Title: Early clarification processes in clients presenting with borderline personality disorder: Relations with symptom level and change

Authors: Kramer U, Sachse R

Journal: Person-Centered Experiential Psychotherapies

Issue: 12

Volume: 2

Pages: 157-175

DOI: 10.1080/14779757.2013.804647

Running Head: Early Clarification Processes in Borderline Personality Disorder

Early Clarification Processes in Clients presenting with Borderline Personality Disorder: Relations with Symptom Level and Change

Ueli Kramer[1] & Rainer Sachse[2]

[1]Institute of Psychotherapy and Section Karl Jaspers, Department of Psychiatry-CHUV, University of Lausanne, Switzerland

[2] Institut für Psychologische Psychotherapie and Ruhr-University of Bochum, Germany

Correspondence concerning this article should be addressed to: Ueli Kramer, PhD, IUP-DP-CHUV, Av. d'Echallens 9, CH-1004 Lausanne, ph. ++41-21-314.00.50, fax ++41-21-314.27.84; e-mail:ueli.kramer@chuv.ch

Acknowledgments: We thank Sandra Schirm for her help with reliability ratings.

Running Head: Early Clarification Processes in Borderline Personality Disorder

Early Clarification Processes in Clients presenting with Borderline Personality Disorder: Relations with Symptom Level and Change

Abstract

Clarification-Oriented Psychotherapy (COP; Sachse, 2003), an integrative treatment form with a basis in process-experiential psychotherapy, is particularly relevant for clients with Personality Disorders (PDs). We argue here that two related core therapeutic COP principles, 'dual action regulation' and 'interactional games' have consequences for symptom severity and therapeutic outcome for clients with PDs. A high quality COP clarification process requires that client's interactional games may be quickly assessed and treated in all (preferably early) therapy sessions. These processes can be observed and measured using the observer-rated Bochum Process and Relationship Rating Scales (BPRRS) which measure both clients' and therapists' contributions to the quality of the clarification processes engaged in therapy. This measure has been successfully applied to COP-therapies, but not, as yet, to therapies other than experiential, nor to specific client populations such as borderline personality disorder. The present study is a first attempt to evaluate the application of COP processes to other therapies and populations. We measured action regulation and interactional games using the BPRRS during intake sessions of a 10-session psychodynamic treatment of borderline personality disorder for a total of $N = 30$ clients and $N = 8$ therapists. Significant relationships were found between the client's degree of interactional games and both pretherapy symptom level and symptom change across therapy. These results are discussed in the context of Clarification-Oriented Psychotherapy, and more generally Person-Centered and Process-Experiential Psychotherapies. The potential relevance of the findings for psychodynamic psychotherapists are explored as well as the potential usefulness of taking into account a detailed analysis of interactional games for the training of psychotherapists working with any model of therapy working with clients presenting with BPD.

Key-Words: Clarification-Process; Interactional Games; Borderline Personality Disorder; Therapeutic Relationship; Observer-Rated Methodology

EARLY CLARIFICATION PROCESSES IN CLIENTS PRESENTING WITH BORDERLINE PERSONALTIY DISORDER: RELATIONS WITH SYMPTOM LEVEL AND CHANGE

Introduction

Case conceptualization and treatment of clients presenting with Borderline Personality Disorder (BPD) remains controversial. “Manipulation”, or manipulative behavior of clients with BPD in particular, is often discussed. Linehan (1993) argues that diagnostic manuals (e.g., DSM-IV; APA, 1994) assume that clients presenting with self-harming behavior do so to attract attention and to «manipulate» others. According to Linehan, such a conception is short-sighted, potentially suggesting that therapists often have negative counter-transference to clients presenting with such problems. If so, such negative affect on the part of the therapists towards clients with BPD may be experienced by clients as rejecting. According to Linehan’s conception, rather than these clients doing anything “to attract attention”, these clients’ self-harming behavior may be better understood as their lack of skill in emotionally regulating intense fundamental (often interpersonal) suffering. Furthermore, and also problematic is that a client’s experience of their therapist’s rejection can confirm – rather than therapeutically disconfirm – client’s early traumatic experience patterns with attachment figures and thereby add to the client's suffering by leaving them feeling invalidated and misunderstood.

Traditionally, client-centered approaches have shown little interest in the disorder-specific treatment of clients presenting with BPD (see the study by Cottraux et al., 2009, and for exceptions Eckert & Biermann-Ratjen, 1998; Warwar, Links, Greenberg, & Bergmans, 2008; Pos & Greenberg, 2012). However, Sachse (2003, 2004; Sachse, Sachse, & Fasbender, 2011; see also Kramer, Püschel, Breil & Sachse, 2009) has developed a specific conceptual

framework for the treatment of clients with personality disorders using Clarification-Oriented Psychotherapy (COP) that is based on client-centered approaches (*i.e.*, focusing) and process-experiential psychotherapy, among others. A recent naturalistic study demonstrated the effectiveness of Clarification-Oriented Psychotherapy as a whole for various psychiatric disorders, in particular for clients presenting with Personality Disorders (Sachse, Schülken, Leisch, & Sachse, 2011). Within COP, *clarification* is a core therapeutic process that aims at the construction of a valid representation in the client of the internal determinants of his/her presenting problem as well as the modification of these internal determinants (Sachse, 2003). Both client and therapist contribute to this clarification process in both positive and negative ways. The client may for instance avoid authentically engaging with core issues; while the therapist may use process-directivity in order to orient the client step-by-step towards engaging in such issues.

COP case conceptualization is consistent with the interpersonal-experiential theories (e.g., van Kessel & Lietaer, 1998; see also Benjamin, 1993) that posit a central and important role of implicit corrective interpersonal experiences for positive therapeutic change. Van Kessel and Lietaer (1998, p. 159) formulate the central therapeutic problem to be solved in the following fashion: “How does the therapist steer away from following the client’s preferred style of interaction in a complementary way?” This clearly formulated question of how the therapist avoids being complementary to client’s unhelpful interactional patterns (see Benjamin, 1993), however, is not clearly answered by Van Kessel and Lietaer. Sachse proposes that what is needed is a case formulation of these clients that conceptualizes client’s authentic and non-authentic action regulation, that is, their two fundamental types of inter-action regulation (so-called dual action regulation), with differential implications for therapist complementarity. Authentic action regulation is thought to serve the individual’s basic needs and motives; therapist complementarity is needed (Sachse, 2003). Alternatively in non-

authentic action regulation, certain behaviors may have strategic intransparent interpersonal aims, such as to control the interaction by the use of “interactional games”; therapist complementarity is generally prohibited (Sachse, 2003). These inauthentic interactional games are those likely to be experienced as «manipulative» by interaction partners. For example, a therapist may feel manipulated by a client's ‘pull for assistance’ if they present as particularly weak and in need of help. COP does not assume any negative conscious intention behind these strategies and aims. Rather, Sachse (2003) hypothesizes that the degree of interactional games represents a low quality of the clarification processes (*i.e.*, a lack of understanding of the client’s internal determinants), both from the therapist and client perspectives. This low quality clarification is thought to relate to the severity of the personality disorder, as well as the severity of the client’s presenting symptoms. Or, conversely, clients with fewer interactional games are expected to present with fewer symptoms and better therapeutic outcomes. This is consistent, in essence, with previous research on interpersonal processes across therapy approaches, in psychodynamic psychotherapy (Coady & Marziali, 1994) and during initial sessions of experiential psychotherapy (Wong & Pos, 2012). According to Sachse, Sachse and Fasbender (2011; Breil and Sachse, 2011), interactional games are therefore an important initial target of any treatment for BPD clients. Gunderson and Links (2008) would likely agree, as they also view clients with BPD as being highly invested in the interpersonal domain. In fact, once identified, Sachse would argue that clients’ interactional games require therapeutic resolution before the client can later access his/her underlying authentic processes, *i.e.*, affects, cognitions, intentions and emotions. Therefore, it is also assumed that low quality of therapist clarification (therapists failing to address interactional games appropriately) will relate to a higher level of symptoms at the end of the session and in the end of therapy. A relationship between therapist contributions to clarification very early-in-process and client’s symptom

level and change is also posited, so that the more quickly this target of treatment is addressed the better the outcome for BPD clients will be. This brings us to argue that the identification and treatment of interactional games may in fact be best conceptualized as a common therapeutic factor in any treatments for clients with BPD, of potential importance independent of any specific therapy form.

COP-informed case formulation implies three tasks for the therapist. The therapist must (1) learn to synthesize the client's problems from the perspective of the dual action regulation model presented above; and, (2) must become quickly aware of «unclear» aspects in the formulation of the client's problem (*i.e.*, therapist using the analytic mode of information processing; asking "what information is missing?"; Sachse, 2003). Finally (3) the therapist must pro-actively provide a complementary therapeutic relationship towards authentic needs and processes, or a "motive-oriented therapeutic relationship" (Caspar, 2007). Derived from Plan Analysis (Caspar, 2007), this means employing a set of relationship intervention heuristics which enable the therapist to encounter the client on increasingly genuine levels, related to his/her authentic needs and motives by pro-actively reassuring the client that in this particular therapeutic relationship, their authentic needs and motives can be satisfied. Throughout this process, the therapist must avoid acting in a complementary (clinically unhelpful) fashion to the client's interactional games understood as unproductive for the clarification process. According to the COP-model (Sachse, 2003), achieving these three tasks carries positive implications for the proficient understanding of cases presenting with BPD that will lead to more productive therapeutic processes.

In the present study, we examined whether the degree of interactional games (IG) hinders the clarification-processes in therapy, and also hinders productive change in symptom distress and overall treatment outcome in clients diagnosed with BPD. If interactional games

are present in all clients with BPD (and are a common important process target) across any treatment approach, it is important to study interactional games and their potential treatment in other-than-COP therapies, such as psychodynamic therapy. As well, measuring these aspects very early in treatment, at best at intake, also provides an opportunity to validate COP-theory concerning the utility of promptly addressing interactional games during treatment for BPD. Early investigation of this process can also potentially establish the relevance of quickly engaging in the clarification process, across all treatments for BPD. Before embarking in our report, we will first briefly present specific elaborations of Clarification-Oriented Therapy (COP) for BPD, with a focus on very-early-in-process analysis and the treatment of interactional games.

Three levels of clinical manifestations and interventions

According to Sachse and Maus (1991), any client manifestation or therapist intervention may be understood from three levels that are presumed to be independent: (1) the level of content, (2) the level of process, and (3) the level of relationship. Interactional games occur on this third level (relationship).

Level (1): The level of *content* encompasses *what* is expressed in the therapeutic interaction, both verbally and non-verbally. Emotions, affects, thoughts and schemes may be found on this content level. Therapeutic focus on content implies that the client is ready to confront his/her own internal determinants, his/her most difficult emotions, and to clarify aspects of cognitive and affective schemes in relation with the problem presented. At this level, client's affective involvement is normally high; experiencing is maximal; new meaning is created; the client's focus is completely turned inward (in the sense of Gendlin, 1978; Sachse, 1992) on relevant content aspects and the quality of the explication process is high

(Sachse, 1992). The therapist's task is to maintain the focus on these relevant contents (Greenberg, 2002; Kramer, 2011; Sachse, 2003).

Level (2): The *process* level means having a focus on *how* the client presents contents and to what extent the focus on contents is (self-) interrupted by avoidance. For example avoidant processes may emerge when the client approaches highly relevant but "uncomfortable" affective schemes and move their focus away from the affect-laden contents into partially relevant or full-blown non-relevant themes which, while easier to experience have little to do with the presenting problem. The therapist's task is to address process-level avoidance by using a variety of techniques described within the context of Clarification-Oriented Therapy (Sachse, 2003) or contemporary Emotion-Focused Therapy (Greenberg, 2002; Pos & Greenberg, 2012). In particular, the therapist's process guidance (or process-directivity; Greenberg, Rice, & Elliot, 1993) has shown to be related to outcome in several studies (Sachse, 1992, 1993; Sachse & Elliott, 2002).

Level (3): Finally, the *relationship* level refers to the relational implications of the therapeutic interaction. In terms of treatment of the interactional games, it is postulated that the therapist who responds in a mode "complementary" to the client's non-authentic action regulation, may become a part of the client's presenting problem, stabilize the client's pathological system and contribute to the maintenance of client's symptoms. Conversely, the therapist who responds in a mode complementary to client's authentic motives (i.e., in a motive-oriented fashion; see Caspar, 2007) that underly their interactional games, efficiently reduces the interactional problems and increases the quality of collaboration. For example, a client presenting with BPD may present as particularly competent in the explanation of her disorder; and in so doing may try to convince her therapist that she is "cured" and does not need any more treatment (as part of an avoidant and non-authentic action regulation). A

therapist acting complementarily to these interactional games may suggest terminating therapy, which may be ineffective and harmful by inaccurately missing or misperceiving the client's deeper authentic needs. An accurate formulation of this particular client's problem might instead hypothesize that her (authentic) needs for or motives of solidarity and recognition are activated. This would suggest that the therapist might best pro-actively provide solidarity with this apparently competent client without falling into the client's 'apparent' wish to terminate treatment. While assuring the client that the therapist continues to be willing to help her, at the same time, the therapist can validate and acknowledge the client's competence concerning her accurate knowledge about her disorder. This kind of therapist complementarity to deeper genuine needs, or motive-oriented therapeutic relationship, has been related to outcome in several studies (e.g., Caspar et al., 2005), in particular for clients presenting with Personality Disorders (Kramer, Rosciano, et al., 2011) and even more specifically, Borderline Personality Disorder (Kramer, Berger et al., 2011).

It is our contention that at the beginning of therapy, particularly during the intake session, most clinical manifestations of the client can and should be understood on the relationship level. Effective therapeutic interventions most often focus on this level because very little productive work on the content level, *i.e*., actual clarification work in the narrower sense, is feasible at this early stage of therapy. In fact, Breil and Sachse (2011) defined five treatment phases facing clients presenting with BPD, out of which only phase (1) is relevant here. This phase (1) encompasses work on the therapeutic relationship (*i.e*., work on level 3 explained above): The therapist must address interactional games, by adopting a motive-oriented therapeutic relationship and by using clarification techniques of underlying interpersonal (authentic) motives hypothetically related to the interactional games. Phase (1) starts with the very first contact between the client and the therapist.

Assessment of the clarification process using the BBBS

The quality of the clarification processes, in particular the client's use of interactional games and their treatment, can be assessed using the *Bochum Process and Relationship Scales* (*Bochumer Bearbeitungs- und Beziehungsskalen;* BBBS; Sachse, Schülken, Sachse, & Leisch, 2011). The BBBS is an observer-rated 54-item instrument, with nine sub-scales. It operationalizes the three afore-mentioned levels of clinical manifestations and interventions (Sachse & Maus, 1991) by measuring the quality of the clarification process on the levels of content, process and relationship, from both the client's and the therapist's perspectives. All items are scored such that higher scores indicate better quality of the clarification process. The measure will be described more fully in the Method section. We are suggesting here that the BBBS can be viewed as a transtheoretical measure of a common process that may be applied to any type of psychotherapy session, irrespective of the therapy approach.

So far, no study has applied the BBBS to a specific uni-diagnostic sample, such as clients presenting with BPD, nor to therapy sessions other than COP. This is the aim of the present study, to illustrate the relevance of interactional games to treatment of clients with BPD within a treatment context other than COP, *i.e.*, the context of psychodynamic intake interviews. Our perspective is that the application of psychodynamic concepts is widespread among clinicians treating clients with BPD (e.g., APA, 2001). From an integrative point of view, researchers and clinicians practicing other than broad-spectrum client-centered and process-experiential psychotherapy may find BBBS-data on a sample of clients with BPD of general relevance as a means for examining core therapy processes with these clients.

Hypotheses

We predicted that the quality of client's and therapist's contributions to the clarification process as measured by the BBBS would be linked with intake symptom level

(measured right after the intake session) and change in symptoms over the course of treatment (measured in the end of treatment). More particularly, we hypothesized that (a) clients use of interactional games (low-quality client's clarification processes) would relate to greater symptom severity at intake. Also, we hypothesized that if addressing interactional games is an 'important common task' in clients with BPD, (b) at the outset of therapy, psychodynamic therapists would exhibit lower quality of clarification process that would relate to higher client symptoms at intake (these therapists would likely be uninformed of the identification and treatment of interactional games – there is no conscious steering away from them). Finally, we hypothesized that (c) clients with higher quality of clarification process at intake would have a "headstart" in this core process of change and therefore would have better therapeutic outcome, and (d) higher therapists' quality of the contribution to the clarification process at intake would indicate therapists who were more quickly on target with this core process of change and have clients with better therapeutic outcome.

Method

Participants

Clients

A total of $N = 30$ clients presenting with Borderline Personality Disorder (BPD) were included in the study. Twenty (67%) were female. Clients had a mean age of 29.5 years (SD = 10.2; ranging from 19 to 55). All were French-speaking and all had a DSM-IV (APA, 1994) diagnosis of Borderline Personality Disorder, as diagnosed by the Structured Clinical Interview for DSM-IV (SCID-II; First, Spitzer, Williams, & Gibbons, 2004). Mean reliability of axis II diagnoses for independent ratings of video-taped SCID-II interviews from a randomly chosen 17% (5) of all cases was satisfactory ($\kappa = .76$). Some of the clients (10; 40%) presented with co-morbid disorders, such as on axis I major depression (4; 16%); with

each of the following diagnoses were found in only one client within the sample (4% occurrence per category) agoraphobia, dysthymia, bulimia, anorexia, panic disorder, alcohol abuse, somatoform disorder and schizoaffective disorder, and on axis II one paranoid and one narcissistic PD. The diagnostic interviews occurred in a session after the intake interview investigated here. The present study was part of a larger research project approved by the relevant departmental Ethics Board; the present study and local Research Council.

Therapists

A total of $N = 8$ therapists participated in the study. Four were psychiatrists, two were psychologists and two were nurses. Each had between 2 and 10 years of resident experience in psychiatry, with some specific training and experience with clients presenting with BPD. Each therapist treated between 2 and 6 clients.

Rater

There was only one rater in the present study. The entire sample was rated by a French-speaking rater (UK), who was not one of the therapists in the present study. He had extensive training in COP and specific training in the BBBS rating scales, including regular supervision with the creator of the BBBS-scale (RS). The rater was blind to both clients' symptom and outcome scores.

Intervention

The present study focused on the intake interview of a 10-session treatment process tailored to the specific needs of clients with BPD, following the manual by Gunderson and Links (2008). This manual-based psychiatric and psychodynamic approach was adhered to, for the intake session, by the therapist providing specific psychodynamic techniques

consistent with dynamic interviewing, developed from clinical practice of psychodynamic psychotherapy (Perry, Fowler, & Semeniuk, 2005).

Instruments

The *Bochum Process and Relationship Scales* (*Bochumer Bearbeitungs- und Beziehungsskalen* BBBS; Sachse, Schülken, Sachse, & Leisch, 2011, for the current short version) is an observer-rated instrument. Fifty-four items contribute to nine sub-scales, each of which aims at measuring the three levels of clinical manifestations and interventions according to the COP-model (Sachse & Maus, 1991). Each of the 54 items are rated on a Likert-type scale, ranging from 0 to 6. Global ratings are made for both client and therapist process that occur during the 15 mid-session minutes of video-/audio-material of a mid-session segment. For example, the degree of clients' interactional games is assessed ranging from 0 to 6 (0 meaning "high frequency or intensity of interactional games" and 6 "no interactional games"). Likewise, therapist interventions are also rated. For example, the item of 'therapist rendering explicit the client's interactional games' (a typical clarification technique) would be rated on the same scale (0 for "no rendering explicit" and 6 for "high frequency of rendering explicit client's interactional games"). Higher scores reflect better quality of the clarification process, both from the client's and the therapist's perspective. The choice of mid-session minutes is based on the validation data of the earlier version of the BBBS (Sachse & Takens, 2004) showing the highest quality of clarification process at mid-session.

A first validation study on the BBBS was carried out by Sachse, Schülken and Leisch (2006) on the original (longer) German version of the BBBS (96 items) on a sample of N = 121 psychotherapy clients with various psychiatric disorders, treated by N = 87 therapists. A factor analysis (method principal component analysis, using VARIMAX-rotation) validated

the client's and therapist's sub-scales. High intra-scale correlations ($r > .84$), and a few significant, otherwise low, inter-scale correlations ($r < .25$), were found (Sachse et al., 2006). The BBBS' external validity has also been established by high correlations between the BBBS and therapist competence and experience in a sample of therapist's practicing COP ($r > .35$; Sachse & Schlebusch, 2006; Sachse et al., 2006) and with symptom change at the end of psychotherapy ($r > .66$), in particular for the «Understanding»-therapist sub-scale ($r = .76$). Only moderate correlations were found between client sub-scales and symptom change at the end of therapy ($r < .42$). The degree of personality disorder (measured on a validated Likert-type scale) correlated negatively with several of the client's sub-scales, such as «Relationship» ($r = -.76$), «Process: avoidance» ($r = -.51$) and «Content: quality of explication» ($r = -.47$). The authors concluded that this first version yielded acceptable validity, in particular concept validity as regards its correlations with the degree of personality disorders.

Recently, Sachse, Schülken, Sachse and Leisch (2011) shortened the original German version from 96 to 54 items using item coefficients from analysis of the previous version, and presented initial validation data for the current short version. Two sessions per client were analysed, (session 5: $N = 177$ clients; session 10: $N = 101$ clients) for clients presenting with depressive and personality disorders. Reliability coefficients (κ) for the BBBS-short version varied between .72 and .85, with Intra-Class Correlation coefficients (ICC (2, 1) varying between .69 and .83. Cronbach alphas were comparable to the long version of the BBBS for all of the sub-scales (over .88), except for the sub-scale of therapist's treatment of avoidance ($\alpha = .59$). The latter sub-scale was dependent on the score for the client's sub-scale of Process-avoidance (i.e., the therapist scale was only rated when the client score was lower than 3), which explains the moderate internal consistency for this scale. It may be concluded that the short version of the BBBS presents validation and reliability coefficients which are as

good as for the long version; thus, the authors recommend its use of further studies on the assessment of the clarification process in psychotherapy.

The short version is constructed as follows. From the client's perspective, three sub-scales are defined: (1) Content (7 items): the quality of the client's work on content (affects, emotions, schemes; e.g., item 3 «The client adopts an internal perspective.»); (2) Process (7 items): the degree of client's avoidance of constructive focus or affective arousal (e.g., item 1 «The client displays avoidance by saying 'I don't know', by answering questions that weren't asked, by changing a theme or by avoiding the question.»); (3) Relationship (6 items): (3A) Functional: constructive therapeutic relationship (3 items; e.g., «The client personally trusts the therapist.»); (3B) Interactional games: see above (3 items; e.g., «The client conveys images to the therapist.»).

From the therapist's perspective, six sub-scales are defined: (1) Relationship : the quality of the relationship that the therapist offers (6 items; e.g., «The therapist is authentic.»); (2) Understanding: the quality of the therapist's model of the client's problem and its expression to the client (6 items; e.g., «The therapist shows the client that he/she understands the client.»); (3) Process guidance: the quality of process-directivity (8 items; e.g., «The therapist internalizes the client's perspective or maintains the client's perspective internal.»); (4) Treatment of client's avoidance: the quality of therapist interventions related to addressing client's avoidance, if relevant (see client (2); 2 items, e.g., «The therapist counter-guides in the case of the client's avoidance in the process.»); (5) Treatment of interactional games: the quality of therapist interventions related to the client's interactional games, if relevant; 6 items, e.g., «The therapist is complementary to the client's motives.»); (6) Treatment of schemes: the quality of therapist interventions aiming at change of client's assumptions and core emotions (6 items, e.g., «The therapist leads the client to evoke counter-affects.»).

The Outcome Questionnaire-45.2 (OQ-45; Lambert, et al., 1996) is a self-report questionnaire that encompasses 45 items addressing three main domains of distress: level of symptoms, interpersonal relations and social role. A Likert-type scale is used to assess the items, from 0 („never“) to 4 („almost all the time“). The validation coefficients of the original English version were satisfactory, in particular for internal consistency and sensitivity to change over psychotherapeutic treatment (Vermeersch, Lambert, & Burlingame, 2000). The French validation study (for the version used in this study) was carried out by Emond, Savard, Lalande, Boisvert, Boutin, and Simard (2004) and yielded satisfactory results. Cronbach's alpha for this sample was .95. In this study, the global sum score for the entire scale was used (primary outcome). In addition, for exploratory purposes, we used the three sub-scores. Due to some missing values, analyses using this questionnaire were performed on a sub-sample with complete data (n = 22). The mean total score at intake was in the clinical range (mean = 88.27; SD = 15.29; range: 69-115). This questionnaire was given after session one and session 10.

Procedure

All intake sessions were video-recorded. The video rating followed Sachse et al.'s (2006) methodology which recommends rating a 10-minute time segment in the middle of the session (from minute 15 until 25) for capturing essential clarification work. Since all ratings of the current French-speaking sessions were accomplished by one rater and no second French-speaking rater was available for providing inter-rater reliability (IRR), IRR was established between the current rater's German ratings against another German-speaking BBBS trained colleague on ratings of N = 9 German psychotherapy sessions taken from a sample with similar client characteristics. The results show that inter-rater reliability of the BBBS was on average very good for N = 9 psychotherapy sessions; Intra-Class Correlation coefficients (2, 1) varied between .68 and .94 (Mean = .84; SD = .10).

Results

Preliminary analyses on the BBBS-R: internal consistencies and means

Table 1 reports descriptive and internal consistency data of the BBBS for the present sample. Seven out of nine sub-scales had adequate Cronbach alphas, varying between .65 and .86. Three therapist sub-scales yielded sub-threshold coefficients: treatment of avoidance (α = .45), treatment of interactional games (α = .31) and treatment of schemes (α = .43). These specific sub-scales represent therapist interventions which should be implemented based on specific in-session markers present in the client. For example, specific items related to treatment of interactional games are only applicable and rated if a particular interactional game is being played in session by the client (as rated lower than 3 on this sub-scale). In addition, whereas a therapist sub-scale encompasses interventions similar in their intended goals, these interventions do not have to be used necessarily in the same session, thus resulting in possible low intra-scale dependency of these items. Calculation of the alphas per sub-scale does not take into account this inter-scale item dependency and low intra-scale item dependency, which likely influenced the low internal consistencies within these therapist sub-scales.

The mean client quality of clarification process on the content level for these intake sessions was very low indicating poor quality of clarification process. Whereas the BPD clients presented, on average, little in-session avoidance (low scores indicate high levels of avoidance), we found quite low scores of clarification quality on the relationship level indicated by both a high prevalence of non-authentic interactional games and a low degree of trust in the therapist as marker of functional relationship. According to the COP-model (Sachse, 2003), these client features on the relationship level represent markers that call for specific therapist interventions on the relationship level which is what the (COP-uninformed)

psychodynamic therapists in our sample actually did! This is indicated by the therapist's relationship and treatment of games sub-scales scores being on average quite high. However, these psychodynamically oriented therapists had poor performance in process guidance. Therapists specifically trained to engage in process guidance have been shown to have mean scores in the 4 range (Sachse, Schülken, Sachse, & Leisch, 2011) which was not the case here.

Links between clarification processes, symptom level and change

We tested our four hypotheses using Pearson correlations. Several significant correlations between the BBBS-scales and client symptom level at intake were found (see Table 2; note that higher BBBS scores always represent higher quality clarification processes, both from the client's and the therapist's perspective). Hypothesis 'a' stated that client's increased use of interactional games would be related to higher symptoms at intake. A significant correlation was found (r = -.46) between the OQ-45's interpersonal problems sub-scale and the degree of interactional games. Therefore, a higher level of interpersonal problems was significantly related to a lower quality client clarification process in intake sessions. Hypothesis 'b' stated that a lower quality of therapists' contributions to the relationship clarification process would also relate to higher client symptoms measured after the intake session. This hypothesis was also confirmed. Significant correlations were found among OQ-45's total score as well as social role sub-scale and therapist's intervention total scale (total: r = -.52; social role: r = -.54, respectively). Therefore, a high level of client symptoms co-occurred with lower quality of therapist clarification. Hypothesis 'c' stated that low frequency of interactional games in clients would be related to better therapeutic outcome. Our results showed that higher change on OQ-45's total scale, as well as symptom distress and interpersonal problems subscales, correlated with higher client clarification in the sense of lower degree in interactional games (r = .50, r = .51, and r = .48, respectively, all p <

.05). After controlling for symptom level at intake (using partial correlations), low frequency of interactional games remained related to higher change in OQ-45 scores ($r_{partial}$ = .46, .49, .44, respectively, all $p < .05$). Therefore, the higher the quality of the client's clarification process on the relationship level at intake, the better the therapeutic outcome. Finally, hypothesis 'd' stated that the higher the quality of the therapists' contribution to the clarification process at intake, the better the outcome. This hypothesis was not confirmed. Our results showed a non-significant correlation between change on OQ's interpersonal subscale and therapists' quality of clarification on the relationship level (r = .30, ns; when controlling for symptom level at intake $r_{partial}$ = .26, ns).

Discussion

This study has shown the potential relevance of the quality of the clarification processes, as defined by Sachse (2003) in the COP-model occurring in intake sessions with BPD-clients treated within a psychodynamic intervention frame, that provides support for the viewing the quality of clarification processes as potentially an important common task or therapeutic principle in treatments of BPD clients. Our results on these very early client-therapist interactions point to the centrality of interactional games and their treatment for BPD clients, across therapeutic approaches. From an integrative therapy perspective, it is interesting to note that while psychodynamic therapists express high frequencies of relationship interventions, they exhibit low frequency of process directivity which are typical process-experiential interventions (*i.e.*, therapist subtle guidance in a constructive fashion, internalization of the client's perspective, use of opportunities for internalization, use of therapeutic questioning, activation of scheme-related emotions in the process, explication of client's contents, accuracy of guidance). Process directivity has been found to relate to psychotherapy outcome (see Greenberg, Rice, & Elliott, 1993; Sachse, 1992; Sachse &

Elliott, 2002; Sachse et al., 2006) and process directivity seems to be of particular importance in treatments for clients presenting with personality disorders, as opposed to sub-optimal non-directive approaches (Cottraux et al., 2009) and content-directive approaches which tend to elicit reactance patterns in clients (Sachse et al., 2011). An example of this is described in a recent case study of positive therapeutic results employing process-directive treatment of a client presenting with BPD presented by Pos and Greenberg (2012).

The fact that low frequency of interactional games co-occurred with better outcomes, even when initial levels of symptoms were controlled, clearly strengthens our argument. The dynamic therapists' lack of process-directivity reported above also argues for COP-consistent integrative training module for BPD, one that encompasses the elements of the following triad of effective intervention principles: process-directivity, interventions on the relationship level and case formulation. Case formulation according to the dual action regulation model seems pivotal here, as it links relationship-focused formulation of BPD with process-directivity: the clear differentiation between authentic and non-authentic client processes on the level of formulation should help the therapist to (a) implement effective interventions on the relationship-level oriented towards the motives and (b) make clinically sound use of process-directivity. Our psychodynamic therapists were only focusing on one aspect of the triad, the relationship, and did not focus as effectively on process. One possible hypothesis within the COP-theory among others that can explain this therapist's lack of process-directivity, might be that the interpersonal functionalities of the clients' expression of symptoms, *i.e.*, their understanding from a dual action regulation perspective, were not sufficiently integrated into the therapists' case formulation of their clients. If these aspects were integrated in the formulation and if the therapists acted accordingly by process-guiding the therapeutic interaction towards authentic action regulation and away from the unproductive interactional games, the quality of clarification, and ultimately outcome, may be increased. Clients' failing

to steer clear from interational games was associated with more symptoms at intake (see the interpersonal-experiential argument by Van Kessel and Lietaer, 1998) and with negative therapeutic outcome. Also, if psychodynamic therapists failed to guide the process away from interactional games that clients were playing in-session this seemed to be related to higher symptom level at intake. It is possible that these therapists may well have realized the distinction between authentic and non-authentic action regulation on the level of formulation, but were simply unable to guide the client on the process-level to deeper authentic issues, due to a lack of specific training in this form of directivity. Alternatively, in light of the correlational nature of our results, therapist interventions either may have contributed to the symptoms after this very first session, or high client pre-therapy symptom levels may have affected the therapist's capacity to implement effective process-directivity.

Let us offer an illustrative clinical example. In a female client with BPD, the expression of symptoms at intake may serve the interactional goal of presenting herself as weak. The client says, sighing, "I get a headache in these sessions, this is not normal; you [therapist] have to do something about it!" and asks for additional sessions with the therapist, or alternatively extra sessions on the phone, in order by this means to get a particularly intense relationship from the therapist, as part of a particular interactional game. In this case, this external focus on the actual relationship replaces a potential productive internal focus on internal determinants necessary for a clarification process, *i.e.*, focusing on the question "What is it inside that makes me feel tense in the session?" If the here-and-now relational implication of the symptom gravity was unclear to the therapist, he/she has at least two major options: 'a' act out, *i.e.*, to give to that client extra sessions to calm her down, or 'b' react with negative counter-transference, *i.e.*, the therapist may become irritated or angry at the client's queries or at his/her own helplessness as a reaction to the client's queries (see Eckert & Biermann-Ratjen, 1998). We think that all these therapist reactions would impede the quality

of an efficient case formulation of their client, which, in turn, may affect negatively the quality of the clarification process and, ultimately, outcome.

Therapeutic outcome was linked with specific contributions (by the client) to the clarification process during the intake session, even when initial symptom level was controlled. This is consistent with a hypothesis that client's characteristics, *i.e.*, processes, relationship aspects, including the degree of interactional games, are related with therapeutic outcome (Sachse, 1992; Sachse, & Takens, 2004) across therapeutic modalities (Fernandez-Alvarez, Clarkin, Salgueiro & Critchfield, 2006; Lambert, 1992). Clients presenting with more interactional problems had poorer treatment outcomes and clients with higher quality clarification right from the intake session on also had better outcomes. The only sub-scale from the therapist's intervention perspective that tended to relate (but not significantly) to outcome was the therapist's relationship offer, *i.e*., therapist acceptance and respect, warmth, authenticity, transparency, competency and confidence in the client's capacity to change. This result is consistent with the theoretical conceptualization of COP and of process-experiential therapies more generally, that underline the important focus on the relationship level in the very first phase of treatment for clients presenting with BPD (Breil & Sachse, 2011; Greenberg, 2002; Paivio, & Pascual-Leone, 2010; Sachse, 2003; Sachse et al., 2011). In this sense, we feel our study has shown that client processes in intake sessions are linked with relationship and outcome variables. Consistent with our result, Wong and Pos (2012) showed that in the initial sessions of experiential psychotherapies, client's self-disclosure as in-session marker of engaging in therapy predicts first session alliances (see also Pos, Greenberg & Warwar, 2009). Furthermore, in this study, early alliance was also independently and negatively predicted by pre-therapy social inhibition in a negative manner which speaks to the importance of the therapist's relationship offer from the very first therapeutic contact (Wong and Pos, 2012). Comparable results have also been found in psychodynamic

psychotherapy (Kramer, Rosciano, et al., 2011). More research on the importance of processes in intake interviews for outcome is definitely needed.

Several limitations of the present study need to be acknowledged. First, we only analyzed intake sessions and did not take into account other sessions of the ten-session treatment, nor the evolution of the clarification process. The choice of the relevant intake session was consistent with the study's aims; nevertheless, we do not know if the processes measured are stable over the course of treatment. Related to this problem were the low means and variance on the sub-scale therapist's modification of schemes in intake session. This is expected given the phase model of COP (Breil & Sachse, 2011) within which the modification of schemes are considered feasible only after the clarification process much later in treatment. However, a more restricted range in therapist variables compared to client variables may have contributed to non-significance between therapist variables and outcome. We would like also to acknowledge the vulnerability to researcher allegiance in the present study, as the first author did all process ratings, without reliability established on the present study's BBBS ratings. However, high reliability coefficients found for this rater on highly similar material argues against any bias by the current rater. Add to this the transparency of the research plan and the due diligence and caution in interpreting the results, we feel that the effect of researcher allegiance on the results presented was sufficiently controlled for and that the results may be dubbed trustworthy. Finally, low power in the present study also prevented us from performing factor analytical procedures that could draw more firm conclusions regarding structural aspects of clarification processes in psychodynamic intake sessions as measured by the BBBS.

In order to overcome some of these limitations, further studies using the BBBS should take into account the session-by-session evolution of client's and therapist's contribution to

clarification, the therapist's impact on client clarification and how the change in clarification predicts outcomes, using a multiple regression analysis. Such a design would permit finer time-linked step-by-step analyses testing the assumption that client processes lead to therapist interventions which facilitate (or impede on) further client's processes (Sachse, 1992, 1993; Sachse, & Elliott, 2002).

Several implications may be noted for the training of psychotherapists working with clients with BPD. Our data on psychodynamically-oriented therapists suggest that psychotherapy training may need to focus on process-directivity or process-guidance (Greenberg, 2002) as part of the triad relationship-focus, process-directivity and case formulation. As well, the results suggest that the systematic interactional-game process analysis, based on the model of dual action regulation presented above (Sachse, 2003) is one possible method for informing highly relevant case formulation for clients with BPD. In addition, from an integrative perspective, we wish to also point to the use of Plan Analysis in the process of case formulation which is consistent to some extent with the COP-model (Caspar, 2007). In particular when working with these clients with BPD, supervision of early sessions is likely to require this focus on the relationship level. Finally, what is indicated here, and contrary to the practice and training of some therapists working with client-centered models, therapist appear to need highly specific knowledge in BPD-psychopathology, its structural and process aspects. Several heuristics within the COP-framework exist in order for the trainee psychotherapist to get some help in the pivotal task of case formulation of the problems related with BPD (see Berthoud, Kramer, de Roten, Despland, & Caspar, in press; Breil & Sachse, 2011; Sachse, Breil, & Fasbender, 2009). Therapists with basic humanistic or other forms of psychotherapy training may find such heuristics particularly helpful to apply to processes with presenting problems related with BPD.

References

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th Edition).* Washington, D. C.: Author.

American Psychiatric Association (2001). Practice Guidelines for the Treatment of Patients with Borderline Personality Disorder. *American Journal of Psychiatry, 158*, 1-52.

Benjamin, L. S. (2003). *Interpersonal Diagnosis and Treatment of Personality Disorders*. New York: Guilford Press.

Berthoud, L., Kramer, U., de Roten, Y., Despland, J.-N., & Caspar, F. (in press). Using Plan Analysis in psychotherapeutic case formulation of Borderline Personality Disorder. *Clinical Psychology and Psychotherapy*. DOI: 10.1002/cpp.784.

Breil, J., & Sachse, R. (2011). Klärungsorientierte Verhaltenstherapie bei Borderline Persönlichkeitsstörung[Clarification-Oriented Behavior Therapy for Borderline Personality Disorder]. In B. Dulz, S. Herpertz, O. F. Kernberg, & U. Sachsse (Eds.), *Handbuch der Borderline-Störungen* (2. Auflage), pp. 652-666. Stuttgart: Schattauer.

Caspar, F. (2007). Plan Analysis. In T. D. Eells (Ed.). *Handbook of Psychotherapy Case Formulations. Second Edition* (pp. 251-289). New York: Guilford Press.

Caspar, F., Grossmann, C., Unmüssig, C., & Schramm, E. (2005). Complementary Therapeutic Relationship: Therapist Behavior, Interpersonal Patterns, and Therapeutic Effects. *Psychotherapy Research, 15*(1-2), 91-105.

Coady, N. F., & Marziali, E. (1994). The association between global and specific measures of the therapeutic relationship. *Psychotherapy: Theory, Research, Practice, Training, 31*, 17-26.

Cottraux, J., Note, I. D., Boutitie, F., Milliery, M., Genouihlac, V., Yao, S. N., Note, B., Mollard, E., Bonasse, F.,Gaillard, S., Djamoussian, D., De Mey Guillard, C., Culem, A., Gueyffier, F. (2009). Cognitive Therapyversus Rogerian Supportive Therapy in Borderline Personality Disorder. Two-Year Follow-up of a Controlled Pilot Study. *Psychotherapy and Psychosomatics, 78*, 307-316.

Eckert, J., & Biermann-Ratjen, E.-M (1998). The treatment of Borderline Personality Disorder. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of Experiential Psychotherapy* (pp. 349-367). New York: Guilford Press.

Emond, C., Savard, K., Lalande, G., Boisvert, N., Boutin, M., & Simard, V. (2004). *Propriétés Psychométriques de la Mesure de l'Impact (MI-45), version francophone du Outcome Questionnaire-45 (OQ-45.2)[Psychometric Characteristics of the OQ-45, French Version]*. Presentation at the ACFAS Conference. Montreal.

Fernandez-Alvarez, H.,Clarkin, J. F., Salgueiro, M. del Carmen, & Critchfield, K. L. (2006). Participant factors in treating personality disorder. In L. G. Castonguay, & L. E. Beutler (Eds.), *Principles of Therapeutic Change that Work* (pp. 203-218). New York: Oxford University Press.

First, M. B., Spitzer, R. L., Williams, J. B. W., & Gibbons, M. (2004). *Structured Clinical Interview for DSM-IV*. New York: Biometrics Research Dpt.

Gendlin, E. T. (1978). *Focusing.* New York: Everest House.

Greenberg, L. S. (2002). *Emotion-Focused Therapy Coaching Clients to work through their Feelings.* Washington, D. C.: American Psychological Association.

Greenberg, L. S., & Paivio, S. C. (1997). *Working with Emotions in Psychotherapy*. New York: Guilford Press.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating Emotional Change. The Moment-by-Moment Process*. New York: Guilford Press.

Greenberg, L. S., & Van Balen, R. (1998). The theory of experience-centered therapies. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of Experiential Psychotherapy* (pp. 28-57). New York: Guilford Press.

Gunderson, J. G., & Links, P. S. (2008). *Borderline Personality Disorder: A Clinical Guide.* Washington, D. C.: American Psychiatric Publishing Inc.

Kramer, U. (2011). De l'importance de l'approfondissement de l'affect en psychothérapie[On the importance of deepening of affect in psychotherapy]. *Pratiques Psychologiques, 17*, 93-102.

Kramer, U., Berger, T., Kolly, S., Marquet, P., Preisig, M., de Roten, Y., Despland, J.-N., & Caspar, F. (2011). Effects of Motive-Oriented Therapeutic Relationship in Early-Phase Treatment of Borderline Personality Disorder: A pilot study of a randomized trial. *Journal of Nervous and Mental Disease, 199*(4), 244-250.

Kramer, U., Püschel, O., Breil, J., & Sachse, R. (2009). Intégrer clinique et recherche: le modèle de la clarification selon R. Sachse, *Psychothérapies, 29*(2), 67-74.

Kramer, U., Rosciano, A., Pavlovic, M., Berthoud, L., Despland, J.-N., de Roten, Y., & Caspar, F. (2011). Motive-Oriented Therapeutic Relationship in Brief Psychodynamic Intervention for Patients with Depression and Personality Disorders. *Journal of Clinical Psychology, 67*(10), 1017-1027. DOI: 10.1002/jclp.20806.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross, & M. R. Goldfried (Eds.), *Handbook of Psychotherapy Integration* (pp. 94-129). New York: Basic Books.

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3*, 249-258.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder.* New York: Guilford Press.

Paivio, S. C., & Pascual-Leone, A. (2010). *Emotion-Focused Therapy for Complex Trauma. An Integrative Approach*. Washington, D. C.: APA.

Perry, J. C., Fowler, J. C., & Semeniuk, T. T. (2005). An Investigation of Tasks and Techniques associated with Dynamic Interview Adequacy. *Journal of Nervous and Mental Disease, 193*(2), 136-139.

Pos, A. E., & Greenberg, L. S. (2012). Organizing awareness and increasing emotion regulation: Revising chair work in Emotion-Focused Therapy for Borderline Personality Disorder. *Journal of Personality Disorders, 26*(1), 84-107.

Pos, A. E., Greenberg, L. S., & Warwar, S. H. (2009). Testing a model of change in experiential treatment of depression. *Journal of Consulting and Clinical Psychology, 77*, 1055-1066.

Sachse, R. (1992). Differential effects of processing proposals and content references on the explication process of clients with different starting conditions. *Psychotherapy Research, 4*, 235-251.

Sachse, R. (1993). The effects of intervention phrasing of therapist-client communication. *Psychotherapy Research, 3*(4), 260-277.

Sachse, R. (2003). *Klärungsorientierte Psychotherapie[Clarification-Oriented Psychotherapy]*. Göttingen: Hogrefe.

Sachse, R. (2004). From client-centered to clarification-oriented psychotherapy. *Person-Centered and Experiential Psychotherapies, 3*(1), 19-34.

Sachse, R., Atrops, A., Wilke, F., & Maus, C. (1992). *Focusing. Ein emotionszentriertes Psychotherapie-Verfahren [Focusing. An emotion-focused psychotherapy treatment]*. Bern: Hans Huber.

Sachse, R., Breil, J., & Fasbender, J. (2009). Beziehungsmotive und Schemata: Eine Heuristik[Relational motives and schemes: heuristics]. In R. Sachse, J. Fasbender, J. Breil, & O. Püschel (Eds.), *Grundlagen und Konzepte Klärungsorientierter Psychotherapie* (pp. 66-88). Göttingen: Hogrefe.

Sachse, R., & Elliott, R. (2002). Process-Outcome Research on Humanistic Therapy Variables. In D. Cain & J. Seeman (Eds.), *Humanistic Psychotherapies. Handbook of Research and Practice* (pp. 83-115). Washington, D. C.: American Psychological Association.

Sachse, R., & Maus, C. (1991). *Zielorientiertes Handeln in der Gesprächspsychotherapie[Goal-orientedness in Person-Centered Psychotherapy]*. Stuttgart: Kohlhammer.

Sachse, R., Püschel, O., Fasbender, J., & Breil, J. (2008). *Klärungsorientierte Schemabearbeitung [Clarification-Oriented Schema-Modification]*. Göttingen: Hogrefe.

Sachse, R., Sachse, M., & Fasbender, J. (2011). *Klärungsorientierte Psychotherapie von Persönlichkeitsstörungen[Clarification-Oriented Psychotherapy of Personality Disorders]*. Göttingen: Hogrefe.

Sachse, R., & Schlebusch, P. (2006)(Eds.). *Perspektiven Klärungsorientierter Psychotherapie[Perspectives in Clarification-Oriented Psychotherapy]*. Lengerich: Pabst Science Publishers.

Sachse, R., Schülken, T., & Leisch, M. (2006). Die Bochumer Beziehungs- und Bearbeitungsskalen BBBS: Skalen-Prüfungen und erste Validierung[The Bochum Relationship and Process Scales BBBS: Scale-reliability and first validation]. In R. Sachse & P. Schlebusch (Eds.), *Perspektiven Klärungsorienterter Psychotherapie* (pp. 228-254). Lengerich: Pabst Science Publishers.

Sachse, R., Schülken, T., Leisch, M., & Sachse, M. (2011). Effektivität Klärungsorientierter Psychotherapie: erste Ergebnisse [Effectiveness of Clarification-Oriented Psychotherapy: first results]. In R. Sachse, J. Fasbender, J. Breil, & M. Sachse (Eds.), *Perspektiven Klärungsorientierter Psychotherapie II* (pp. 239-276). Lengerich: Pabst Science Publishers.

Sachse, R., Schülken, T., Sachse, M., & Leisch, M. (2011). Die Kurzform der Bochumer Beziehungs- und Bearbeitungsskalen BBBS-K: Skalenprüfung und Reliabilitäten [The short version of the Bochum Relationship and Process Scales BBBS-K: Scale-verification and reliabilities]. In R. Sachse, J. Fasbender, J. Breil, & M. Sachse (Eds.), *Perspektiven Klärungsorientierter Psychotherapie II* (pp. 207-225). Lengerich: Pabst Science Publishers.

Sachse, R., & Takens, R. J. (2004). *Klärungsprozesse in der Psychotherapie[Clarification processes in psychotherapy]*. Göttingen: Hogrefe.

Van Kessel, W., & Lietaer, G. (1998). Interpersonal processes. In In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of Experiential Psychotherapy* (pp. 155-177). New York: Guilford Press.

Vermeersch, D. A., Lambert, M. J., & Burlingame, G. M. (2000). Outcome Questionnaire: Item Sensitivity to Change. *Journal of Personality Assessment, 74*(2), 242-261.

Warwar, S. H., Links, P. S., Greenberg, L. S., & Bergmans, Y. (2008). Emotion-focused principles for working with Borderline Personality Disorder. *Journal of Psychiatric Practice. 14*(2), 94-104.

Wong, K., & Pos, A. E. (2012). Interpersonal processes affecting early alliance formation in experiential therapy for depression. *Psychotherapy Research.* DOI: 10.1080/10503307.2012.708794

Table 1

Mean, SD, range and Cronbach α per sub-scale

BBBS-R	Nb items	*α*	Range	Mean	SD
Client					
(1)Content	7	.79	0.14 – 4.00	1.28	1.77
(2)Process	7	.65	1.33 – 6.00	4.06	1.84
(3A)Functional relationship	3	.86	0.00 – 5.67	3.20	1.11
(3B)Interactional games	3	.70	0.67 – 5.67	3.06	1.23
Therapist					
(1)Relationship	6	.80	2.33 – 5.67	4.56	1.10
(2)Understanding	6	.71	1.33 – 5.67	3.89	1.99
(3)Process guidance	8	.85	0.25 – 4.25	1.84	1.61
(4)Treatment of avoidance	2	.45	0.00 – 3.50	0.54	0.53
(5)Treatment of games	6	.31	2.67 – 6.00	4.44	1.83
(6)Treatment of schemes	6	.43	0.00 – 0.67	0.03	0.05

Note. *α:* Cronbach alpha. Explanations of the scales in the text.

Table 2

Pearson correlations between the BBBS-R scales, symptom level at intake and symptom change after three months of treatment (n = 22)

BBBS-R	Symptom level at intake				Symptom change (residual gains)			
	Total	SD	IR	SR	Total	SD	IR	SR
Client total					.37	.32	.32	
(1)Content								
(2)Process						.45	.33	
(3A)Functional relationship						.41	.36	
(3B)Interactional games			-.46*		.50*	.51*	.48*	
Therapist total	-.52*	-.44	-.41	-.54*				
(1)Relationship							.30	
(2)Understanding	-.32		-.37	-.35				
(3)Process guidance								
(4)Treatment of avoidance								
(5)Treatment of games			.36					

Note. Are reported only correlations $r > .30$. Subscales of Outcome Questionnaire – 45.2: SD: Symptoms Distress; IR: Interpersonal Relationships; SR: Social Role

Explanations of the scales in the text.

* $p < .05$