Personality disorder and early therapeutic alliance in two time-limited therapies

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Published online: 24 Oct 2013.

To cite this article: Sumru Tufekcioglu, J. Christopher Muran, Jeremy D. Safran & Arnold Winston (2013) Personality disorder and early therapeutic alliance in two time-limited therapies, Psychotherapy Research, 23:6, 646-657, DOI: 10.1080/10503307.2013.843803

To link to this article: http://dx.doi.org/10.1080/10503307.2013.843803

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Personality disorder and early therapeutic alliance in two time-limited therapies

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(Received 22 May 2013; revised 30 August 2013; accepted 9 September 2013)

Abstract
This study examined the relationship of pre-treatment personality disorder diagnosis to the quality of early therapeutic alliance in 145 patients randomly assigned to either cognitive behavioral therapy or brief relational therapy. The pre-treatment diagnosis was established by DSM-IV (SCID) and Wisconsin Personality Inventory. Quality of the alliance was assessed by patient and therapist reports using the 12-item Working Alliance Inventory, Session Evaluation Questionnaire, and direct questions of ruptures. Results indicated that pre-treatment personality disorder as determined by SCID predicted no variables of early psychotherapy process. Factor scores yielded from a PCA of the WISPI indicated that high impulsivity, dysregulation, and lability were associated with lower patient and therapist ratings of session depth of exploration and higher patient ratings of rupture intensity.

Keywords: therapeutic alliance; personality disorders; time-limited psychotherapy

It is agreed by clinicians from diverse orientations such as the cognitive (Pretzer & Beck, 2005), interpersonal (Benjamin, 2005), attachment (Levy, 2005), and object relations perspectives (Clarkin, Yeomans, & Kernberg, 2006) that clients with personality disorders encounter difficulties with self or identity and interpersonal functioning. Patients with DSM Axis II personality disorders often seek treatment for a variety of different reasons, e.g., interpersonal problems in the social or work environment, or DSM Axis I symptoms such as anxiety or depression that lead to problems with daily functioning or both, which is more often than not the case. Further, recent empirical evidence suggests that more severe personality-disordered functioning is associated with more Axis I symptoms (DiMaggio et al., 2013). As such, treatment of personality disorders requires a balance between treatment of symptoms and interpersonal functioning. Although attending to both of these dimensions is critical for effective treatment of personality disorders, the core of personality pathology remains in interpersonal dysfunction.

A growing number of treatments have been developed for treating personality disorders. For example, in the treatment of Borderline Personality Disorder, Dialectical Behavior Therapy (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991), Mentalization-Based Therapy (Bateman & Fonagy, 1999), and Transference-Focused Psychotherapy (Clarkin, Levy, Lenzenweger, & Kernberg, 2007) have all been demonstrated to be effective. Although from different theoretical orientations, these treatments all prove to be effective in treating personality disorders, suggesting that it might be the common elements in these various approaches, rather than the modalities of treatments, that are responsible for change. Further, some recent research studies found no significant differences between various specialized treatments and general psychiatric management based on APA guidelines (Bateman & Fonagy, 2009; Chanen et al., 2008; McMain et al., 2009).

A task force of APA Division 12 and the North American Society for Psychotherapy Research identified effective principles of therapeutic change and
the common factors in different forms of therapy that are important factors in treatment of personality disorders (Castonguay & Beutler, 2006). These factors include a strong therapeutic alliance, therapist ability to repair ruptures, therapist attitude of caring, warmth and positive regard, agreement on goals, and high level of therapist activity (Critchfield & Benjamin, 2006). As such, findings of the task force suggest that one of the most important components of therapy for an effective approach to treating personality disorders would be the much-researched therapeutic alliance.

After decades of ongoing research, therapeutic alliance remains a robust predictor of outcome in psychotherapy, regardless of treatment modality (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Further, an increasing number of studies show that development and growth of the alliance precedes as well as predicts symptom improvement, especially in the beginning stages of therapy (Baldwin, Wampold, & Imel, 2007; Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Zuroff & Blatt, 2006). There is also ample evidence that weakened alliances are correlated with unilateral termination by the patient (Samstag et al., 2008). These findings suggest that the process of building and maintaining the therapeutic alliance may play an important role in treatment retention and outcome.

Empirical studies have identified a number of important patient factors that contribute to the formation of a strong alliance. For example, patient expectations of improvement have been shown to be associated with the quality of the therapeutic alliance, such that positive expectations predict stronger alliances and better overall outcome (Joyce & Piper, 1998; Joyce, Ogrodniczuk, Piper, & McCallum, 2003; Kwan, Watson, & Stermac, 2000). Patient interpersonal functioning has also been associated with stronger alliance: Patients who have a history of positive interpersonal relationships who generally perceive people as helpful and trustworthy are more likely to form strong alliances (Marmor, Weiss, & Gaston, 1989; Marziali, 1984); further, patients presenting with hostile styles have been demonstrated to have weaker alliances, and in contrast, those with friendly styles have been shown to form stronger alliance (Dunkle & Friedlander, 1996). In addition, patients who distance themselves from the therapist, who are anxious, avoidant, uncomfortable with interpersonal exchanges, and fearful of interpersonal closeness are more likely to have difficulties establishing strong alliance (Benjamin & Critchfield, 2010; Messer & Woltz, 2010; Watson & Kelogram, 2010). Other patient variables investigated include the attachment style: Numerous studies have found that client attachment accounts for a large percentage (up to 33%) of the variance in patient-rated therapeutic alliance, and that secure patient attachment is associated with stronger alliance (Eames & Roth, 2000; Justitz, 2002; Kivlighan, Patton, & Foote, 1998; Parish & Eagle, 2003; Reis & Grenyer, 2004; Satterfield & Lyddon, 1995, 1998), such that patients who have secure attachment styles are more likely to have a positive experience with their therapists compared to patients with insecure attachment styles. Patients’ object relations have also been demonstrated to be associated with therapeutic alliance. For example, patients with good object relations, a stable sense of themselves, and a good sense of self-other differentiation are more likely to establish stronger alliance (Marmar, Horowitz, Weiss, & Marziali, 1986). Finally, patient personality is another pre-treatment factor that has been found to be associated with stronger alliance. For example, personality traits such as openness, agreeableness, extraversion, and conscientiousness are associated with strong alliance, whereas the presence of personality pathology strongly predicts poor early alliance (Sharpless, Muran, & Barber, 2010).

Empirical evidence suggests that patients with personality disorders present with longstanding and inflexible patterns of emotional and interpersonal difficulties (Benjamin, 1993; Livesley, 2001; Millon & Davis, 1996), which invariably pose great challenges to psychotherapists, especially with regard to the negotiation of the therapeutic alliance (Benjamin & Karpik, 2002). Therapists are more likely to encounter ruptures in the therapeutic alliance with personality-disordered patients, given the emotional lability or constriction of these patients that makes empathy difficult, as well as their restricted range of interpersonal behavior that elicits certain behavioral responses from therapists, which in turn confirm and perpetuate patients’ pathogenic beliefs.

In particular, as Muran, Segal, Samstag, and Crawford (1994) found in their study of short-term cognitive therapy, clients with a tendency toward hostile, dominant interpersonal behaviors, which are characteristic of Cluster B PDs, might have difficulty establishing a good alliance. Further, outcome research has shown that patients with personality disorders are especially challenging and resistant to treatment, resulting in more negative process, higher attrition rates, and greater treatment length (Benjamin & Karpik, 2001; Clarkin & Levy, 2004;
Westen & Morrison, 2001). This is particularly significant, given that patients diagnosed with personality disorders in our clinic and practices are as many as 45% (Zimmerman, Chelminski, & Young, 2008).

More recent studies of interpersonal patterns in personality disorders demonstrate the presence of multidimensional characteristics (Dimaggio, Salvatore, et al., 2012). As such, personality-disordered patients are observed, regardless of the particular type of disorder, to present with the following characteristics: (a) poor metacognition, difficulties understanding states of mind or mentalization regarding self and other (Bateman & Fonagy, 2004; Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007), (b) dysfunctional constructions of self-with-other relationships such as self as not lovable, unworthy, guilty, omnipotent, and betrayed, and other as rejecting, abusing, etc. (Benjamin, 1996), and (c) emotion and impulse dysregulation (Linehan et al., 1991) or over-regulation (Linehan et al., 1991), all of which pose serious challenges to interpersonal functioning and relations.

In examining the therapeutic alliance with personality-disordered clients, a particular issue that requires further consideration is that each type of personality disorder produces its own type of interpersonal challenge. Bender (2005) suggests that each type of personality disorder poses different challenges to forming a working alliance in psychotherapy and outlines specific challenges for each DSM cluster of personality disorder (APA, 1994) as follows: Cluster A PDs, the so-called odd eccentric cluster, demonstrate a profound impairment in interpersonal relationships, often with paranoid characteristics. In negotiating the therapeutic alliance, these patients pose challenges to their therapists, such as suspiciousness of the therapist’s intentions, profound interpersonal discomfort with the therapist, emotional aloofness, and hypersensitivity to perceived criticism. Cluster B PDs, the “dramatic” cluster, is associated with pushing the limits and poses challenges to the therapeutic alliance such as extremely demanding behavior, unstable emotional states, proneness to acting out, and need for constant approval. Cluster C PDs, the “anxious” cluster, are observed to be emotionally inhibited and averse to interpersonal conflict. Building alliance with these clients involves certain specific challenges, as they would likely be overly compliant, thereby foreclosing possibilities of building an authentic therapeutic relationship.

Further, it has been observed that patients with different types of PDs within the Cluster C group present with different challenges in establishing alliance. For example, some Cluster C patients such as dependent and obsessive-compulsive PDs may seem to form a positive and cooperative relationship with the therapist early on in therapy, while avoidant PDs may be quite difficult in terms of building rapport, keeping the patients in therapy, and repairing ruptures. Further, clinical observations suggest that Cluster C patients are typically emotionally constricted, have difficulties in naming emotions and using emotions as a reliable source of information, and have difficulty focusing on how they feel in the here-and-now of interpersonal interactions (Dimaggio, Attinà, Popolo, & Salvatore, 2012). In summary, Cluster C patients, while seemingly compliant and cooperative in therapy, are by no means easy in treatment as they pose specific challenges to therapists in building and maintaining therapeutic alliance. In addition to the above-noted clinical observations in building alliance with patients with personality disorders, some empirical studies have examined the challenges in forming therapeutic alliance in therapy that are unique to different types of personality disorders. For example, Bradley, Heim, and Westen (2005) have studied the structure of patient relational patterns in psychotherapy and their relation with DSM-IV personality disorder symptoms in a sample of 181 experienced clinicians. Exploratory factor analysis identified five transference dimensions: angry/entitled, anxious/preoccupied, avoidant/counterdependent, secure/engaged, and sexualized. Consistent with the hypotheses, cluster A (odd/ eccentric) disorders were found to be associated negatively with the secure/engaged factor, cluster B (dramatic/erratic) disorders were found to be associated with angry/entitled and sexualized factors, and cluster C (anxious/fearful) disorders were found to be associated with anxious/preoccupied transference (Bradley et al., 2005).

The purpose of this study was to examine the relationship of pre-treatment personality pathology to the nature of early psychotherapy process with a sample of outpatients (some diagnosed with Cluster C or PD NOS on Axis II and others with no Axis II diagnosis) in two time-limited psychotherapies: Cognitive behavioral therapy and brief relational therapy. The data were derived from the archives of the Brief Psychotherapy Research Program at the Beth Israel Medical Center in New York City. The psychotherapy process was evaluated with regard to the quality of the working alliance (including alliance rupture), session impact (including depth of exploration and session quality) in the first six sessions, as well as premature termination.

We aimed to answer the following research questions: Will the psychotherapy process with personality-disordered patients be more negative, involving lower patient and therapist ratings of early psychotherapy process? We hypothesized that personality
disorder in general would predict poorer alliance, more ruptures, poorer session impact, and premature termination. Further, we asked: Will there be differences between the different types of personality disorder regarding early process? We anticipated that certain interpersonal characteristics associated with certain specific types of personality disorders would predict better process and that others would not. Based on previous studies (e.g., Gerstley et al., 1989; Muran et al., 1994), we hypothesized thatpatients with Cluster B personality pathology (i.e., patients with a tendency towards hostile, dominant interpersonal behaviors, more impulsivity and liability characteristic of Cluster B) have more problematic early process. Given our sample included only patients with and without Cluster C and NOS Axis II diagnoses, we aimed to answer this research question by including a dimensional measure of personality disorder.

Methods

Participants

The data analyzed in this study are based on data collected in a previous study over an 8-year period from 1992 to 2000, regarding 145 outpatients who were sequentially admitted into a psychotherapy research program at a major metropolitan medical center in New York City. Some of these patients (i.e., those diagnosed with personality disorders) were included in a previously published study (Muran, Safran, Samstag, & Winston, 2005).

Patients. The patients included 64 men and 86 women (N = 145), ranging in age from 22 to 69 (M = 41.33, SD = 10.52). Fifty-eight percent of the patients were diagnosed with Personality Disorders, and 42% did not have diagnoses of any Personality Disorders. Among the patients diagnosed with one or more Personality Disorders (n = 84), ranging in age from 22 to 69 (M = 41.79, SD = 10.844), 50% were men, 50% were women. Forty-six percent of the patients were single, never married, 32% married or remarried, 21% divorced or separated, and 1% widowed. Seventeen percent were high-school graduates, 52% college graduates, and 31% had graduate degrees. Eighty-four percent were employed. Eighty-five percent were white, 1% black, 7% Latino, 5% Asian or Pacific Islander, and 2% other. Thirty-six percent were Christian, 26% Jewish, 30% none, and 8% other. Fifty-four percent received CBT treatment, while 46% received BRT treatment. The patients presented with a myriad of longstanding difficulties related to depression, anxiety, and interpersonal functioning. Fifty-six percent met criteria for a current primary diagnosis of Mood Disorder, 25% Anxiety Disorder, 9% V-Code, 3% Adjustment Disorder, and 7% other on Axis I of DSM-IV (APA, 1994); and 46% met criteria for multiple Axis I diagnoses. The principal inclusion criterion was that they met a diagnosis of Personality Disorder (PD) Cluster C or Not Otherwise Specified (NOS) on Axis II. To qualify for PD-NOS diagnosis, a patient needed to be sub-threshold on more than one personality disorder. More specifically, a patient is sub-threshold on a particular personality disorder if he/she rates: (a) 1 or 2 fewer scores of “3” or “yes,” the patient shows this features” than are needed for that diagnosis; (b) the patient scores “2” or “maybe” on the number of features needed for a full diagnosis; (c) the patient scores “2” or “maybe” on 1 or 2 fewer features than needed for diagnosis; (d) a mixture of 2s and 3s but not enough 3s for a full diagnosis. We focused on Cluster C patients rather than Cluster A or B personality-disordered patients because of a concern that patients meeting criteria for A or B diagnoses would be more likely to need a longer-term therapeutic approach. Sixty-two percent met criteria for a diagnosis of PD NOS, 21% Avoidant PD, 12% Obsessive–Compulsive PD, 5% Depressive PD; and 18% met criteria for multiple Axis II diagnoses (see below for how DSM diagnoses were established). They were randomly assigned to the treatment conditions in blocks (i.e., one treatment condition at a time).

Patients who were not diagnosed with one or more Personality Disorders (n = 61) ranged in age from 23 to 63 (M = 34.25, SD = 11.92); 69% were women, 31% were men. Fifty-four percent of the patients were single, never married, 22% married or remarried, and 24% divorced or separated. Nineteen percent were high-school graduates, 48% college graduates, and 30% had graduate degrees. Seventy-nine percent were employed. Eighty-one percent were white, 10% Black, 3% Latino, and 3% other. Forty-nine percent were Christian, 21% agnostic, 8% Buddhist, 2% atheist, and 20% other. Forty-nine percent percent received CBT treatment, while 51% received BRT treatment. The patients presented with difficulties related to depression, anxiety, and other Axis I disorders. Forty-three percent met criteria for a current primary diagnosis of Mood Disorder, 13% Anxiety Disorder, 27% V-Code, 8% Adjustment Disorder, and 9% other on Axis I of DSM–IV (APA, 1994); and 57% met criteria for multiple Axis I diagnoses.

Exclusion criteria included evidence of organicity, psychosis, mania, impulse control and compulsive disorder, and any current substance use disorder; patients on psychotropic medication or in another psychosocial treatment were also excluded to better
isolate the effect of psychotherapy. Patients provided informed consent with respect to the parameters of the research protocol. They also paid a nominal fee per session based on an income-sensitive sliding scale in order to approximate a naturalistic treatment setting, but there was no fee for the intake evaluation.

**Therapists.** The 145 cases included 98 therapists (34% men and 66% women), ranging in age from 25 to 55 (M = 34.45, SD = 6.311), who were clinical psychologists (24%), psychiatry attendings (10%), social workers (8%), and psychology interns and externs (58%) in a psychiatry department at the major metropolitan medical center. Ninety-three percent of the therapists were White, 1% Black, 1% Hispanic, 2% Asian, and 2% other. Fifty-nine percent were single, never married; 39% married or remarried, and 2% divorced or separated. Forty-seven percent were Jewish, 18% Christian, 11% other, and 24% reported no religious affiliation. Clinical experience averaged 3.13 years (SD = 5.316). Ninety-four percent of the therapists had been in personal therapy. Therapists also provided informed consent with respect to the parameters of the research protocol.

**Treatment Models and Training Procedure**

Two treatment models were used in this study: Brief Relational Therapy (BRT) and Cognitive-Behavioral Therapy (CBT). The two treatment models were manualized and designed to treat patients in a fixed 30-session, one-session-per-week format. Therapists were only permitted to participate in one treatment condition. All the psychotherapy sessions were videotaped. All sessions were conducted at an outpatient mental health clinic in a general hospital setting. Below are brief descriptions of the treatments.

**Cognitive-behavioral therapy.** The cognitive-behavioral therapy (CBT; Turner & Muran, 1992) is a schema-focused model (Beck, Freeman, & Associates, 1990) that was designed to treat personality disorders and begins with the establishment of a case formulation, in which a core belief system is defined (Persons, 1989). The treatment protocol then entails two intervention phases: (a) Symptom Reduction, in which the Axis I conditions are addressed, and (b) Schema Change, in which core beliefs are modified or restructured. Both phases include traditional cognitive-behavioral strategies, including self-monitoring, cognitive restructuring, behavioral exercises and experimentation. The therapeutic relationship is founded on the principle of “collaborative empiricism” (Beck, Rush, Shaw, & Emery, 1979), and alliance ruptures are typically approached as examples of patients’ presenting problems (Newman, 1998).

**Brief relational therapy.** Brief relational therapy (BRT: Muran & Safran, 2002; Safran, 2002; Safran & Muran, 2000) is a model that integrates principles primarily from relational psychoanalysis and humanistic psychotherapy (see Safran, Muran, Samstag, & Winston, 2005, for more detail). It has also been greatly informed by our research on rupture resolution (Safran & Muran, 1996). BRT places greater emphasis on process than the other model and eschews establishing a case formulation early in treatment. It is oriented toward cultivating awareness of self in relation to other rather than resolving a central conflict or correcting an irrational belief. Its primary task is to track alliance ruptures and engage the patient in a process of metacommunication (e.g., establish a communication about the communication process) in order to bring awareness to bear on what is going on unwittingly in the therapeutic relationship (in other words, on the implicit negotiation between patient and therapist with regard to their respective needs). BRT is essentially based on a social constructionist model of the therapeutic relationship, whereby ruptures and their resolution are understood as co-participatory processes involving both patient and therapist. Because of its intensive focus on interpersonal process and functioning, it is considered a treatment for personality disorder.

**Training procedure.** All therapists attended a 90-minute weekly case seminar throughout their participation in the study. Each seminar was co-led by two senior supervisors. Therapists also received 1-hour weekly individual supervision by a senior supervisor for their first case. Those who were unlicensed continued in individual supervision. Both supervision formats made extensive use of the videotaped psychotherapy sessions. Training in CBT was primarily didactic in orientation, and CBT supervision instructed therapists on establishing a case formulation and developing various cognitive-behavioral change strategies. In contrast, the supervision process in BRT had an experiential orientation involving intensive exploration of therapist internal experience through the use of various awareness exercises in order to facilitate metacommunication.

**Measures and Assessment Procedure**

**Diagnostic status.** The Structured Interview for DSM–IV-Axis I & II (SCID: First, Spitzer, Gibbon, & Williams, 1995) was used to establish the diagnostic status of each patient. The SCID is a
Treatment fidelity. The extent to which therapists conducted the treatments according to the respective manuals was assessed by the Beth Israel Fidelity Scale (BIFS), a 44-item measure scaled in a Likert-type format and derived from an interpersonal perspective on the DSM-III-R model of PDs. It includes 11 PD subscales. Some normative data and adequate psychometric properties have been reported. In this study, the overall mean score for each cluster of PD was used to determine diagnostic status. The rationale for the use of this measure was to address the criticism that has been made against the categorical system, including the arbitrary cutoff points for the diagnosis of personality disorders (Widiger, 1993). This measure includes dimensional ratings of the DSM Axis II categories.

Treatment process. Patients paid a session fee, on a sliding scale based on their income, to ensure external validity. After every session, patients and therapists were asked to complete parallel forms of a postsession questionnaire (PSQ: Muran, Safran, Samstag, & Winston, 1992), which consists of several measures assessing session impact and the therapeutic alliance. Patients were assured that their therapists would not have access to their responses to the PSQ. They were also provided with identification numbers, a private area to complete the measure, and a deposit system of locked mailboxes for completed questionnaires in order to ensure the confidentiality of their reports and to increase the probability of accurate reporting. PSQ data collected from the first six sessions were used in this study as evidence of early psychotherapy process. Completion rates for the PSQ across the first six therapy sessions ranged from 70% to 86% for patients and from 74% to 92% for therapists. The focus was on early psychotherapy process—postsession ratings of the first six sessions of 30-session treatment protocols—because the quality of the alliance as measured early in treatment has been shown to be the most predictive of outcome (Horvath & Symonds, 1991) and because the preponderance of dropouts occur within the first few sessions of treatment, with several studies finding a median length of treatment of about six sessions (Garfield, 1994).

The PSQ includes two measures that have been widely used in psychotherapy research and have demonstrated sound psychometric properties, including internal consistency and predictive validity with regard to a variety of overall outcome indices. One is the 12-item version of the Working Alliance Inventory (WAI: Tracey & Kokotovic, 1989), from which an overall mean score can be calculated. The other is the 12-item Session Evaluation Questionnaire (SEQ: Stiles, 1980), which is a measure of session impact scaled according to a semantic differential and yields two subscales regarding session smoothness (or quality) and depth of exploration. The overall mean of the WAI and the SEQ smoothness and depth subscales (SEQ/S and SEQ/D) were used as standard measures of psychotherapy process in this study. These measures were averaged across the six sessions. Additionally, treatment process was examined by rupture intensity as measured by session-by-session therapist and patient reports of ruptures in the therapeutic alliance, and treatment completion (i.e., completion of all 30 sessions of the treatment protocol) or patient compliance to protocol. In this regard, cases were categorized as completed or dropped out. Drop-out status was defined as termination before the contracted 30 sessions and unilaterally determined by the patient; premature termination resulting from a change in location of residence was not considered dropout.
Results

Preliminary Analyses

We tested to see if there were any demographic differences between the PD and non-PD samples and found nothing significant. We also tested to see if there were any differences between the treatment conditions with regard to the ratings on the measures of early psychotherapy used in the study and again found no differences. As result of the absence of between-condition differences and with the aim to increase the power of our subsequent statistical analyses, we combined the treatment conditions.

Analysis by SCID Diagnosis

We first examined the relationship between pre-treatment Axis II diagnosis and early psychotherapy process variables, based on DSM-IV diagnosis using The Structured Interview for DSM-IV-Axis I & II (SCID: First et al., 1995) to establish the diagnostic status of each patient. The results from a series of two-factor ANOVAs indicated that the patients with Axis II pre-treatment diagnosis (PD) reported significantly higher session depth (SEQ/D) and session smoothness (SEQ/S), as compared to the patients without an Axis II diagnosis (non-PD). The PD group of patients also reported significantly higher in-session rupture intensity (RPI). There was no significant difference on the Working Alliance (WAI). Table I presents the means and standard deviations on the patient reports of psychotherapy process variables, i.e., working alliance (WAI), session depth (SEQ/D), session smoothness (SEQ/S), and session rupture intensity (RPI).

The results from a series of two-factor ANOVAs indicated that therapists reported significantly higher session depth (SEQ/D) with the PD group as compared to the non-PD group. The working alliance ratings (WAI) from therapist reports were significantly higher with the non-PD group. In addition, WAI and SEQ/S ratings from therapist reports were significantly higher with the PD group in the CBT treatment condition. There was no other significant difference between the two treatment conditions. There was no significant difference between the PD and non-PD groups with respect to drop-out rates. Table II presents the means and standard deviations on the therapist reports of psychotherapy process variables, i.e., working alliance (WAI), session depth (SEQ/D), session smoothness (SEQ/S), and session rupture intensity (RPI).

Analysis by WISPI Diagnosis

To reduce the number of tests and experiment-wise error rate, we conducted a principal component analysis with varimax rotation with forced three-factor solution to test whether three personality clusters emerged. Table III presents the WISPI rotated component matrix. We interpreted the three diagnostic clusters that emerged as: component 1: guarded/detached; component 2: impulsive/dysregulated; component 3: anxious/controlling. We then correlated the emergent component scores to the psychotherapy process measures. The resulting correlation matrix is presented in Table IV. In sum, the results indicate statistically significant negative correlations between WISPI diagnostic component 2 and patient-rated SEQ/D, likewise between WISPI diagnostic component 2 and therapist-rated SEQ/D, such that a higher score on WISPI diagnostic component 2 was correlated with lower ratings of session depth. Significant positive correlations were found between WISPI diagnostic component 2 and patient-rated RPI, such that a higher score on WISPI diagnostic component 2 was correlated with higher ratings of rupture intensity. The number of significant findings regarding the WISPI modeling exceeded what would be expected by chance.

Discussion

The results of this study regarding the predictive relationship of patient personality disorder to early psychotherapy process differed depending on the measures used. In sum, personality disorder as determined by the SCID indicated no predictive relation to any of the variables measured concerning early psychotherapy process, while factor scores yielded from a PCA of the WISPI indicated some predictive relationship: Specifically, higher factor scores suggesting high impulsivity, dysregulation, and lability were associated with lower ratings of patient-reported and therapist-reported session depth of exploration, as well as with higher levels of patient-reported in-session rupture intensity. Limitations to the study findings include the nature and size of the sample, the setting and treatments of the research clinic, and the various measures and
procedures used: Many of these factors will be discussed below.

The study results should be considered in light of the DSM conceptualization of personality disorder. Both the SCID and WISPI were developed based on this conceptualization. The DSM defines personality disorders within a categorical, hierarchical taxonomic system. This diagnostic approach has its origins in Kraepelinian assumptions about mental illness as conditions that are discrete with clear boundaries between normality and pathology. It has been questioned whether this approach adequately and accurately captures “the true nature” of personality disorders (Livesley, 1985; Trull & Durett, 2005; Widiger & Frances, 1985). For example, findings from empirical studies indicate that: (a) there is a great deal of comorbidity among PD diagnoses (Clark, 2007; Oldham, Skodol, Kellman, Hyler, & Rosnick, 1992); (b) Axis II diagnoses do not appear to be stable over time (Trull & Durrett, 2005); (c) poor diagnostic agreement among different diagnostic instruments is very common (Trull & Durrett, 2005). These findings suggest that personality disorders may not be as distinct diagnostic entities as it is assumed by the DSM conceptualization of PDs. Based on these findings, it has been argued that the DSM formulation of PDs is substantially flawed, and many alternatives have been suggested (Bornstein, 1997; Clark, 2007; Hopwood et al., 2011; Krueger et al., 2011; Widiger & Mullins-Sweat, 2009).

Empirical evidence shows that the characteristics that pertain to personality disorders in general seem to be multidimensional (Dimaggio, Salvatore, et al., 2012). Personality-disordered patients are observed, regardless of the particular type of disorder, to present with constricted and inhibited personality traits such as (a) poor metacognition (Bateman & Fonagy, 2004; Dimaggio et al., 2007); (b) dysfunctional constructions of self-with-other relationships such as self as not loveable, unworthy, guilty, omnipotent, and betrayed, and other as rejecting, abusing, etc. (Benjamin, 1996); and (c) emotion and impulse over-regulation (Linehan et al., 1991). For example, a patient might have poor metacognition while also presenting with negative constructions of self with others. This multidimensional aspect of

### Table II. Therapist-rated means, standard deviations, and results from ANOVAs on the process variables.

<table>
<thead>
<tr>
<th></th>
<th>PD M (SD)</th>
<th>Non-PD M (SD)</th>
<th>Main: diagnosis F value (df)</th>
<th>ES (r)</th>
<th>Main: treatment F value (df)</th>
<th>ES (r)</th>
<th>Interaction: Dx by Tx F value (df)</th>
<th>ES (r)</th>
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<tbody>
<tr>
<td>WAI</td>
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<tr>
<td>CBT</td>
<td>4.87 (.53)</td>
<td>4.84 (.65)</td>
<td>6.01 (1,144)*</td>
<td>.20</td>
<td>5.21 (1,144)*</td>
<td>.19</td>
<td>7.25 (1,144)**</td>
<td>.22</td>
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<tr>
<td>BRT</td>
<td>4.34 (.66)</td>
<td>4.88 (.69)</td>
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<td>SEQ-D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>4.91 (.65)</td>
<td>3.83 (.30)</td>
<td>148.50 (1,144)**</td>
<td>.71</td>
<td>5.34 (1,144)*</td>
<td>.19</td>
<td>2.15 (1,144)</td>
<td>.12</td>
</tr>
<tr>
<td>BRT</td>
<td>4.61 (.46)</td>
<td>3.76 (.27)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEQ-S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>4.51 (.68)</td>
<td>4.09 (.25)</td>
<td>3.88 (1,144)</td>
<td>.16</td>
<td>5.58 (1,144)*</td>
<td>.19</td>
<td>7.93 (1,144)**</td>
<td>.23</td>
</tr>
<tr>
<td>BRT</td>
<td>4.07 (.57)</td>
<td>4.14 (.25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RPI</td>
<td>2.79 (.79)</td>
<td>2.64 (.69)</td>
<td>1.55 (1,75)</td>
<td>.14</td>
<td>2.27 (1,75)</td>
<td>.17</td>
<td>5.68 (1,75)*</td>
<td>.27</td>
</tr>
</tbody>
</table>

* * < .05; ** < .01.

### Table III. WISPI rotated component matrix.*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>−.34</td>
<td>1.44</td>
<td>.654</td>
<td>.568</td>
<td>.050</td>
</tr>
<tr>
<td>Schizoid</td>
<td>−.34</td>
<td>1.76</td>
<td>.612</td>
<td>.136</td>
<td>−.157</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>−.48</td>
<td>.96</td>
<td>.656</td>
<td>.435</td>
<td>.135</td>
</tr>
<tr>
<td>Histrionic</td>
<td>−.51</td>
<td>1.54</td>
<td>.181</td>
<td>.811</td>
<td>.223</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>−.75</td>
<td>1.16</td>
<td>.717</td>
<td>.414</td>
<td>.166</td>
</tr>
<tr>
<td>Antisocial</td>
<td>−.23</td>
<td>1.52</td>
<td>.199</td>
<td>.859</td>
<td>−.086</td>
</tr>
<tr>
<td>Borderline</td>
<td>−.01</td>
<td>1.47</td>
<td>.500</td>
<td>.648</td>
<td>.118</td>
</tr>
<tr>
<td>Avoidant</td>
<td>−.14</td>
<td>1.35</td>
<td>.883</td>
<td>.050</td>
<td>.122</td>
</tr>
<tr>
<td>Dependent</td>
<td>−.35</td>
<td>1.30</td>
<td>.470</td>
<td>.351</td>
<td>.609</td>
</tr>
<tr>
<td>Obs-compulsive</td>
<td>−.11</td>
<td>1.59</td>
<td>−.068</td>
<td>−.002</td>
<td>.898</td>
</tr>
<tr>
<td>Passive-aggressive</td>
<td>−.23</td>
<td>1.39</td>
<td>.690</td>
<td>.395</td>
<td>.105</td>
</tr>
</tbody>
</table>

* Extraction method: principal component analysis.
  Rotation method: varimax with Kaiser normalization.

* Rotation converged in four iterations.
personality disorder necessitates a conceptualization that takes into consideration the multiple dimensions of personality-disordered functioning. Although the WISPI was originally developed to provide dimensional ratings of the DSM PD categories, our PCA of WISPI ratings (which was conducted to reduce experiment-wise error rate) provided a reconceptualization to some extent that yielded significant findings. This result is an interesting contrast to what was found with the SCID categorization and provides some support for using multidimensional measures of personality disorder based on a conceptualization other than DSM. Of course, the findings based on the WISPI and the patient-rated PSQ should be viewed with caution due to the shared method variance and the possibility of artificially inflated correlations between these two instruments.

Despite concerns regarding DSM and the SCID cited above, our findings should also be interpreted in light of the fact that our PD sample included Cluster C and PD NOS patients. Accordingly, our findings regarding the predictive relationship of SCID Axis II diagnosis to early psychotherapy process provides some support for Bender’s (2005) suggestion that these patients are easier to build an alliance with because of their overly compliant disposition. This suggestion is furthered when considering the use of patient self-report of early alliance: In Muran et al. (1994), friendly-submissive patients were found to report better early alliance, and as a result the authors raised the question as to whether patient-rated alliance measures are rating compliance, rather than alliance. As Bender (2005) suggested, Cluster C patients may especially be disposed to avoiding or denying problems that may threaten the therapeutic relationship. As highlighted by Safran and Muran (2000), compliance invokes the notion of pseudo-alliance and raises the question regarding the match between concept and method: In this case, can the therapeutic alliance truly be measured by patient self-report? The value of patient self-report of the alliance becomes more questionable when one considers that a typical characteristic of PD is poor self-awareness and poor metacognition, especially in the early phases of treatment. The collection of patient ratings later in treatment and the use of an observer-based measure (e.g., Colli & Lingiardi, 2009; Eubanks-Carter, Muran, & Safran, 2009; Samstag, Safran, & Muran, 2006) may address and shed some light on this question.

It also seems worthwhile to explore in future studies how different treatment models consider and approach patient compliance, or, put more precisely, over-compliance, as a reflection of Cluster C personality disorder and the notion of pseudo-alliance. In other words, how would a highly structured treatment, such as many cognitive-behavioral therapies and even some short-term dynamic models, where the therapist assumes a relatively more active-directive stance and patient compliance would be greatly appreciated, aim to affect change in such a problematic interpersonal pattern? It is reasonable such treatments might misconstrue over-compliance as purposeful collaboration. It is also possible such compliance might result in a patient report of good outcome, at least in the immediacy of termination (maybe less likely at long-term follow-up). However, this perspective requires empirical investigation.

Further interpretations of our findings concern our examination of the early psychotherapy process (first six sessions) as opposed to later stages of treatment. Considering that PD patients often present in therapy with Axis I symptoms such as mood and anxiety disorders (e.g., 82% of our sample of patients with PDs), it could be argued that patients with PDs tend to focus on their symptoms in the early sessions and to receive some relief from symptoms, which could lead to reporting positive process. However, as therapy progresses in the later sessions, more problematic relational patterns emerge and adversely affect the therapeutic alliance—even though it is also

### Table IV. Correlations of pre-treatment and early process measures.

<table>
<thead>
<tr>
<th>Pre-treatment diagnosis</th>
<th>WAI</th>
<th>SEQ/D</th>
<th>SEQ/S</th>
<th>RPI</th>
<th>WAI</th>
<th>SEQ/D</th>
<th>SEQ/S</th>
<th>RPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1</td>
<td>−.10</td>
<td>−.04</td>
<td>−.07</td>
<td>.01</td>
<td>−.07</td>
<td>.01</td>
<td>−.03</td>
<td>.07</td>
</tr>
<tr>
<td>Component 2</td>
<td>.08</td>
<td>−.25**</td>
<td>−.07</td>
<td>.24*</td>
<td>−.10</td>
<td>−.20*</td>
<td>−.08</td>
<td>−.03</td>
</tr>
<tr>
<td>Component 3</td>
<td>−.05</td>
<td>−.11</td>
<td>−.06</td>
<td>.15</td>
<td>−.04</td>
<td>−.04</td>
<td>−.02</td>
<td>−.10</td>
</tr>
</tbody>
</table>

Note. Component 1 = WISPI diagnostic cluster 1 (guarded/detached); Component 2 = WISPI diagnostic cluster 2 (impulsive/dysregulated); Component 3 = WISPI diagnostic cluster 3 (anxious/controlling); SEQ/D = Session Evaluation Questionnaire–Depth of Exploration Subscale; SEQ/S = Session Evaluation Questionnaire–Smoothness Subscale; WAI = Working Alliance Inventory (Overall Mean); RPI = rupture intensity.

* p < .05; ** p < .01.
important to consider that the therapists were trained to treat personality disorders. Thus it will be important in future studies to examine middle and later therapy process with PDs. Additionally, some pre-treatment patient variables that were shown to be relevant to PDs and important for consideration in the treatment of this group of patients, such as poor metacognition, were not directly examined in our study and would be another area to examine in future studies. Finally, another variable to investigate further that has been shown to impact the therapy relationship is symptom severity and overall PD severity as measured by number of criteria (Dimaggio et al., 2013; Verheul, Bartak, A., & Widiger, 2007).

In conclusion, it is noteworthy that we found a relationship of high impulsivity, dysregulation, and liability to negative early therapy process in a sample of Cluster C PD, PD NOS and non-PD patients, and it should be worthwhile to explore this relationship in a sample including Cluster B patients who should evidence such behavior more demonstrably. In short, this study highlights the complexity and difficulty of not only establishing but also studying therapeutic alliance with this type of personality-disordered patients.

Funding
The research was supported in part by a grant from the National Institute for Mental Health MH50246.

References


Paper presented at the Annual Meeting of the Society for Psychotherapy Research, Pittsburgh, PA.


