Relationship Between SWAP-200 Patient Personality Characteristics and Patient-Rated Alliance Early in Treatment

Scott W. Smith, PhD, Mark J. Hilsenroth, PhD, ABAP,† Katherine L. Fiori, PhD,† and Robert F. Bornstein, PhD†*

Abstract: Research on the therapeutic alliance suggests patient personality characteristics to be plausible correlates of alliance formation. To date, research has largely focused on the relationship between the alliance and facets of patient personality measured via patient self-report, versus personality syndromes.

In the present study, we assess patient personality using a clinician-rated measure—the Shedler-Westen Assessment Procedure–200 (SWAP-200; Shedler and Westen [*Assessment* 5:335–355, 1998; *Am J Psychiatry* 161:1350–1365, 2004; *Am J Psychiatry* 161:1743–1754, 2004]; Westen and Shedler [*Am J Psychiatry* 156:258–272, 1999; *Am J Psychiatry* 156:273–285, 1999)—and investigate the extent to which empirically derived personality configurations correlate with patient-rated alliance. The study sample consisted of 94 patients receiving psychodynamic psychotherapy at an outpatient clinic.

The SWAP-200 Dependent Clinical Prototype and Dysphoric: Dependent-Masochistic Q-Factors were found to significantly correlate with early alliance. Also identified were specific SWAP-200 items that independently correlated with early alliance scores.

The results of the present study demonstrate a relation between patient personality characteristics and therapeutic alliance that may serve to further a conceptual understanding of the alliance.

Key Words: Shedler-Westen assessment procedure (SWAP-200), personality disorders, therapeutic alliance, psychodynamic psychotherapy

(*J Nerv Ment Dis* 2014;202: 372–378)

A prodigious literature on the therapeutic alliance suggests that the alliance is a common therapeutic factor that is moderately, yet robustly, correlated with therapy outcome ($r = 0.275$), accounting for approximately 8% of outcome variance (Horvath et al., 2011; Horvath and Bedi, 2002; Horvath and Symonds, 1991; Martin et al., 2000; Norcross and Wampold, 2011), with patients' appraisals of the alliance having a favorable relation with outcome (Barber et al., 1999; Henry and Strupp, 1994; Horvath et al., 2011; Horvath and Symonds, 1991; Martin et al., 2000; Zuroff and Blatt, 2006). A second wave of therapeutic alliance research has advanced to identify factors within treatment (*e.g.*, patient characteristics, therapist characteristics) that contribute to the alliance. Patient personality characteristics have emerged as particularly viable predictors of alliance strength. The present study investigates clinician-rated patient personality and its relationship to patient-rated therapeutic alliance early in treatment.

Research on the relationship between patient personality and patient-rated alliance has focused almost exclusively on investigating the strength of the therapeutic alliance with circumscribed personality factors. Facets of patient personality shown to relate to alliance include interpersonal styles (Constantino et al., 2005; Dinger et al., 2009; Hersoug et al., 2010; Muran et al., 1994), early memories (Hersoug et al., 2010, 2002), defensive functioning (Gaston et al., 1988), attachment styles (Diener and Monroe, 2011; Smith et al., 2010), and quality of object relations (Pinsker et al., 2007; Piper et al., 1991). For example, past research has demonstrated that patients who characterize their interpersonal problems as stemming from being submissive, nonassertive, and overly affiliative tend to have stronger alliances with their therapists (Constantino and Smith-Hansen, 2008; Dinger et al., 2009; Muran et al., 1994; Paivio and Bahr, 1998). In addition, inverse relationships have been found between patients' reports of domineering/controlling, vindictive/self-centered, and cold/distant interpersonal problems and patient-rated therapeutic alliance early in treatment (Connolly-Gibbons et al., 2003; Hersoug et al., 2002; Johansson and Eklund, 2006).

The present study sought to address a gap in the alliance literature by investigating the relationship between empirically derived patient personality syndromes and strength of the therapeutic alliance early in treatment. Assessment of facets of personality fails to represent the psychological structure of an individual's personality as a whole. Personality syndromes are conceptualized as being composed of individual features of personality (*e.g.*, attachment style, interpersonal style, defensive functioning) organized by an overarching personality structure, which in turn is posited to be vitalized by motivations in the service of goal achievement (Block, 1995). Thus, an investigation of the relationship between therapeutic alliance and personality syndromes may provide novel insight into the alliance construct. In addition, the few studies that have investigated the relationship between the therapeutic alliance and personality disorders (PDs; *e.g.*, Lingiardi et al., 2005; Taft et al., 2004) have mostly used patient self-report in assessing PDs (either interview based or questionnaire) rather than measures that harness the expertise of clinicians' observations. The criteria of personality constructs derived from self-report measures of personality have been criticized for lacking sufficient criterion validity (*e.g.*, Bornstein, 2003). To address these issues, the present study assesses patient personality using an empirically derived, clinician-rated measure, the Shedler-Westen Assessment Procedure–200 (SWAP-200; Shedler and Westen, 1998, 2004a, 2004b; Westen and Shedler, 1999a, 1999b), to examine the extent to which empirically derived personality syndromes (SWAP-200 Q-Factors and Clinical Prototypes) correlate with patient-rated alliance. The investigation also analyzes the relationship of patient-rated alliance and the SWAP-200 at an item level. These differing levels of analysis present an opportunity to understand the patient personality-alliance relationship on a personality syndrome level (*i.e.*, Q-Factor and Clinical Prototype) in addition to identifying stand-alone descriptors of personality most and least related to patient-rated alliance early in treatment.

The following hypotheses (with the exclusion of hypothesis 4, an exploratory analysis) were formulated on the basis of prior research assessing the relationship between therapeutic alliance and patient personality:

1. Scores on selected SWAP-200 Q-Factors (Dysphoric, Dysphoric: Dependent-Masochistic, Dysphoric: High-Functioning Neurotic,

*Pathways to Housing, New York, NY; and †Department of Psychology, Derner Institute of Advanced Psychological Studies, Garden City, NY.
Send reprint requests to Scott W. Smith, PhD, 212 South Oxford St, Apt. 7B, Brooklyn, NY 11217. E-mail: sw17smith@gmail.com.

ISSN: 0022-3018/14/20205–0372
DOI: 10.1097/NMD.0000000000000134

O

RIGINAL

A

RTICLE

Relationship Between SWAP-200 Patient Personality Characteristics and Patient-Rated Alliance Early in Treatment

Scott W. Smith, PhD, Mark J. Hilsenroth, PhD, ABAP,Þ Katherine L. Fiori, PhD,Þ and Robert F. Bornstein, PhDÞ*

Abstract: Research on the therapeutic alliance suggests patient personality characteristics to be plausible correlates of alliance formation. To date, re- search has largely focused on the relationship between the alliance and facets of patient personality measured via patient self-report, versus personality syndromes.

In the present study, we assess patient personality using a clinician-rated measureVthe Shedler-Westen Assessment ProcedureY200 (SWAP-200; Shedler and Westen [Assessment 5:335Y355, 1998; Am J Psychiatry 161:1350Y1365, 2004; Am J Psychiatry 161:1743Y1754, 2004]; Westen and Shedler [Am J Psy- chiatry 156:258Y272, 1999; Am J Psychiatry 156:273Y285, 1999)Vand investi- gate the extent to which empirically derived personality configurations correlate with patient-rated alliance. The study sample consisted of 94 patients receiving psychodynamic psychotherapy at an outpatient clinic.

The SWAP-200 Dependent Clinical Prototype and Dysphoric: Dependent- Masochistic Q-Factors were found to significantly correlate with early alli- ance. Also identified were specific SWAP-200 items that independently correlated with early alliance scores.

The results of the present study demonstrate a relation between patient personality characteristics and therapeutic alliance that may serve to further a conceptual understanding of the alliance.

include interpersonal styles (Constantino et al., 2005; Dinger et al., 2009; Hersoug et al., 2010; Muran et al., 1994), early memories (Hersoug et al., 2010, 2002), defensive functioning (Gaston et al., 1988), attachment styles (Diener and Monroe, 2011; Smith et al., 2010), and quality of object relations (Pinsker et al., 2007; Piper et al., 1991). For example, past research has demonstrated that pa- tients who characterize their interpersonal problems as stemming from being submissive, nonassertive, and overly affiliative tend to have stronger alliances with their therapists (Constantino and Smith- Hansen, 2008; Dinger et al., 2009; Muran et al., 1994; Paivio and Bahr, 1998). In addition, inverse relationships have been found between patients' reports of domineering/controlling, vindictive/self-centered, and cold/distant interpersonal problems and patient-rated therapeutic alliance early in treatment (Connolly-Gibbons et al., 2003; Hersoug et al., 2002; Johansson and Eklund, 2006).

The present study sought to address a gap in the alliance lit- erature by investigating the relationship between empirically derived patient personality syndromes and strength of the therapeutic alliance early in treatment. Assessment of facets of personality fails to rep- resent the psychological structure of an individual's personality as a whole. Personality syndromes are conceptualized as being composed Key Words: Shedler-Westen assessment procedure (SWAP-200), personality disorders, therapeutic alliance, psychodynamic psychotherapy

of individual features of personality (e.g., attachment style, inter- personal style, defensive functioning) organized by an overarching (J Nerv Ment Dis 2014;202: 372Y378)

personality structure, which in turn is posited to be vitalized by motivations in the service of goal achievement (Block, 1995). Thus, an investigation of the relationship between therapeutic alliance and A prodigious alliance is a literature common on

therapeutic the therapeutic factor alliance that is suggests moderately, that the yet robustly, correlated with therapy outcome (r = 0.275), accounting for approximately 8% of outcome variance (Horvath et al., 2011; Horvath and Bedi, 2002; Horvath and Symonds, 1991; Martin et al., 2000; Norcross and Wampold, 2011), with patients' appraisals of the alliance having a favorable relation with outcome (Barber et al., 1999; Henry and Strupp, 1994; Horvath et al., 2011; Horvath and Symonds, 1991; Martin et al., 2000; Zuroff and Blatt, 2006). A second wave of therapeutic alliance research has advanced to identify factors within treatment (e.g., patient characteristics, therapist char- acteristics) that contribute to the alliance. Patient personality char- acteristics have emerged as particularly viable predictors of alliance strength. The present study investigates clinician-rated patient per- sonality and its relationship to patient-rated therapeutic alliance early in treatment.

Research on the relationship between patient personality and patient-rated alliance has focused almost exclusively on investigating the strength of the therapeutic alliance with circumscribed personal- ity factors. Facets of patient personality shown to relate to alliance

personality syndromes may provide novel insight into the alliance construct. In addition, the few studies that have investigated the re- lationship between the therapeutic alliance and personality disorders (PDs; e.g., Lingiardi et al., 2005; Taft et al., 2004) have mostly used patient self-report in assessing PDs (either interview based or ques- tionnaire) rather than measures that harness the expertise of clini- cians' observations. The criteria of personality constructs derived from self-report measures of personality have been criticized for lacking sufficient criterion validity (e.g., Bornstein, 2003). To ad- dress these issues, the present study assesses patient personality using an empirically derived, clinician-rated measure, the Shedler- Westen Assessment ProcedureY200 (SWAP-200; Shedler and Westen, 1998, 2004a, 2004b; Westen and Shedler, 1999a, 1999b), to examine the extent to which empirically derived personality syn- dromes (SWAP-200 Q-Factors and Clinical Prototypes) correlate with patient-rated alliance. The investigation also analyzes the rela- tionship of patient-rated alliance and the SWAP-200 at an item level. These differing levels of analysis present an opportunity to under- stand the patient personality-alliance relationship on a personality syndrome level (i.e., Q-Factor and Clinical Prototype) in addition to identifying stand-alone descriptors of personality most and least re- lated to patient-rated alliance early in treatment. *Pathways to Housing, New York, NY; and †Department of Psychology, Institute of Advanced Psychological Studies, Garden City, NY.

Derner

The following hypotheses (with the exclusion of hypothesis 4, an exploratory analysis) were formulated on the basis of prior re-

Send reprint requests to Scott W. Smith, PhD, 212 South Oxford St, Apt. 7B, Brooklyn, NY 11217. E-mail: sw17smith@gmail.com. ISSN: 0022-3018/14/20205Y0372 DOI: 10.1097/NMD.0000000000000134

search assessing the relationship between therapeutic alliance and patient personality:

1. Scores on selected SWAP-200 Q-Factors (Dysphoric, Dysphoric: Dependent-Masochistic, Dysphoric: High-Functioning Neurotic,

Psychological Health Index) and Clinical Prototypes (Histrionic, Dependent) would positively correlate with patient-rated alliance.
2. Scores on selected SWAP-200 Q-Factors (Paranoid, Schizoid, Narcissistic, Obsessional, Antisocial-Psychopathic, Dysphoric: Emotionally Dysregulated, Dysphoric: Avoidant, Dysphoric: Hostile-Externalizing) and Clinical Prototypes (Paranoid, Schizoid, Antisocial, Narcissistic, Borderline, Avoidant, Obsessive-Compulsive) would negatively correlate with patient-rated alliance.
3. The SWAP-200 Schizotypal Clinical Prototype would have no significant relationship with patient-rated alliance.
4. In an exploratory analysis, we aimed to assess which individual SWAP-200 items would correlate most and least with patient-rated therapeutic alliance early in treatment.

METHODS

Participants

All participants were adults seeking outpatient treatment at a suburban, university-based community clinic located in the northeastern United States. Cases were assigned to treatment practice and clinicians in an ecologically valid manner on the basis of aspects of clinician availability, caseload, etc. Ninety-four outpatients were consecutively admitted for individual psychotherapy to a psychodynamic psychotherapy treatment team based at the clinic (Hilsenroth, 2007). Patients were not excluded on the basis of diagnosis or comorbidity.

The final sample (Table 1) consisted of 67 women and 27 men. The sample was composed of patients diagnosed with a variety of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*), axis I diagnoses, with mood disorders being the most prevalent. More than half of the patients were diagnosed with an axis II PD; just less than one quarter of the patients had subclinical PD features. Thus, this sample consisted primarily of patients with mood disorders, relational problems and diagnosed with axis II PDs or subclinical PD features. The severity of pathology was in the mild to moderate range, which is consistent with what one would expect from a sample of a university-based, community outpatient clinic. Interrater reliability for the dimensional classification of personality pathology, a) presence of a PD (2), b) presence of subclinical traits/features (1), and c) absence of a PD (0), was excellent (*i.e.*, Intraclass Correlation Coefficient, $1.2 > 0.74$; Fleiss, 1981) for this project (Hilsenroth et al., 2000; Peters et al., 2006). Finally, each participant provided written informed consent to be included in this research.

TABLE 1. Demographic Information ($N = 94$)

Variable	*n*	%
Sex	94	100
Male	27	29
Female	67	71
Age, mean (SD)	30 (11.6)	
Marital status		
Single	58	61
Married	21	22
Divorced	14	15
Widowed	1	1
Primary axis I diagnosis		
Adjustment disorder	12	13
Anxiety disorder	12	13
Eating disorder	3	3
Mood disorder	50	53
Substance-related disorder	1	1
V code relational problem	15	16
Impulse control disorder	1	1
Axis II diagnosis	52	55
Axis II trait/features	23	24
Axis II cluster A	9	12
Axis II cluster B	39	52
Axis II cluster C	27	36
Psychiatric Severity	**Mean**	**SD**
Intake GAF	60	5.6
SCL-GSI	1.1	0.58

GAF indicates Global Assessment of Functioning; SCL-GSI, Global Severity Index of the SCL-90-R.

Procedure

Advanced graduate students (13 men and 13 women) in an American Psychological Association–approved clinical PhD program conducted the assessment, feedback sessions, and treatment and rated the clinical measures. Clinicians completed structured training on the clinical rating scales before rating their patients. Clinical interviews centered on presenting problems, history, and relational episodes. Feedback sessions followed a therapeutic model of assessment (Finn and Tonsager, 1997, 1992), which emphasizes fostering of alliance and a relational focus on the collaborative work of identifying factors deleteriously affecting the patient and potential ways of addressing these issues (Hilsenroth, 2007; Hilsenroth et al., 2000). After the feedback session and the first two sessions of psychotherapy, the treating clinicians completed the SWAP-200. For the present study, measurements of the alliance by the patients occurred early in treatment (3rd/4th session). The patients were informed both verbally by the treating clinician and in writing on the alliance forms that their alliance ratings would not be made available to their therapist.

Measures

Shedler-Westen Assessment Procedure–200

The therapists used the SWAP-200 to describe their patients after completing the therapeutic assessment and the first two therapy sessions (approximately 5–6 contact hours). The SWAP-200 Q-Sort (Shedler and Westen, 1998, 2004a, 2004b; Westen and Shedler, 1999a, 1999b) is a clinically derived, empirically based diagnostic measure that has been shown to have excellent retest reliability as well as good interrater, discriminant, and convergent validities with a range of external criteria (Diener and Hilsenroth, 2004; Shedler and Westen, 2004b; Smith et al., 2009; Westen and Muderrisoglu, 2003). To complete the SWAP-200, the rater arranges a set of 200 personality descriptions into eight different categories ranging from 0 (irrelevant or inapplicable to the patient) to 7 (highly descriptive of the patient). The Q-Sort has a fixed distribution that mitigates measurement error. Correlation coefficients are then calculated to assess the match between the characteristics of a particular patient and the empirically derived, aggregate descriptions (Clinical Prototypes and Q-Factors). Several studies support the reliability and validity of the SWAP-200 in the diagnosis of PDs (Shedler and Westen, 1998; Westen and Shedler, 1999a, 1999b).

Combined Alliance Short Form–Patient Version

The Combined Alliance Short Form–Patient Version (CASF-P; Hatcher and Barends, 1996) was derived from a factor analysis of responses from 231 outpatients at a university clinic who completed three popular alliance measures as follows: a) the Penn Helping Alliance Questionnaire (Alexander and Luborsky, 1986; Luborsky et al., 1983), b) the Working Alliance Inventory (Horvath and Greenberg, 1989), and c) the California Psychotherapy Alliance Scales (Gaston, 1991).

The CASF-P consists of 20 items rated on a 7-point Likert-type scale consisting of 1 (never), 2 (rarely), 3 (occasionally), 4 (sometimes),

Psychological Health Index) and Clinical Prototypes (Histrionic,

axis II PD; just less than one quarter of the patients had subclinical Dependent) would positively correlate with patient-rated alliance.

PD features. Thus, this sample consisted primarily of patients with 2. Scores on selected SWAP-200 Q-Factors (Paranoid, Schizoid,

mood disorders, relational problems and diagnosed with axis II PDs Narcissistic, Obsessional, Antisocial-Psychopathic, Dysphoric:

or subclinical PD features. The severity of pathology was in the mild Emotionally Dysregulated, Dysphoric: Avoidant, Dysphoric:

to moderate range, which is consistent with what one would expect Hostile-Externalizing) and Clinical Prototypes (Paranoid, Schizoid,

from a sample of a university-based, community outpatient clinic. Antisocial, Narcissistic, Borderline, Avoidant, Obsessive-Compulsive)

Interrater reliability for the dimensional classification of personality would negatively correlate with patient-rated alliance.

pathology, a) presence of a PD (2), b) presence of subclinical traits/ 3. The SWAP-200 Schizotypal Clinical Prototype would have no

features (1), and c) absence of a PD (0), was excellent (i.e., Intraclass significant relationship with patient-rated alliance.

Correlation Coefficient, 1.2 9 0.74; Fleiss, 1981) for this project 4. In an exploratory analysis, we aimed to assess which individual

(Hilsenroth et al., 2000; Peters et al., 2006). Finally, each participant SWAP-200 items would correlate most and least with patient-

provided written informed consent to be included in this research. rated therapeutic alliance early in treatment.

Procedure METHODS

Advanced graduate students (13 men and 13 women) in an American Psychological AssociationYapproved clinical PhD pro- Participants

gram conducted the assessment, feedback sessions, and treatment All participants were adults seeking outpatient treatment at a

and rated the clinical measures. Clinicians completed structured suburban, university-based community clinic located in the northeast-

training on the clinical rating scales before rating their patients. ern United States. Cases were assigned to treatment practice and clini-

Clinical interviews centered on presenting problems, history, and cians in an ecologically valid manner on the basis of aspects of clinician

relational episodes. Feedback sessions followed a therapeutic model availability, caseload, etc. Ninety-four outpatients were consecutively

of assessment (Finn and Tonsager, 1997, 1992), which emphasizes admitted for individual psychotherapy to a psychodynamic psycho-

fostering of alliance and a relational focus on the collaborative work therapy treatment team based at the clinic (Hilsenroth, 2007). Patients

of identifying factors deleteriously affecting the patient and potential were not excluded on the basis of diagnosis or comorbidity.

ways of addressing these issues (Hilsenroth, 2007; Hilsenroth et al., The final sample (Table 1) consisted of 67 women and 27

2000). After the feedback session and the first two sessions of psy- men. The sample was composed of patients diagnosed with a variety

chotherapy, the treating clinicians completed the SWAP-200. For the of Diagnostic and Statistical Manual of Mental Disorders, Fourth

present study, measurements of the alliance by the patients occurred Edition (DSM-IV), axis I diagnoses, with mood disorders being the

early in treatment (3rd/4th session). The patients were informed both most prevalent. More than half of the patients were diagnosed with an

verbally by the treating clinician and in writing on the alliance forms that their alliance ratings would not be made available to their therapist.

TABLE 1. Demographic Information (N = 94)

Measures

Variable n %

Shedler-Westen Assessment ProcedureY200

Sex Male Female Age, mean (SD) Marital status Single 94 27 67 30 (11.6)

100 29 71

The therapists used the SWAP-200 to describe their patients after completing the therapeutic assessment and the first two therapy sessions (approximately 5Y6 contact hours). The SWAP-200 Q-Sort (Shedler and Westen, 1998, 2004a, 2004b; Westen and Shedler, 1999a, 1999b) is a clinically derived, empirically based diagnostic

58 61

measure that has been shown to have excellent retest reliability as well as good interrater, discriminant, and convergent validities with a Married 21 22

range of external criteria (Diener and Hilsenroth, 2004; Shedler and Divorced 14 15

Westen, 2004b; Smith et al., 2009; Westen and Muderrisoglu, 2003). Widowed 1 1

To complete the SWAP-200, the rater arranges a set of 200 person- Primary axis I diagnosis Adjustment disorder 12 Anxiety disorder 12 Eating disorder 3 Mood disorder 50 Substance-related disorder 1 V code relational problem 15 ality descriptions into eight different categories ranging from 0 (ir-

13 13 3 53 1 16

relevant or inapplicable to the patient) to 7 (highly descriptive of the patient). The Q-Sort has a fixed distribution that mitigates measure- ment error. Correlation coefficients are then calculated to assess the match between the characteristics of a particular patient and the empirically derived, aggregate descriptions (Clinical Prototypes and Q-Factors). Several studies support the reliability and validity of the SWAP-200 in the diagnosis of PDs (Shedler and Westen, 1998; Impulse control disorder 1 1

Westen and Shedler, 1999a, 1999b). Axis II diagnosis

52 55 Axis II trait/features 23 24

Combined Alliance Short FormYPatient Version Axis II cluster A 9 12

The Combined Alliance Short FormYPatient Version (CASF-P; Axis II cluster B 39 52

Hatcher and Barends, 1996) was derived from a factor analysis of re- Axis II cluster C 27 36

sponses from 231 outpatients at a university clinic who completed three Psychiatric Severity Mean SD Intake GAF 60 5.6 SCL-GSI 1.1 0.58

GAF indicates Global Assessment of Functioning; SCL-GSI, Global Severity Index of the SCL-90-R.

popular alliance measures as follows: a) the Penn Helping Alliance Questionnaire (Alexander and Luborsky, 1986; Luborsky et al., 1983), b) the Working Alliance Inventory (Horvath and Greenberg, 1989), and c) the California Psychotherapy Alliance Scales (Gaston, 1991).

The CASF-P consists of 20 items rated on a 7-point Likert-type scale consisting of 1 (never), 2 (rarely), 3 (occasionally), 4 (sometimes),

TABLE 2. Relationship Between SWAP-200 Q-Factors and Patient-Rated Alliance Early in Treatment

Q-Factors	Q-Factor T-Scores				CASF-P
	Mean (SD)	Median	Minimum	Maximum	Total Score, *r* (*p*)
Dysphoric	53.61 (6.71)	54.76	34.80	64.60	0.17 (0.12)
Antisocial-psychopathic	46.54 (5.69)	45.81	35.60	67.76	−0.16 (0.13)
Schizoid	48.15 (6.44)	47.50	35.67	64.96	−0.12 (0.24)
Paranoid	44.71 (8.31)	43.70	24.60	64.30	0.00 (0.96)
Obsessional	55.27 (7.24)	56.75	37.30	69.80	−0.08 (0.46)
Histrionic	50.74 (7.56)	49.95	38.30	70.12	0.16 (0.12)
Narcissistic	45.79 (8.52)	45.46	29.10	66.87	−0.20 (0.06)
DS: Avoidant	51.83 (7.16)	51.69	35.31	64.41	−0.01 (0.91)
DS: High-Functioning Neurotic	56.81 (6.13)	57.75	38.30	68.90	0.11 (0.29)
DS: Emotionally Dysregulated	46.40 (7.37)	46.10	29.60	66.10	0.08 (0.42)
DS: Dependent-Masochistic	53.68 (8.48)	53.89	37.75	73.03	0.20 (0.05*)
DS: Hostile-Externalizing	47.26 (7.75)	46.95	30.30	65.74	−0.08 (0.43)
High Functioning	55.77 (6.94)	56.65	40.20	69.65	−0.01 (0.95)

$N = 94$.
*Indicates statistical significance.
DS indicates Dysphoric Q-Factor.

5 (often), 6 (very often), and 7 (always). An examination of the internal consistency of this measure has demonstrated a total scale coefficient α of 0.93 (R. L. Hatcher, personal communication, 1997) and a coefficient α of 0.91 for the total scale using a subset of the current participants (Ackerman et al., 2000). Furthermore, an examination of the internal consistency of the CASF-P using subsets of the current participants has demonstrated coefficient α values ranging from 0.72 to 0.93 across the four subscales: Confident Collaboration, Goals and Tasks, Bond, and Idealized Therapist (Ackerman et al., 2000; Clemence et al., 2005).

RESULTS

Characteristics of Patient Personality

Tables 2 and 3 present the SWAP-200 Q-Factor and Clinical Prototype T-scores (mean, standard deviation, median, minimum, and maximum) for the present sample. The mean Q-Factor T-scores ranged from 44.71 (Paranoid) to 56.81 (Dysphoric: High-Functioning Neurotic), whereas the mean Clinical Prototype T-scores ranged from 44.47 (Paranoid) to 55.77 (Healthy Functioning). Norms for the SWAP-200 were established from an outpatient sample of patients diagnosed with a *DSM-IV* axis II PD (Westen and Shedler, 1999a). Thus, the average patient diagnosed with a PD would have a T-score of 50 with an SD of 10. Consequently, the present study's sample—with T-score means ranging from approximately 45 to 57 for both the Q-Factors and Clinical Prototypes—is composed largely of patients with personality pathology of moderate severity and consistent with the original SWAP clinical sample (Westen and Shedler, 1999a).

Characteristics of the Alliance

The mean patient-rated alliance for this sample at an early psychotherapy session (third/fourth session) was high (CASF-P: $N = 94$; mean, 6.14; SD, 0.61) and thus reflects, on the whole, a patient sample that felt that they were working collaboratively with their therapists, largely agreed with their therapists on therapeutic goals and tasks, and experienced a very strong bond with their therapists.

Relationship Between SWAP-200 Q-Factors/Clinical Prototypes and Patient-Rated Alliance

In testing our initial hypotheses, Pearson's correlations were computed for both SWAP-200 Q-Factors and SWAP-200 Clinical

TABLE 3. Relationship Between SWAP-200 Clinical Prototypes and Patient-Rated Alliance Early in Treatment

Clinical Prototypes	Clinical Prototype T-Scores				CASF-P
	Mean (SD)	Median	Minimum	Maximum	Total Score, *r* (*p*)
Paranoid	44.47 (7.74)	43.20	31.70	66.68	−0.13 (0.22)
Schizoid	49.58 (6.55)	49.20	35.80	63.60	−0.07 (0.51)
Schizotypal	48.22 (5.92)	48.20	34.76	64.40	−0.10 (0.33)
Antisocial	45.92 (5.78)	44.75	35.30	66.64	−0.15 (0.15)
Borderline	48.98 (8.61)	47.05	33.80	71.60	0.09 (0.38)
Histrionic	47.36 (7.57)	45.53	34.60	69.49	0.06 (0.54)
Narcissistic	44.74 (6.44)	42.77	34.50	64.58	−0.16 (0.13)
Avoidant	51.54 (7.13)	52.15	35.00	65.70	0.04 (0.70)
Dependent	53.60 (7.40)	54.80	36.90	67.34	0.21 (0.04*)
Obsessive	50.27 (7.47)	50.50	34.30	66.01	−0.05 (0.65)
Healthy Functioning	55.77 (6.95)	56.56	40.20	69.65	−0.01 (0.95)

$N = 94$.
*Indicates statistical significance.

TABLE 2. Relationship Between SWAP-200 Q-Factors and Patient-Rated Alliance Early in Treatment

Q-Factors

374 www.jonmd.com * 2014 Lippincott Williams & Wilkins

Q-Factor T-Scores

CASF-P Mean (SD) Median Minimum Maximum Total Score, r (p) Dysphoric 53.61 (6.71) 54.76 34.80 64.60 0.17 (0.12) Antisocial-psychopathic 46.54 (5.69) 45.81 35.60 67.76 j0.16 (0.13) Schizoid 48.15 (6.44) 47.50 35.67 64.96 j0.12 (0.24) Paranoid 44.71 (8.31) 43.70 24.60 64.30 0.00 (0.96) Obsessional 55.27 (7.24) 56.75 37.30 69.80 j0.08 (0.46) Histrionic 50.74 (7.56) 49.95 38.30 70.12 0.16 (0.12) Narcissistic 45.79 (8.52) 45.46 29.10 66.87 j0.20 (0.06) DS: Avoidant 51.83 (7.16) 51.69 35.31 64.41 j0.01 (0.91) DS: High-Functioning Neurotic 56.81 (6.13) 57.75 38.30 68.90 0.11 (0.29) DS: Emotionally Dysregulated 46.40 (7.37) 46.10 29.60 66.10 0.08 (0.42) DS: Dependent-Masochistic 53.68 (8.48) 53.89 37.75 73.03 0.20 (0.05*) DS: Hostile-Externalizing 47.26 (7.75) 46.95 30.30 65.74 j0.08 (0.43) High Functioning 55.77 (6.94) 56.65 40.20 69.65 j0.01 (0.95)

N = 94. *Indicates statistical significance. DS indicates Dysphoric Q-Factor.

5 (often), 6 (very often), and 7 (always). An examination of the internal

with a DSM-IVaxis II PD (Westen and Shedler, 1999a). Thus, the av- consistency of this measure has demonstrated a total scale coefficient >

erage patient diagnosed with a PD would have a T-score of 50 with an of 0.93 (R. L. Hatcher, personal communication, 1997) and a coefficient

SD of 10. Consequently, the present study's sampleVwith T-score > of 0.91 for the total scale using a subset of the current participants

means ranging from approximately 45 to 57 for both the Q-Factors (Ackerman et al., 2000). Furthermore, an examination of the internal

and Clinical PrototypesVis composed largely of patients with person- consistency of the CASF-P using subsets of the current participants has

ality pathology of moderate severity and consistent with the original demonstrated coefficient > values ranging from 0.72 to 0.93 across the

SWAP clinical sample (Westen and Shedler, 1999a). four subscales: Confident Collaboration, Goals and Tasks, Bond, and Idealized Therapist (Ackerman et al., 2000; Clemence et al., 2005).

Characteristics of the Alliance

The mean patient-rated alliance for this sample at an early

RESULTS

psychotherapy session (third/fourth session) was high (CASF-P: N = 94; mean, 6.14; SD, 0.61) and thus reflects, on the whole, a patient Characteristics of Patient Personality

Tables 2 and 3 present the SWAP-200 Q-Factor and Clinical Prototype T-scores (mean, standard deviation, median, minimum, and

TABLE 3. Relationship Between SWAP-200 Clinical Prototypes and Patient-Rated Alliance Early in Treatment

Clinical Prototype T-Scores

C

ASF-P Clinical Prototypes Mean (SD) Median Minimum Maximum Total Score, r (p) Paranoid 44.47 (7.74) 43.20 31.70 66.68 j0.13 (0.22) Schizoid 49.58 (6.55) 49.20 35.80 63.60 j0.07 (0.51) Schizotypal 48.22 (5.92) 48.20 34.76 64.40 j0.10 (0.33) Antisocial 45.92 (5.78) 44.75 35.30 66.64 j0.15 (0.15) Borderline 48.98 (8.61) 47.05 33.80 71.60 0.09 (0.38) Histrionic 47.36 (7.57) 45.53 34.60 69.49 0.06 (0.54) Narcissistic 44.74 (6.44) 42.77 34.50 64.58 j0.16 (0.13) Avoidant 51.54 (7.13) 52.15 35.00 65.70 0.04 (0.70) Dependent 53.60 (7.40) 54.80 36.90 67.34 0.21 (0.04*) Obsessive 50.27 (7.47) 50.50 34.30 66.01 j0.05 (0.65) Healthy Functioning 55.77 (6.95) 56.56 40.20 69.65 j0.01 (0.95)

N = 94. *Indicates statistical significance.

sample that felt that they were working collaboratively with their therapists, largely agreed with their therapists on therapeutic goals and tasks, and experienced a very strong bond with their therapists.

maximum) for the present sample. The mean Q-Factor T-scores ranged from 44.71 (Paranoid) to 56.81 (Dysphoric: High-Functioning Neu- rotic), whereas the mean Clinical Prototype T-scores ranged from 44.47

Relationship Between SWAP-200 Q-Factors/Clinical Prototypes and Patient-Rated Alliance (Paranoid) to 55.77 (Healthy Functioning). Norms for the SWAP-200

In testing our initial hypotheses, Pearson's correlations were were established from an outpatient sample of patients diagnosed

computed for both SWAP-200 Q-Factors and SWAP-200 Clinical

Prototypes with CASF-P total scores early in treatment. Table 2 presents the relationships between SWAP-200 Q-Factor scores and patient-rated alliance early in treatment. The results show that the Dysphoric: Dependent-Masochistic Q-Factor subtype was positively related to higher patient-rated alliance ($r = 0.20$; $p < 0.05$), confirming part of our first hypothesis. In addition, a notable relationship (marginally significant) was found between the Narcissistic Q-Factor and patient-rated alliance ($r = -0.20$, $p = 0.06$). All additional correlations between SWAP-200 Q-Factors and patient-rated alliance were nonsignificant.

Relationships between SWAP-200 Clinical Prototype scores and patient-rated alliance early in treatment are presented in Table 3. One significant relationship was found in these analyses: a positive correlation between the Dependent Clinical Prototype and patient-rated alliance ($r = 0.21$, $p = 0.04$), again confirming part of our first hypothesis. A nonsignificant relationship ($r = -0.10$, $p = 0.33$) was found for the Schizotypal Clinical Prototype and patient-rated alliance, confirming our third hypothesis. All additional correlations among SWAP-200 Clinical Prototypes and patient-rated alliance were found to be nonsignificant. All significant correlations were of a small effect size (Cohen, 1988).

Identification of Patient Personality Descriptors Most and Least Associated With Patient-Rated Therapeutic Alliance

In exploratory analyses, we examined the strongest positive and negative correlations for SWAP-200 items and patient-rated alliance mean total score early in treatment. The mean total score of patient-rated alliance for this sample was 6.14 (SD, 0.61), indicative of a strong early therapeutic alliance. A higher positive correlation between an individual SWAP-200 item and patient-rated alliance mean total score would indicate that a particular SWAP-200 item is more descriptive of the prototypical patient with strong early alliance than are other items in the SWAP-200 item set. A greater negative correlation between a given SWAP-200 item and patient-rated alliance mean total score would suggest that the patient personality characteristic reflected in the item is negatively related to strong early alliance. Table 4 presents the SWAP-200 items that were found to correlate significantly ($p \leq 0.05$) with patient-rated alliance early in treatment. (All 200 item-level correlations are available upon request from the first author.) The results revealed that several individual SWAP-200 items that correlated with strong, early alliance are highly descriptive of the SWAP-200 Dependent Clinical Prototype and Dysphoric: Dependent-Masochistic Q-Factor. The SWAP-200 items descriptive of narcissistic personality were found to negatively correlate with strong, early patient-rated alliance.

TABLE 4. Item-Level Analyses of SWAP-200 Items With Significant Positive and Negative Relationships to Patient-Rated Alliance Early in Treatment

Item No.	Item	CASF-P, *r* (*p*)
127	Tends to feel misunderstood, mistreated, or victimized	0.36 (0.0003)
17	Tends to be ingratiating or submissive (*e.g.*, may consent to things he/she does not agree with or does not want to do, in the hope of getting support or approval)	0.28 (0.01)
77	Tends to be overly needy or dependent, requires excessive reassurance or approval	0.25 (0.02)
26	Tends to get drawn into or remain in relationships in which he/she is emotionally or physically abused	0.24 (0.02)
117	Is unable to soothe or comfort self when distressed, requires involvement of another person to help regulate affect	0.24 (0.02)
171	Seems to fear being alone, may go to great lengths to avoid being alone	0.21 (0.04)
88	Tends to be insufficiently concerned with meeting own needs, seems not to feel entitled to get or ask for things he/she deserves	0.20 (0.05)
144	Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential	−0.28 (0.01)
71	Tends to seek thrills, novelty, adventure, etc.	−0.28 (0.01)
52	Has little empathy, seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own	−0.27 (0.01)
2	Is able to use his/her talents, abilities, and energy effectively and productively	−0.25 (0.01)
133	Tends to be arrogant, haughty, or dismissive	−0.23 (0.02)
43	Tends to seek power or influence over others (whether in beneficial or destructive ways)	−0.23 (0.03)
130	Reasoning processes or perceptual experiences seem odd and idiosyncratic (*e.g.*, may make seemingly arbitrary inferences, may see hidden messages or special meanings in ordinary events)	−0.22 (0.03)
4	Has an exaggerated sense of self-importance	−0.21 (0.04)

DISCUSSION

The present study sought to investigate the relationship between the therapeutic alliance and patient personality using a clinician-rated, empirically derived personality measure and a patient-rated alliance measure. Three of our hypotheses were confirmed: we found positive relationships between patient-rated alliance early in treatment and patients with dependent personalities (*i.e.*, Dependent Clinical Prototype and Dysphoric: Dependent-Masochistic Q-Factor) and no significant relationship with schizotypal personality (*i.e.*, Schizotypal Clinical Prototype). There was an additional negative correlation (marginally significant) between the patients with narcissistic personalities (*i.e.*, Narcissistic Q-Factor) and strong therapeutic alliance. Lastly, we identified several individual SWAP-200 items descriptive of dependent and dysphoric: dependent/masochistic personalities that significantly and positively correlated with early patient-rated therapeutic alliance, along with SWAP-200 items that were inversely related to alliance that are descriptive of narcissistic personalities.

The present results suggest that the therapeutic alliance early in treatment is only weakly related to the personality of the patient (*i.e.* largely small effect sizes), specifically to dependent personality syndromes and features, and inversely to narcissistic personality features. This overall finding is in line with past research that has found small to moderate effect sizes for features of patient personality (*e.g.*, interpersonal problems, psychological defenses, object relations) and alliance using alternate personality measures (cf. Connolly-Gibbons et al., 2003; Constantino and Smith-Hansen, 2008; Dinger et al., 2009; Gaston et al., 1988; Hersoug et al., 2002; Johansson and Eklund, 2006; Muran et al., 1994; Paivio and Bahr, 1998; Pinsker et al., 2007; Piper et al., 1991). Thus, although it seems that patient personality does play a role in the formation of the alliance early in treatment, additional patient, therapist, and treatment factors must also contribute. Nevertheless, a significant relationship was detected, and therefore, we will discuss how the relationship between patient personality and alliance can add to our evolving conceptual understanding of the alliance.

Prototypes with CASF-P total scores early in treatment. Table 2 presents the relationships between SWAP-200 Q-Factor scores and patient-rated alliance early in treatment. The results show that the Dysphoric: Dependent-Masochistic Q-Factor subtype was positively

TABLE 4. Item-Level Analyses of SWAP-200 Items With Significant Positive and Negative Relationships to Patient-Rated Alliance Early in Treatment

related to higher patient-rated alliance (r = 0.20; p G 0.05), confirming part of our first hypothesis. In addition, a notable rela-

Item No. Item tionship (marginally significant) was found between the Narcissistic Q-Factor and patient-rated alliance (r = j0.20, p = 0.06). All addi- tional correlations between SWAP-200 Q-Factors and patient-rated alliance were nonsignificant.

Relationships between SWAP-200 Clinical Prototype scores and patient-rated alliance early in treatment are presented in Table 3. One significant relationship was found in these analyses: a positive correlation between the Dependent Clinical Prototype and patient- rated alliance (r = 0.21, p = 0.04), again confirming part of our first hypothesis. A nonsignificant relationship (r = j0.10, p = 0.33) was found for the Schizotypal Clinical Prototype and patient-rated alliance, confirming our third hypothesis. All additional correla- tions among SWAP-200 Clinical Prototypes and patient-rated alli- ance were found to be nonsignificant. All significant correlations were of a small effect size (Cohen, 1988).

Identification of Patient Personality Descriptors Most and Least Associated With Patient-Rated Therapeutic Alliance

In exploratory analyses, we examined the strongest positive and negative correlations for SWAP-200 items and patient-rated al- liance mean total score early in treatment. The mean total score of patient-rated alliance for this sample was 6.14 (SD, 0.61), indicative of a strong early therapeutic alliance. A higher positive correlation between an individual SWAP-200 item and patient-rated alliance mean total score would indicate that a particular SWAP-200 item is more descriptive of the prototypical patient with strong early alliance than are other items in the SWAP-200 item set. A greater negative correlation between a given SWAP-200 item and patient-rated alli- ance mean total score would suggest that the patient personality characteristic reflected in the item is negatively related to strong early alliance. Table 4 presents the SWAP-200 items that were found to correlate significantly (p e 0.05) with patient-rated alliance early in treatment. (All 200 item-level correlations are available upon request from the first author.) The results revealed that several individual SWAP-200 items that correlated with strong, early alliance are highly descriptive of the SWAP-200 Dependent Clinical Prototype and Dysphoric: Dependent-Masochistic Q-Factor. The SWAP-200 items descriptive of narcissistic personality were found to negatively corre- late with strong, early patient-rated alliance.

DISCUSSION The present study sought to investigate the relationship between the therapeutic alliance and patient personality using a clinician-rated, empirically derived personality measure and a patient-rated alliance measure. Three of our hypotheses were confirmed: we found positive relationships between patient-rated alliance early in treatment and pa- tients with dependent personalities (i.e., Dependent Clinical Prototype and Dysphoric: Dependent-Masochistic Q-Factor) and no significant relationship with schizotypal personality (i.e., Schizotypal Clinical Pro- totype). There was an additional negative correlation (marginally signif- icant) between the patients with narcissistic personalities (i.e., Narcissistic Q-Factor) and strong therapeutic alliance. Lastly, we identified several individual SWAP-200 items descriptive of dependent and dysphoric: dependent/masochistic personalities that significantly and positively correlated with early patient-rated therapeutic alliance, along with SWAP-200 items that were inversely related to alliance that are descrip- tive of narcissistic personalities.

CASF-P, r (p)

127 Tends to feel misunderstood,

mistreated, or victimized

0.36 (0.0003)

17 Tends to be ingratiating or submissive

(e.g., may consent to things he/she does not agree with or does not want to do, in the hope of getting support or approval)

0.28 (0.01)

77 Tends to be overly needy or dependent,

requires excessive reassurance or approval

0.25 (0.02)

26 Tends to get drawn into or remain in

relationships in which he/she is emotionally or physically abused

0.24 (0.02)

117 Is unable to soothe or comfort self when

distressed, requires involvement of another person to help regulate affect

0.24 (0.02)

171 Seems to fear being alone, may go to great lengths to avoid being alone

0.21 (0.04)

88 Tends to be insufficiently concerned with

meeting own needs, seems not to feel entitled to get or ask for things he/she deserves

0.20 (0.05)

144 Tends to see self as logical and rational,

uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential

j0.28 (0.01)

71 Tends to seek thrills, novelty, adventure, etc. j0.28 (0.01) 52 Has little empathy, seems unable to

understand or respond to others' needs and feelings unless they coincide with his/her own

j0.27 (0.01)

2 Is able to use his/her talents, abilities, and

energy effectively and productively

j0.25 (0.01)

133 Tends to be arrogant, haughty, or dismissive j0.23 (0.02) 43 Tends to seek power or influence over others (whether in beneficial or destructive ways)

j0.23 (0.03)

130 Reasoning processes or perceptual experiences seem odd and idiosyncratic (e.g., may make seemingly arbitrary inferences, may see hidden messages or special meanings in ordinary events)

j0.22 (0.03)

4 Has an exaggerated sense of self-importance j0.21 (0.04)

The present results suggest that the therapeutic alliance early in treatment is only weakly related to the personality of the patient (i.e. largely small effect sizes), specifically to dependent personality syndromes and features, and inversely to narcissistic personality features. This overall finding is in line with past research that has found small to moderate effect sizes for features of patient personality (e.g., interpersonal problems, psychological defenses, object re- lations) and alliance using alternate personality measures (cf. Connolly-Gibbons et al., 2003; Constantino and Smith-Hansen, 2008; Dinger et al., 2009; Gaston et al.,

1988; Hersoug et al., 2002; Johansson and Eklund, 2006; Muran et al., 1994; Paivio and Bahr, 1998; Pinsker et al., 2007; Piper et al., 1991). Thus, although it seems that patient personality does play a role in the formation of the alliance early in treatment, additional patient, therapist, and treatment factors must also contribute. Nevertheless, a significant relationship was detected, and therefore, we will discuss how the relationship between patient person- ality and alliance can add to our evolving conceptual understanding of the alliance.

Largely fashioned from Bordin's (1976) tripartite model, contemporary definitions of the alliance compose the conscious, collaborative, purposeful elements of the treatment—specifically agreement on therapeutic tasks and goals—that operate within an affective bond between patient and therapist (Constantino et al., 2002; Gaston, 1990; Gelso and Carter, 1994; Horvath and Bedi, 2002; Horvath and Symonds, 1991; Saunders et al., 1989). It is clear that the alliance "takes two to tango" in that it is composed of constructs that are by definition interactive: collaboration, agreement, and connection. From the present results, it seems as if positive therapeutic collaboration, agreement, and connection are reflected in patient dependency.

Patient dependency has been conceptualized within the two-polarities model of personality (for a review, see Blatt, 2008; Luyten and Blatt, 2013). Dependent and dysphoric: dependent-masochistic personalities fall into what Blatt and colleagues have deemed the anaclitic dimension of personality development; that is, this style stems from the individual's attempts to maintain interpersonal relationships at the expense of the development of a sense of self (Blatt, 1974, 2004, 2006, 2008; Blatt and Blass, 1990, 1996; Blatt and Shichman, 1983). These personality constellations can be considered "sociotropic" (Beck, 1983) because they are dominated by concerns of interpersonal relatedness and intimacy. Thus, stronger therapeutic alliances early in treatment may favor patients who are other-focused. Indeed, individual SWAP-200 items that were found to inversely correlate with strong early alliance occupy high item ranks within SWAP-200 narcissistic personality syndromes, describing a patient who is self-focused and "introjective" (Table 4). In addition, patients described as more dependent in the present sample seem to engage with their therapist with relative ease, even though they tend to feel guilty, blame themselves when bad things happen, and fear rejection. Consequently, strong alliances early in treatment may depend upon a patient's willingness to acknowledge some responsibility in having created the problems that led him/her to seek treatment, which in turn leads to a patient's willingness to collaborate with the therapist to better understand and eventually alleviate the problems (Bender, 2005).

In presenting his model of the alliance, Bordin (1976) described patients as those "seeking change" and therapists as "change agent(s)," whereas Luborsky (1976) suggested that the alliance requires a patient to see his/her therapist as a likely source of help. The patients in the present sample resembling the Dependent Clinical Prototype and Dysphoric: Dependent-Masochistic Q-Factor are characterized as help-seeking and inclined to solicit others for emotional support, reassurance, guidance, and approval, in addition to being compliant and suggestible. This may be because dependent individuals tend to view others in their life as potential caregivers available and willing to offer support (Mongrain, 1998), a tendency that could arise in part from having a schema-related interpretation bias, which causes them to interpret ambiguous social interactions as more helpful and supportive (Weertman et al., 2006). A strong alliance may in part be a product of the patient's readiness for his/her therapist to act as an agent of change, for example, by engaging in specific tasks and pursuing certain goals proposed by the therapist, tasks and goals that the patient may view as too anxiety provoking if pursued in other types of relationships (*e.g.*, discussing fantasies of anger or dissatisfaction with other relationships) because of fears of abandonment and rejection.

Thus, it may be that the formation of a strong alliance early in treatment is facilitated by those aspects of patient personality that allow the patients to recognize that they are currently unable to solve problems on their own, prefer to rely on others during times of emotional distress, and expect that a connection will quickly develop between themselves and their therapist. A strong early alliance may be facilitated when there is a greater "readiness for change" (cf. Prochaska and DiClemente, 1992), with patients' personality traits allowing for greater help-seeking and acceptance of aid. Indeed, such a stance seems to work: past research on dependent personality features and therapy engagement and outcome has demonstrated that dependent patients are broadly invested in psychotherapy, missing fewer psychotherapy sessions, completing therapeutic homework more conscientiously, and having better long-term outcomes than nondependent patients with comparable diagnoses and demographics (see Bornstein, 1992, 1993, 2005, for reviews). Parallel findings have emerged in medical treatment as well (Porcerelli et al., 2009).

The identification of SWAP-200 items that individually correlated with strong patient-rated alliance early in treatment revealed a personality composite largely composed of personality descriptors considered prototypic of dependent and dysphoric: dependent-masochistic personalities (*i.e*, SWAP-200 Dependent Clinical Prototype and Dysphoric: Dependent-Masochistic Q-Factor). Thus, this composite personality description is also one of a patient who is other-focused; help-seeking; and concerned with issues of interpersonal relatedness, intimacy, and abandonment. Coupled with the item-level findings of individual SWAP-200 items prototypic of narcissistic personality (reflecting a self-focused, introjective configuration) that were inversely related to alliance early in treatment and the significant positive relationships between dependent personality syndromes and the alliance reported above, these results lend credence to the validity of contemporary conceptualizations of the alliance as composed of relationally based core elements (*i.e.*, collaboration, agreement, bond).

In light of past correlational findings linking better alliance to patients' nonassertive and submissive interpersonal problems, some authors have questioned whether measuring the alliance is analogous to measuring a patient's willingness to acquiesce to or comply with the parameters of treatment (*e.g.*, Muran et al., 1994). The present results demonstrating patient dependent personality and personality features correlating with strong alliance may seem to corroborate this notion at first glance. However, only small to moderate effect sizes have been found in the literature on the relationship between alliance and patient personality as well as features of patient personality that reflect nonassertiveness and compliance during the past 2 decades (including the present results). Small to moderate effects would suggest nonredundant constructs, that is some overlap between alliance with personality but far from identical. In addition, in the present study, the patients were informed both verbally, when presented with the alliance measure form, and in writing, on the top of the form, that their treating clinician would be unaware of their alliance scores; this would help protect against what might otherwise be dependent patients' penchant for ingratiating themselves to their therapists (*e.g.*, artificially inflating scores). Related, and most central to this discussion, recent findings demonstrate that therapist effects, rather than differences between patients, account for the largest amounts of variance in the alliance-outcome correlation (Baldwin et al., 2007; Del Re et al., 2012), even when accounting for patient axis II diagnosis. This suggests that therapists are largely responsible for the strength of their alliances regardless of the personalities of the patients with whom they work. Even if a patient is highly submissive and overly compliant, if paired with a therapist who has demonstrated a track record of poor alliances, this patient is more likely to rate their alliance as poor (viz, not agreeing with the parameters of the treatment, poor connection or bond). In fact, it seems as if the effect of the therapist may have the largest impact on situations in which patients are less receptive and open to such engagement with the therapist or when they are too much so. In addition, the therapist is still able to create facilitative conditions for change whereby patients become more engaged in or better able to adaptively assert their disagreements in the therapeutic relationship.

There are some limitations to this study. First, an unavoidable limitation stems from the study sample: although the sample is

Largely fashioned from Bordin's (1976) tripartite model,

Prochaska and DiClemente, 1992), with patients' personality traits contemporary definitions of the alliance compose the conscious,

allowing for greater help-seeking and acceptance of aid. Indeed, such collaborative, purposeful elements of the treatmentVspecifically

a stance seems to work: past research on dependent personality fea- agreement on therapeutic tasks and goalsVthat operate within an

tures and therapy engagement and outcome has demonstrated that affective bond between patient and therapist (Constantino et al.,

dependent patients are broadly invested in psychotherapy, missing 2002; Gaston, 1990; Gelso and Carter, 1994; Horvath and Bedi,

fewer psychotherapy sessions, completing therapeutic homework 2002; Horvath and Symonds, 1991; Saunders et al., 1989). It is clear

more conscientiously, and having better long-term outcomes than that the alliance ''takes two to tango'' in that it is composed of con-

nondependent patients with comparable diagnoses and demographics structs that are by definition interactive: collaboration, agreement,

(see Bornstein, 1992, 1993, 2005, for reviews). Parallel findings have and connection. From the present results, it seems as if positive

emerged in medical treatment as well (Porcerelli et al., 2009). therapeutic collaboration, agreement, and connection are reflected in

The identification of SWAP-200 items that individually cor- patient dependency.

related with strong patient-rated alliance early in treatment revealed a Patient dependency has been conceptualized within the two-

personality composite largely composed of personality descriptors polarities model of personality (for a review, see Blatt, 2008;

considered prototypic of dependent and dysphoric: dependent- Luyten and Blatt, 2013). Dependent and dysphoric: dependent-

masochistic personalities (i.e, SWAP-200 Dependent Clinical Pro- masochistic personalities fall into what Blatt and colleagues have

totype and Dysphoric: Dependent-Masochistic Q-Factor). Thus, this deemed the anaclitic dimension of personality development; that is,

composite personality description is also one of a patient who is this style stems from the individual's attempts to maintain inter-

other-focused; help-seeking; and concerned with issues of interper- personal relationships at the expense of the development of a sense of

sonal relatedness, intimacy, and abandonment. Coupled with the self (Blatt, 1974, 2004, 2006, 2008; Blatt and Blass, 1990, 1996;

item-level findings of individual SWAP-200 items prototypic of Blatt and Shichman, 1983). These personality constellations can be

narcissistic personality (reflecting a self-focused, introjective con- considered ‘‘sociotropic’’ (Beck, 1983) because they are dominated figuration) that were inversely related to alliance early in treatment by concerns of interpersonal relatedness and intimacy. Thus, stronger and the significant positive relationships between dependent per- therapeutic alliances early in treatment may favor patients who are sonality syndromes and the alliance reported above, these results lend other-focused. Indeed, individual SWAP-200 items that were found credence to the validity of contemporary conceptualizations of the to inversely correlate with strong early alliance occupy high item alliance as composed of relationally based core elements (i.e., col- ranks within SWAP-200 narcissistic personality syndromes, de- laboration, agreement, bond). scribing a patient who is self-focused and ‘‘introjective’’ (Table 4). In

In light of past correlational findings linking better alliance to addition, patients described as more dependent in the present sample patients’ nonassertive and submissive interpersonal problems, some seem to engage with their therapist with relative ease, even though authors have questioned whether measuring the alliance is analogous they tend to feel guilty, blame themselves when bad things happen, to measuring a patient’s willingness to acquiesce to or comply with and fear rejection. Consequently, strong alliances early in treatment the parameters of treatment (e.g., Muran et al., 1994). The present may depend upon a patient’s willingness to acknowledge some re- results demonstrating patient dependent personality and personality sponsibility in having created the problems that led him/her to seek features correlating with strong alliance may seem to corroborate this treatment, which in turn leads to a patient’s willingness to collaborate notion at first glance. However, only small to moderate effect sizes with the therapist to better understand and eventually alleviate the have been found in the literature on the relationship between alliance problems (Bender, 2005).

and patient personality as well as features of patient personality that In presenting his model of the alliance, Bordin (1976) de- reflect nonassertiveness and compliance during the past 2 decades scribed patients as those ‘‘seeking change’’ and therapists as ‘‘change (including the present results). Small to moderate effects would suggest agent(s),’’ whereas Luborsky (1976) suggested that the alliance re- nonredundant constructs, that is some overlap between alliance with quires a patient to see his/her therapist as a likely source of help. The personality but far from identical. In addition, in the present study, the patients in the present sample resembling the Dependent Clinical patients were informed both verbally, when presented

with the alliance Prototype and Dysphoric: Dependent-Masochistic Q-Factor are

measure form, and in writing, on the top of the form, that their treating characterized as help-seeking and inclined to solicit others for emo-

clinician would be unaware of their alliance scores; this would help tional support, reassurance, guidance, and approval, in addition to

protect against what might otherwise be dependent patients' penchant being compliant and suggestible. This may be because dependent

for ingratiating themselves to their therapists (e.g., artificially inflating individuals tend to view others in their life as potential caregivers

scores). Related, and most central to this discussion, recent findings available and willing to offer support (Mongrain, 1998), a tendency

demonstrate that therapist effects, rather than differences between pa- that could arise in part from having a schema-related interpretation

tients, account for the largest amounts of variance in the alliance- bias, which causes them to interpret ambiguous social interactions as

outcome correlation (Baldwin et al., 2007; Del Re et al., 2012), even more helpful and supportive (Weertman et al., 2006). A strong alli-

when accounting for patient axis II diagnosis. This suggests that ther- ance may in part be a product of the patient's readiness for his/her

apists are largely responsible for the strength of their alliances regard- therapist to act as an agent of change, for example, by engaging in

less of the personalities of the patients with whom they work. Even if a specific tasks and pursuing certain goals proposed by the therapist,

patient is highly submissive and overly compliant, if paired with a tasks and goals that the patient may view as too anxiety provoking if

therapist who has demonstrated a track record of poor alliances, this pursued in other types of relationships (e.g., discussing fantasies of

patient is more likely to rate their alliance as poor (viz, not agreeing anger or dissatisfaction with other relationships) because of fears of

with the parameters of the treatment, poor connection or bond). In fact, abandonment and rejection.

it seems as if the effect of the therapist may have the largest impact on Thus, it may be that the formation of a strong alliance early in

situations in which patients are less receptive and open to such en- treatment is facilitated by those aspects of patient personality that

gagement with the therapist or when they are too much so. In addition, allow the patients to recognize that they are currently unable to solve

the therapist is still able to create facilitative conditions for change problems on their own, prefer to rely on others during times of

whereby patients become more engaged in or better able to adaptively emotional distress, and expect that a connection will quickly develop

assert their disagreements in the therapeutic relationship. between themselves and their therapist. A strong early alliance may

There are some limitations to this study. First, an unavoidable be facilitated when there is a greater ‘‘readiness for change’’ (cf.

limitation stems from the study sample: although the sample is

representative of a patient population receiving outpatient treatment, certain PDs (notably, those in *DSM-IV* cluster A) were not well represented in the present sample. It is suggested that future research in this area seek to address this limitation by using more diverse patient samples with regard to distribution of patient personality and severity of PD pathology (*e.g.*, inpatient or partial hospitalization samples). Second, alliance scores for this sample of patients were relatively high (CASF-P: mean, 6.14; SD, 0.61). The patients included in this study underwent a comprehensive assessment (*i.e.*, Therapeutic Model of Assessment [TMA]) procedure that emphasizes alliance building early in treatment by advising the patient and the therapist to collaboratively work together to identify the patient's problematic issues and to attempt to agree on potential ways to address these issues. Past research has shown TMA to correlate with stronger therapeutic alliances compared with more traditional information-gathering models of assessment (*e.g.*, Hilsenroth et al., 2002, 2004). This emphasis on building alliance early in treatment may have served to enhance the therapeutic relationship for the sample as a whole and could in part account for nonsignificant findings. Third, given the total number of correlations run between individual SWAP-200 items and the CASF-P for the exploratory hypothesis, there is a statistical likelihood that 10 significant correlations can be expected by chance at $p < 0.05$ (cf. Shedler and Block, 1990). Fourth, interrater reliability for SWAP-200 measurements were not available (past research has found good to excellent interrater reliability for the SWAP-200: Westen and Muderrisoglu, 2003).

Future investigations into the relationship between patient personality and the therapeutic alliance may also consider the interaction between patient personality × therapeutic modality × alliance. The present study used psychodynamic psychotherapy. It could be that specific facets of patient personality or select patient personality syndromes may contribute to varying alliances within alternate treatment modalities. In addition, we assessed alliance at one time point (the early stage of treatment), and therefore, we were not able to investigate how patient personality may predict alliance trajectories. Subsequent investigations may choose to focus on these probable interactions (*e.g.*, by way of cluster analysis) during the course of treatment and in this way represent the alliance as an ongoing process, which it is. Lastly, future research may also take direction from recent findings demonstrating reciprocal relationships between changes in patient distress, well-being, and symptoms with changes in the alliance in which the strength of the alliance predicts changes in patient distress, well-being, symptoms and vice versa (Falkenstrom et al., 2013; Fluckiger et al., 2012; Tasca and Lampard, 2012). Perhaps a reciprocal relationship also holds true for patient personality and alliance.

DISCLOSURE

The authors declare no conflict of interest.

REFERENCES

Ackerman SJ, Hilsenroth M, Baity M, Blagys M (2000) Interaction of therapeutic process and alliance during psychological assessment. *J Pers Assess*. 75:82–109.

Alexander LB, Luborsky L (1986) The Penn Helping Alliance Scales. In Greenberg LS, Pinsof WM (Eds), *The psychotherapeutic process: A research handbook* (pp 325–366). New York: Guilford.

Baldwin SA, Wampold BE, Imel ZE (2007) Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *J Consult Clin Psychol*. 6:842–852.

Barber JP, Luborsky L, Crits-Christoph P, Thase ME, Weiss R, Frank A, Onken L, Gallop R (1999) Therapeutic alliance as a predictor of outcome in treatment of cocaine dependence. *Psychother Res*. 9:54–73.

Beck AT (1983) Cognitive therapy of depression: New perspectives. In Clayton PJ, Barrett JE (Eds), *Treatment of depression: Old controversies and new approaches* (pp 265–290). New York: Raven Press.

Bender DS (2005) The therapeutic alliance in the treatment of personality disorders. *J Psychiatr Pract*. 11:73–87.

Blatt SJ (1974) Levels of object representation in anaclitic and introjective depression. *Psychoanal Study Child*. 29:107–157.

Blatt SJ (2004) *Experiences of depression: Theoretical, clinical and research perspectives*. Washington, DC: American Psychological Association.

Blatt SJ (2006) A fundamental polarity in psychoanalysis: Implications for personality development, psychopathology, and the therapeutic process. *Psychoanal Inq*. 26:492–518.

Blatt SJ (2008) *Polarities of experience: Relatedness and self-definition in personality development, psychopathology, and the therapeutic process*. Washington, DC: American Psychological Association Press.

Blatt SJ, Blass RB (1990) Attachment and separateness: A dialectic model of the products and processes of psychological development. *Psychoanal Study Child*. 45:107–127.

Blatt SJ, Blass RB (1996) Relatedness and self definition: A dialectic model of personality development. In Noam GG, Fischer KW (Eds), *Development and vulnerabilities in close relationships* (pp 309–338). Hillsdale, NJ: Erlbaum.

Blatt SJ, Shichman S (1983) Two primary configurations of psychopathology. *Psychoanal Contemp Thought*. 6:187–254.

Block J (1995) A contrarian view of the five-factor approach to personality description. *Psychol Bull*. 117:187–215.

Bordin ES (1976) The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy*. 3:252–260.

Bornstein RF (1992) The dependent personality: Developmental, social, and clinical perspectives. *Psychol Bull*. 112:3–23.

Bornstein RF (1993) *The dependent personality*. New York: Guilford Press.

Bornstein RF (2003) Behaviorally referenced experimentation and symptom validation: A paradigm for 21st century personality disorder research. *J Pers Disord*. 17:1–18.

Bornstein RF (2005). *The dependent patient: A practitioner's guide*. Washington, DC: American Psychological Association.

Clemence AJ, Hilsenroth MJ, Ackerman SJ, Strassle CG, Handler L (2005) Facets and perceived progress in psychotherapy: Relationship between patient and therapist perspectives. *Clin Psychol Psychother*. 12:443–454.

Cohen J (1988) *Statistical power analysis for the behavioral sciences* (2nd ed). Hillsdale, NY: Erlbaum.

Connolly-Gibbons MB, Crits-Christoph P, de la Cruz C, Barber JP, Siqueland L, Gladis L (2003) Pretreatment expectations, interpersonal functioning and symptoms in the prediction of the therapeutic alliance across supportive-expressive psychotherapy and cognitive therapy. *Psychother Res*. 13:59–76.

Constantino M, Smith-Hansen L (2008) Patient interpersonal factors and the therapeutic alliance in two treatments for bulimia nervosa. *Psychother Res*. 18:683–698.

Constantino MJ, Castonguay LG, Schut AJ. (2002) The working alliance: A flagship for the scientist-practitioner model in psychotherapy. In GS Tryon (Ed), *Counseling based on process research: Applying what we know*. (pp 81–131). Boston: Ally & Bacon.

Constantino MJ, Arnow BA, Blasey C, Agras SW (2005) The association between patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa. *J Consult Clin Psychol*. 73: 203–211.

Del Re AC, Fluckiger C, Horvath AO, Symonds D, Wampold BE (2012) Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. *Clin Psychol Rev*. 32:642–649.

Diener M, Hilsenroth MJ (2004) Multimethod validity assessment of the SWAP-200 Dysphoric Q-Factor. *J Nerv Ment Dis*. 192:479–486.

Diener MJ, Monroe JM (2011) The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: A meta-analytic review. *Psychotherapy*. 48:237–248.

Dinger U, Strack M, Sachsse T, Schauenburg H (2009) Therapists' attachment, patients' interpersonal problems and alliance development over time in inpatient psychotherapy. *Psychotherapy*. 46:277–290.

Falkenstrom F, Granstrom F, Holmqvist R (2013) Therapeutic alliance predicts symptomatic improvement session by session. *J Couns Psychol*. 60:317–328.

Finn S, Tonsager M (1997) Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychol Assess*. 9:374–385.

representative of a patient population receiving outpatient treatment, certain PDs (notably, those in DSM-IV cluster A) were not well rep- resented in the present sample. It is suggested that future research in this area seek to address this limitation by using more diverse patient samples with regard to distribution of patient personality and severity of PD pathology (e.g., inpatient or partial hospitalization samples). Second, alliance scores for this sample of patients were relatively high (CASF-P: mean, 6.14; SD, 0.61). The patients included in this study underwent a comprehensive assessment (i.e., Therapeutic Model of Assessment [TMA]) procedure that emphasizes alliance building early in treatment by advising the patient and the therapist to

Beck AT (1983) Cognitive therapy of depression: New perspectives. In Clayton PJ, Barrett JE (Eds), Treatment of depression: Old controversies and new ap- proaches (pp 265Y290). New York: Raven Press. Bender DS (2005) The therapeutic alliance in the treatment of personality disor-

ders. J Psychiatr Pract. 11:73Y87. Blatt SJ (1974) Levels of object representation in anaclitic and introjective depres-

sion. Psychoanal Study Child. 29:107Y157. Blatt SJ (2004) Experiences of depression: Theoretical, clinical and research per-

spectives. Washington, DC: American Psychological Association. Blatt SJ (2006) A fundamental polarity in psychoanalysis: Implications for person- ality development, psychopathology, and the therapeutic process.Psychoanal Inq. 26:492Y518.

collaboratively work together to identify the patient's problematic issues and to attempt to agree on potential ways to address these issues. Past research has shown TMA to correlate with stronger

Blatt SJ (2008) Polarities of experience: Relatedness and self-definition in person- ality development, psychopathology, and the therapeutic process. Washington, DC: American Psychological Association Press. therapeutic alliances compared with more traditional information- gathering models of assessment (e.g., Hilsenroth et al., 2002, 2004). This emphasis on building alliance early in treatment may have served to enhance the therapeutic relationship for the sample as a whole and could in part account for nonsignificant findings. Third, given the total number of correlations run between individual SWAP- 200 items and the CASF-P for the exploratory hypothesis, there is a statistical likelihood that 10 significant correlations can be expected by chance at p G 0.05 (cf. Shedler and Block, 1990). Fourth, interrater reliability for SWAP-200 measurements were not available (past research has found good to excellent interrater reliability for the

Blatt SJ, Blass RB (1990) Attachment and separateness: A dialectic model of the products and processes of psychological development. Psychoanal Study Child. 45:107Y127. Blatt SJ, Blass RB (1996) Relatedness and self definition: A dialectic model of personality development. In Noam GG, Fischer KW (Eds), Development and vulnerabilities in close relationships (pp 309Y338). Hillsdale, NJ: Erlbaum. Blatt SJ, Shichman S (1983) Two primary configurations of psychopathology.

Psychoanal Contemp Thought. 6:187Y254. Block J (1995) A contrarian view of the five-factor approach to personality de-

scription. Psychol Bull. 117:187Y215. Bordin ES (1976) The generalizability of the psychoanalytic concept of the work-

ing alliance. Psychotherapy. 3:252Y260. SWAP-200:

Westen and Muderrisoglu, 2003).

Future investigations into the relationship between patient

Bornstein RF (1992) The dependent personality: Developmental, social, and clin-

ical perspectives. Psychol Bull. 112:3Y23.

personality and the therapeutic alliance may also consider the inter- action between patient personality x therapeutic modality x alliance. The present study used psychodynamic psychotherapy. It could be

Bornstein RF (1993) The dependent personality. New York: Guilford Press. Bornstein RF (2003) Behaviorally referenced experimentation and symptom vali- dation: A paradigm for 21st century personality disorder research. J Pers that specific facets of patient personality or select patient personality

Disord. 17:1Y18. syndromes may contribute to varying alliances within alternate

Bornstein RF (2005). The dependent patient: A

practitioner's guide. Washington, treatment modalities. In addition, we assessed alliance at one time

DC: American Psychological Association. point (the

early stage of treatment), and therefore, we were not able to

Clemence AJ, Hilsenroth MJ, Ackerman SJ, Strassle

CG, Handler L (2005) Facets investigate how patient personality may predict alliance trajectories. Subsequent investigations may choose to focus on these probable

and perceived progress in psychotherapy: Relationship between patient and therapist perspectives. Clin Psychol Psychother. 12:443Y454. interactions (e.g., by way of cluster analysis) during the course of treatment and in this way represent the alliance as an ongoing process, which it is. Lastly, future research may also take direction from recent findings demonstrating reciprocal relationships between changes in patient distress, well-being, and symptoms with changes

Cohen J (1988) Statistical power analysis for the behavioral sciences (2nd ed).

Hillsdale, NY: Erlbaum. Connolly-Gibbons MB, Crits-Christoph P, de la Cruz C, Barber JP, Siqueland L, Gladis L (2003) Pretreatment expectations, interpersonal functioning and symptoms in the prediction of the therapeutic alliance across supportive-expressive psychotherapy and cognitive therapy. Psychother Res. 13:59Y76. in the alliance in which the strength of the alliance predicts changes in patient distress, well-being, symptoms and vice versa (Falkenstrom

Constantino M, Smith-Hansen L (2008) Patient interpersonal factors and the ther- apeutic alliance in two treatments for bulimia nervosa. Psychother Res. et al., 2013; Fluckiger et al., 2012; Tasca and Lampard, 2012). Per-

18:683Y698. haps a reciprocal relationship also

holds true for patient personality

Constantino MJ, Castonguay LG, Schut AJ. (2002) The

working alliance: A flag- and alliance.

ship for the scientist-practitioner model in psychotherapy. In GS Tryon (Ed), Counseling based on process research: Applying what we know. (pp 81Y131). Boston: Ally & Bacon. DISCLOSURE

Constantino MJ, Arnow BA, Blasey C, Agras SW (2005) The

association between The authors declare no conflict of interest.

patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa. J Consult Clin Psychol. 73: 203Y211. Del Re AC, Fluckiger C, Horvath AO, Symonds D, Wampold BE (2012) Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum REFERENCES

likelihood meta-analysis. Clin Psychol Rev. 32:642Y649.

Ackerman SJ, Hilsenroth M, Baity M, Blagys M (2000) Interaction of therapeutic process and alliance during psychological assessment. J Pers Assess.

Diener M, Hilsenroth MJ (2004) Multimethod validity assessment of the SWAP-

200 Dysphoric Q-Factor. J Nerv Ment Dis.

192:479Y486. 75:82Y109.

Diener MJ, Monroe JM (2011) The relationship

between adult attachment style Alexander LB, Luborsky L (1986) The Penn Helping Alliance Scales. In Greenberg LS, Pinsof WM (Eds), The psychotherapeutic process: A research

and therapeutic alliance in individual psychotherapy: A meta-analytic review. Psychotherapy. 48:237Y248. handbook (pp 325Y366). New York: Guilford.

Dinger U, Strack M, Sachsse T, Schauenburg H (2009)

Therapists' attachment, pa- Baldwin SA, Wampold BE, Imel ZE (2007) Untangling the alliance-outcome cor- relation: Exploring the relative importance of therapist and patient variability

tients' interpersonal problems and alliance development over time in inpatient psychotherapy. Psychotherapy. 46:277Y290. in the

alliance. J Consult Clin Psychol. 6:842Y852.

Falkenstrom F, Granstrom F, Holmqvist R (2013) Therapeutic alliance predicts Barber JP, Luborsky L, Crits-Christoph P, Thase ME, Weiss R, Frank A, Onken L,

symptomatic improvement session by session. J Couns Psychol. 60:317Y328. Gallop R (1999) Therapeutic alliance as a predictor of outcome in treatment of

Finn S, Tonsager M (1997) Information-gathering and therapeutic models of as- cocaine dependence. Psychother Res. 9:54Y73.

sessment: Complementary paradigms. Psychol Assess. 9:374Y385.

Finn SE, Tonsager ME (1992) Therapeutic effects of providing MMPI-2 test feedback to college students awaiting therapy. *Psychol Assess*. 4:278–287.

Fleiss J (1981) *Statistical methods for rates and proportions* (2nd ed). New York: Wiley.

Fluckiger C, Del Re AC, Wampold BE, Symonds D, Horvath AO (2012) How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *J Couns Psychol*. 59:10–17.

Gaston L (1990) The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy*. 27:143–153.

Gaston L (1991) The reliability and criterion-related validity of the patient version of the California Psychotherapy Alliance Scale. *Psychol Assess*. 3:68–74.

Gaston L, Marmar CR, Thompson LW, Gallagher D (1988) Relation of patient pretreatment characteristics to the therapeutic alliance in diverse psychotherapies. *J Consult Clin Psychol*. 56:483–489.

Gelso CJ, Carter JA (1994) Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *J Couns Psychol*. 3:296–306.

Hatcher RL, Barends AW (1996) Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *J Consult Clin Psychol*. 64:1326–1336.

Henry WP, Strupp HH (1994) The therapeutic alliance as interpersonal process. In Horvath AO, Greenberg LS (Eds), *The working alliance: Theory, research, and practice* (pp 51–89). New York: Wiley.

Hersoug AG, Hoglend P, Havik OE, von der Lippe A, Monsen JT (2010) Pretreatment patient characteristics related to the level and development of working alliance in long-term psychotherapy. *Psychother Res*. 19:172–180.

Hersoug AG, Monsen JT, Havik OE, Hoglend P (2002) Quality of early working alliance in psychotherapy: Diagnoses, relationship and intrapsychic variables as predictors. *Psychother Psychosom*. 71:18–27.

Hilsenroth MJ (2007) A programmatic study of short-term psychodynamic psychotherapy: Assessment, process, outcome and training. *Psychother Res*. 17:31–45.

Hilsenroth MJ, Ackerman S, Clemence A, Strassle C, Handler L (2002) Effects of structured clinician training on patient and therapist perspectives of alliance early in psychotherapy. *Psychotherapy*. 39:309–323.

Hilsenroth MJ, Ackerman SJ, Blagys MD, Baumann BD, Baity MR, Smith SR, Price JL, Smith CL, Heindselman TL, Mount MK, Holdwick DJ (2000) Reliability and validity of *DSM-IV* axis V. *Am J Psychiatry*. 157:1858–1863.

Hilsenroth MJ, Peters E, Ackerman S (2004) The development of the therapeutic alliance during psychological assessment: Patient and therapist perspectives across treatment. *J Pers Assess*. 83:332–344.

Horvath A, Del Re AC, Fluckiger C, Symonds D (2011) Alliance in individual psychotherapy. *Psychotherapy*. 48:9–16.

Horvath AO, Bedi RP (2002) The alliance. In Norcross J (Ed), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp 37–70). New York: Oxford University Press.

Horvath AO, Greenberg LS (1989) Development and validation of the Working Alliance Inventory. *J Couns Psychol*. 36:223–233.

Horvath AO, Symonds BD (1991) Relation between working alliance and outcome in psychotherapy: A meta-analysis. *J Couns Psychol*. 38:139–149.

Johansson H, Eklund M (2006) Helping alliance and early dropout from psychiatric out-patient care. *Soc Psychiatry Psychiatr Epidemiol*. 41:140–147.

Lingiardi V, Ludovica F, Baiocco, R (2005) Therapeutic alliance evaluation in personality disorders psychotherapy. *Psychother Res*. 15:45–53.

Luborsky LL (1976) Helping alliances in psychotherapy. In Cleghhorn JL (Ed), *Successful psychotherapy* (pp 92–116). New York: Brunner/Mazel.

Luborsky LL, Crits-Christoph P, Alexander L, Margolis M, Cohen M (1983) Two helping alliance methods for predicting outcomes of psychotherapy: A counting signs vs. a global rating method. *J Nerv Ment Dis*. 171:480–490.

Luyten P, Blatt SJ (2013) Interpersonal relatedness and self-definition in normal and disrupted personality development: Retrospect and prospect. *Am Psychol*. 68:172–183.

Martin DJ, Garske JP, Davis KM (2000) Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *J Consult Clin Psychol*. 68:438–450.

Mongrain M (1998) Support-seeking behaviors related to dependency and self-criticism. *J Pers*. 2:151–173.

Muran CJ, Zindel SV, Samstag LW, Crawford CE (1994) Patient pretreatment interpersonal problems and therapeutic alliance in short-term cognitive therapy. *J Consult Clin Psychol*. 62:185–190.

Norcross JC, Wampold BE (2011) Evidence-based therapy relationships: Research conclusions and clinical practice. *Psychotherapy*. 48:98–102.

Paivio SC, Bahr LB (1998) Interpersonal problems, working alliance, and outcome in short-term experiential therapy. *Psychother Res*. 8:392–406.

Peters EJ, Hilsenroth MJ, Eudell-Simmons EM, Blagys MD, Handler L (2006) Reliability and validity of the Social Cognition and Object Relations Scale in clinical use. *Psychother Res*. 16:617–626.

Pinsker JH, Stein MB, Hilsenroth MJ (2007) Clinical utility of early memories as a predictor of early therapeutic alliance. *Psychotherapy*. 44:96–109.

Piper WE, Azim H, Joyce AS, McCallum M, Nixon G, Segal P (1991) Quality of object relations versus interpersonal functioning as predictors of therapeutic alliance and psychotherapy outcome. *J Nerv Ment Dis*. 179:432–438.

Porcerelli JH, Bornstein RF, Markova T, Huprich SK (2009) Physical health correlates of pathological and healthy dependency in urban women. *J Nerv Ment Dis*. 197:761–765.

Prochaska JO, DiClemente CC (1992) Stages of change in the modification of problem behaviors. In Hersen M, Eisler RM, Miller PM (Eds), *Progress in Behavior Modification* (pp 184–214). Sycamore, IL: Sycamore Press.

Saunders SM, Howard KI, Orlinsky DE (1989) The therapeutic bond scales: Psychometric characteristics and relationship to treatment effectiveness. *Psychol Assess*. 4:323–330.

Shedler J, Block J (1990) Adolescent drug use and psychological health: A longitudinal inquiry. *Am Psychol*. 45:612–630.

Shedler J, Westen D (1998) Refining the measurement of Axis II: A Q-sort procedure for assessing personality pathology. *Assessment*. 5:335–355.

Shedler J, Westen D (2004a) Refining personality disorder diagnosis: Integrating science and practice. *Am J Psychiatry*. 161:1350–1365.

Shedler J, Westen D (2004b) Dimensions of personality pathology: An alternate to the Five- Factor Model. *Am J Psychiatry*. 161:1743–1754.

Smith AEM, Msetfi RM, Golding L (2010) Client self rated adult attachment patterns and the therapeutic alliance: A systematic review. *Clin Psychol Rev*. 30:326–337.

Smith SW, Hilsenroth MJ, Bornstein RF (2009) Convergent validity of the SWAP-200 dependency scales. *J Nerv Ment Dis*. 197:613–618.

Taft CT, Murphy CM, Musser PH, Remington NA (2004) Personality, interpersonal, and motivational predictors of the working alliance in group cognitive-behavioral therapy for partner violent men. *J Consult Clin Psychol*. 72: 349–354.

Tasca GA, Lampard AM (2012) Reciprocal influence of alliance to the group and outcome in day treatment for eating disorders. *J Couns Psychol*. 4:507–517.

Weertman A, Arntz A, Schouten E, Dreessen L (2006) Dependent personality traits and information processing: Assessing the interpretation of ambiguous information using the Thematic Apperception Test. *Br J Clin Psychol*. 45:273–278.

Westen D, Muderrisoglu S (2003) Assessing personality disorders using a systematic clinical interview: Evaluation an alternative to structured interviews. *J Pers Disord*. 17:351–369.

Westen D, Shedler J (1999a) Revising and assessing axis II, part 1: Developing a clinically and empirically valid assessment method. *Am J Psychiatry*. 156:258–272.

Westen D, Shedler J (1999b) Revising and assessing axis II, part 2: Toward an empirically based and clinically useful classification of personality disorders. *Am J Psychiatry*. 156:273–285.

Zuroff DC, Blatt SJ (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and advanced adaptive capacities. *J Clin Psychol*. 74:130–140.

Finn SE, Tonsager ME (1992) Therapeutic effects of providing MMPI-2 test feed-

Mongrain M (1998) Support-seeking behaviors related to dependency and self- back to college students awaiting therapy. Psychol Assess. 4:278Y287.

criticism. J Pers. 2:151Y173. Fleiss J (1981) Statistical methods for rates and proportions (2nd ed). New York:

Wiley.

Muran CJ, Zindel SV, Samstag LW, Crawford CE (1994) Patient pretreatment in- terpersonal problems and therapeutic alliance in short-term cognitive therapy. Fluckiger C, Del Re AC, Wampold BE, Symonds D, Horvath AO (2012) How

J Consult Clin Psychol. 62:185Y190. central is the alliance in psychotherapy? A multilevel longitudinal meta- analysis. J Couns Psychol. 59:10Y17.

Norcross JC, Wampold BE (2011) Evidence-based therapy relationships: Research

conclusions and clinical practice. Psychotherapy. 48:98Y102. Gaston L (1990) The concept of the alliance and its role in psychotherapy: Theo-

retical and empirical considerations. Psychotherapy. 27:143Y153.

Paivio SC, Bahr LB (1998) Interpersonal problems, working alliance, and out-

come in short-term experiential therapy. Psychother Res. 8:392Y406. Gaston L (1991) The reliability and criterion-related validity of the patient version of the California Psychotherapy Alliance Scale. Psychol Assess. 3:68Y74. Gaston L, Marmar CR, Thompson LW, Gallagher D (1988) Relation of patient pretreatment characteristics to the therapeutic alliance in diverse psychother- apies. J Consult Clin Psychol. 56:483Y489. Gelso CJ, Carter JA (1994) Components of the psychotherapy relationship: Their interaction and unfolding during treatment. J Couns Psychol. 3:296Y306. Hatcher RL, Barends AW (1996) Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. J Consult Clin Psychol. 64:1326Y1336. Henry WP, Strupp HH (1994) The therapeutic alliance as interpersonal process. In Horvath AO, Greenberg LS (Eds), The working alliance: Theory, research,

Peters EJ, Hilsenroth MJ, Eudell-Simmons EM, Blagys MD, Handler L (2006) Re- liability and validity of the Social Cognition and Object Relations Scale in clinical use. Psychother Res. 16:617Y626. Pinsker JH, Stein MB, Hilsenroth MJ (2007) Clinical utility of early memories as

a predictor of early therapeutic alliance. Psychotherapy. 44:96Y109. Piper WE, Azim H, Joyce AS, McCallum M, Nixon G, Segal P (1991) Quality of object relations versus interpersonal functioning as predictors of therapeutic alliance and psychotherapy outcome. J Nerv Ment Dis. 179:432Y438. Porcerelli JH, Bornstein RF, Markova T, Huprich SK (2009) Physical health cor- relates of pathological and healthy dependency in urban women. J Nerv Ment Dis. 197:761Y765. and practice (pp 51Y89). New York: Wiley.

Prochaska JO, DiClemente CC (1992) Stages of change in the modification of Hersoug AG, Hoglend P, Havik OE, von der Lippe A, Monsen JT (2010) Pretreatment patient characteristics related to the level and development of

problem behaviors. In Hersen M, Eisler RM, Miller PM (Eds), Progress in Be- havior Modification (pp 184Y214). Sycamore, IL: Sycamore Press. working alliance in long-term psychotherapy. Psychother Res. 19:172Y180.

Saunders SM, Howard KI, Orlinsky DE (1989) The therapeutic bond scales: Psy- Hersoug AG, Monsen JT, Havik OE, Hoglend P (2002) Quality of early working alliance in psychotherapy: Diagnoses, relationship and intrapsychic variables

chometric characteristics and relationship to treatment effectiveness. Psychol Assess. 4:323Y330. as predictors. Psychother

Psychosom. 71:18Y27.

Shedler J, Block J (1990) Adolescent drug use and psychological health: A longi- Hilsenroth MJ (2007) A programmatic study of short-term psychodynamic psy-

tudinal inquiry. Am Psychol. 45:612Y630. chotherapy: Assessment, process, outcome and training. Psychother Res. 17:31Y45.

Shedler J, Westen D (1998) Refining the measurement of Axis II: A Q-sort proce-

dure for assessing personality pathology. Assessment. 5:335Y355. Hilsenroth MJ, Ackerman S, Clemence A, Strassle C, Handler L (2002) Effects of structured clinician training on patient and therapist perspectives of alliance early in psychotherapy. Psychotherapy. 39:309Y323.

Shedler J, Westen D (2004a) Refining personality disorder diagnosis: Integrating

science and practice. Am J Psychiatry. 161:1350Y1365.

Hilsenroth MJ, Ackerman SJ, Blagys MD, Baumann BD, Baity MR, Smith SR, Price JL, Smith CL, Heindselman TL, Mount MK, Holdwick DJ (2000) Reli-

Shedler J, Westen D (2004b) Dimensions of personality pathology: An alternate to

the Five- Factor Model. Am J Psychiatry. 161:1743Y1754. ability and validity of DSM-IV axis V. Am J Psychiatry. 157:1858Y1863.

Smith AEM, Msetfi RM, Golding L (2010) Client self rated adult attachment pat- Hilsenroth MJ, Peters E, Ackerman S (2004) The development of the therapeutic alliance during psychological assessment: Patient and therapist perspectives

terns and the therapeutic alliance: A systematic review. Clin Psychol Rev. 30:326Y337. across treatment. J Pers Assess. 83:332Y344.

Smith SW, Hilsenroth MJ, Bornstein RF (2009) Convergent validity of the SWAP- Horvath A, Del Re AC, Fluckiger C, Symonds D (2011) Alliance in individual

200 dependency scales. J Nerv Ment Dis. 197:613Y618. psychotherapy. Psychotherapy. 48:9Y16.

Taft CT, Murphy CM, Musser PH, Remington NA (2004) Personality, interperson- Horvath AO, Bedi RP (2002) The alliance. In Norcross J (Ed), Psychotherapy re-

al, and motivational predictors of the working alliance in group cognitive- lationships that work: Therapist contributions and responsiveness to patients

behavioral therapy for partner violent men. J Consult Clin Psychol. 72: (pp 37Y70). New York: Oxford University Press.

349Y354. Horvath AO, Greenberg LS (1989) Development and validation of the Working

Alliance Inventory. J Couns Psychol. 36:223Y233.

Tasca GA, Lampard AM (2012) Reciprocal influence of alliance to the group and

outcome in day treatment for eating disorders. J Couns Psychol. 4:507Y517. Horvath AO, Symonds BD (1991) Relation between working alliance and out- come in psychotherapy: A meta-analysis. J Couns Psychol. 38:139Y149.

Weertman A, Arntz A, Schouten E, Dreessen L (2006) Dependent personality traits and information processing: Assessing the interpretation of ambiguous Johansson H, Eklund M (2006) Helping alliance and early dropout from psychiat-

ric out-patient care. Soc Psychiatry Psychiatr Epidemiol. 41:140Y147.

information using the Thematic Apperception Test. Br J Clin Psychol. 45:273Y278. Lingiardi V, Ludovica F, Baiocco, R (2005)

Therapeutic alliance evaluation in per-

Westen D, Muderrisoglu S (2003) Assessing personality disorders using a system- sonality disorders psychotherapy. Psychother Res. 15:45Y53.

atic clinical interview: Evaluation an alternative to structured interviews. J Luborsky LL (1976) Helping alliances in psychotherapy. In Cleghhorn JL (Ed),

Pers Disord. 17:351Y369. Successful psychotherapy (pp 92Y116). New York: Brunner/Mazel.

Westen D, Shedler J (1999a) Revising and assessing axis II, part 1: Developing a Luborsky LL, Crits-Christoph P, Alexander L, Margolis M, Cohen M (1983) Two helping alliance methods for predicting outcomes of psychotherapy: A

clinically and empirically valid assessment method. Am J Psychiatry. 156:258Y272. counting signs vs. a global rating method. J Nerv Ment Dis. 171:480Y490.

Westen D, Shedler J (1999b) Revising and assessing axis II, part 2: Toward an em- Luyten P, Blatt SJ (2013) Interpersonal relatedness and self-definition in normal and disrupted personality development: Retrospect and prospect. Am Psychol.

pirically based and clinically useful classification of personality disorders. Am J Psychiatry. 156:273Y285. 68:172Y183.

Zuroff DC, Blatt SJ (2006). The therapeutic relationship in the brief treatment of Martin DJ, Garske JP, Davis KM (2000) Relation of the therapeutic alliance with outcome

depression: Contributions to clinical improvement and advanced adaptive ca- and other variables: A meta-analytic review. J Consult Clin Psychol. 68:438Y450.

pacities. J Clin Psychol. 74:130Y140.