that psychoanalytic research would be extremely complex, and a concern that research would distort the therapy. This is particularly related to the conception that these treatments are difficult, if not impossible, to manualize (Busch, Milrod, & Sandberg, 2009). Additionally, psychodynamic oriented therapists have generally been more skeptical towards the use of randomized controlled studies and standardized outcome measures to assess the efficacy of treatment. This might explain why it took longer for psychodynamic therapy to be evaluated using this method (Nissen-Lie, 2018; Shedler, 2010). However, the necessity of research in order to assess the role of psychoanalysis and psychodynamic psychotherapy has been recognized (Busch et al., 2009). Consequently, from the 1990s and onwards, there have been increasingly more studies examining the therapeutic efficacy of therapies from the dynamic tradition (Shedler, 2010).

Several recent studies and meta-analyses indicate that the efficacy of psychodynamic therapy in a variety of disorders is equivalent to that of other established therapy orientations (Kivlighan et al., 2015; Leichsenring, Leweke, Klein, & Steinert, 2015; Leichsenring et al., 2015; Leichsenring & Rabung, 2011; Steinert, Munder, Rabung, Hoyer, & Leichsenring, 2017). Other studies have found satisfying efficacy of psychodynamic therapy on more specific disorders, such as emotional and anxiety disorders, and personality disorders (Driessen et al., 2015; Leichsenring & Steinert, 2018).

1.2 Theoretical background

1.2.1 Psychodynamic therapy

Psychodynamic therapy (PDT) refers to a range of different treatments based on principles from the psychoanalytic tradition modern dynamic psychology and psychotherapy originating from Sigmund Freud's scientific psychological innovations. During the late 19th and 20th century, contemporary approaches evolved from Freudian theory and practice. Today, psychodynamic or psychoanalytic psychotherapy refers to a range of treatments that derive from psychoanalytic concepts and methods. These treatments often involve less frequent sessions and may be significantly briefer than psychoanalysis proper (classical psychoanalysis), which could entail 3-5 sessions per week and last for several years (Fulmer, 2018; Shedler, 2010; Wallerstein, 1989).

According to Blagys and Hilsenroth (2000), the following five factors are considered principles of psychodynamic treatment, 1. Focus on affect and expression of affect. 2. Exploration of patients' attempts to avoid distressing thoughts and emotions. 3. Emphasis on development and exploration of early experience's effect on the present. 4. Focus on interpersonal relations, including the therapeutic relationship and how relational expectations can be transferred to the therapeutic relation, which can be explored with the patient 5. Lastly, a unique aspect of PDT is the exploration of unconscious wishes and fantasies. In this thesis, factor number four is of particular importance. Psychodynamic therapy places considerable weight on patients' relationships and interpersonal experience. Relevant theoretical terms relating to this are attachment and object relations. In early attachment relationships with caregivers, aspects of personality and self-concept are formed, as well as the ways in which we relate to significant others (Pallini, Baiocco, Schneider, Madigan, & Atkinson, 2014; Shedler, 2010). Psychological difficulties often arise when interpersonal patterns are problematic and nonadaptive, which can interfere with a person's ability to fulfill his or her basic needs and wishes (Shedler, 2010). The following section will elaborate on a few important theoretical perspectives and terms, which are relevant to the thesis.

1.2.2 Object relations theory

In the early 1940s, after the debates discussing the nature of human "drive", a group of analysts split from the dominant groups within the British Psychological Association. This group developed theories which came to be known as object relation theories.

Object relations theory emphasizes on the way in which our internal representations of our relationships with important individuals in our lives influence the way we shape relationships, select friends and partners, and understand and experience our relationships.

These internal representations are called *internal object relations* (Safran, 2012). The object-relations theory emphasize object seeking as a primary motive of the child rather than drive gratification, which is more in line with the classical Freudian view (Gabbard, 2010).

Psychological symptoms came to be understood as embedded in cyclic, self-sustaining interpersonal patterns and transactions (Henry, 1996). The role of the therapeutic relationship as a transformative emotional experience was played down in the early years of psychoanalysis (Wachtel, 2008). However, there has been a general shift from the classical analytical theory dominated by a one-person focus (focus on the patient in therapy), towards the two-person focus (focus on the patient-therapist relation in therapy) of more

contemporary analytic theories. Early generations of analysts considered the ideal attitude of the therapist to be calm, objective and detached (Heimann, 1950). From the contemporary interpersonal perspective, neither the patients nor the analyst's affective involvement in the therapeutic relation is considered neutral (Mitchell, 2016).

Problematic interpersonal relationships are a dominant feature of many psychological disorders (Linden, Linden, & Schwantes, 2015). A patient's inability to form stable and rewarding relationships is a major risk factor for the development and maintenance of psychopathology (Girard et al., 2017). In mainstream clinical psychodynamic theory, it is maintained that the patients' past relational history, affective experiences and attachment patterns influence the ongoing interaction between patient and therapist (Dahl et al., 2014). Grolnick et al. (1997, p. 136) define internalization as a natural developmental process in which children (as well as adolescents and adults) absorb, integrate and accept socially transmitted values and behaviors and integrate these to a coherent sense of self. The internalization of relational experiences is thought to occur through three mechanisms: incorporation, introjection and identification. These mechanisms correspond to different levels of a child's development. When relational experiences are integrated with parts of the self, they contribute to a core sense of self. The contents of our representational inner world are formed by repeated internalized, externalized and re-internalized experiences, while our daily interactions are formed by the quality of the inner world (Piper & Duncan, 1999).

Object relations theory considers early relationships crucial to personality development, and the quality of these relations will affect an individual's pattern of relating to others later in life (Ogrodniczuk & Piper, 2004). More specifically, they affect the ability to form stable, rewarding and mutual relations to important people in their lives. A person with high Quality of object relations would entail having a fundamental positive sense of self and relating to both positive and negative traits of others. On the other hand, a person with low Quality of object relations is characterized by dependency, exploitation, instability and lack of reciprocity and emotional investment. *Splitting* often occurs, in which a person categorizes other people in as good or bad objects. A person's Quality of object relations can be measured using the Quality of Object Relations Scale (QORS) (Azim, Piper, Segal, Nixon, & Duncan, 1991; Høglend, 2003). The QORS measures the patient's life-long tendency to

establish certain kinds of relationships with others, from mature to primitive, using three eight-point scales. The QORS provides a system designed to quantify a person's relative level and quality of object relations.

1.2.3 Transference

Transference can be defined as a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribes to other relationships (Levy & Scala, 2012).

Within the psychoanalytic tradition, transference is one of the most long-established and vastly used terms. Sigmund Freud first described transference more than a hundred years ago in the case study of Dora (Freud, 1905). He originally used the term to describe the process in which the patient's difficulties are transferred onto the analyst, who becomes the object of the patient's conflicts. At first Freud viewed transference as a hinderance to free association, and consequently, insight. Therefore, it became an element which had to be removed for further therapeutic work to be possible (Freud, 1905). Later on, Freud came to view the transference as a process which provided the analyst with valuable insight into the patients forbidden thoughts and feelings (Mitchell, 2016). However, Freud never viewed the whole therapeutic process in light of transference. Today, interpreting the transference revealed during therapy is considered a key component of psychodynamic psychotherapy. In this regard, there has been a radical change within the psychodynamic tradition (Gullestad & Killingmo, 2013). The patient's transference represents a repetition and projection of internalized object relations in interactions with the therapist (Gullestad, 2014).

1.2.4 Transference interpretations

A *transference interpretation* is normally considered as the therapist making a comment concerning the patient's reaction to him/her, which is understood to be connected to the patient's previous relationships (Ogrodniczuk & Piper, 2004). It can be defined as “*a tactful comment that clarifies and links the patient's experience of others outside of therapy with that of the therapist in therapy and to the patients experience of past relationships with caregivers*” (Levy & Scala, 2012, p. 394). The focus on the phenomenon of transference in therapy has led to an emphasis on transference analysis and transference interpretations. An alternative to such interpretations is to interpret conflicts and interpersonal patterns in the patient's current relationships or memories, without addressing the therapist-patient relation

(Ulberg, Amlo, Critchfield, Marble, & Høglend, 2014). An example from Ulberg et al. (2014, p. 258) of the latter form of intervention goes as follows: *“I notice that you tend to avoid talking about your insecurity and may be also angry and sad after your teacher resigned. Maybe it’s because it reminds you of the situation when your father left you after your parent’s divorce.”* An intervention addressing the transference in the same material might include a reference to the patient–therapist relation by including: *“..and now you seem to avoid talking about these feelings here when we have decided to end therapy.”*

For some time, transference interpretations have been viewed as potentially harmful and dependent of a strong working alliance to be potentially effective. In addition, contradictory research findings exist regarding the relation between the level/amount of transference interpretations and high/low Quality of object relations (QOR) (Connolly et al., 1999; Ogrodniczuk & Piper, 2004; Ogrodniczuk, Piper, Joyce, & McCallum, 1999; Piper, Azim, Joyce, & McCallum, 1991). However, more recent studies suggest that low to moderate levels of transference interpretations are highly effective and can lead to structural change, increased insight and affect awareness (Høglend & Gabbard, 2012; Høglend & Hagtvat, 2019). Interpreting transference may increase insight that again may lead to better interpersonal functioning. Insight gained through transference interpretation might be especially valuable as it effectively facilitates integration of affect and cognition. Transference interpretations are interventions specifically used to help patients understand relational patterns within the therapy process (Johansson et al., 2010).

Given the diverse understandings of transference interpretations, there may be disagreement when it comes to identifying them (Ulberg et al., 2014). In the following, we will use the more general term “transference work”, which refers to all interventions regarding the transference. The defined categories of transference work used in the study of which the present study is based on, the First Experimental Study of Transference (FEST), will be presented in section 1.4.

1.2.5 Countertransference

Countertransference can be broadly defined as the totality of the therapist reactions to the client (Safran, 2012). According to Hayes et al. (2018) three understandings of

countertransference (CT) have been the most prominent: the *classical* (the therapist's conflict-based and unconscious reaction to the patient's transference), the *totalistic* (all of the therapist's reactions to the patient are CT) and the *complementary*. The complementary view considers countertransference as a counterpart to the patient's interpersonal style, where the patient "pulls" on the therapist. This understanding of countertransference is based on interpersonal, relational, and object relations theory. Based on this view of countertransference, one would for example assume that a patient with an oppositional style would evoke oppositional reaction in the therapist (Hayes et al., 2018).

The ideas about countertransference have followed the same development as those of transference. It was by Freud originally considered to be a problematic concept and potentially harmful for the therapeutic process (Hayes et al., 2018). Early generations of analysts considered the ideal attitude of the therapist to be calm and objective. This ideal might stem from Freud's use of the phrase "free hovering attention" and the comparison to a surgeon's state of mind (Heimann, 1950). Over the past decades there has been a shift within all schools of psychoanalytic theory regarding countertransference. It came to be understood as an inevitable aspect of psychotherapy, and this aspect could be dealt with in different ways which again could lead to a positive or negative outcome. The shift from a one-person perspective to a two-person perspective has shaped the use and understanding of the phenomenon of countertransference, as well as transference. While there are theoretical differences and views regarding countertransference in contemporary psychoanalytic thought, different schools have come to find countertransference to be a valuable tool (Hayes et al., 2018; Mitchell, 2016).

Psychodynamic theorists have maintained that therapists' emotional reactions often resemble caring parental attitudes, which may facilitate or hinder change. Several studies have found that in treatment of patients with mild personality pathology, benevolent parental feelings are more apparent in the therapist, compared to negative feelings (Betan, Heim, Zittel Conklin, & Westen, 2005; Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; Dahl et al., 2014; Rossberg, Karterud, Pedersen, & Friis, 2007). Dahl et al. (2012) found that parental therapist feelings (dominant, affectionate, motherly, and important) had the highest mean value while working with cluster C personality disorders (the anxious-fearful cluster; including avoidant, dependent, and obsessive-compulsive personality disorders) (American Psychiatric Association, 2013). A meta-analytic review, Hayes et al. (2018) found that the correlation

between countertransference and psychotherapy outcome was not significant, however better management of countertransference was associated with larger gains from psychotherapy.

1.3 Structural Analysis of Social Behavior (SASB)

1.3.1 Background

The present study aims to expand the knowledge from the FEST study by investigating the communication interactions between therapist and patient. With this objective in mind, the Structural Analysis of Social Behavior (SASB) was selected to code patient-therapist interactions. SASB is a circumplex model first published in 1974 by Lorna Smith Benjamin (Lorna Smith Benjamin, 1974). The model draws on developmental clinical knowledge, earlier interpersonal models, as well as interpersonal theory, which states that interpersonal behaviors can be characterized along two orthogonal dimensions of (1) status/interdependence (e.g., dominant and submissive), and (2) affiliation (i.e., friendly and hostile) (Kiesler, 1983).

1.3.2 Description

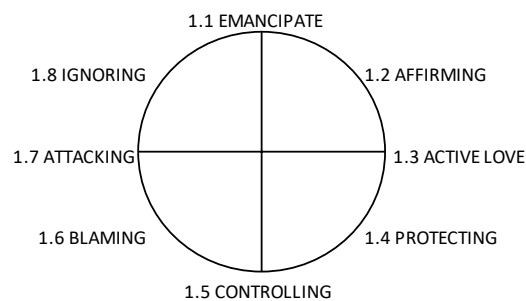
The model provides a lens to describe interpersonal and intrapsychic events and the coding system allows for an operationalization of these relations. There are different versions of SASB, one more complex (the full model) than the other (the one-word model). A short presentation of the one-word model follows, based on Benjamin (1979).

Attentional focus is shown by three separate surfaces. Thus, one has to consider if the focus is transitive; about you (e.g. therapist focus on the patient) or if it is intransitive: about me (the patient focuses on him/herself). The third focus of the model concerns the introject (the way the patient treat him/herself as a result of how he/she have been treated by others). The different types of focus are described by two dimensions: Affiliation on the horizontal axis (friendly or hostile), and Interdependence on the vertical axis (sharing space or separating). The horizontal axis places maximum affiliation or sexuality on the right and maximum attack or murder on the left and the vertical places maximum separating on the top and maximum enmeshment at the bottom (Benjamin & Cushing, 2000) In other words, everything interactive is described in terms of underlying “primitive” basics of sexuality, aggression, dominance and separate territory. For example, a therapist focuses on her patient

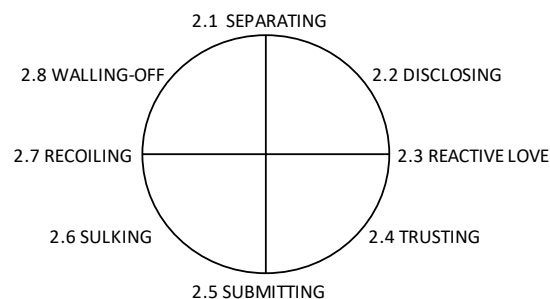
(transitive focus) with care and moderate degrees of influence (control), to show behavior described as “protecting” on the 1-word cluster model. Normally and naturally, the patient complements that position with focus on self (intransitive), that is, loving and moderately submissive and described as “trusting”. The one-word model, with transitive and intransitive focus, is presented in figure 1.

Figure 1. The Structural Analysis of Social Behavior (SASB): The eight-cluster version modeled after Benjamin and Cushing (2000). Observer rated SASB cluster. Surface on top shows the transitive focus; the therapist on the patient. Surface on bottom shows the intransitive focus; the patient focus on the self.

FOCUS ON OTHER (TRANSITIVE)



FOCUS ON SELF (INTRANSITIVE)



(Benjamin & Cushing, 2000)

1.3.3 Coding

Data are gathered by using SASB coding that provides objective observer ratings of the interpersonal situations of interest, from observing the actual session, from video or audiotapes. Interactions are divided into small units for coding (“though units”), each of which consist, more or less, of one spoken sentence (L.S. Benjamin & Cushing, 2000). Because SASB coding is expensive and time-consuming, Benjamin et al. (2000) suggests that the decision of what material to be coded should be taken carefully. Due to the assumption

that coding a small sample of a person's interpersonal behavior often is a representative sample of interpersonal patterns, it is not necessary to code large amounts of material. SASBWorks is a computer program designed by Benjamin et al. (2000) to assist in the analysis of SASB coded data. SASBWorks includes the possibility of coding the content of the social interaction, in addition to the process-codes. The present study includes data on the process only.

1.3.4 Theory

The SASB methods are theory neutral and have been used for assessing aspects of a variety of therapy approaches (Benjamin, 2018). It envisions interpersonal and intrapsychic events on three surfaces that represent corresponding parenting and childlike behavior, as well as one representing expected self-concept as a result of the interaction between a child and the caregiver's behavior (Benjamin, 1996a).

The models most important predictive principles are Complementarity, Similarity, Opposition, Antithesis and Introjection (Benjamin, 1996b). A brief description follows, based on Benjamin (1974, 1979, 1996a). *Complementarity* happens in the model when two people are matched on the affiliation and interdependence dimension, with one-person transitive and the other person intransitive (e.g. a therapist is Protecting, and a patient is Trusting). Complementarity works both ways, transitive to intransitive and vice versa (e.g. therapist to patient, patient to therapist and parent to child, child to parent. If one person Ignores, the other person is likely to Wall-off. If one person Walls-off, the other is likely to Ignore him/her. Complementarity has been defined in different ways (Henry, Schacht, & Strupp, 1986; Sohlberg, Claesson, & Birgegard, 2003; von der Lippe, Monsen, Rønnestad, & Eilertsen, 2008). The present study defines complementarity as the sum of patient and therapist communication given the identical cluster code. *Similarity* is, in contrast to complementarity, when two people are rated with the same focus as well as the same level of affiliation and interdependence. Similarity would thus describe the event of two submissive people, or two “blamers”, talking together. *Opposites* are placed on different sides of the surface (180° apart), with the same focus. E.g. for the patient the opposite of Disclose is Sulk. For therapists, Affirm is the opposite of Blame. *Antithesis* is different in every possible way. They are shown at 180° angles and on different surfaces. The antitheses of Affirm, for

example, is Sulk. *Introjection* is placed on the third surface and means treating yourself as you were treated by early significant others. For example, if a parent blamed the patient, the patient is likely blame him/herself. This surface will not be included in the present study (see Benjamin (1974, 1979, 1996a)).

1.3.5 Studies using SASB

SASB has proved useful to researchers and clinicians to investigate momentary interpersonal micro-processes in therapy. SASB has been applied to a variety of psychosocial events, including areas beyond what was Benjamin's initial interests. Today, SASB has been used in events such as setting treatment goals, formulating interpersonal diagnoses, and studying differentiating failures (Constantino, 2000). Nevertheless, most relevant to this study is SASB's application to psychotherapy process- outcome research.

Henry et al. (1986) used SASB to study interpersonal transactions in the therapy dyad in psychodynamic-interpersonal therapies. They studied 4 therapists each with one good and one poor outcome of psychotherapy (N=8). They found that greater levels of therapists Protecting and Affirming, and lower levels of Blaming were associated with high-change cases. Patient behavior of Disclosing was significantly more frequent in high change-cases, whereas Walling off and Trusting were significantly more frequent in the low-change cases (Henry et al., 1986). In a similar vein, Henry, Schacht, and Strupp (1990) studied fourteen therapeutic dyads with SASB. This study aimed to replicate their initial findings and to gain insight into *how* mechanisms in therapy affect therapy outcome. In line with their initial findings, they noted that patients in the poor outcome group (which they defined as low change on introject surface) were significantly more Watching toward the therapist. They were also more Asserting and Separating, Sulking, Avoiding, and less Disclosing (Henry et al., 1990).

A more recent study (Critchfield, Henry, Castonguay, & Borkovec, 2007) examined early sessions from three variants of cognitive-behavioral therapy (CBT) to replicate the work done in the abovementioned studies; Henry et al. (1986; 1990), linking psychotherapy processes to outcome. Sessions from treatment of patients with generalized anxiety disorder (GAD) with good and poor outcome, were examined with SASB. They, however, did not find interpersonal behaviors to be strong predictors of outcome in their sample.

Von der Lippe et al. applied to study patient-therapist interactions in 14 positive change, and 14 negative change/nonchanged therapies (von der Lippe et al., 2008). Their analyses showed that stable hostile complementarity defined the negative change and nonchanged therapies. Therapists met client's invitations to hostile responses most often in nonhostile ways, yet they initiated more belittling and ignoring interaction with negative change/ nonchanged clients. Friendly complementarities predicted positive outcome. Their results also indicated a negative effect of being "out of tune", that is, lower correlations between therapist and patient communication. They found that in positive outcomes, correlations in the communication patterns are both higher and more stable.

Dahl et al. (2016) used SASB in a case comparison study of two transference based psychodynamic therapies. Both therapies were successful, however only one of the patients had a favorable outcome at the 3 years-follow up. In the case of the patient experiencing the continuing positive change after termination, the communication between therapist and patient was characterized by therapist Control in the beginning and more Protection and less control at the end. This patient showed more Disclosing behavior at the end. The communication between the therapist and the patient with less favorable long-term outcome, was characterized by the patient Disclosing and Trusting and the therapist Protecting in the beginning, but with increasingly more Control-Submit interactions towards the end of therapy.

1.4 First Experimental Study of Transference interpretations (FEST)

The First Experimental Study of Transference interpretations (FEST) was an experimental study of transference work in psychodynamic psychotherapy, which received international attention and recognition for its dismantling design, thorough methodology, and results (Høglend et al., 2006; Høglend et al., 2008). The FEST study originally showed for whom transference work in psychodynamic therapy is effective. However, there was found no main effect of the randomized variable (transference work). As methods and research design of the FEST study previously have been described in a detailed matter, a brief summary of the

methodology will follow (Høglend et al., 2006; Høglend et al., 2008). The study protocol was approved by The Regional Ethics Committee, Health-Region 1, Norway. (First Experimental Study of Transference-interpretations (FEST307/95). Registration number: ClinicalTrials.gov Identifier: NCT00423462)

Patients

The patients in the FEST study sought psychotherapy for anxiety disorders, depressive disorders, personality disorders and interpersonal problems. Patients with bipolar illness, psychosis, organic mental disorder, or substance abuse were excluded from the study. One hundred patients were included.

Treatment

The treatment consisted of one 45-minute session weekly for one year, with maximum 40 sessions. The sessions were audio recorded. After the written informed consent and completion of the pretreatment ratings, the patients were randomized to one of two treatment groups. Half of the patients ($n = 52$) received dynamic psychotherapy with a moderate use of transference intervention (the transference work group). For this group, specific techniques were prescribed and the therapists used a treatment manual (Høglend et al., 2000). Among other techniques, they were to address the patient-therapist relationship, encourage exploration of thoughts and feelings about the therapy and the therapist, and interpret direct manifestations of transference (Høglend et al., 2006) as described in Table 1. The other half of the patients ($n = 48$) also received dynamic psychotherapy with the same therapists, but without transference work (non-transference work group) the therapists focused on other relationships than the one between therapist and patient.

Table 1: The five categories of transference work (TW) defined in FEST.

Five Categories of Transference Work Defined in FEST
1. The therapist was to address transactions in the patient-therapist relationship.
2. The therapist was to encourage exploration of thoughts and feelings about the therapy and therapist.
3. The therapist was to encourage patients to discuss how they believed the therapist might feel or think about them.
4. The therapist was to include him-/herself explicitly in interpretive linking of dynamic elements (conflicts), direct manifestations of transference, and allusions to the transference.
5. The therapist was to interpret repetitive interpersonal patterns (including genetic interpretations) and link these patterns to transactions between the patient and the therapist.

Based on Bøgwald, Høglend & Sørbye (1999) and Ulberg (2014).

Therapists and evaluators

Patients were assigned to seven highly experienced and trained therapists. The therapists included five men and two women, six psychiatrist and one clinical psychologist. They also served as clinical evaluators of other patients. In order to ensure that all raters were blinded, the statistical analysis did not include ratings of their own patients.

Assessment/ Measures

Before randomization, all patients went through a 2-hour psychodynamic interview, in addition to interviews on symptom and personality pathology (Høglend et al., 2006; Høglend et al., 2008). The interviews were audio recorded, and at least 3 evaluators scored it using the PFS (Høglend, 2000; Bøgwald & Dahlbender, 2004) and the Quality of Object Relations Scale (Azim et al., 1991; Høglend, 2003). The predetermined cut-off score for differentiating high versus low QOR scores was 5.00. QOR scores above the cut-off means that recent relationships may be difficult, but there is evidence for at least one mature relationship in the patient's history. QOR scores at or below the cut-off indicates a history of less gratifying relationships, characterized by less emotional investment, less stability, and need for dependency or overcontrol (Hersoug, Ulberg, & Høglend, 2014). In addition, the patients completed a number of self-reports including the IIP-C (Alden, Wiggins, & Pincus, 1990)

that measures interpersonal problems, and the SCL-90 (Derogatis, 1977) which is a symptom measure. The patients were evaluated with questionnaires at the beginning, during, end of treatment, and one and three years after termination of treatment. Interviews were not used during treatment, but at pretreatment, end and at follow ups. All 100 patients were evaluated at the 3 years follow-up (Høglend et al., 2006).

The Psychodynamic Functioning Scale (PFS) was the primary outcome measure of the FEST study. This clinician rated measure was developed in the pilot phase of the FEST study (Høglend et al., 2000; Bøgwald & Dahlbender, 2004). It consists of six scales which measure psychological capacities during the previous 3 months. There are three *relational subscales*: quality of family relationships, quality of romantic and sexual relationships, quality of friendships; and three *dynamic subscales*: tolerance for affects, insight, and problem-solving capacity. Three clinical raters, blind to treatment group, made four evaluations with the PFS; at pre-treatment, post-treatment, 1-year follow-up, and 3-year follow-up. According to the interrater reliability estimates, the PFS was 0.91 based upon the average scores of the three raters (Hagtvet & Høglend, 2008; Høglend et al., 2006).

Moderators

QOR was the preselected moderator (Azim et al., 1991; Høglend, 2003). The QORS three scales measure a person's life-long tendency to establish certain kinds of relationships, from mature to primitive (Høglend et al., 2006). The interrater reliability estimates for the average scores of three raters was 0.84 for the QORS.

Statistical analysis

Linear mixed model analysis was used to analyze longitudinal data. An alpha level of 0.10 was set before the moderator and subgroup analyses in order to deal with the possibility of false negatives (type II errors) (Cohen, Cohen, West, & Aiken, 2003). This may lead to increased risk of false positive (type I errors). According to Kraemer et. al (2002) moderators and mediators should not be defined based on p-values as the moderator and mediator status would change with sample size. Focusing on the magnitude of the effects may be more valid (Ulberg, Høglend, Marble, & Johansson, 2012).

Results

The researchers did not find significant differences of transference work. However, patient level Quality of object relations (QOR) was found to be a significant moderator. That is, patients with low QOR benefited more from transference work than patients with high QOR (Høglend et al., 2006). This effect was stable three years after treatment termination (Høglend et al., 2008) and seemed to be mediated by an increase in the level of insight during treatment (Johansson et al., 2010). The impact of transference work on PFS was more positive within the context of a weak therapeutic alliance for patients with low QOR. For patients with higher QOR and high alliance, the authors observed a negative effect of transference work (Høglend et al., 2011). When patient gender was combined with the moderator quality of object relations (QOR), a strong effect emerged: Women with low QOR showed a large positive effect of transference work and men with high QOR showed a large negative effect of transference work (Ulberg, Johansson, Marble, & Hoglend, 2009). This interaction effect was found to be stable 3 years after treatment termination (Ulberg et al., 2012).

In order to understand more about the interaction between transference work, QOR, and gender, the processes in therapies including men with high QOR (with a slight negative effect of transference work) and women with low QOR were analyzed using Structural Analysis of Social Behavior (SASB). The access to the momentary descriptions of interpersonal events in the therapy sessions allows the present study to take a closer look at what took place between therapist and patient in the transference and non-transference work group.

2 Research questions

As previously mentioned, the First Study of Transference interpretations (FEST) was conducted to evaluate the effect of transference work in psychodynamic therapy (Høgland et al., 2006). While there was no main effect of transference work, a significant interaction effect between transference work, time, Quality of object relations (QOR) and genders, was uncovered (Ulberg et al., 2009). The outcome measure Psychodynamic Functioning Scale (PFS) increased on average for all groups: men and women with low and high QOR and with and without transference work. However, women with low QOR had significantly better outcome on all measures, also PFS, when in the transference work group. While the opposite was found for men with high QOR, they had best outcome in the non-transference work/control group. Statistical Analysis of Social Behavior (SASB) was chosen as one possible way of exploring the psychotherapeutic process leading to differential effects of transference work on outcomes for women with low QOR and men with high QOR.

Specifically, we aimed to answer the following questions:

1. What characterizes the communication across time, as measured by SASB, between therapists and male patients with high QOR in psychodynamic therapy?
2. What characterizes the communication across time, as measured by SASB, between therapists and female patients with low QOR in psychodynamic therapy?
3. Are there differences between high QOR men and low QOR women in the transference work (TW) group and non-TW group?
4. If so, can these differences explain differing development in PFS score in the aforementioned groups?

3 Methods

3.1.1 Patients

Of the original sample of 100 patients, 42 were selected to have 3 therapy sessions coded using the SASB instrument. The patients selected were from two subgroups; men with high QOR (N=21) and women with low QOR (N=21). This means that the two characteristics are completely confounded. When referring to “men” and “women” we are therefore referring to men with high quality of object relations and women with low quality of object relations.

Most pretreatment patient characteristics were evenly divided in the TW group vs. the non-TW group, for both genders. Nevertheless, women in the TW group (N=11) were in average 2,1 years older than women in the non-TW group (N=10). The mean PFS score at pretreatment was 2,8 points higher at pretreatment, for women in TW-group than women in the non-TW group. This was more than one standard deviation (SD) higher than the mean PFS score for women in the TW group. 6 women had a civil status as single in the TW-group compared to 4 in the non-TW group

Men in the TW-group (N=11) had a General Symptom Index of 0,3 points higher than men in the non-TW group (N=10) at pretreatment. In the TW-group there were also more personality problems, as indicated by 3 men given a personality disorder (PD) diagnosis and average of 7,3 criteria scored on the assessment tool SCID-II, compared to 1 in the non-TW group with a PD diagnosis and 3,9 criteria (American Psychiatric Association, 2013). Pre-treatment characteristics are shown in table 2.

Table 2. Pre-Treatment Characteristics for Patients Receiving Dynamic Psychotherapy for 1 year with and without transference work. Characteristics for women/low QOR and men/high QOR are shown separately.

Characteristic	Low QOR women (N=21)				High QOR men (N=21)			
	TW group (N=11)		Non-TW group (N=10)		TW group (N=11)		Non-TW group (N=10)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Age	32,6	7,3	34,7	9,5	40,7	9,8	40,4	9,8
IIP-C	1,2	0,3	1,3	0,5	1,2	0,6	1,2	0,5
GSI (SL-90)	1,2	0,8	1,2	0,4	1,1	0,6	0,8	0,5
PFS	61,8	1,8	59	4,8	65,1	3,7	67,6	3,1
Criteria (SCID-II)	11,5	6,3	11,5	7,6	7,3	6,4	3,9	3,1
	N	%	N	%	N	%	N	%
Single	6	54,5	4	40	1	9	1	10
Caucasian	11	100	10	100	11	100	10	100
Personality Disorder	7	63,6	6	60	3	27,3	1	10

3.1.2 SASB

Two experienced therapists were trained for the SASB coding. Based upon the previously described FESTs findings of interaction between QOR, patient gender and treatment group, women with low QOR (N=21) and men with high QOR (N=21) were selected for further analysis. Three sessions from different phases of the therapy of each patient were selected for coding. One session from the beginning of the therapy (approximately session 7), one from mid-treatment (approximately session 16) and one from the late phase (approximately session 29). 10 minutes x 3 of each of the three sessions, from the beginning, middle, and end of the session. The therapists worked with the transcripts while listening to audio recordings for intonation and nonverbal signals. The inter-rater reliability (weighted kappa) for the three assessments was on average .72 (Ulberg, Høglend, Marble, & Sørbye, 2009). Landis and Koch (1977) state that kappa values above 0.75 can be interpreted as excellent agreement, 0.60 to 0.75 as good, between 0.40 and 0.60 as fair, and that 0.40 indicates poor agreement.

3.1.3 Outcome measures

PFS was the primary outcome measure in the FEST study (Høglend et al., 2006; Høglend et al., 2008), and was chosen in the present study. As previously described, PFS was assessed pre-treatment, post-treatment, 1-year follow-up, and 3-year follow-up.

3.1.4 Statistical analysis

An alpha level of 0.10 was chosen a priori for all subgroup analyses in the FEST study (Høglend et al., 2006). All analyses were conducted using SPSS (version 25) (SPSS, 2017).

ANOVA

First, we conducted a series of ANOVA in order to select a subset of SASB dimensions that could subsequently be used as predictor variables in multilevel models. We wanted to see if these predictor variables account for different degree of changes in PFS over time observed in the original FEST study. Due to a small sample size, the number of predicting variables that might be reasonable to include was limited. We therefore selected *time* and *treatment type* before conducting two-way mixed ANOVAs, including one factor (time) within patients, and another (treatment) between patients. The three ratings within each session were merged into one score as the variation *between*, rather than *within* sessions, was of main interest. We also created a mean from the three measuring points and transformed this into a standardized Z-score. The transitive focus where the patient focuses on the therapist and the intransitive focus where the therapist focus on him/herself, was almost not coded and was excluded from the analysis.

Multi-level modeling

After potential SASB domains that differed between transference work and non-transference work groups were selected, longitudinal analyses of PFS were conducted. While such analyses could be conducted using ANOVA, ANOVA models rely on the assumptions of homogeneity of variance and independence of measurement, and they require complete data (Quené & van den Bergh, 2004). For longitudinal studies with related measures, where variance can change considerably over time, and dropout is to be expected, multilevel (linear mixed) models (MLM) represent a good alternative. MLM allows one to estimate variance and covariance components explicitly. MLM does not require homogeneity of variance, it takes the sampling hierarchy into account, and it can analyze incomplete data (Field, 2013; Quené & van den Bergh, 2004).

Akaike's information criterion (AIC) was used to compare models (Vrieze, 2012; Wagenmakers & Farrell, 2004). Lower values of AIC indicate better model fit accounting for the number of freely estimated parameters, model complexity or risk for overfitting.

Intraclass correlation coefficient (ICC) is a statistic that quantifies how much of the variance is explained by a grouping factor (e.g. patients having the same therapist) in multilevel data (Field, 2013). The ICC was used to determine whether to use multilevel modelling or a simpler analysis technique. It was also used estimate the dependability in the data and how much of the overall variation in the outcome measure was could be accounted for difference *within* each person compared to difference *between* people. Hence, an ICC of 1 would indicate that all of the variability would be attributable to stable differences between people.

The analysis

First, we fitted a set of unconditional multilevel models, in order to determine how time best describes levels of PFS across the study period. In these models, we compared models with linear effect of time, quadratic effect of time, and a linear effect of log-transformed time. The best representation of time was log transformed time, which from now on will be referring to as time in the present thesis. Once logtime was selected, a series of multilevel models assessing the impact of type of treatment and patient-therapist communication, were fitted. In all, five models were fitted, which are described in the following paragraph.

The following steps were identical for men with high QOR (N=21) and women with low QOR (N=21) (see tables 2 and 3); We started with an empty model, **model 1**, before testing more complex models. We ran analyzes with and without a random effect of time. A model without a random effect of time fitted the data better according to AIC-criterion and only a fixed effect of time was therefore included in **model 2**. The absence of random effects of time indicated that the participants PFS scores changed in a similar way across time. Two fixed effects were added in **model 3**; 1) treatment (therapy with/without transference work), 2) the interaction between type of treatment and time. The results indicated support for a model including these predictors. We wanted to see if a model including the therapist Control would explain even more of the variance and if the effect of therapist Control on outcome across time was negative or positive for women and for men. We included the fixed effects; Control and the interaction between Control and time to **model 4**. Our hypothesis was that there would be a positive effect of Control on outcome women and a negative effect of Control on outcome for men. As a final step, we included a three-way interaction between time, Control and type of treatment to **model 5**. The question of interest was how the interaction between time and treatment group (time x treatment) would be affected by this inclusion, as a decreasing score would imply that the effect of therapist “Control” on outcome would be

different in the TW-group compared to non-TW group, in the group of women and men separately.

4 Results

4.1 Research questions and results

4.1.1 Line charts

What characterizes the communication across time, as measured by SASB, between therapist and patients (that is; men with high QOR and women with low QOR) in psychodynamic therapy?

In visual representations of the data on women and men (see figure 2 and figure 3), three types of patient-therapist interactions stood out; Protect-Trust, Affirm-Disclose and Control-Submit. All communication between therapist and patient was predominantly classified in these three categories, with both women and with men. Virtually none of the therapist or patient statements were coded as one of the remaining five interaction styles. Patient and therapist codes were highly correlated on the different SASB cluster scores. However, both line charts of mean therapist and patient scores, suggest there could be a discrepancy between therapist Protect and patient Trust.

Figure 2. SASBWork mean interaction scorings for women with low QOR. These are based on transcripts of audio recordings of 3X10 minutes from three therapy sessions. Blue line indicates therapist focus on other; red line indicates patient focus on self. SASB clusters scores along the x-axis and the SASB clusters scores (ranging from 0-1) on the y-axis.

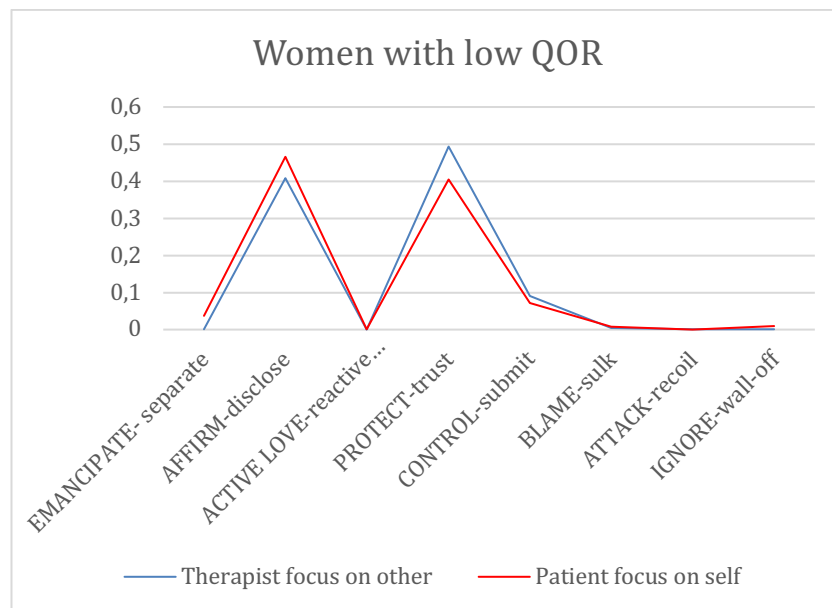
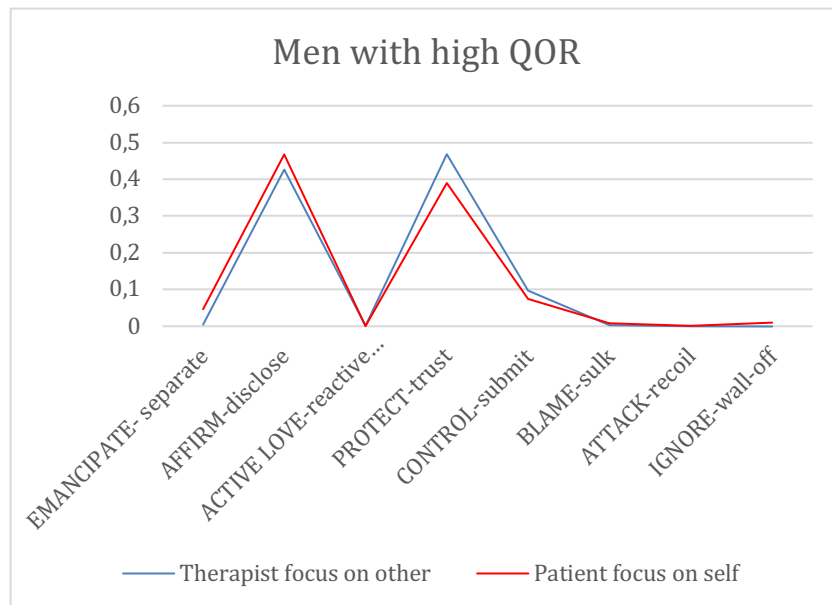
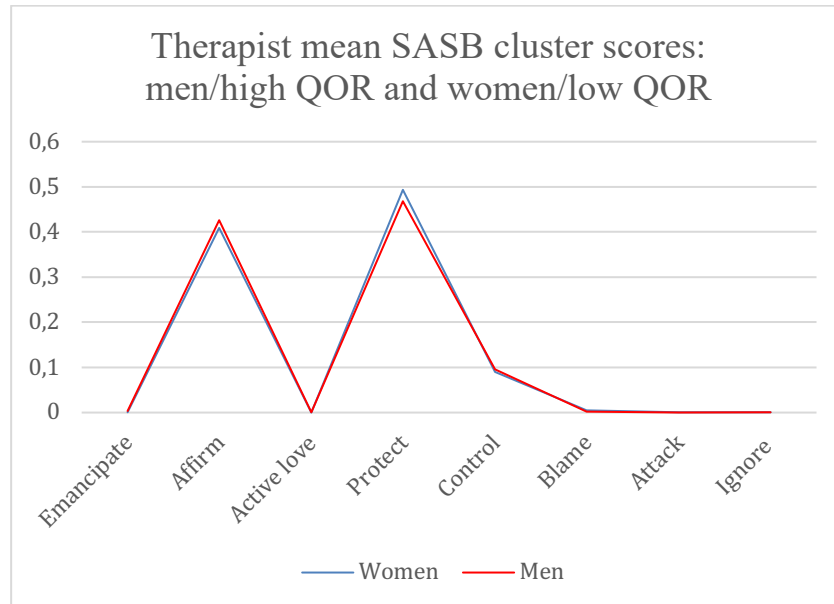


Figure 3. SASBWork mean interaction scorings with men with high QOR. These are based on transcripts of audio recordings of 3X10 minutes from three therapy sessions: Blue line indicates therapist focus on other; red line indicates patient focus on self. SASB clusters along the x-axis and the SASB clusters scores (ranging from 0-1) on the y-axis.



As stated earlier, there was a high degree of complementarity between therapist and patient scores. We selected therapist scores for further exploration, as the dataset includes a randomized variable (transference work), which is a technique implemented by the therapist. A line chart with therapist SASB cluster codes with women and with men, illustrates the almost identical therapist behavior with these two groups.

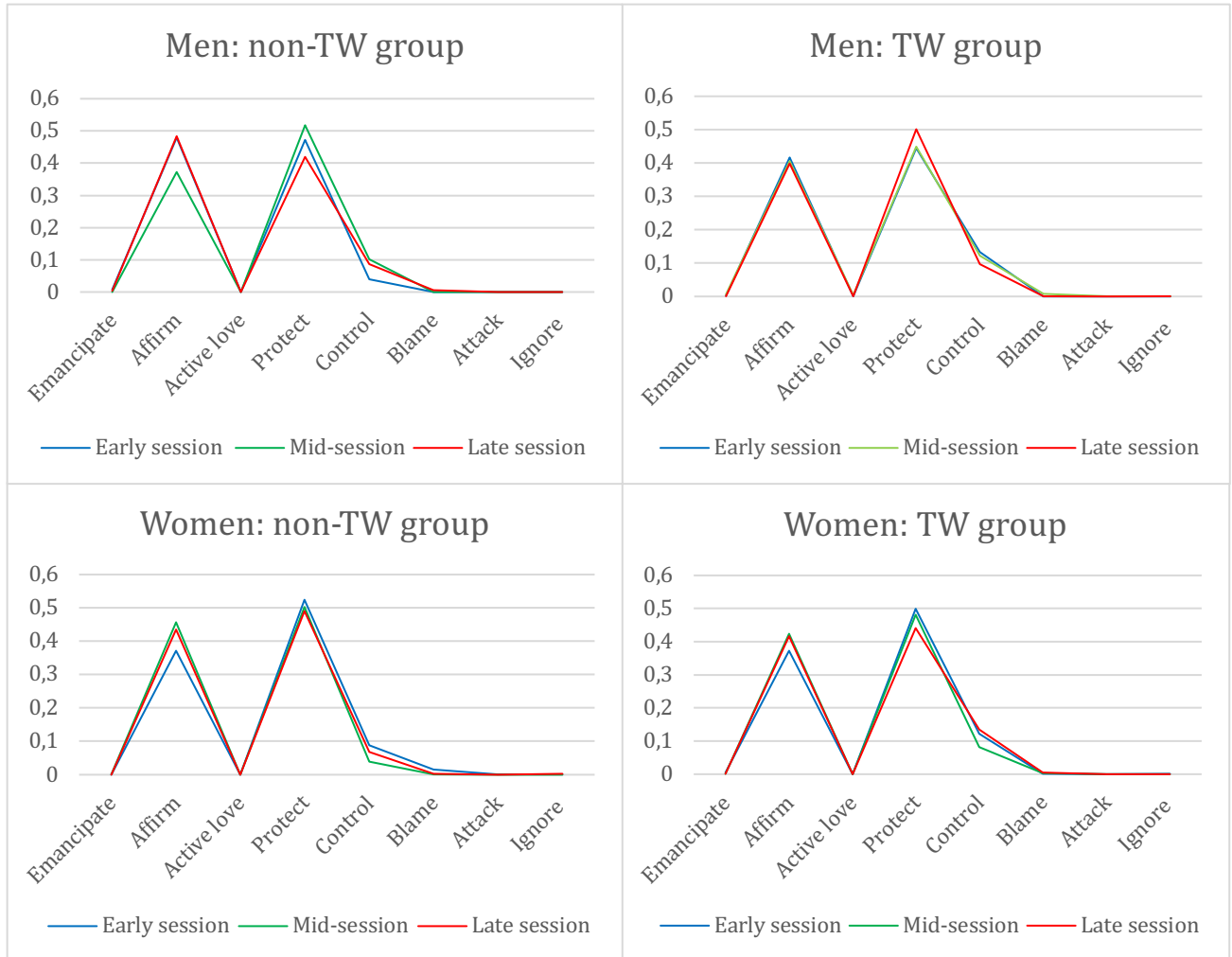
Figure 4. SASBWork mean interaction scorings with women/low QOR and men/high QOR. These are based on transcripts of audio recordings of 3X10 minutes from three therapy sessions: early treatment, mid-treatment and late treatment. Blue line indicates women/low QOR and red line indicates men/high QOR. SASB clusters along the x-axis and SASB cluster scores (ranging from 0-1) on the y-axis.



Are there any differences in the communication across time and between therapist and patient (women with low QOR and men with high QOR) in psychotherapy with transference work and psychotherapy without transference work?

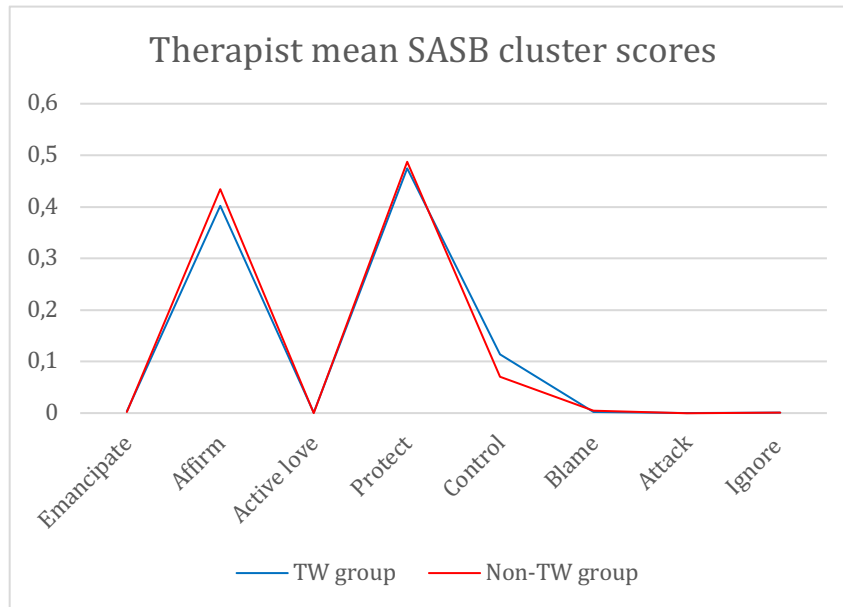
Plots of SASB codings in men and women in both the TW group and the non-TW group indicated little systematic variability over time in scores across three sessions from the beginning, middle and end of therapy (see figure 5). However, therapist Control seemed to be slightly higher in women and men in the TW group compared to women and men in the non-TW group.

Figure 5. SASB-work mean interaction scorings. These are based on transcripts and audio recordings 3X10 minutes. The four plots represent each subgroup. Top left: Men in the non-TW group, top right: men in the TW group, bottom left women in the non-TW group, bottom right: women in the TW group Blue line indicates session early in the treatment, green line indicates mid-treatment, red line indicates late phase of treatment. SASB clusters along the x-axis and the SASB cluster scores (ranging from 0-1) on the y-axis.



In order to investigate potential differences associated with transference work, men in the TW group were combined with women in the TW group, and men in the non-TW group were combined with women in the non-TW group. A line-chart indicated similar therapist behavior in both groups. However, a larger amount of therapist Control seemed to be present for the group, including both women and men, receiving transference work. This is more clearly illustrated in figure 6.

Figure 6. SASBWorks therapist mean scores: transference work group (including men/high QOR and women/low QOR) and non-TW groups (including men/high QOR and women/low QOR). Based on transcripts of audio recordings 3X10 minutes from 3 sessions. The four plots represent each subgroup. Blue line indicates transference work group; red line indicates non-transference work group. SASB clusters along the x-axis and the SASB cluster scores (ranging from 0-1) on the y-axis.



4.1.2 ANOVA

We conducted mixed ANOVAs with the factors *time* and *treatment group*. First, we compared women in the TW group and women in the non-TW group. The same was done for the men. We also compared women in the TW group to men in the non-TW group and vice versa. Both patient and therapist variables were analyzed. The results indicated no differences in the amount, or change over time, of therapist or patient communications in all combinations of groups ($p > 0,1$).

Scores for the “distance” between therapist and patient for the 8 different communication styles were computed. When analyzing these with ANOVA, the Protect-Trust distant score was the only one with a close to significant result ($p = 0,112$). This difference was between the TW non- TW group. When analyzing only the women, a significant difference ($p = 0,026$) was found, indicating more distance between therapist Protecting and patient Trusting in the group of women in the TW group compared to women in the non-TW group. No such difference was found between men TW group and men non-TW group.

When analyzing the TW group (including both women and men) vs. the non-TW group (including both women and men), a difference was found only with respect to the Control-Submit interaction, with $p < 0,1$ (see table 3). Based on this result, therapist Control codings were selected for further analyses. This decision was based on the high degree of complementarity between therapist Control and patient Submit, which led to the assumption that the difference in analyses would be small to insignificant based on whether Control or Submit was selected. Additionally, as previously mentioned, the dataset includes a randomized variable (transference work), which is a technique implemented by the therapist. We created a mean from the three measuring points (early session, mid-session and late session) and transformed this into a standardized Z-score.

Table 3. Results from two-way ANOVA over the factors time and treatment (TW group). The results indicate a higher level of Control in the TW group ($p < 0,1$).

Control	Type III sum of Squares	<i>p</i>
Intercept	1,001	< 0,000
Treatment	0,57	< 0,088

As therapist Control was more prominent in the TW group, we wondered if this might be connected to the therapist being more involved and being more in charge of the interaction and relation though implementing the transference work. Based on previous results showing women with low QOR benefitting from psychodynamic psychotherapy with transference work (Ulberg et al., 2012; Ulberg et al., 2009), we wondered if variance in therapist Control could explain variance in outcome in the four subgroups. More specifically – would a higher degree of therapist Control positively affect outcome for women with low QOR? Would it negatively affect outcome for men with high QOR in the transference work group?

4.1.3 Multilevel Models

Since there are differences between in the communication between transference work (TW) group and non-TW group, as measured by Structural Analysis of Social Behavior (SASB), can these differences explain differing development in Psychodynamic Functioning Scale (PFS) score in men with high quality of object relations (QOR) and women with low QOR?

Multilevel modelling was used to assess change over time and possible interaction effects. Due to the complete confounding between patient gender and the quality of object relations, the data for males (N=21) and females (N=21) were analyzed separately. Consequently, we will not be able to compare the results from the subgroups. This study is on a small population (N=42) and the models that will be presented includes three-way interactions and thus are complex. Consequently, in the interpretation of the results, emphasis will be placed on Akaike's criterion (AIC), in addition to p-values.

Table 4. Results from multilevel models, model 1-5, for women with low QOR subgroup (N=21).

Fixed effects	Model 1			Model 2			Model 3			Model 4			Model 5		
	Estimate	(SE)	p	Estimate	(SE)	p	Estimate	(SE)	p	Estimate	(SE)	p	Estimate	(SE)	p
PSF															
Intercept	66.93	(.95)	< .001	61.37	(1.09)	< .001	59.8	(1.51)	< .001	59.84	(1.55)	< .001	59.84	(1.49)	< .001
Time				6.54	(.62)	< .001	6.28	(.91)	< .001	5.72	(.92)	< .001	6.29	(1.02)	< .001
Treatment							3	(2.09)	.16	2.94	(2.18)	.188	2.94	(2.1)	.171
Time x treatment							.49	(1.26)	.698	1.45	(1.29)	.267	.97	(1.36)	.477
Control										.11	(1.2)	.925	.12	(1.16)	.922
Control x time										-1.59	(.71)	.029	.05	(1.43)	.975
Control x time x treatment													-2.03	(1.54)	.191
Random effects															
Residual	3.84	(5.49)	< .001	11.29	(2.03)	< .001	11.45	(2.07)	< .001	1.74	(1.96)	< .001	11.02	(2.04)	< .001
Intercept	11.41	(6.2)	.066	16.3	(6.07)	.007	14.04	(5.51)	.011	13.85	(5.53)	.012	11.97	(5.13)	.02
ICC	.27														
Model fit (AIC)	546.723			481.534			472.618			463.263			458.969		

The results from table 4 indicate that the mean PFS score at pretreatment was 66.93 for women (**model 1**). The intraclass correlation was .27, indicating that almost three quarters of the variation in PFS scores were attributable to other conditions than stable ones in each person. Time explained a significant amount of the variance in outcome, as indicated by lower residuals and better model fit (AIC) (**model 2**). The PFS score of women in the TW group increased by approximately 0.5 points more for each unit of time, than in the non-TW group (**model 3**). These results indicate that women with low QOR benefitted more of psychotherapy with transference work, than therapy without this intervention. This is consistent with the findings from FEST, which included a population of 100 patients. However, in our study (on 42 patients), this result was not significant. The results indicated a

negative effect of therapist controlling on outcome across time in women (**model 4**). When including treatment condition (transference work), the results indicated a negative effect of therapist control across time on outcome for women in the TW-group compared to women in the non-TW group (**model 5**). This result was not significant. However, in the last model the AIC was even lower than in the earlier model, indicating that a model including the three-way interaction fitted the data better. In addition, the interaction between time and type of treatment (time x treatment) decreased when adding the three-way interaction (Control x time x treatment). This indicates that including the different effect of Control on outcome in the TW-group across time, compared to the effect of Control on outcome in non-TW group across time, lead to more explained variance. In sum, a small and nonsignificant relationship between therapist Control and outcome for women with low QOR was observed, indicating that more therapist Control had a negative effect on outcome. The results also indicated a stronger negative effect in the TW-group compared to the non-TW group.

Table 5. Results from multilevel models, model 1-5, for men with high QOR subgroup (N=21).

Fixed effects	Model 1		Model 2		Model 3		Model 4		Model 5	
	Estimate (SE)	p	Estimate (SE)	p	Estimate (SE)	p	Estimate (SE)	p	Estimate (SE)	p
PSF										
Intercept	71.51(.86)	< .001	67.53 (1)	<.001	69.64 (1.3)	< .001	69.75 (1.3)	< .001	69.75 (1.31)	< .001
Time			4.69 (.59)	< .001	4.82 (.86)	< .001	4.92 (.87)	< .001	4.81 (.91)	< .001
Treatment					-4.04(1.8)	.03	-4.28(1.83)	.025	-4.28 (1.84)	.025
Time x treatment					-.26(1.2)	.753	-.48(1.23)	.698	-.39 (1.24)	.753
Control							.5 (.84)	.562	.5 (.85)	.564
Control x time							.44 (.57)	.441	-.06 (1.2)	.963
Control x time x treatment									.59 (1.27)	.641
Random effects										
Residual	20.1 (3.58)	< .001	10.11(1.82)	< .001	10.26 (1.86)	< .001	10.33 (1.89)	< .001	10.42 (1.91)	< .001
Intercept	10.63 (5)	.035	13.13 (4.97)	< .001	8.92 (3.76)	.018	8.57(3.75)	.022	8.71 (3.81)	.022
ICC	.346									
Model fit (AIC)	515.747		470.66		458.777		454.65		458.969	

The results, presented in table 5, shows that for men the mean PFS score at pretreatment was 71.51. The intraclass correlation was .346 for men, indicating that about two thirds of the variation in PFS scores were attributable to other conditions than stable ones in each person (**model 1**). Time explained a significant amount of the variance in outcome, as indicated by lower residuals and better model fit (AIC) (**model 2**). The PFS score for men in the TW group decreased by .26 points for each unit of time, compared to the non-TW group (**model 3**). This result suggested that men with high QOR benefited more from psychotherapy without transference work, than psychotherapy with this intervention. This is consistent with

the findings from FEST, which included a population of 100 patients. However, in our study on 42 patients, the difference was small and nonsignificant. There was a positive, but not significant, relationship between therapist Control on outcome over time for men (**model 4**). However, according to the AIC, an inclusion of therapist Control suggested a better model. When including the three-way interaction between time, treatment condition and therapist Control, the results indicated a positive effect of therapist Control across time on outcome for men in the TW group (**model 5**). This result was non-significant, and the AIC increased as a result of the last step. The change in the interaction between time (time x treatment) and treatment condition, was almost nonexistent when including this three-way interaction, and the AIC increased. This suggests that the effect of Control on outcome was not different for men in the TW group compared to the non-TW group. In short, the results indicate that for men with high QOR, therapist Control does not seem to explain much of variance in outcome.

In sum, we observed the same trend as the results from the original FEST study; a positive relationship between transference work and outcome for women with low QOR and a negative one for men with high QOR. We found a small negative relationship between therapist Control and outcome for women with low QOR across time, and an even smaller positive effect of Control on outcome for men with high QOR. This result was the opposite of the assumptions we formulated at the end of section 4.1.2. Based on the findings from multilevel modelling, variance in therapist Control might seem to explain the variance in outcome for women with low QOR to a small degree, pointing in a negative direction, and to a lesser degree for men with high QOR. The effects were small and nonsignificant. However, it does not rule out the possibility of a relationship, as the small and nonsignificant results can partly be explained by few patients in each subgroup.

5 Discussion

5.1 Main findings

What characterizes therapist-patient communication style across time, as measured by SASB, between therapists and patients (men with high QOR and women with low QOR)?

Little variation in coded SASB clusters

The present study indicated that communication between therapist and patient in the FEST study was mainly characterized by the Protect-Trust, Disclose-Affirm, and Control-Submit SASB cluster scores. See figure 3 and table 6 for an illustration and examples of SASB coded interactions between therapist and patient.

Figure 3: The one-word cluster version of SASB highlighting the three clusters found to characterize patient-therapist interaction in the present study. Therapist communication in capital letters, and patient communication in lowercase letters.

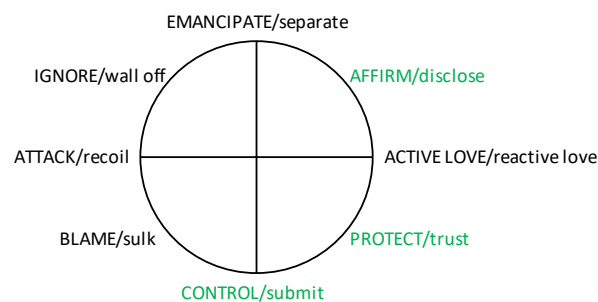


Table 6. Examples of SASB coded interactions from the FEST study illustrating the most commonly coded SASB process clusters in the present study: protect-trust, control-submit and affirm-disclose.

Individual speaking	Part of dialogue	SASB process cluster
Patient	<i>I feel like shit. Yes, I feel really silly.</i>	Disclose, Sulk
Therapist	<i>Then it is especially important for you to explore that you come here and feel stupid. You have made yourself a notion that I think you are stupid and difficult in a way. One who doesn't manage to say what you're supposed to.</i>	Control, Protect
Patient	<i>Mm mm.</i>	Submit
Therapist	<i>You feel that I am not interested in you, that I don't care, that you are just a number in the row, a burden in a way?</i>	Affirm, Protect
Patient	<i>Yes, that is correct.</i>	Trust, Sulk
Therapist	<i>And then you have a lot of thoughts and it hurts inside.</i>	Protect
Patient	<i>But how can I change such a mindset?</i>	Trust
Therapist	<i>After all, you have a place to go.</i>	Affirm, Protect
Patient	<i>Yes. It's good even though I think it's hard.</i>	Trust, Disclose
Therapist	<i>I understand.</i>	Affirm
Patient	<i>I have to learn that it's not like that.</i>	Trust, Self-control
Therapist	<i>You can learn that in therapy because here you can ask about anything and examine it here while we talk about it.</i>	Protect
Patient	<i>Yes, because, I get the feeling that they really hate me, but I sort of know that they don't.</i>	Disclose

(Ulberg et al., 2014)

Protect-Trust and Affirm-Disclose has been frequently coded in the studies investigating psychotherapy process with SASB, across different theoretical orientation such as psychodynamic (Henry et al., 1986, 1990) and cognitive-behavioral orientations (Critchfield et al., 2007). A meta-review by Orlinsky et al. from 2004 found therapist affirmative behavior to demonstrate a predominantly positive effect (87 of 154 studies) on treatment outcome (Lambert, 2013). Based on this it seems reasonable that this pattern is also observable in the present study, particularly as the outcome for all groups included was good.

The presence of hostility and communication characterized by separateness was insignificant in the present study. This finding contradicts others using SASBs interpersonal coding system, who have found that hostile complementarity between therapist and patient is not unusual (Tasca & McMullen, 1992; von der Lippe et al., 2008) One possible reason for why hostility was absent in the therapies might be because the therapists were highly experienced. Navajatis and Strupp (1994) concluded that effective (defined as fewer drop-out and better patient outcome) therapists received fewer hostile SASB codings (Navajits & Strupp, 1994). As data from the present study is based on material from FEST, which had no drop-out and

good outcome across all groups, it seems reasonable that we would observe insignificant amounts of hostility.

Nevertheless, considering that the groups consist of men with high quality of objects relations and women with low quality of object relations, one might expect communication characterized by more hostility and separateness in the low QOR group. Problematic communication patterns unavoidably emerge in therapy with personality disordered patients, for example in situations such as therapeutic ruptures, misalliances and patient reenactments of past experiences, or the emotions activated in the therapist in response to working with personality disordered patients (Levenson, 2004; Stern & Yeomans, 2018).

Countertransference

The present study found therapist communication to be mostly characterized by Protecting, Affirming and Controlling. This is in compliance with several studies reporting more positive parental and protective feelings in therapists working with patients with personality pathology (Betan et al., 2005; Colli et al., 2014; Rossberg et al., 2007). Parental countertransference was described by Dahl et al. (2012) as supportive and guiding attitude comprised of the feelings motherly, affectionate, dominant and important. A finding by Dahl et al. (2014) based on FEST, found a strong association between the interaction between parental feelings and personality pathology, and long-term specific effects of transference work. Based on this, one could wonder if the higher amount of therapist Control present in the TW group of the current study could be explained by a parental element to transference work. It is important to mention that in this study, the data did not allow for investigating whom “pulled” for this interaction - the patient or the therapist. More specifically, it is not possible to determine whether patient trusting, disclosing and submitting communication elicited the complementary response in the therapist, or whether the interaction originates from the therapist’s communication.

Alliance and transference work

The SASB codings of the present study can be viewed in light of alliance. In an article by Constantino (2000), therapeutic alliance is conceived in terms of interpersonal processes and presents SASB's wide-ranging applications to observing the therapist-patient relationship,

therapy process, and outcome. The SASB codings of the present study can be viewed in light of alliance. Positive complementarity in SASB codings is associated with positive outcome (Henry et al., 1986; von der Lippe et al., 2008). Complementarity interactions also tend to sustain relationships, are assumed to enhance security, and reinforce current interaction patterns (Sullivan, 1953). In addition, studies indicate that therapists' non-defensive responses to client negativity or hostility are critical to maintaining a good alliance (Horvath et al., 2011). As there is a high degree of complementary between patient and therapist on Protect-Trust and Affirm-Disclose in the present study, in addition to a low degree of hostility, one might consider the SASB profile discovered in the current study as an indication of good alliance. In the FEST study, Høglend et al. (2011) found that for patients with low QOR and more severe psychopathological struggles, the effect of transference work was positive independently of the alliance being good or poor. The importance of both alliance and TW is an indication of the growing consensus in clinical psychology that common and specific factors both shape therapeutic outcomes (Hofmann & Barlow, 2014; Laska et al., 2014).

Little change across time

The present study demonstrated insignificant change in therapist communication across the three measuring points. Apart from lower degrees in therapist Affirmation in the mid-treatment session with men/high QOR, no differences across time were found in the subgroups. This finding diverges from the theory of stage models. These models argue that psychotherapy can be differentiated into an early, middle and late stage, with elements of the therapeutic relationship highlighted differently during each stage (Weiner, 1975). A study on stage models in psychotherapy using SASB partially supported this theory (Tasca & McMullen, 1992).

In a case study by Dahl et al. (2016), partly based on the same material as the present study, two cases with divergent long-term results were presented. In the case with continued good outcome at follow up, the SASB codes were characterized by a decrease in Control-Submit interaction and increase in Protection. In the case with poorer outcome at follow up was characterized by increased Control-Submit interaction. Based on this, one could wonder if a variation in SASB cluster codes would be visible across the three coded sessions in the present study, as the degree of good outcome varies between the four subgroups. However, this does not seem to be the case.

Small differences between groups

Small differences were found between the subgroups concerning the most frequently coded SASB cluster scores. Affirm-Disclose and Protect-Trust were almost identical within the four groups, while a difference on Control-Submit was apparent between the TW group and non-TW groups. This was surprising, as we expected to see more variance in the SASB codings in the groups that would reflect the different outcomes from the FEST study. Based on this, it was considered plausible that the amount of positive and negative interactions between the group with positive outcome (women with low QOR in TW group) and less positive outcome (men with high QOR in TW group) would be visible in the SASB codings. However, both groups in the FEST study respectively had a positive outcome, and therefore the differences might not be as apparent as they would if the study included a good outcome and bad outcome group, as found in earlier studies using SASB (Henry et al., 1986, 1990). A more recent study on CBT-therapies did, however, not find interpersonal behaviors measured by SASB to be strong predictors of outcome (Critchfield et al., 2007).

Moreover, the overall positive SASB codings (high affiliative control and affiliative autonomy) is consistent with previous research connecting these interactions to good outcome (Henry et al., 1986). Despite this, several studies show an interaction between interpersonal problems and personality disorders (Monsen, Hagtvet, Havik, & Eilertsen, 2006). As the sample of the present study is comparing two groups with differing degrees of interpersonal problems/personality pathology, we could expect to observe different interpersonal processes in the group which is characterized by higher degree of interpersonal problems (in this study: women), compared to a group where these problems are present to a lower degree (in this study: men). On the other hand, it is relevant to mention that this study is based on average scores for groups, and thus has a nomothetic perspective. Therefore, individual variation is disguised behind average cluster scores.

Affirmation

There seemed to be little difference in therapist behavior while working with people with high vs. low object relations. Based on psychoanalytic theory, patients with personality pathology and low mentalization ability, in this sample represented by patients with low Quality of object relations, may need therapy more focused on affirming rather than

interpretations (Killingmo, 2006). Nonetheless, there does not seem to be more therapist affirmation in the low QOR group, compared to the high QOR group.

Protect-Trust

A “distance” between patient and therapist SASB cluster scores within the Protect-Trust cluster was found, indicating that when therapist was protecting, patient was not always trusting, and vice versa. Protect-Trust is complementarity placed on the warm- and controlling part of SASB. This difference was present between the TW-and non-TW group, with a larger “gap” between therapist and patient in the TW group. The difference was even larger in the women/low OOR subgroup, the results were pointing in the same direction; larger distance between therapist protecting and patient trusting in the TW group. This was contrary to our expectations, as complementarity (in this case: small “distance” between patient Trust and therapist Protect) defined as positive, is associated with positive outcome (Henry et al., 1986; von der Lippe et al., 2008). As the women group has a positive outcome in the FEST study, we did not expect to find a significant discrepancy between therapist protecting and patient trusting within this group.

Control-Submit

The present study indicated a difference in therapist Control and patient Submit across the TW group and non-TW groups. There was a higher degree of Control-Submit complementarity in the TW group (including both gender and level of QOR.) Based on this it seems fair to assume the findings indicate a relation between technique (transference work) and interpersonal processes. Henry and colleagues (Henry, 1996) state that alliance is related to the ongoing interpersonal process in the therapeutic relation. They have conducted a series of process studies using SASB to define the alliance directly in terms of momentary interpersonal process (Henry et al., 1986, 1990; Henry & Strupp, 1994).

Why is there more Control?

In the FEST study the therapists were to use specific interventions concerning the transference and therapeutic relationship with one group of their patients. The therapist continually addressing these subjects entails the therapist “taking the lead” in the therapeutic dialogue. This might be associated with an element of Control, which our analyses found to be more dominating in the TW group (across gender and QOR). Psychodynamic oriented therapy is seldom associated with guiding therapist behavior, compared to CBT, which often

is goal directed, manualized and involves guidance (Keijsers, Schaap, & Hoogduin, 2000). One might assume that these types of therapeutic focus and interventions would be reflected in the communication between therapist through a pattern of therapist Control and patient Submit. A case study on processes in psychodynamic-interpersonal and cognitive-behavioral group therapy supports this assumption, as the results implied higher levels of controlling (i.e., directive) behavior performed by the cognitive therapist than the psychodynamic therapist (Tasca et al., 2011)

Is the amount of Control connected to outcome?

Based on what we already knew from the FEST study, we wondered if higher therapist Control would positively affect outcome for women with low QOR and negatively affect outcome for men with high QOR. Yet, we found the opposite tendency; therapist Control seemed to negatively affect outcome for women with low QOR and positively affect outcome for men with high QOR. Again, the effects were small and nonsignificant. With a larger population, and more statistical strength, stronger (or different) relationships might have been observed. Even so, the results suggest that there must be something SASB failed to capture, which might explain why women with low QOR in this study benefitted more from psychotherapy with transference work, than psychotherapy without transference work. The difference that was observed; a larger “distance” between therapist Protect and Patient trust in the TW-group compared to the non-TW group, does not seem to be a plausible explanation of the different development in PFS-scores. This is because, as already mentioned, complementarity previously has been associated with positive outcome (Henry et al., 1986; von der Lippe et al., 2008)

To summarize, a clear relationship between therapist Control and outcome was not found. This suggests that therapist control might not be neither very helpful, nor very harmful, in psychotherapy. Similar to the present study, Von der Lippe et al. (2008) did not find interdependence to be related to outcome.

5.2 Methodological discussion

In the present study Structural Analysis of Social Behavior was the main process measure. Contrary to other studies using SASB (Henry et al., 1986, 1990; Tasca & McMullen, 1992;

von der Lippe et al., 2008), the present study did not include data on the momentary response to a therapist, or patients, statement. This means that the study of complementarity was limited to analysis on mean scores, as information on speaking turns was not available. SASB codes “thought units”, each of which consist of, more or less, one spoken sentence. Due to the nature of the material, coding will be vulnerable to biases.

A simplified model of SASB was used to gather the codes for which the present study is based on – a one-word model. It is reasonable to believe more variation would be revealed if a more complex model had been used. According to Benjamin (2018), the full model is best for analysis of complex situations that require high precision. On the other hand, the less exact judgements are easier to comprehend and often satisfying. Moreover, studies by Henry et al. (1986, 1990) found more variation in SASB clusters using the simplified models. The study of differences between groups, instead of between patients alone might have led to missing variance. Another potential source could be the fact that only three sessions (3x10 minutes per session) was coded with SASB. Understandably so, as it is a time consuming and challenging task. However, it is likely that more variability would be visible if more sessions were coded. In contrast to SASB, PQS analyses an entire session, and thus has the advantage of including more of the material.

5.2.1 Strengths and limitations

All 100 patients from the FEST study completed the 3-year follow up. Consequently, the same goes for the 42 patients in this study, which means no missing data. The application of SASB in the study offers fine-grained information on the communication between therapist and patient. In contrast to other measurements of process (e.g. self-report) which might be more biased, the SASB codings were rated by two uninvolved observers, showing high reliability (.72) (Ulberg et al., 2009). The present study has used multi-level modelling to compare the suitability of five models. Multi-level modelling is considered to be the preferred choice of method when dealing with hierarchal data, as with this study. Apart from lower PFS score at pre-treatment for the non-TW group vs the TW group for women, and the other way around for men, most patient characteristics were evenly distributed across the subgroups.

A limitation of the study is the small sample size (N=42). Because the present study consists of a selection of 42 patients from originally 100 patients from FEST, the analyses and results are based on data from a limited number of participants. Additionally, the selection of participants from the original study only consists of women with low QOR and men with high QOR. This limits the generalizability, as the sample does not include men with low QOR and women with high QOR. The complete confounding of the variables QOR and patient gender also leads to the impossibility of concluding on the basis of gender or QOR separately. Consequently, this study cannot exclusively conclude on gender or QOR. Pretreatment characteristics was not completely evenly divided in women in the TW group compared to women in the non-TW group, nor for men in the TW group compared to men in the non-TW group. This means that there is a possibility of the interpretations of results to be affected by different pre-treatment characteristics in the subgroups.

The SASB cluster codes from the psychotherapy sessions have a sum of 1 for each focus. (e.g. 0.5 on Affirm + 0.4 on Protect + 0.1 on Control=1). This introduces a dependency in the codes, as a high score on one SASB-cluster would necessarily mean a lower score on another.

5.3 Future research

Interpersonal processes are key variables to study in order to reach a better understanding of the active and most important ingredients that make psychotherapy effective. The present study found a higher degree of therapist Control in therapies with transference work than therapies without this intervention. Future research should further investigate the relationship between interpersonal communication and the implementation of specific techniques. The current study did not find a clear relationship between therapist Control and outcome. However, this study was based on a small number of participants and consequently the possibilities of observing strong effects and relationships was limited. It is therefore recommended that future research on process and outcome mechanisms in psychotherapy, builds upon a larger number of participants.

6 Conclusion

The present study aimed to investigate what characterizes the communication across time, as measured by SASB, between therapists and patients (men/high QOR and women/low QOR) in psychodynamic therapy with and without transference work (TW). Additionally, if differences in communication was present, we aimed to investigate whether this could explain varying development in PFS-score in the different groups (men/high QOR and women/low QOR with and without TW).

Communication between therapist and patient was found to be mainly characterized by the following SASB-cluster scores: Protect-Trust, Affirm-Disclose, and Control-Submit. We did not find differences between communication in men with high QOR with/without transference work, and women with low QOR with/without transference work. A high degree of complementarity between therapist and patient was observed. One exception was a larger “gap” between patient Trust and therapist Protect for women in the transference work group vs non-transference group. However, we found a difference between the transference work group (including both genders) and the non-transference work group (including both genders). The results from multilevel modelling indicated no clear association between therapist Control and outcome for women or men respectively. However, it seemed to have negative impact on outcome for women, especially in the TW-group compared to non-TW group. This was nonsignificant. The small sample size (N=42) and the complete confounding of the subgroup characteristics (gender and QOR) limit the possibility to draw a clear conclusion from this study.

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