

The Pennsylvania State University

The Graduate School

College of the Liberal Arts

**EARLY ALLIANCE AND DROPOUT**

A Thesis in

Psychology

by

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Submitted in Partial Fulfillment  
of the Requirements  
for the Degree of

Doctor of Philosophy

May 2005

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## ABSTRACT

In this study, we attempted to identify interactions that characterize alliance ruptures in the early sessions. Neither disaffiliative interactions (i.e., traditional rupture markers) that distinguished good from poor outcome cases in previous studies, nor affiliative interactions that we proposed to uniquely characterize ruptures in the early sessions distinguished early dropouts from treatment continuers. Sheer verbosity during the session did not distinguish dropouts from continuer clients. Furthermore, aggregate measures of affiliation did not distinguish client-therapist dyads that terminated treatment from those that persisted with treatment beyond a few sessions. However, when a therapist engaged in any disaffiliative interaction, the client was more likely to discontinue with treatment than if the therapist did not. This was the case only when a more liberal definition of disaffiliation was employed, i.e., when ambiguously disaffiliative interactions were grouped with clearly disaffiliative interactions. Clinical and research implications are discussed.

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### Acknowledgements

To my mate, Daniel Shanfield, who, at once, urges me to dance at the edge and holds me close. To the *maestro*, Louis Castonguay, for sensitive orchestration. To dad and mom, I may never know the depth of my indebtedness to you.

*Nagmamahal,*

Gia

## INTRODUCTION

### **Early Alliance and Dropout**

Knowing whether or not a client will return for another session and understanding why she does not are questions that vex clinicians and researchers alike. Unarguably, dropouts are a heterogeneous group, with numerous client, therapist, treatment, and relational variables accounting for such attrition (Kazdin, 1994). Despite the multiple factors that seem to be related to dropout, empirical inquiry has largely focused on demographic variables. As demonstrated in a recent meta-analysis, however, demographic qualities of client and therapist alike are poor predictors of attrition (Reis & Brown, 1999). Echoing earlier observations made by Weirzbicki and Pekarik (1993), Reis and Brown (1999) surmised that demographic characteristics are related to dropout inasmuch as they reflect client-therapist differences that impinge on the development of a therapeutic relationship. In other words, perhaps the variance in treatment progress (i.e., dropout or continuance) seemingly accounted for by individual traits is, more precisely, indicative of client-therapist relational characteristics. It is ironic that that which may be least helpful in understanding the phenomenon of dropout, i.e., demographic characteristics, has been studied the most while that which holds more promise, i.e., relational variables, has received far less attention.

### **Early Dropout as a Manifestation of Alliance Rupture**

Despite the lack of empirical attention, dropout has often been conceptually related to client-therapist relational variables. In his seminal formulation of the alliance, Bordin (1979) characterized dropout as a manifestation of a poor alliance. For Safran, Crocker, McMain and Murray (1990), strains in the relationship, left unchecked, can



precipitate dropout. Thus, dropout has been regarded as an extreme, albeit terminal, form of an alliance rupture.

Client-therapist relationship issues may play a particularly important role in early treatment dropout. Compared to later in treatment, clients who dropout in the early sessions are more likely to report negative therapy experiences as their reason for ending treatment. As reported by Hynan (1990), early terminators more frequently end treatment because of a sense that therapy is not going anywhere, therapy does not seem useful, or because of negative feelings toward the therapist. Furthermore, compared to clients who do not fare well after completing treatment, clients who dropout in the early sessions are suspected to experience breaches in the alliance more often and more severely (Bordin, 1979). Early termination may result when a crisis cannot be sustained by a fledgling relationship (Frayn, 1992). The client-therapist relationship in the early sessions may be more delicate than what is typically referred to as the therapeutic relationship.

Understanding the role of relational issues in the early phase of treatment is especially important considering the large number of early terminators. In fact, a glaring 30-40% of individuals who initiate treatment attend no more than three sessions, with the rate of dropout significantly diminishing thereafter (Elkin, Shea, Watkins, 1989; Frayn, 1992; Garfield, 1994). Perhaps clients are more prone to dropping out in the early sessions precisely because of the delicacy of the nascent alliance. Furthermore, whereas disruptions in the later sessions may damage the existing alliance, the risk in the early sessions is not simply the arrested development of the alliance, but perhaps the derailment of treatment altogether.

### **Uniqueness of the Alliance in the Early Sessions**

As previously proposed (Maramba, 2001), alliance ruptures, or strains, in the early session can be distinguished from those that occur in the later sessions in three respects: impact, manifestation, and source. For one, the impact of ruptures on the course of treatment in the early alliance may differ from the latter alliance. Safran et al. (1990) have argued that one of the determinants of the impact of breaches in the client-therapist relationship on the course of treatment is the quality of the existing alliance. It seems then that the strength of and strains on the alliance mutually influence each other: the stronger the existing alliance, the greater its tolerance to strains; yet, the more strains the alliance is able to withstand, the stronger it becomes. An implication of this feedback loop is the notion of an optimal level of strain that, at once, is tolerated by and precipitates a stronger relationship. Ruptures have been described as poorly executed interventions on the part of the therapist or manifestations of the client's maladaptive relational patterns (Safran & Muran, 1996). In any event, a positive alliance allows for rupture tolerance and, if followed by an appropriate intervention, the rupture becomes an opportunity for a corrective experience. As such, alliance ruptures are not phenomena to be avoided altogether but opportunities for positive change (Safran, 1993): the positive alliance allows the client and therapist to sidestep or weather the strain. Such is the case in the later session, but not when treatment commences and no relationship is present. It is likely then that, in the early sessions, a positive alliance is not yet present to buttress the impact of the strain, and the fledgling relationship would bear the full brunt of the strain.

Ruptures early and later in treatment may also differ in how they manifest. Ruptures are often characterized as negative interactions (Maramba, 2001). However, negative interactions alone do not indicate strains in the alliance. Broadly categorized, it has been suggested that ruptures can either take the form of client confrontation or withdrawal (Safran & Muran, 2001). Confrontation behaviors such as anger and resentment are direct expressions of negative feelings of the client toward the therapist and can manifest as disaffiliative interactions. Withdrawal, on the other hand, stems from fear and avoidance of acknowledging negative feelings. In this case, a client may appear acquiescing and submissive. Yet, in spite of possessing a neutral, if not altogether positive affiliative tone, the withdrawal behaviors may seem restricted or forced. Inasmuch as they occur covertly or subtly, there is some evidence that withdrawal markers go largely unnoticed by therapists (Hill, Thompson & Corbett, 1992).

Personality differences may account for differences in the way ruptures manifest. Ruptures, it has been suggested, may be subtler with clients who have a low tolerance for conflict (Safran et al., 1990; Safran & Muran, 2001). More relevant to the current issue, the demand characteristics of the early sessions may decrease the likelihood of ruptures manifesting as overt confrontational behaviors. In most other social situations, differences between strangers are not discussed openly and are even glossed over. Consequently, clients may be less inclined to make their displeasures or disagreements known to therapists that they have just met. In other words, to expect a client to openly display her negative reaction by interacting disaffiliatively with the therapist in the early sessions may be presumptive. Such an expectation implies that the therapist is, to some degree, a partner in the pursuit of relief. This is not necessarily the case in the early

sessions when the therapist may more likely be under scrutiny rather than perceived as a collaborator. Understandably, a client may tend to withdraw when there is a breach in the early alliance.

Lastly, the source of ruptures in the early sessions may differ from those in later sessions. Drawing inferences from limited information about the other seems par for the course early in treatment for therapist and client alike. For example, despite a lack of idiographic information, a therapist may make inferences about the client based on normative data. These inferences are invaluable efficiencies in making early treatment decisions: if the client is extremely despondent, the therapist would assess for suicidality; if the client is a recent immigrant, the therapist may retain the services of a translator; a therapist may approach an adolescent client differently than she would an elderly client. Clients, likewise, may have limited knowledge of the therapist and may draw inferences based on their assumptive world (Frank, 1974). In other words, the therapist is not a “blank slate,” but a stimulus to which the client responds. In time, a client’s sensibilities become more familiar to a therapist. In the later sessions, a therapist may be in a better position to anticipate and to recognize the reactions of a client. However, this is not the case in the early sessions when the therapist may not necessarily be privy to the client’s perceptions, and unable to anticipate a client’s reactions; what may seem innocuous to a therapist may invoke a negative response from the client. It seems, then, that there is a greater risk in the early sessions of actions by the therapist that could unwittingly impinge upon the development of the therapeutic relationship.

In all, the differences in the relationship and ruptures early and later in therapy seem to stem from two reasons: (1) the client and therapist do not have a shared history

that provides a context for current interactions and, (2) there is no legitimate expectation of collaboration. These differences may give rise to an increased vulnerability of the early alliance. Given this vulnerability, any strains occurring in the early phase of therapy may, perhaps more so than at any time in therapy, lead to dropout. Thus, there appears to be an early critical period in which the successful negotiation of alliance development is paramount.

### **Successful Negotiation of the Early Sessions: Two Pathways**

The literature indicates two pathways to the positive resolution of the early sessions. The first pathway characterizes the early sessions as a phase in which the therapeutic alliance is “coming into being,” (Saltzman, Letugert, Roth, Creaser, & Howard, 1976; p. 546). Although there is debate within the psychodynamic arena as to whether the initial bond is based on positive transference, “infantile expectation” (p. 454, Ticho, Applebaum, Binstock & Applebaum, 1971) or a hint of a real relationship, there nonetheless seems to be an agreement on an early period of growth (Ticho et al., 1971). Regarding the strength of the connection, the bar seems quite low at this point. The goal may not necessarily be to instill unwavering confidence in the therapist or treatment, as much as it is to inspire hope (Howard, Nance, & Myers, 1986). This early success, by no means, guarantees eventual treatment success: in their review of the literature on psychotherapy effectiveness, Lambert and Bergin (1994) observe that not all who complete treatment respond favorably to it. The goal in the early sessions is modest: to encourage the client to continue the current treatment course. Unlike the later alliance that seems to be founded on affective and cognitive congruence (Constantino, Castonguay, & Schut, 2002), it seems sufficient in the early sessions for the connection to

be based on a mutual liking *or* a meeting of the minds (Bordin, 1979). Although the therapist has some input in this early stage, the relationship is not fully collaborative. Luborsky (1976) has attributed this early, not yet collaborative, connection to the client's perceptions of whether the therapist and the treatment she represents *could* be helpful.

Perhaps success in the early sessions is contingent on a minimum threshold connection. This pathway suggests that success is a diffuse phenomenon and based on the overall efforts of a therapist. It is the overall "gestalt," or tone that seems to be at issue. Conversely, the unsuccessful negotiation of the early sessions seems to result from the failure to achieve even a slight connection. Whether due to limitations on the part of the therapist or client, what transpired in the sessions, somehow, does not amass into a minimal necessary connection for treatment to proceed. In this sense, failure in the early sessions can be described as a "sin of omission."

A second pathway to the successful negotiation of the early sessions involves avoiding potential pitfalls. This perspective acknowledges that the early sessions are inherently difficult (Bordin, 1979). This perspective also draws from the notion that not all instances in therapy are equally predictive of treatment progress (Elliott, 1983; Greenberg, 1986). In terms of predicting who will continue and who will suspend treatment, instances of alliance strain are thought to be particularly telling (Safran & Muran, 2001). In the case of early dropout, it would seem that these crossroads come fairly early in treatment: in fairly short order, two strangers are expected to arrive at a modicum of an agreement regarding treatment specifics. Hence, the critical moments in which this tenuous agreement is reached are inevitable. They may be early and infrequent, but nonetheless weighty in consequence. Success hinges on the ability to

finesse these crucial moments. Accordingly, the failure of a dyad to coalesce into a mature therapeutic alliance can be likened to a “sin of commission.”

Although the two dropout pathways are conceptually distinguishable, they are not necessarily mutually exclusive. In other words, in order to maximize the chances of success, a therapist may need to, at once, actively engage the client in order to establish a minimal connection, *and* refrain from actions that would alienate the client. Nonetheless, the two pathways imply distinct methodological foci. The first pathway suggests that the overall tone of the alliance would predict retention/attrition; global measures would be sufficient to predict whether a client and therapist would progress beyond the early sessions. On the other hand, the second pathway suggests that specific instances are more critical than others in predicting client retention or attrition; fine-grained measures would be required to isolate and qualify low-frequency change events. Furthermore, global measures may be deceptive: inasmuch as they reflect a modal interaction. In other words, global measures may mask more telling, yet less frequent, interactions.

The following section will examine the viability of the two pathways, as revealed by existing studies. What is quite conspicuous about the existing literature, however, is the scarcity of studies on the early alliance and dropout altogether. By way of providing a context of the current state of the research, the assumptions regarding the early alliance implied by the paucity of research will be explored first.

## REVIEW OF LITERATURE

### State of Empirical Inquiry Into Early Dropout

Only a few studies have directly examined the relationship between the alliance and dropout in the early sessions. This paucity of studies may be due to the limited opportunity to collect early alliance information. As noted by Samstag, Batchelder, Muran, Safran, and Winston (1998), it is not uncommon for dropouts to be excluded from analysis. If a client only attends a couple of sessions, there are few occasions in which to gather data. However, pragmatic limitations alone may not account for the dearth of studies. For example, in discussing their finding of no relationship between early alliance and dropout, Kokotovic and Tracey (1990) suggested that a single rating taken at the first session may not adequately portray the developing alliance; multiple measures may more appropriately characterize the alliance in its formative stage. In a follow-up study, Tryon and Kane (1993) concurred that client-therapist relations in the early sessions may be erratic. However, they further inferred that the instability indicates the absence of an alliance in the early sessions altogether. Consequently, they elected to investigate dropout in later sessions, in lieu of dropout in the early sessions. In effect, further investigation of early dropout was bypassed for conceptual reasons: the instability of the alliance was interpreted as an indicator of absence rather than immaturity.

Other factors may contribute to the lack of empirical attention paid to early dropouts. In the tradition of treatment efficacy studies, the focus has been on the relative merit of one type of treatment versus another (Saltzman et al., 1976; Samstag et al., 1998). From this perspective, early dropouts are an awkward group to classify: the appropriateness of comparing early dropouts (i.e., individuals who have not received a



sufficient dose of the treatment) to individuals who have completed treatment is questionable. As such, early dropouts were often not included in analysis, and consequently, the reasons for dropout, overlooked (e.g., Piper, Joyce, McCallum, & Azim, 1998). Thus, the oversight of dropouts as a group may be an unfortunate holdover from the efficacy tradition. The implication of this reasoning, however, is that early dropouts do not represent a meaningful group in understanding what makes treatment work.

The relationship versus technique factors (or what many have called common versus specific factors) dichotomy may also, inadvertently, deflect attention away from early dropout. A common characterization of the alliance (although not unchallenged; see Constantino et al., 2002) is that it is the foundation upon which techniques can take place (e.g. Freud 1913/1958; Greenson, 1965; Horvath & Symonds, 1991). Taking this line of reasoning further, if the primary aim of an investigation is to distinguish treatment from relational factors, the formative time of the alliance is of less interest. The later sessions - when the alliance is formed and the foundation for the specific techniques is in place - is of more interest. The implication of this line of reasoning is that there are no unique treatment effects that take place in the early sessions. However, although the interplay of the alliance and treatment orientation may be different early and later in treatment, alliance and technique factors are present in the early sessions.

As much as the distinction between relationship and treatment effects is a convenient one, it is limited. In applied terms, for example, Butler and Strupp (1986) argued that, just as the execution of therapy's tasks and goals form the basis of the client-therapist relationship, it is only through the relationship that these same tasks and

goals can be executed. In the same vein, Castonguay (2000) reasoned that to say that a mechanism, such as the alliance, is common across treatment approaches is not to say that it takes the same form in each approach. Similarly, Bordin (1979) proposed that different approaches to treatment place different demands on the type of relationship in which the client and therapist engage. Drawing on the work of Greenson (1967), Gelso and Carter (1985) posited components of every therapeutic relationship: the working alliance, the transference configuration, and the real relationship. They further argued that the demands that will be placed on the later relationship for positive change to occur dictate the necessary strength of the early relationship. For example, longer, more intensive therapies that target more areas of change in the client would require a “strong” early alliance. It seems then that treatment orientation has an effect on the character of the early alliance.

In summary, the reasons for the scarcity of early dropout research reveal implicit assumptions and areas in need of empirical verification. The dearth of early alliance and dropout studies may be the result of pragmatic and theoretical lines of reasoning. Certainly, a lack of measures that could adequately reflect the alliance in the early sessions may have also discouraged attempts to study early dropout. In addition, the lack of empirical attention to early treatment dropout seems to imply that early dropouts are not a meaningful group in attempting to understand the optimal progress of treatment. However, closer scrutiny suggests that, whether the interest in intratreatment milestones, the dynamic character of the therapeutic alliance, or the interplay of relational and technical factors in treatment, inquiry into early alliance and dropout has much to offer.

In addition to future directions suggested by the paucity of research, the existing literature, sparse as it is, further illuminates promising research directions.

### **Review of Studies**

Only three studies have empirically investigated the alliance and dropout in the early sessions. Saltzman, Letugert, Roth, Creaser, and Howard (1976) identified interaction dimensions (as opposed to individual characteristics) that they considered relevant to the early development of the therapeutic relationship. From their review of the literature, they determined that client and therapist alike must experience respect, understanding, openness, continuity (that the relationship is relevant to events outside of the therapy sessions), responsibility, movement (that progress is being made), sensitivity to the emotional reactions of the other, and sensitivity to emotional reactions to the other. The authors also identified client dimensions of security (confidence in the therapist) and uniqueness of the relationship. For the therapists, the authors also identified dimensions of involvement (concern for and involvement of the therapist), prognosis (an opinion regarding the client's ability to change), and emotional availability (attending to the client). Client and therapist self-reported alliance ratings on these dimensions were taken at each of the first ten sessions. Attending fewer than ten sessions was considered premature termination. Seven individuals dropped out after the first session, and 11 left shortly after the third session. Dimensions were most powerful at distinguishing dropouts at the third session than at any other session observed. Specifically, dropouts scored significantly lower than continuers in client dimensions of respect, understanding, openness, security, uniqueness, continuity and movement, and in therapist dimensions of respect, understanding, openness, involvement, continuity, sensitivity to the emotional

reactions of the other, sensitivity to emotional reactions to the other, and prognosis.

Based on their findings, the authors suggested that the third session is the earliest point at which a relationship forms and for the clients who dropout at this point, it is fraught with problems.

In the aforementioned Kokotovic and Tracey (1990) study, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was administered at the first treatment session and used to predict dropout before the fourth session. Based on Bordin's (1979) pantheoretical articulation of the therapeutic alliance, the WAI taps the bond, task, and goal components of the therapeutic alliance. Two versions of the WAI, client- and therapist-report forms, were administered. Client and therapist WAI ratings were uniformly high. Neither the client nor therapist scores discriminated dropouts from remainers. The authors speculated that perhaps the alliance is inherently unstable in its formative stage and that its developmental course, rather than its initial level, determines whether a client will elect to remain or to end treatment in the first few sessions.

As part of a scale development study of the Vanderbilt Therapeutic Alliance Scale (VTAS), Hartley and Strupp (1983) attempted to predict outcome from alliance scores. Participants who attended fewer than six sessions were considered dropouts. Continuers were classified as high and low outcome, based on a median split of a composite outcome score. Alliance scores of all groups at the first and last sessions attended were compared, as were continuers' alliance scores at quartile points in treatment.

In addition to a total alliance score, VTAS includes three rationally derived subscales: Patient, Therapist, and Interaction. The first two subscales reflect the degree to which participants engage in identified behaviors, while the Interaction subscale

contains items that are meant to reflect the atmosphere created by the client and therapist in session. The authors also conducted a principal component analysis of the VTAS items, which revealed six factors. Two of these factors, Positive Climate and Therapist Intrusiveness, are dominated by items from the therapist subscale. The rest of the factors are dominated by patient items: Level of Motivation, Responsibility, Anxiety, and Resistance. The interaction subscale items were distributed among and did not dominate any of the six factors.

Although not regarded as such by the investigators, scores that reflected the beginning and end of the early alliance's formation were provided. The first session ratings reflect the early alliance at the beginning of its formation. The early alliance ratings for the last session attended by dropouts (session  $m = 3$ ; range = 2-5), and for the session marking the first quartile of treatment for all continuers (session  $m = 4$ ; range = 2-6) reflect the alliance at the end of its formative stage. The early alliance ratings at the beginning and end of its development are summarized by the present author in Table 1. As post hoc analysis, the present author compared alliance ratings of all three disposition groups at the beginning and end of the development of the early alliance.

In the Hartley and Strupp (1983) analysis, neither the total nor the subscale alliance scores taken at the first session distinguished between dropout, low outcome, and high outcome groups. Similarly, this post hoc analysis revealed that the total alliance scores taken at the end of the early formative stage did not differ according to disposition group. However, post hoc analysis by the present author reveals subscale differences after several sessions. At the end of the alliance's formative stage, the therapist subscale scores of the low outcome group are significantly lower than that of the dropout group.

Table 1

**Mean VTAS Ratings at Beginning and End of the Early Alliance Phase.  
Post-hoc Analysis by Present Author based on data from Hartley & Strupp (1983)**

Score	Disposition					
	Drop-out n = 6		Low Outcome n = 11		High Outcome n = 11	
	Beginning	End	Beginning	End	Beginning	End
Total						
M	111.30	115.30	111.40	106.50	112.80	130.90
SD	25.60	20.60	30.10	23.10	23.90	30.20
Subscales						
Therapist						
M	46.70	54.10	44.50	40.70 **	45.20	51.10
SD	11.30	12.70	15.20	12.20	13.10	12.70
Patient						
M	32.80	30.80	35.00	34.60	36.90	43.10 **
SD	8.80	11.20	8.10	5.90	8.10	10.40
Interaction						
M	31.80	30.30	31.80	31.20	30.70	36.60
SD	6.70	9.10	9.20	6.40	5.10	9.40
Factor						
Positive Climate						
M	47.30	53.20	46.20	42.20	43.40	54.50
SD	13.00	9.90	17.00	14.70	16.20	14.80
Therapist Intrusiveness <sup>(a)</sup>						
M	12.00	13.10	11.60	11.20	13.20	13.10
SD	3.50	4.60	4.20	3.00	3.50	3.10
Patient Resistance <sup>(a)</sup>						
M	14.90	12.70	16.70	16.80	17.50	19.50 **
SD	4.90	7.20	4.60	3.00	3.50	3.70
Patient Motivation						
M	17.40	16.40	17.20	15.80	17.40	18.60
SD	3.60	4.40	4.50	4.40	3.90	6.80
Patient Responsibility						
M	12.80	12.30	13.50	13.60	14.30	17.20 *
SD	5.30	5.10	3.10	2.40	3.60	5.80
Patient Anxiety <sup>(a)</sup>						
M	5.80	5.20	4.80	5.20	5.80	6.70 *
SD	1.20	2.10	1.80	1.50	0.80	1.50

<sup>(a)</sup> reverse coded, lower scores mean more intrusiveness, resistance, or anxiety

\*p < .05    \*\* p < .025 significant difference from dropouts at end of early alliance phase

Furthermore, the patient subscale scores of the high outcome group are significantly higher than that of the dropout group. This suggests that therapists of patients who dropout during the alliance formation stage are far more active (in the behaviors under scrutiny) than therapists of clients who eventually fare poorly from treatment, while patients who dropout during the alliance formation stage are far less active than patients who eventually fare well from treatment.

The factors that emerged in the Hartley and Strupp (1983) factor analysis revealed a similarly complex story. As with the total and subscale scores, the original analysis revealed that the groups do not significantly differ at the first sessions. Also consistent with the analysis of total and subscale scores, the post hoc analysis of factor scores conducted by the present author revealed that differences emerged at the end of early alliance development. The three groups did not significantly differ in terms of Positive Climate and Therapist Intrusiveness. This suggests that neither the tone of the session (as indicated largely by therapist behaviors) nor the level at which the therapist expresses her feelings distinguish dropouts from low or high outcome groups. The patient's Level of Motivation did not distinguish between the different groups either. In terms of Responsibility, Anxiety, and Resistance, patients who dropped-out were virtually indistinguishable from the low outcome group. Dropouts and low outcome patients alike tended to take less responsibility for their treatment, and were more anxious and resistant than high outcome patients. In all, the factor scores seem to indicate that there are no differences at the beginning of alliance formation, no differences in the tone of the session or therapist-related factors at the end of alliance formation, and some differences in patient-related factors at the end of alliance formation.

This survey of the existing empirical literature on the early alliance and dropout highlights interesting issues. For one, a qualitative shift in the alliance seems to occur around the third session, and this shift seems to be related to dropout. Saltzman and colleagues (1976) and Hartley and Strupp (1983) considered terminators prior to the eleventh and fifth sessions, respectively, as homogeneous dropout groups. Although not anticipated by either set of authors, the number of dropouts and sensitivity of the alliance measures to dropouts peaked at the third session. The crest in attrition rate after several sessions is consistent with observations of others (Garfield, 1994). However, outside of the studies reviewed, the link between alliance and progress has been investigated mostly with continuers. The studies reviewed here extend the observation of the alliance-progress link to dropouts, thereby lending credence to the erstwhile conceptual claim that early dropout is precipitated by failures in alliance-building. It seems that alliance formation and dropout in the early sessions are not mere coincidence.

A second implication is that this early alliance phase is distinct from the later alliance or what is typically regarded as the therapeutic alliance. The qualities of the alliance that distinguish continuers from dropouts are different from those that discriminate between good and poor outcome. As Hartley & Strupp (1983) revealed, dropout dyads shared alliance characteristics with poor outcome *and* good outcome dyads alike. The dropout group is not merely an extreme poor outcome group. It seems that the optimal qualities of the alliance related to early dropout are different from those related to eventual treatment benefit. That optimal relation qualities differ in the early and later sessions is consistent with the notion of a distinct early alliance.



Lastly, the existing empirical literature seems to support the notion that failure in the early sessions is characterized by a “sin of commission” rather than a “sin of omission.” Macro characterizations, such as the WAI (Kokotovic & Tracey, 1990) and the total VTAS scores (Hartley & Strupp, 1983) did not predict early treatment disposition. However, micro characterizations of the alliance, such as the subscale and component scores of the VTAS (Hartley & Strupp, 1983) and the dimensions explored by Saltzman and colleagues (1976), evinced differences between dropouts and continuers. Thus, it seems that discrete instances rather than the overall tenor of the developing relationship are related to whether a client continues with or terminates treatment in early sessions.

Inasmuch as the efforts of Hartley and Strupp (1983) and Saltzman and colleagues (1976) constitute attempts to examine therapeutic behaviors, they are limited. An alternative fine-grained approach focuses instead on interactions.

### **A Fine-Grained Interpersonal Approach**

The efforts of Hartley and Strupp (1983) and Saltzman and colleagues (1976) represent different approaches to exploratory process research, in which the alliance is characterized in detailed rather than global terms (Werzbicki & Pekarik, 1993). According to Hill’s (1990) categorization of exploratory process approaches, Hartley and Strupp (1983) identified overt behaviors – observable actions in which participants engaged during treatment. On the other hand, the rationally-derived dimensions identified by Saltzman and colleagues (1976) – personal experiences, such as respect and understanding, resulting from interactions – fall under the category of covert behaviors. One limitation of analyzing overt and covert behaviors alone is that they do not

necessarily reflect the context within which the behaviors take place (Hill, 1990). This was illustrated by the curious finding of Hartley and Strupp (1983) that, unlike continuers, the dropout group experienced a *rise* in their overall alliance scores at the last session. Upon closer inspection, the original investigators found that this was due to an increase in therapist activity. They suggested that, perhaps in the face of what they perceived as reluctance from the clients (as suggested by lower client subscale scores), the therapist persisted in behaviors that, in other circumstances, had been helpful (as suggested by high therapist subscale scores) but were apparently not in this context. However, this was not directly tested by their measures. Furthermore, based on the characteristics of patient and therapists in the dropout group, they speculated that, early in treatment, an active therapist coupled with a reluctant client hinders persistence in treatment, while an active therapist coupled with an active client promotes persistence in treatment. Unfortunately, VTAS ratings only reflect the extent to which the therapist (or client) engages in certain behaviors and not whether these behaviors occurred in tandem.

In recognition of these findings, Hartley and Strupp conceded that, although they shed some light on antecedents of dropouts, aggregate indices of the alliance, which imply that the degree to which something is present is related to favorable outcome, are limited. Similarly, the context from which the covert behaviors explored by Saltzman and colleagues result are not clear from the measures used. As such, the covert and overt behaviors seem to be distal antecedents of the alliance (Hartley & Strupp, 1983; Hill, 1990).

An alternative to overt and covert behavior approaches is an interaction approach (Hill, 1990). An interpersonal interaction approach involves understanding how the

therapeutic enterprise is mutually influenced by client and therapist alike through their behaviors. Rather than summarizing the presence or absence of the behaviors themselves, it accounts for the antecedents and impact of a sequence of behaviors.

To view the alliance through an interpersonal lens brings into stark relief the instances (i.e., interactions) more proximal to the phenomenon of interest (i.e., the alliance). Indeed, Henry and Strupp (1994) have proposed that the moment-by-moment interactions between client and therapist, in and of themselves, are the alliance. This seems especially applicable in the early sessions when the participants are strangers and the interactions are the building blocks of the eventual relationship. The ways client and therapist relate to each other in session have successfully been measured in moment-by-moment terms and related to how clients fare from treatment. In fine-grained studies of psychotherapy sessions, although the majority of the client-therapist interactions were clearly affiliative, momentary instances of disaffiliation, particularly when they were embedded in complex and potentially confusing interactions (i.e., coupled with an affiliative behavior), were related to poor outcome (Henry, Schacht & Strupp, 1986; Henry, Schacht & Strupp, 1990). Thus, by using disaffiliative interactions as indicators of alliance strain, fine-grained approaches have linked ruptures to treatment outcome.

## HYPOTHESES

This study attempts to extend to early dropouts the findings from outcome studies on completers, namely, that poor working alliance quality results in poor outcome. As discussed above, dropout in the early sessions in particular seems to precipitate from poor alliance development. It is predicted that the quality of the early alliance, as indicated by client-therapist interactions, will similarly distinguish dropouts from continuers.

Two out of the three proposed unique characteristics of early alliance ruptures are examined in this study. For one, this study focuses on the impact of ruptures in the early alliance. As discussed above, although client and therapist interactions may possess an overall positive tone, a few instances of disaffiliation may precipitate poor outcome. We expect the same in this study. We predict that, although the overall tenor of interactions will be affiliative, there will be more disaffiliative interactions among dropout dyads. In addition, we also expect differences between our findings and results from later alliance sessions. As discussed earlier, the alliances early and later in session may differ. One way they may differ is in impact of ruptures, i.e., alliance strains have a more adverse effect early compared to later in session. A consistent finding of previous outcome studies is that, although disaffiliative interactions occur in both good and poor outcome cases, they occur more frequently among poor outcome cases. That even good outcome cases have disaffiliative interactions suggests that some degree of disaffiliation is tolerable, perhaps because of the cache from a positive relational history. However, in light of no positive history between client and therapist when treatment commences, we predict that the impact of any disaffiliative interaction will be great in the early sessions and quite likely to result in termination.

This study also focuses on the manifestation of early alliance ruptures. In early sessions, ruptures are thought to appear more subtly (Hill, Thompson, & Corbett, 1992). Thus, overly-focusing on disaffiliative markers of alliance strain may limit our ability to identify ruptures, particularly in the early sessions. Early alliance ruptures may not manifest as disaffiliative interactions alone. As suggested by Safran and Muran (2001), neutral if not altogether affiliative interactions, or what they characterized as withdrawal rupture markers, may belie negative experiences of clients who are on the verge of dropping out. The end of treatment may be imminent if a client is agreeable but restrained, or gives overt signs of agreement only when probed, but not spontaneously.

In all, this study will test a broad prediction that client-therapist interactions of early dropouts and continuers will differ. Furthermore, it will test more specific predictions related to *how* the interactions differ. Hypotheses regarding the last sessions attended by dropouts and similar sessions of matched continuers are summarized below:

Hypothesis 1: With regard to extending findings on the later alliance to the early alliance, we predict that fine-grained measures of interpersonal interactions will distinguish dropouts from continuers.

Hypothesis 2: Inasmuch as the impact of any rupture is proposed to be dire in the early alliance, it is hypothesized that, for dropouts and continuers alike, sessions will possess an overall positive tone and few disaffiliative interactions. Nonetheless, disaffiliative interactions will more likely occur with dropout dyads.

Hypothesis 3: Inasmuch as ruptures manifest more subtly in the early sessions and will nonetheless be related to dropout, it is hypothesized that, although not necessarily

disaffiliative, dropout clients will be less communicative and more restrained than continuers.

## METHOD

Data for the present investigation were collection from two National Institute of Mental Health (NIMH)-funded, generalized anxiety disorder (GAD) therapy trials conducted at The Pennsylvania State University (Borkovec, Newman, Castonguay, & Ray, 2001). Both studies attempted to improve on the current gold standard for the treatment of GAD (Borkovec & Whisman, 1996). In spite of its superiority as a treatment approach, cognitive-behavioral therapy (CBT) is highly effective for only 50% of clients treated (Borkovec & Whisman, 1996). Borkovec and colleagues (2001) have argued that a lack of focus on interpersonal/emotional processes in purely CBT (i.e., intrapersonally focused) approaches may contribute to clients' limited positive response to treatment. By adding an interpersonal/emotional processing element to the already effective CBT package, the authors hypothesized even greater treatment efficacy. In an effort to answer this question, two treatments were compared: (1) CBT with an equal length supportive listening (SL) component, and (2) CBT with an equal length interpersonal/emotional processing (IEP) component.

The first study was conducted as an open trial to determine whether two discrete treatment segments could indeed be combined in one session. Furthermore, the opportunities for the therapists to administer the new experimental protocol were maximized: of the 21 clients included in the study, 18 were assigned to the CBT/IEP condition. In addition, each of the three therapists was assigned one CBT/SL case. Having established that the CBT/IEP and CBT/SL protocols were performed adequately, competently, and promisingly (i.e., findings indicated that the combination of CBT/IEP was greater than CBT/SL), the second study was conducted as a random trial.

Participants for this study were drawn from both GAD trials. The early dropouts from both studies were combined in order to maximize the number of cases that could be included in the present study. The combination of early dropouts from both groups was deemed acceptable because the protocols of both studies were the same, the therapists were the same for both studies, the samples were drawn from the same population, the same therapist training and supervision procedures were in place for both studies, and inclusion and exclusion criteria were identical. In all, outside of open versus random trial differences, the conditions under which the two trials were conducted were similar, and the participants, comparable.

### **Participants**

**Clients.** Clients were recruited via referral from community practitioners, the Center for Counseling and Psychological Services at The Pennsylvania State University, The Psychological Clinic of The Pennsylvania State University Department of Psychology, and a number of media announcements. Of those who passed an initial telephone screening process, clients included only those who: (a) received a principle DSM-IV (American Psychiatric Association, 1994) diagnosis of GAD by two independent assessors (i.e., an advanced graduate student and the eventual therapist); (b) received an assessor severity rating greater than 4 on the 8-point severity scale of GAD-related anxious symptomatology; and, (d) were between 18 and 65 years of age. Furthermore, exclusion criteria included: (a) substance abuse, psychosis, and/or an underlying medical or physical condition, (b) participation in concurrent psychotherapy, and (c) an unstable dose of psychotropic medication.



At the time the sample for this study was selected, 14 participants had prematurely terminated from the GAD trials: 6 attended only one session, 4 attended only two sessions, and 1 each attended only three, five, six, and eight sessions. This pattern of dropping out is similar to that found in most other studies, with most dropouts occurring in the early sessions (Garfield, 1994). In recognition of the heterogeneity of reasons that clients dropout, and for the purpose of increasing the likelihood that clients included in the present study did so at the end of the early alliance stage, only the 10 participants who dropped out in the earliest sessions were included in this study: 6 attended only one session, and 4 attended only two sessions. This increased the probability that this study scrutinizes a distinct phase of the alliance, which, as argued above, differs from the more often investigated later working alliance.

In addition to the dropout group, a comparison group was selected from individuals who remained in treatment. The present study included ten participants in the dropout group (mean number of sessions attended = 1.3;  $sd = .49$ ) and ten participants in the continuer group. Each continuer was matched to a dropout participant by therapist and treatment condition. When more than one continuer matched to a dropout, the self-reported credibility and expectancy scores of the first sessions were compared, and the continuer with scores most similar to that of the dropout participant was selected.

The two treatment conditions were equally represented in the dropout group, with five dropout participants in each of the randomly-assigned CBT/IEP and CBT/SL conditions. Consequently, the matched continuers also equally represented the treatment conditions.

The therapists were polled and recalled no constraints outside the purview of treatment having precipitated the termination of the clients who dropped out. This is consistent with the finding that clients who dropout early in treatment do so for reasons related to what transpires in sessions, and not because of external constraints (Hunsley, Aubry, Verstervelt & Vito, 1999; Hynan, 1990). This also provided further assurance of the homogeneity of the selected early dropout sample.

**Therapists.** The three therapists (2 male) were all licensed clinical psychologists and were trained extensively in the CBT, IEP and SL treatment protocols. Supervision was provided by the principle investigators of the GAD trials and outside consultants (J. Safran, L. Greenberg, and R. Elliott), all experts in several if not all components of CBT and IEP.

### **Treatment**

In blocks of six, clients were randomly assigned to the two treatment conditions and the three protocol therapists. Treatment consisted of 14 sessions, with each comprised of two one-hour segments (either CBT/SL or CBT/IEP). A 15<sup>th</sup> “fading” session was available two weeks after treatment to foster adaptive termination and to facilitate independence in the application of learned techniques.

For all clients, the first half of all sessions consisted of CBT, which is based on the seminal work of Beck and Emery (1985). This therapeutic approach involves multiple components aimed at addressing clients’ intrapersonal experiences of anxiety and worry. The cognitive element of this treatment includes the presentation of a cognitive model of distress that attributes anxiety to how people view themselves, the world, and the future. Interventions involve monitoring thought processes, identifying

anxiety triggers, recognizing and challenging errors in logic, linking maladaptive processes to their corresponding negative emotions, developing more adaptive and rational responses to anxiety-provoking situations, and incorporating new views of self in daily living. The behavioral component of CBT involves developing a variety of adaptive coping responses to identified triggers. Altogether, the CBT model attempts to disrupt what the client experiences as an uncontrollable cycle of worry and anxiety by facilitating the client's mastery over the cyclical process.

Drawn from psychodynamic, interpersonal, and humanistic approaches, IEP techniques address the interpersonal experiences of clients and foster emotional processing of their experiences (Newman, Castonguay, Borkovec, & Molnar, in press). Interpersonal techniques include examining one's impact in interpersonal relationships and one's contribution to interpersonal difficulties. Emotional processing techniques include exposing clients to feared emotions. These techniques were chosen because they tap dimensions not typically addressed in CBT, but which basic and process research have found to be helpful for clients with GAD (Newman, Castonguay, Borkovec, & Molnar, in press).

Supportive Listening (SL) is the condition that controls for time spent in treatment, and in which relational interventions are kept to a minimum (e.g., reflection and empathizing). Consistent with the Client-Centered treatment approach of unconditional positive regard, and the Humanistic-Experiential appreciation for an individual's inherent capacity to actualize, SL techniques provide a supportive context in which a client is allowed the freedom, with little more than subtle encouragement from the therapist, to independently explore important issues and to come to a resolution.

## Data Preparation

**SASB System.** To be clear, this study was not designed to directly test the veracity of interpersonal communications as manifestations of the strength of the alliance. However, this study was designed to provide data that is consistent with the premise that what transpires interpersonally between client and therapist indicates the state of the alliance.

The alliance in the early sessions was measured with the Structural Analysis of Social Behavior (SASB; Benjamin, 1974, 1993, 1996). SASB is a circumplex model of interpersonal and intrapsychic behavior that allows for fine-grained description of the quality of interpersonal communications between members of any dyad. Clinical researchers have reliably utilized the SASB system for a micro-level characterization of how client and therapist interpersonal processes promote or impede therapeutic change (Henry, 1996). Basic SASB concepts draw from interpersonal (e.g., Sullivan, 1953) and object relations (e.g., Fairbairn, 1952) psychoanalytic traditions and from the interpersonal/personality theories of Leary (1957), Murray (1938), and Schaefer (1965). Undergirding the SASB model is the notion that every interpersonal behavior can be described in terms of interpersonal focus, affiliation, and interdependence. The reader is referred to other sources for more detailed discussions (Benjamin, 1996; Constantino, 2000; Henry, 1994).

Coding in the present study was guided by the SASB manuals of Benjamin, Giat, and Estroff (1981) and Benjamin and Cushing (2000). Each patient and therapist speaking turn was segmented into individual "thought units" or portion of speech that expresses one complete thought. After the focus (speaker or another person) of the

thought unit was determined, the unit was coded on the two orthogonal dimensions underlying the SASB model of affiliation and interdependence. The dimensions combine with interpersonal focus to form two interrelated circumplex surfaces designed to describe interpersonal behavior.

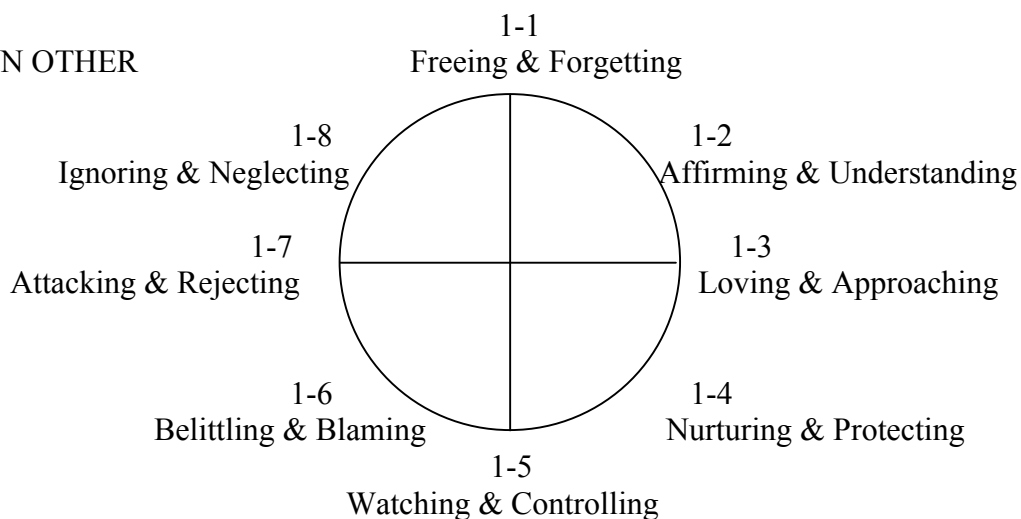
The two circumplex surfaces of the SASB, as illustrated in Figure 1, are Focus on Other (Surface 1; transitive actions toward a directed object) and Focus on Self (Surface 2; intransitive reactions). Similar dimensions define the two surfaces. As one moves from left to right on the horizontal affiliation axis of either surface, interpersonal behaviors range from disaffiliative to affiliative. As one moves from the top to bottom of the vertical interdependence axis of either surface, interpersonal behaviors range from differentiated to enmeshed. Based on an eight-cluster model, a two-digit code and descriptive label mark each point around each surface of the circumplex. The first digit indicates interpersonal focus (i.e., 1 = focus on other; 2 = focus on self), and the second digit indicates a point (1 through 8) on the circumplex. To illustrate, a 1-2 code (Affirming & Understanding) indicates a behavior directed to another person that is moderately affiliative and moderately differentiating. In contrast, a 2-7 code (Protesting & Recoiling) is focused on the self, and extremely disaffiliative and neutral in differentiation. Furthermore, interpersonally complementary behaviors (i.e., a behavior and the corresponding one for which it “pulls”) are represented at homologous points across the surfaces. To illustrate, “Watching and Controlling” (1-5) behavior by one interactant pulls for the complementary behavior of “Deferring and Submitting” (2-5) by the other interactant.

Figure 1. The SASB circumplex model, cluster version, interpersonal surfaces.

Adapted from Benjamin (1993), **Interpersonal diagnosis and treatment of personality disorders**. New York: Guilford Press.

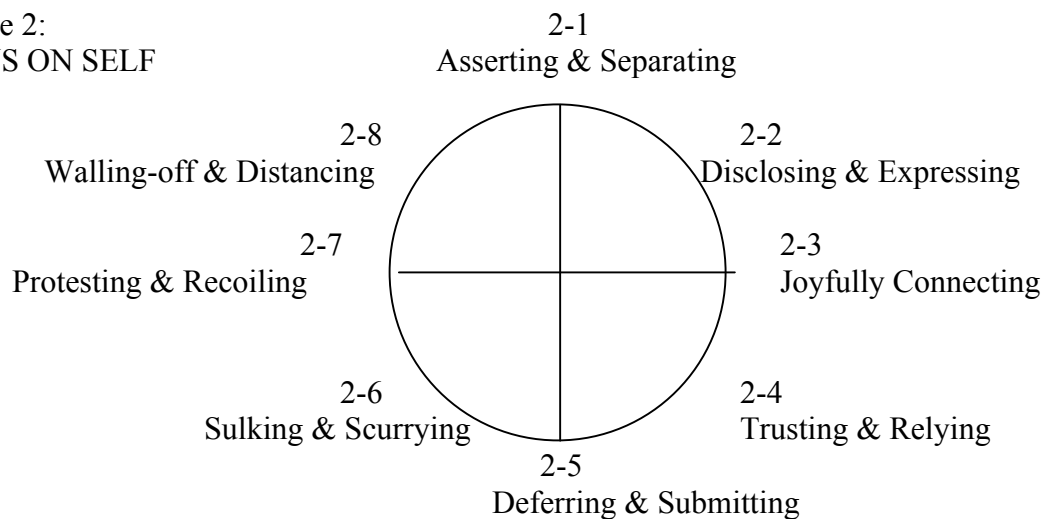
Surface 1:

FOCUS ON OTHER



Surface 2:

FOCUS ON SELF



**Data Selection.** For dropouts, the last session attended was selected for analysis. The continuer session selected for coding was matched to the dropout's last session. Consistent with other studies (e.g., Hillard, Henry, & Strupp, 2000) the present study utilized the middle 15-minute portions of each segment (i.e., first CBT segment and second IEP or SL segment) of the last sessions attended by dropouts and matched sessions of continuers. The identified 15-minute portions were transcribed by undergraduate students. Audio recordings and transcripts were available for coding.

**Coders.** Benjamin, Giat, and Estroff (1981) and Henry and colleagues (1986, 1990) have found coders to be reliable in assigning SASB codes to client and therapist thought units. For the present study, coders were four advanced graduate students at The Pennsylvania State University, each of whom had received 100+ hours of training. The group established high inter-rater reliability, ranging from weighted kappas (Cohen, 1969) of .82 to .89. The SASB group at the University of Utah, distributors and trainers of the SASB system, were consulted during coder training. Reliability with a transcript supplied by this expert (or Utah) SASB group was also high, ranging from weighted kappa of .81 to .86. Feedback from the expert (or Utah) SASB group regarding a segmented transcript indicated that the present coders and the expert (or Utah) group were segmenting in a similar way.

Coders were blind to the purpose of the study and to the treatment conditions of the sessions they coded. Transcripts were randomly assigned in a block design: each transcript was assigned to a pair of coders, with the workload being evenly distributed between the four coders. With the exception of the middle 100 thought units of the transcript that were coded independently, thought units were coded in tandem. The inter-

rater agreement on the middle 100 thought units ranged from weighted kappa of .71 to .95, with most correlations better than .80. Coding discrepancies were resolved through consensus, and the consensus codes were used in all statistical analyses.

### **Data Analysis**

Observed frequencies in each SASB cluster for clients and therapists were weighted to adjust for the disproportionate number of thought units across cases.

**Significance Level.** In the present study, increasing the power to detect an effect by utilizing a significance level of  $p < .10$  was justified for three reasons. First, the available sample was small ( $n = 20$ ). The inherently constrained sample size compromised the ability to detect a meaningful effect (i.e., greater probability of Type II error). Second, the effect size is expected to be small because the frequency of the event that would discriminate dropouts from continuers, i.e., ruptures, is expected to be low (Henry, Schacht, & Strupp, 1986; Safran & Muran, 1996). Third, albeit small in effect size, the phenomenon of early dropout is of clinical importance (Rosenthal, 1991). Thus, consistent with guidelines set by Kazdin (1994), weak power from a small sample size coupled by a small effect that, nonetheless, is alleged to be indicative of a clinically meaningful phenomenon justify employing a more liberal alpha level.

**Hypothesis 1.** The types of interactions that previous empirical inquiries found to be related to outcome were tested. Across two studies by Henry, Schacht, and Strupp (1986, 1990), patients in the poor outcome group engaged in significantly fewer 2-2 (Disclosing & Expressing) interactions with the therapists, and the therapists engaged in significantly more 1-6 (Belittling & Blaming) interactions with the patients. In the first study, patients in the poor outcome group also engaged in significantly more 2-4



(Trusting & Relying), and 2-8 (Walling-off & Distancing) interactions with their therapists, while the therapists engaged in significantly fewer 1-2 (Affirming & Understanding) and 1-4 (Nurturing & Protecting) interactions with their patients. In the second study, the patients in the poor outcome group also engaged in significantly more 2-1 (Asserting & Separating) and 2-6 (Sulking & Scurrying) interactions with their therapists, while their therapists engaged in significantly more 1-8 (Ignoring & Neglecting) behaviors. Overall, the tendency identified by Henry and colleagues in both studies was for patients and therapists in the good outcome groups to engage more affiliatively with each other than participants in the poor outcome groups. A similar tendency of greater affiliation among continuer cases compared to dropout cases was expected in this study. In addition, the previous studies consistently found that therapists in the poor outcome groups tended to engage in more complex communications with the clients, i.e., utterances that conveyed a mixed message of affiliation and disaffiliation. Similar findings were expected from this study. These findings were expected to extend those of outcome research to early premature termination, namely, that the disposition of treatment is related to the quality of client-therapist interpersonal interactions.

**Hypothesis 2.** To test the proposed highly disruptive impact of ruptures in the early alliance, the ability to predict treatment disposition from overall session tone was compared to the predictive ability of any disaffiliative interaction in session. The SASB weighted affiliation (AF) score indicated the overall affective tone of the session (Benjamin & Cushing, 2000). The AF score was based on thought units weighted according to degree of affiliation, which ranges from -9 (i.e., high disaffiliation) to +9 (i.e., high affiliation). An AF score was calculated for each participant, and the scores

were grouped by disposition and by participant. Through t-tests, the AF scores of the dropout clients were compared to those of the continuer clients, as were the dropout therapists to the continuer therapists. AF scores were expected to be high, with no significant differences between groups. This would suggest that, on the whole, clients and therapists engage affiliatively with each other in dropout and continuer dyads alike, and that the overall tone of sessions does not predict treatment disposition.

To test whether the presence of any rupture is associated with dropout, the Predictive Power of disaffiliative interactions was computed. Predictive Power is an appropriate measure of probability when the equal sample size of groups being compared belies the low prevalence rate of a dichotomous variable (Baldessarini, Finklestein, & Arana, 1983). Such is the case in this study in which dropout versus retention is a dichotomous phenomenon. Although the frequency of early dropout is relatively low compared to the number of completers in the greater population, equal dropout and continuer samples were included in the study. In this study, Positive Predictive Power (PPP) indicates the proportion of all dyads in which disaffiliative interactions occurred that, indeed, dropped out of treatment. Negative Predictive Power (NPP) indicates the proportion of all dyads in which no disaffiliative interactions occurred that, indeed, continued with treatment.

Consistent with previous SASB coding classifications (e.g., Henry, Schacht & Strupp, 1986, 1990; Hillard et al., 2000), sessions that contained any thought unit coded as 1-6 (Belittling & Blaming), 1-7 (Attacking & Rejecting), 1-8 (Ignoring & Neglecting), 2-6 (Sulking & Scurrying), 2-7 (Protesting & Recoiling), or 2-8 (Walling-off & Distracting) were grouped together and considered ones in which disaffiliative

interactions took place. Sessions that contained only thought units coded as 1-2 (Affirming & Understanding), 1-3 (Loving & Approaching), 1-4 (Nurturing & Protecting), 2-2 (Disclosing & Expressing), 2-3 (Joyfully Connecting) and 2-4 (Trusting & Relying) were grouped together and considered ones in which only affiliative interactions took place.

Thought units coded as 1-1 (Freeing & Forgetting), 1-5 (Watching & Controlling), 2-1 (Asserting & Separating), and 2-5 (Deferring & Submitting), which are regarded as neutral in affiliation, present a classification problem that is inherent in the SASB cluster coding system. The affiliation levels of these thought units are, theoretically, not identical but hover, albeit slightly, around neutral. Furthermore, the range in which they differ from each other in affiliation/disaffiliation is relatively small (Benjamin, 1974). Without more specifics, the definitive classification of these utterances as affiliative or disaffiliative is not possible. Despite unclear classification, the overall effect of these neutral thought units was thought to be small for two reasons. These 'primitive' responses are at polar extremes of control (emancipation for 1-1 and 2-1 and enmeshment for 1-5 and 2-5) and were not expected to occur frequently in sessions (Benjamin, 1974). Indeed, studies that have utilized SASB have revealed very low occurrences of these neutral responses (Henry, Schacht, & Strupp, 1986, 1990). In addition, given the small degree of affiliation/disaffiliation these thought units possess, participants may experience them as neutral. Nonetheless, given the newness of the current area of study, separate Predictive Power analyses that classify neutral thought units as affiliative and disaffiliative were run and compared. A change in Predictive

Power between the two analyses could mean that the neutral interactions were perceptibly affiliative or disaffiliative and meaningfully distinct in predicting early dropout.

In all, high PPP was anticipated, which would suggest that the presence of any disaffiliative interaction in the early session is likely to result in early dropout. However, NPP was expected to be low, which would suggest that the absence of disaffiliative interactions in the early sessions alone does not ensure retention. Low NPP is consistent with the notion that ruptures are subtle in the early sessions, i.e., ruptures do not come in the form of negative interactions alone. That ruptures manifest in more subtle forms than disaffiliation in the early sessions was further tested in the next hypothesis.

**Hypothesis 3.** This hypothesis attempted to identify the less obvious rupture markers that manifest subtly in the early alliance. In other words, one challenge of this study was to operationalize what Safran and Muran (2001) characterized as withdrawal ruptures. As discussed above, these subtler forms of ruptures are not altogether disaffiliative in tone. Perhaps a client who is feeling disinclined about continuing treatment may simply volunteer less information than a client who remains invested in treatment. The tendency of clients to withdraw, as described by Safran and Muran (2001), may also be reflected in the SASB dimension of control. Perhaps, when they do speak, clients leaning towards quitting treatment do so in a more restrained, less spontaneous manner. Thus, withdrawal ruptures may manifest in the quantity and quality of interactions of dropout clients when compared to continuer clients. As an indication of quantity of speech, the numbers of thought units uttered by dropout and continuer clients were compared. T-tests were expected to reveal significantly fewer utterances by dropouts when compared to continuers. As an indicator of quality of speech, affiliative

interactions not tested in previous hypotheses that may indicate that a client is withdrawing were examined.

Three of the possible affiliative client interactions were already included in previous hypotheses (2-1, Asserting & Separating; 2-2, Disclosing & Expressing; and 2-4, Trusting and Relying). Similar to the earlier discussion, the inherent difficulty in the SASB system with classifying thought units designated as neutral applied to the remaining two affiliative interactions. The affiliation level of 2-5 (Deferring & Submitting) thought units are, theoretically, not identical but hover, albeit slightly, around neutral. Because these thought units could involve affiliation and definitely reflect control, they were included in the analysis. Similarly, the control level of 2-3 (Joyfully Connecting) thought units are, theoretically, not identical but hover, albeit slightly, around neutral. Because these thought units could reflect some level of control, they were also included in the analysis. Using t-tests, dropout clients were expected to engage in more 2-5 (Deferring & Submitting) statements compared to continuers. No specific predictions were made regarding the difference in 2-3 (Joyfully Connecting) utterances of dropout and continuer clients. In all, fewer utterances in general and more 2-5 (Deferring & Submitting) statements by dropouts when compared to continuer clients would be consistent with the notion that, although on the whole affiliative in their dealings with the therapist, dropouts would be more withdrawn than continuers.

## RESULTS

In preparation for analysis, the observed frequencies of client and therapist codes were separately weighted according to the grand mean for number of thought units for each speaker (see Henry, Schacht, & Strupp, 1986; Henry, Schacht, & Strupp, 1990; see Table 2). Each weighted frequency was then multiplied by the average number of thought units of each speaker per session.

Table 2  
**Weighted Mean Number of Thought Units by Type of Interaction (SASB Code)**

Type of Interaction	Disposition							
	Dropout (n = 8)				Continuer (n = 7)			
	Client		Therapist		Client		Therapist	
	M	SD	M	SD	M	SD	M	SD
Focus on Other								
1-1 Freeing & Forgetting							.21	0.36
1-2 Affirming & Understanding	.96	1.69	75.55	23.52	.38	0.47	78.28	26.92
1-3 Loving & Approaching			.70	0.80			.53	0.74
1-4 Nurturing & Protecting	1.20	1.32	149.85	19.53	.52	0.89	139.36	12.81
1-5 Watching & Controlling			5.55	6.83			15.11	23.29
1-6 Belittling & Blaming	.53	0.99	.16	0.45	.13	0.33	.33	0.87
1-7 Attacking & Rejecting								
1-8 Ignoring & Neglecting								
Focus on Self								
2-1 Asserting & Separating	1.51	2.08			1.96	3.56		
2-2 Disclosing & Expressing	134.07	46.23	14.31	11.50	144.52	33.42	7.60	10.72
2-3 Joyfully Connecting	1.72	2.31			2.04	2.28	.63	0.89
2-4 Trusting & Relying	76.09	40.74	.41	0.87	63.45	36.33	.86	1.35
2-5 Deferring & Submitting	.23	0.66			.56	1.49		
2-6 Sulking & Scurrying	2.38	4.94						
2-7 Protesting & Recoiling								
2-8 Walling-off & Distancing	.98	2.11			1.58	2.92	.11	0.28
Uncodable	6.45	2.63	4.61	2.21	11.00	6.93	8.11	2.97

### **Hypothesis 1: Extending Findings of Previous Outcome Studies to Dropout**

A series of t-tests were conducted on the SASB cluster codes that distinguished good versus poor treatment outcome in previous studies. The degree to which therapists of clients who dropped out engaged in freeing (1-2;  $t(13) = .837$ , ns), nurturing and protecting (1-4;  $t(13) = .248$ , ns), and belittling and blaming (1-6;  $t(13) = .637$ , ns) interactions compared to therapists of clients who continued with treatment did not significantly differ. Neither dropout nor continuer therapists engaged in ignoring and neglecting behaviors (1-8).

The differences to which clients who dropped out compared to clients who continued with treatment engaged in behaviors that were asserting and separating (2-1;  $t(13) = .766$ , ns), disclosing and expressing (2-2;  $t(13) = .629$ , ns), trusting and relying (2-4;  $t(13) = .629$ , ns), sulking and scurrying (2-6;  $t(13) = .226$ , ns), and walling off and distancing (2-8;  $t(13) = .649$ , ns) did not reach significance.

The numbers of dropout (3 out of 8) and continuer (4 out of 7) clients who engaged in complex communication were similar. Likewise, the numbers of therapists who engaged in complex communications and whose clients dropped-out (1 out of 8) compared to those whose clients continued with treatment (2 out of 7) were similar.

### **Hypothesis 2: Overall Tone Versus Single Event Measures**

An indication of the overall affiliative tone of a session was calculated by summing the affiliation score of each individual utterance into an AF score. The mean AF score of therapists in the dropout group (966.17) indicated that the average therapist utterance was moderately affiliative (3.88), while the mean composite score of those in the continuer group (913.11) indicated that the average utterance was moderately

affiliative (3.60), too. The AF scores of dropout therapists as a group compared to continuer therapists as a group did not significantly differ ( $t(13) = .188$ , ns).

The mean AF score of clients who dropped-out (849.26) indicated that their typical utterance was moderately affiliative (3.98). The mean AF score (846.95) of clients who continued with treatment indicated that their typical utterance was moderately affiliative (3.51), too. The AF scores of dropout and continuer client groups did not significantly differ ( $t(13) = .942$ , ns).

The possible impact of any disaffiliative interaction on the early disposition of treatment was quantified in terms of predictive power. Each case was classified according to whether or not any disaffiliative interaction was present; separate analyses were done for clients and therapists. In the first set of analysis, neutrally coded interactions were not considered disaffiliative, and Positive Predictive Power (PPP) of statements by clients was 43%. This means that, of the seven clients who engaged in a disaffiliative communication, three dropped out of treatment (see Table 3). Disaffiliative communications on the part of the therapist had PPP of 33% in predicting dropout (see Table 4). In the second set of analyses, neutrally coded interactions were considered disaffiliative. In this instance, the PPP of disaffiliative communication increased to 56 % (see Table 5) and 58 % (see Table 6) for clients and therapists, respectively.

The absence of any disaffiliative interaction as a predictor of continued treatment or Negative Predictive Power (NPP) was first calculated with neutrally coded thought units classified as affiliative. The NPP of 38% for clients (see Table 3) and 42% for therapists (see Table 4) reflects the proportion that did not engaged in any disaffiliative interaction and remained in treatment. NPP increased to 50% (see Table 5) and 67% (see



Table 3  
**Number of Cases by Presence of Disaffiliative Client Utterances  
 with Neutrally Coded Thought Units Not Classified as Disaffiliative**

Thought Units	Disposition	
	Dropout	Continuer
Any Disaffiliative	3	4
No Disaffiliative	5	3

Note: Total number of cases = 15.

Positive Predictive Power = 3/7 (43%).

Negative Predictive Power = 3/8 (38%).

Sensitivity = 3/8 (38%)

Specificity = 3/7 (43%)

Table 4  
**Number of Cases by Presence of Disaffiliative Therapist Utterances  
 with Neutrally Coded Thought Units Not Classified as Disaffiliative**

Thought Units	Disposition	
	Dropout	Continuer
Any Disaffiliative	1	2
No Disaffiliative	7	5

Note: Total number of cases = 15.

Positive Predictive Power = 1/3 (33%).

Negative Predictive Power = 5/12 (42%).

Sensitivity = 1/8 (13%)

Specificity = 5/7 (71)%

Table 5  
**Number of Cases by Presence of Disaffiliative Clients Utterances  
 with Neutrally Coded Thought Units Classified as Disaffiliative**

Thought Units	Disposition	
	Dropout	Continuer
Any Disaffiliative	5	4
No Disaffiliative	3	3

Note: Total number of cases = 15.

Positive Predictive Power = 5/9 (56%).

Negative Predictive Power = 3/6 (50%).

Sensitivity = 5/8 (63%)

Specificity = 3/7 (43%)

Table 6  
**Number of Cases by Presence of Disaffiliative Therapist Utterances  
 with Neutrally Coded Thought Units Classified as Disaffiliative**

Thought Units	Disposition	
	Dropout	Continuer
Any Disaffiliative	7	5
No Disaffiliative	1	2

Note: Total number of cases = 15.

Positive Predictive Power = 7/12 (58%).

Negative Predictive Power = 2/3 (67%).

Sensitivity = 7/8 (88%)

Specificity = 2/7 (29%)

Table 6) for clients and therapists, respectively, when neutrally coded thought units were considered disaffiliative.

When neutrally coded thought units were reclassified from affiliative to disaffiliative, two cases were affected because of client statements, and nine because of therapist statements. As noted above, there are four possible types of neutrally coded statements: 1-1 (Freeing & Forgetting), 1-5 (Watching & Controlling), 2-1 (Asserting & Separating), and 2-5 (Deferring & Submitting). The two cases that were reclassified because of neutrally coded client statements involved 2-1 (Asserting & Separating) statements. All nine cases that were reclassified because of neutrally coded therapists statements involved 1-5 (Watching & Controlling) statements, and one also involved a 1-1 (Freeing & Forgetting) statement. No other type of neutrally coded statements accounted for the reclassification of client and therapist cases.

In order to further assess the usefulness of disaffiliative statements as indicators of dropout, sensitivity and specificity (Baldessarini, Finklestein, & Arana, 1983) were computed post-hoc. Sensitivity reflects the rate of true positives of a “test”. In this study, we tested for the presence of disaffiliative interactions among dropouts. Sensitivity indicated the proportion of the eight dropouts in which any disaffiliative communication occurred. Three clients among the dropout dyads made a clearly disaffiliative statements, which indicates 38% sensitivity (see Table 3). One dropout dyad included a disaffiliative therapist statement, indicating 13% sensitivity (see Table 4). When neutrally coded statements were grouped with disaffiliative statements, at least one disaffiliative statement was made by five clients and seven therapists among the

dropout dyads, reflecting sensitivity of 63% (see Table 5) and 88% (see Table 6), respectively.

Specificity reflects the rate of true negatives of a test, or the proportion of the seven continuers in which only affiliative statements occurred. Three clients among the continuer dyads made only affiliative statements, indicating 43% specificity (see Table 3). Five continuer dyads included only affiliative statements, indicating 71% specificity (see Table 4). When neutrally coded statements were groups with disaffiliative statements, only affiliative statements were made by three clients and two therapists, indicating specificity of 43% (see Table 5) and 29% (see Table 6), respectively.

### **Hypothesis 3: Unique Predictors of Early Dropout**

The mean number of utterances in a session by clients who dropped out of treatment ( $m = 213.13$ ) did not significantly differ from the mean number of utterances in a session by clients who continued with treatment ( $m = 241.00$ ;  $t(13) = .338$ , ns). A series of t-tests were conducted to compare the types of statements that were predicted to distinguish between dropouts and continuers. Clients who dropped out of treatment did not differ from those who continued with treatment in the degree to which they were loving and approaching ( $2-3$ ;  $t(13) = .797$ , ns), and deferring and submitting ( $2-5$ ;  $t(13) = .576$ , ns) toward the therapist.

## DISCUSSION

In this study, we attempted to identify interactions that characterize alliance ruptures in the early sessions. Neither disaffiliative interactions (i.e., traditional rupture markers) that distinguished good from poor outcome cases in previous studies, nor affiliative interactions that we proposed to uniquely characterize ruptures in the early sessions distinguished early dropouts from treatment continuers. Sheer verbosity during the session did not distinguish dropouts from continuer clients. Furthermore, aggregate measures of affiliation did not distinguish client-therapist dyads that terminated treatment from those that persisted with treatment beyond a few sessions. However, when a therapist engaged in any disaffiliative interaction, the client was more likely to discontinue with treatment than if the therapist did not. This was the case only when a more liberal definition of disaffiliation was employed, i.e., when ambiguously disaffiliative interactions were grouped with clearly disaffiliative interactions.

Interaction styles that were demonstrated in previous studies to distinguish between good and poor outcome were examined in analyses that attempted to distinguish between early session dropouts and continuers. In contrast to previous studies, therapists of dropout and continuer dyads were similarly affirming and understanding, nurturing and protecting, and belittling and blaming. Clients who dropped out versus those who continued with treatment were similarly asserting and separating, disclosing and expressing, trusting and relying, and sulking and scurrying. To wit, interactions that significantly distinguished treatment responders from nonresponders in previous studies did not distinguish between dropout and continuer cases in this study. Neither clients nor therapists of continuer cases were more affiliative in their dealings with each other than

participants in the dropout group. Contrary to predictions, the features of the alliance that predict outcome later in treatment do not seem to generalize to predicting dropout in the early sessions. Alternatively, perhaps a larger sample would reveal significant differences between dropout and continuer groups.

Aside from testing the generalizability of findings from previous outcome studies to the phenomenon of early dropout, this study also attempted to identify characteristics of interactions that are proposed to uniquely distinguish dropouts from continuers in the early sessions. Specifically, the manifestation and impact of ruptures in the early sessions was explored. Early alliance ruptures were proposed to manifest as withdrawal (Safran & Muran 2001) in the quantity and quality of clients' speech. In terms of quantity, the observed numbers of client utterances of the groups were compared. No significant difference was found: clients who quit treatment spoke no more or less than those who remained. In terms of quality, withdrawal ruptures were operationalized as interactions in which the client was controlled but not disaffiliative (i.e., was either neutral or affiliative) in their dealing with the therapist. In all of the different types of control measures, dropout clients did not significantly differ from continuer clients. Thus, the degree to which clients are controlled (or not) as they relate to therapists does not seem to be a salient indicator of their eventual intent to pursue or end treatment. Perhaps the measures of withdrawal employed do not adequately capture how ruptures manifest in the early sessions.

Thus far, we have addressed types of interactions that may be telling of early treatment disposition. Whether the inquiries above explored traditional (i.e., disaffiliative interactions) or proposed (i.e., affiliative but controlling interactions, verbosity) forms of

ruptures, every inquiry assumed that each interaction weighed equally in determining early treatment disposition. However, the early and delicate alliance may possess heightened sensitivity to any negative event; the impact of ruptures may be grave in the early sessions. To test the proposed impact of ruptures in early sessions, this study explored the relative merits of an overall measure of the alliance versus measures that allow for the possibility that any interaction may weigh more heavily in a client's decision to stick with or abandon treatment.

The overall measure of the alliance that aggregates the degree of affiliation of every statement uttered did not significantly differ dropouts from continuers: dropout and continuer ratings were similar and moderately affiliative for clients and therapists alike. In contrast, the measure that highlighted the potential effect of any interaction was relatively better at identifying dropouts. Whereas any disaffiliative event is highlighted in predictive power analysis, the potential effect of any disaffiliative event is tempered by others in overall measures. Thus, the relative merit of predictive power over overall alliance scores seems to support the notion of a low tolerance for ruptures in the early sessions. Ruptures seem to have a grave impact on the alliance in the early sessions.

Inasmuch as the overall tone of a session is reflected in the aggregate measure, a therapist's or client's positive tone during a session does not seem to indicate that a client will show up at the next scheduled session. This result is consistent with Kokotovic and Tracey's (1990) finding that gross alliance ratings of dropouts and continuers were similarly high. One possible reason for this finding is that, faced with the prospect of imminent termination, client and therapist may collude in glossing over the reason for the rupture by engaging affiliatively on some other topic. Hartley and Strupp (1983)

encountered a similar situation in their study in which, unlike continuers, dropout dyads experienced a rise in overall alliance score at the last session attended. They attributed this to therapists persisting in behavior that was helpful in other situations, but not in the situation at hand. Perhaps an elevated gross alliance rating does not take into account the context within which the affiliative behaviors take place. In dropouts dyads, there may be a disconnect between the topic of the immediate pleasant interaction and the reason for a recent unpleasant interaction.

Among the dyads in which a client made any clearly disaffiliative comment, PPP equaled 43%, meaning that the odds of predicting who would drop out of treatment based on disaffiliative comments by the client were worse than chance. However, when the more liberal definition of disaffiliative interactions was used, the odds were 56% or slightly better than chance. Among the dyads in which a therapist made any clearly disaffiliative comment, PPP equaled 33%, while a more liberal definition of disaffiliation yielded a PPP of 58%. The proper classification of dropouts and continuers using NPP also varied depending on the definition of disaffiliative interaction used. When a liberal definition of disaffiliative interaction was used, NPP improved from 38% to 50% for client interactions, and from 42% to 67% for therapists. That the predictive power measure fared better only when a liberal rather than conservative definition of disaffiliative interactions was used underscores how ruptures may manifest subtly in the early sessions.

In spite of the relatively improved performance of PPP in some cases over the aggregate measure, PPP was not as robust a predictor of dropout as expected. At its best, PPP performed slightly better than chance. NPP performed as expected and seems to be



a poor predictor of treatment retention. Most of the NPP results were close to or worse than chance, suggesting that purely disaffiliative affiliative interactions may not be enough to ensure treatment attendance. The exception is the 67% NPP of therapist utterances, when a liberal criterion for disaffiliative interactions was used. This figure suggests that, in some cases, consistent and clearly affiliative communication on the part of the therapist may be warranted in order to assure a client's early attendance of sessions. However, such an interpretation is made with caution because it is based on only three cases.

In cases that predictive power fared best, sensitivity and specificity shed some light on how disaffiliative interactions may be related to dropout. Predictive power analysis performed best when a liberal definition of disaffiliative interactions was used with therapist statements. The 58% PPP of the liberally defined disaffiliative statements on the part of the therapist is slightly better than chance in predicting dropout. However, a clear majority (88% sensitivity) of all dropout dyads involved liberally defined disaffiliative communications by the therapists. These figures suggest that disaffiliative therapist communications (liberally defined) may play a notable role in clients deciding to drop out of treatment. Subtly disaffiliative statements by the therapists may be common, but insufficient indicators that clients will drop out of treatment. Weak PPP (56%) coupled with weak sensitivity (63%) suggest that the same does not hold true for subtly disaffiliative statements by the client

A clinical implication of these findings is that therapists may find clues in their own behaviors regarding whether clients will quit treatment or not. Fortunately, in the early sessions, most therapists seem to steer clear of the clearly disaffiliative behaviors

that previous studies (e.g., Henry et al., 1986; Henry et al., 1990) have repeatedly found to be related to poor outcome. Unfortunately, seemingly innocuous but potentially subtly disaffiliative therapist acts in the early sessions may be enough to tend a client toward terminating. Recognizing the potency of even a few disaffiliative communications by the therapist, Henry and colleagues (1990) cautioned that, "...the presence of even relatively low levels of negative therapist behavior may be sufficient to prevent change." In the current study, the potency of seemingly innocuous events warrants a corollary warning: in the early sessions, seemingly innocuous therapist statements that belie a hint of disaffiliation may be sufficient to preempt the possibility of change.

The subtly disaffiliative interactions that could portend early treatment termination overwhelmingly fell under the category of watching and controlling statements by the therapist. These statements can involve the therapist redirecting the client, indicating what is best for the client, or guiding the client through a practice (e.g., relaxation). Such statements can reflect a therapist's intention to effectively manage the session. Nonetheless, these statements that on the surface do not clearly smack of disaffiliation, and may be therapeutically indicated later in treatment, may have a negative impact on the client in the early sessions. Perhaps it is not all that surprising that therapists are often caught unaware of how they contribute to disruptions in treatment (Hill, Thompson, & Corbett, 1992), particularly in the early sessions. Watching and controlling interactions, in and of themselves, may not be damaging to the early alliance. Indeed, post hoc analysis that compared the mean number of these statements in dropout to continuer groups yielded no significant difference. Yet, the high frequency of disaffiliative communications in dropout dyads suggests that, when the alliance is still

tenuous, the therapist may need to be more judicious in engaging in these behaviors toward the client.

In response to the question posed earlier, the relative improvement of measures sensitive to single events in identifying dropout over aggregate measures suggests that dropout may reflect a sin of commission rather than a sin of omission. Clients may tend to drop out not because an optimal level of affiliation has not been reached, but because a circumscribed event has occurred. Nonetheless, redemption seems possible: close to half the dyads that involved a disaffiliative interaction persisted with treatment.

To simply advise therapists to refrain from watching and controlling behaviors seems naïve to evidence that therapists are prone to engaging in such behaviors and that these behaviors do not inadvertently lead to termination. While recognizing that the potential effect of these behaviors is serious, efforts may be better directed at understanding what distinguished dyads in which a client elects to remain from those in which the client quits. Therapist, client, and relational factors may come into play. One possibility is that a therapist may astutely repair the alliance rupture caused by the disaffiliative communication. Another possibility may be that certain types of client characteristics (e.g., level of demoralization, psychological mindedness) may be associated with a dyad persisting in spite of an early rupture. Another possibility is that the alliance may have been strong at the moment the rupture occurred, allowing the therapist and client to weather it with their collaboration intact. Yet another possibility may have to do with the heterogeneity of interactions that are considered disaffiliative: certain disaffiliative interactions may be more easily weathered than others. Identifying

conditions under which dyads progress rather than end treatment despite a disaffiliative action on the part of the therapist is a fitting topic of future research.

The general lack of significant findings in this study legitimately gives one pause. There are two general issues that this may be the case: measurement and design. In terms of measurement error, the nonsignificant findings may belie meaningful phenomenon because of the statistical analysis employed. For one, instead of the group mean analyses that were used, paired comparisons could be used because each dropout was matched to a continuer. Furthermore, in the event that the dropout and continuer variances in the phenomenon under scrutiny significantly differ, nonparametric group comparisons could be employed. In either case, the power to detect significant differences would increase, and differences may reach statistically significant levels. In addition, power to detect differences could also be increased by specifying a one-tail rather than two-tail direction of significance. Such an approach would be justified because the prediction made for differences in frequencies are in a specific direction.

In terms of design, the nonsignificant differences found between dropouts and continuers may be due to heterogeneity of the continuer group. Although measures were taken to ensure the homogeneity of the dropout group (e.g., no apparent extra-therapy reasons for discontinuing treatment), the continuer clients may nonetheless significantly differ from each other such that the within-group variance may have obscured meaningful differences between continuer and dropout groups. One alternative would be to take further measures to ensure the similarity of continuers in the group to each other. However, the continuer group differences may be meaningful. For example, as revealed in the study of Hartley and Strupp (1983), the subset of continuers who eventually do

well in treatment may be similar to dropouts in some ways, while continuers who eventually do poorly in treatment may be similar to dropouts in other ways. Thus, another alternative would be to include different continuer groups for comparison to dropouts.

Client characteristics may play a moderating role in explaining which clients tend to remain in treatment while others quit. For example, based on Frank's (1974) description of reactivity, some clients may tolerate managing behaviors more than others. It would be interesting for future research to examine whether those clients who dropped out of treatment are also those who would be characterized as reactive. Observing the reactivity of clients in their last therapy sessions may be supplemented with client self-report measures. Using the two measures would also reveal markers, subtle as they may be, of reactivity of clients. Such an approach exemplifies combining relational and individual characteristics to predict dropout.

The results of this study warrant a closer inspection of managing behaviors. The results of the predictive power analysis on the SASB codes suggest that managing behavior may be counterindicated in early sessions. Discerning the instances, through qualitative analysis, in which managing behavior is warranted, or at least not damaging, from the times that it is ill-advised would be an appropriate goal of future research. One possible approach would be to listen to relevant portions of the sessions and to classify the managing therapist behaviors according to themes that emerge from them. Such qualitative analysis, guided by grounded theory (Glaser & Strauss, 1967) is consistent with recommendations of Mahrer (1988) of a discovery-oriented approach to psychotherapy research.

The generalizability of the findings is limited by the small sample size. Although this study utilized a larger sample than previous studies with significant findings (Henry, Schacht, & Strupp, 1986; Henry, Schacht, & Strupp, 1990), perhaps the effect sizes during the earlier sessions are smaller and would require an even larger sample. A larger sample size may reveal statistically significant differences. Findings from predictive power analyses are even more sensitive to additional cases than findings from group mean analyses: whereas the effect of a single case in group mean analysis is tempered by the other cases, one case alters the proportions of groups being compared in predictive power analysis. For example, in the current study, the addition of one continuer case that included a disaffiliative interaction changed the PPP from 67% to 58%. This one case also changed the NPP, and specificity of the sample. Furthermore, the proportion of cases with no disaffiliative interaction to those with a disaffiliative interaction decreased. Consequently, although specificity remained high, sensitivity decreased, and the likelihood that disaffiliative interactions would be more prevalent among dropouts and continuers alike increased.

This study is also limited because only portions and not whole sessions were analyzed. What transpired in the unanalyzed portions of the sessions may have a bearing on the early treatment disposition, but was not taken into account in this study. Previous investigators who also analyzed portions rather than whole sessions reasoned that portions are representative of the interactional style of dyads (Benjamin & Cushing, 2000). Inasmuch as the middle portion of a session was selected for this study because it is likely when the therapist and client were most involved in therapeutic tasks, it is still

possible that single but meaningful events that affected the course of treatment occurred outside of the selected portion.

Much effort was expended to assure the sound completion of this study. Coding time alone illustrates the point. Each coder was trained for over 100 hours over a two-year period in the coding procedure. It then took 12 hours for each half hour portion of a session to be coded by each of two coders. In all, the work-hours invested by coders, trainers, and administrators to get the data ready for analysis totaled some 900 hours. Although the process was laborious, the results support what was suspected all along. The alliance in the early sessions does not seem to merely mimic the alliance in the later sessions. The early alliance does not seem to be prone to ruptures that often mark poor outcome. Not surprisingly, overtly disaffiliative interactions seem easily avoided by client and therapist alike who, in the early sessions, are virtual strangers. More importantly, the results of this study point in the direction of what, instead, may be the early warning signs of treatment in jeopardy. Highly managing statements, rather than disaffiliative ones, may mark trouble. In other words, the efforts expended in this study were rewarded with strong suggestions as to where not to look, and where to look, to answer the question of why close to a third of individuals who start treatment do not progress past the third sessions (Elkin, Shea, Watkins, 1980; Frayn, 1992; Garfield, 1994). It is the author's hopes that this study demonstrates the feasibility of studying the alliance in the early sessions, highlights meaningful questions to ask, and encourages additional research on the alliance in the much-neglected early sessions.

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**AWARDS:**

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- Manager of Fundraising and Information Systems 9/93 - 2/95  
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**SELECT PUBLICATIONS:**

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