



8-2006

## **Anaclitic and Introjective Personality Distinctions among Psychotherapy Outpatients: Examining Clinical Change across Baseline and Therapy Phases**

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To the Graduate Council:

I am submitting herewith a dissertation written by David Dix Kemmerer entitled "Anaclitic and Introjective Personality Distinctions among Psychotherapy Outpatients: Examining Clinical Change across Baseline and Therapy Phases." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Michael R. Nash, Major Professor

We have read this dissertation and recommend its acceptance:

Robert G. Wahler, Robert E. Levey, John W. Lounsbury

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Accepted for the Council:

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Vice Chancellor and Dean of  
Graduate Studies

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ANACLITIC AND INTROJECTIVE PERSONALITY DISTINCTIONS  
AMONG PSYCHOTHERAPY OUTPATIENTS:

EXAMINING CLINICAL CHANGE ACROSS  
BASELINE AND THERAPY PHASES

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

David Dix Kemmerer

August, 2006

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## ACKNOWLEDGEMENTS

I want to thank a number of people who helped me in different ways throughout this process. To begin, I am grateful to Michael Nash, my advisor, who has always been willing to work with me on whatever I am passionate about. Thank you, Mike, for mentoring me in many ways—not the least of which has been by sharing a strong interest in human nature and psychoanalytic theory.

I want to thank my loving parents, Bill and Caroline, and my wonderful sister Beth for supporting me, as always, in all of my ambitions.

I feel privileged to have been inspired, taught, supervised, and befriended by a number of caring and thoughtful folks from the University of Tennessee and the Appalachian Psychoanalytic Society: Jack Barlow, Joyce Cartor, Len Handler, Mike Hawthorne, Chris Hebb, Robert Levey, Lance Laurence, Bill MacGillivray, Bruce Seidner, Bob Wahler, and Kathryn White.

This dissertation would not have been possible without the project-initiative and inspiration of Mark Moore. Likewise, I am grateful to Jeff Borckardt and Warren Lambert for their guidance with statistics, and Janet Carnes for proofing help.

I feel particularly lucky to have been through this whole Ph.D. journey with Peter Haugen, Elizabeth Hardaway, Samantha Litzinger, and Sharon Risch—thank you for playing, and for sharing an openness and curiosity-about-experience that I have not found often in others. Finally, I want to thank Minde Meece, who showed an interest, care, and patience that was unparalleled. Thank you, Minde, for being with me in so many ways throughout this whole process.

## ABSTRACT

S. J. Blatt and colleagues (e.g., Blatt, 1995; Blatt & Blass, 1996; Blatt & Shichman, 1983) have theorized that individuals develop and function along two basic lines—that of interpersonal relatedness and that of self-definition. These two modes, while moderately-oscillatory across the lifespan, suggest two respective, relatively-fixed, personality configurations—the anaclitic and the introjective. It is suggested that psychopathology arises when investment in the themes of one's preferred personality configuration become enduringly over-emphasized. Individuals with anaclitic psychopathologies tend to be plagued by feelings of helplessness and weakness, and they tend to have fears of being abandoned; they generally have a depleted sense of self. Individuals with introjective psychopathologies tend to be plagued by feelings of guilt, self-criticism, and inadequacy; they generally have a distorted sense of self. Some individuals struggle with both types of feelings and problems. Previous research, conducted mostly among seriously disturbed *inpatients* in *long-term* therapy, with only a *few measurements* over time, suggests differential responses to treatment as a function of these anaclitic—introjective distinctions. Uniquely, the present study employs a form of hierarchical modeling, using *continuously collected* outcome measurements, to examine therapeutic course and outcome in relatively *short-term* psychotherapy among *outpatients*. More specifically, it tests a number of hypotheses examining the role of personality configuration in clinical change during baseline as well as therapy phases. Results indicate that duration-of therapy, and therapeutic alliance levels did not differ significantly as a function of personality

configuration; pre-treatment level of symptomatology did not differ between anaclitic and mixed-type patients, and was lower among introjective patients—who as a group reported a symptomatology-level that was subclinical. In the sample as a whole, significant symptom improvement occurred during baseline-phase—most of which was driven by clear improvement in the anaclitic and mixed-type groups, while attenuated some by the lack of improvement in the introjective group. During therapy-phase, patients as a whole, and by group, did not report any meaningful change in symptomatology. Several possible explanations for this no-therapy-effect phenomenon, as well as study-limitations, are discussed.



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## Chapter 1

### Introduction

Depression and anxiety are ubiquitous phenomena among patients who come for psychotherapy. But those simple words alone are as broad and uninformative as the words “emotional distress,” which is to say they beg further explication. What does it mean when a patient says s/he is “depressed?” Does it mean intense hopelessness? Or intense helplessness? Or both? Does it derive more from guilt and self-criticism? Or does it derive more from loneliness and emptiness? Or, when a patient presents with anxiety is it primarily related to self-consciousness around others? Or is it more a sense of fear and/or discomfort about being alone? Moreover, besides the problem of understanding what it *means* for patients to say they are depressed or anxious, they may present with noncircumscribed problems (e.g., personality disorders) for which the words depression or anxiety do not seem to fit, as they are traditionally used. In short, depression and anxiety mean different things to different people—lay individuals and clinicians, alike. Thus, therapists would be well-advised to think about their patients’ “distress” in a more qualitatively nuanced way—one that goes beyond simply looking at symptoms and behaviors, and delves into what that experience is like for the patient. Indeed, if a patient presented for treatment, it would be important for the therapist to make distinctions between hopelessness and helplessness, anger and fear, and shame and guilt; all of these have implications for good case conceptualization and, so, proper treatment interventions.

### ***Personality Configuration—Clarifying Patients' Experiences***

S. J. Blatt and colleagues (e.g., Blatt, 1995; Blatt & Blass, 1996; Blatt & Shichman, 1983) have articulated a way to conceptualize and clarify the unique sense of distress that a patient experiences with their theory of anaclitic and introjective psychopathologies. This theory expanded out of work by Blatt (1974) who posited two types of depression, each based on different developmental considerations. Blatt juxtaposed an anaclitic depression, in which the patient feels helpless, weak, and fears abandonment, with that of an introjective depression, in which the patient feels worthless, guilty, and fears loss of approval (Ibid). Blatt & colleagues drew from a variety of theoretical perspectives to suggest that personality normally develops dialectically, throughout the lifespan, along two basic lines—an anaclitic one, in which the focus is on “the establishment of satisfying, intimate interpersonal relationships,” and an introjective one, in which the focus is on developing “a stable, realistic, and essentially positive identity” (Blatt & Shichman, 1983, p. 187). In short, the anaclitic configuration is that of *interpersonal relatedness*, in which issues of connectedness and relationship are primary; the introjective configuration is that of *self-definition*, in which issues of autonomy, self-control, and identity are germane (Blatt, 1995; Blatt & Blass, 1996; Blatt & Shichman, 1983).

Important to their theory of personality configurations, is the notion that personality development involves a dialectical interaction between these realms of interpersonal relatedness and self-definition (Blatt & Blass, 1996). That is, “...the development of concepts of the self is dependent upon establishing satisfying

interpersonal experiences, and the continuation of satisfying interpersonal experiences is contingent upon the development of more mature concepts of the self” (Blatt & Shichman, 1983, pp. 187-188). In normal personality development there is an integration of these two lines that occurs in an oscillatory-fashion, such that at different times throughout one’s life there is an emphasis on one or the other. And, while a balanced integration of interpersonal relatedness and self-definition may constitute what we think of as normality (Blatt, 1995), individuals usually show a consistently greater psychic-investment in the developmental issues of one or the other configuration (much the way introversion and extraversion are relatively stable categories of personality style) (Blatt & Shichman, 1983).

It is when the emphasis on one or the other developmental lines becomes overly-disparate that these configurations of *personality* become configurations of *psychopathology*. Such psychopathology (and, so, the type of distress that is linked with it) can be thought of in terms of exaggerations or preoccupations with the tasks that characterize either configuration. In short, as Blatt & Shichman (1983) note, “Anaclitic psychopathologies are distorted and exaggerated attempts to maintain satisfying interpersonal experiences, (and) introjective psychopathologies are distorted and exaggerated attempts to establish an effective concept of the self” (p.189). The anaclitically-oriented patient tends to feel precarious in *being* and desperately struggles to keep contact with need-gratifying objects, while the introjectively-oriented patient tends to feel precarious in *doing* and desperately works to maintain approval and recognition from others. Individuals with anaclitic

psychopathologies define and experience their sense of self in terms of the quality of their *interpersonal relations* (Blatt, 1995) That is, they attempt to fashion a sense of identity out of relatedness. Individuals with introjective psychopathologies interpret and experience their interpersonal relations in terms of how these relations impact *self-definition* (Ibid). That is, they attempt to fashion a sense of relatedness out of identity.

Importantly, there is a qualitative difference between the anaclitic and the introjective with regard to the structural, dynamic, and experiential dimensions of each. As Blatt & Shichman (1983) note, “Each configuration involves a fundamentally different experiential mode and behavioral orientation, with very different types of gratification and preferred modes of cognition, defense, and adaptation...” (p. 195). Within each of these two configurations there are varying levels of pathology ranging in severity from the more primitive to the more integrated.

### ***Anaclitic Psychopathology***

Blatt & Shichman (1983) comprehensively articulate that those with anaclitic disorders are plagued by feelings of helplessness and weakness; they have fears of being abandoned, and they have strong wishes to be cared for, protected, and loved. Within the anaclitic configuration, neurotic-level pathology ranges from the infantile personality, in which pre-oedipal, dyadic issues predominate (e.g., anaclitic depression), to hysteria, in which more oedipal, triadic issues are found. Borderline-

level pathology is of an anaclitic, or hysteroid type. Psychotic-level pathology includes nonparanoid schizophrenia, characterized by more diffuse—and less rigid—qualities (Ibid). If we are mapping anaclitic personality pathology onto a *DSM-III-R* nosology, we find the Dependent, Histrionic, and Borderline personality disorders (Ouimette, Klein, Anderson, Riso, & Lizardi, 1994).

Blatt & Shichman (1983) go on to explain that what is common among anaclitic pathologies is the preoccupation with libidinal themes of closeness, intimacy, giving and receiving care, love, and sexuality. In the pathologically-anaclitic, the development of a sense of self is neglected as these individuals are inordinately preoccupied with establishing and maintaining satisfying interpersonal relationships (Ibid). Indeed, as the authors note, the pathologically anaclitic individual's symptoms "...are expressions of exaggerated attempts to compensate for disruptions in interpersonal relations. These disturbances are manifested in conflicts around establishing satisfactory intimate relationships and around feeling loved and being able to love. *The basic wish is wanting to be loved*" (1983, p. 200) (italics added). They go on to suggest that this preoccupation stems, in part, from a past in which important others have been depriving, rejecting, overindulging, inconsistent, or unpredictable—thus creating an environment in which closeness was precarious (Ibid).

Regarding defensive maneuvers, the anaclitic tends to use avoidant ones, such as denial, repression, and displacement (Blatt & Shichman, 1983). The cognitive processes of the anaclitic tend to be more figurative, focusing on images and affects.



They tend to think less critically, and more simultaneously as opposed to sequentially (Ibid).

### ***Introjective Psychopathology***

In contrast, Blatt & Shichman (1983) posit that patients with introjective disorders are plagued by feelings of guilt, self-criticism, inferiority, and worthlessness. They tend to be more perfectionistic, duty-bound, and competitive individuals, who often feel like they have to compensate for failing to live up to the perceived expectations of others. Within the introjective configuration, neurotic-level pathology ranges from paranoia, at the more primitive end of this spectrum, to obsessive compulsive disorders in the middle of the spectrum, to phallic narcissism and guilt-laden depression (i.e., introjective depression) at the higher end. Borderline-level pathology is of an introjective, or over-ideational type. Psychotic-level pathology includes paranoid schizophrenia, characterized by more rigid and fragmented-functioning compared with their more amorphous anaclitic counterparts (Ibid). If we are mapping introjective personality pathology onto *DSM-III-R* nosology, we find the Paranoid, Schizoid, Schizotypic, Antisocial, Narcissistic, Avoidant, Obsessive-Compulsive, and Self-Defeating personality disorders (Ouimette et al., 1994).

Blatt & Shichman (1983) suggest that what is common among introjective pathologies is the preoccupation with more aggressive themes (as opposed to libidinal) of identity, self-definition, self-worth, and self-control. In the pathologically-introjective, development of satisfying interpersonal relationships is

neglected as these individuals are inordinately preoccupied with establishing an acceptable identity (Ibid). As the authors note well, “The focus...is not on sharing affection—of loving and being loved—but rather on defining the self as an entity separate from and different than another, with a sense of autonomy and control of one’s mind and body, and with feelings of self-worth and integrity...*The basic wish is to be acknowledged, respected, and admired*” (Blatt & Shichman, 1983, pp. 203-204) (italics added). It is suggested this preoccupation stems, in part, from a past in which important others have been controlling, overly-critical, punitive, judgmental, and intrusive—thus creating an environment in which independence and separation was made difficult (Ibid).

The introjective tends to use counteractive defenses (as a means of controlling the conflict or impulse, as opposed to avoiding it), such as projection, doing and undoing, reaction formation, intellectualization, rationalization, isolation, identification-with-the-aggressor, and overcompensation (Blatt & Shichman, 1983). The cognitive processes of the introjective tend to be more literal, focusing on thoughts, rationality, and things, as opposed to relationships. They tend to think more critically, and more linearly as opposed to simultaneously (Ibid).

### ***Personality Configuration—Implications for Treatment Response***

Conceptualizing patients as having problems stemming from preoccupations with primarily anaclitic or introjective themes is an excellent starting point when beginning therapy. Just as each of these types of patients has different

preoccupations, it is reasonable to assume that the course and outcome of therapy would be different between them. Indeed, literature has suggested that anaclitic and introjective patients show marked differences in how they relate with their therapist (i.e., therapeutic alliance), and, intimately related to this, how they respond to treatment (i.e., outcome) (Blatt, 1992; Blatt, 1995; Blatt & Ford, 1994).

Since anaclitic individuals are theoretically more focused on interpersonal relatedness and connectedness, it is reasonable to suspect they would respond better to therapists who interact more, such as those using primarily supportive- as opposed to more “traditional” psychoanalytic-techniques. Indeed, psychoanalysis arguably tends to involve less immediate gratification of nurturant needs. Likewise, it is reasonable to imagine that introjective patients, who are more concerned with issues of self-definition, independence, and separateness, would respond better in a more psychoanalytically-oriented therapy, since traditionally this provides less “nurturance” and emphasizes more “insight.”<sup>1</sup> This hypothesis was supported by results from the Menninger Psychotherapy Research Project (MPRP) in which outpatients received either long-term supportive-expressive (SE) therapy or psychoanalysis. Among the patients receiving twice-weekly SE psychotherapy, there was a significantly greater positive change among anaclitics; among those receiving 4-times weekly psychoanalysis, there was a significantly greater positive change among introjectives (Blatt, 1992). Moreover, this finding was not limited to the

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<sup>1</sup> This distinction between supportive vs psychoanalytic techniques is clearly a broad generalization and one that many would take to task—especially in light of more modern analytic techniques that are quite relational and expressive and belie the traditional caricature of the psychoanalyst as being rather silent and blank. The point here is that the major differences between supportive-expressive versus more exploratory and insight-oriented work would seem likely to hold different appeal to anaclitic and introjective patients.

MPRP. Indeed, as Blatt (1998) summarizes from multiple studies (e.g., Blatt, 1992; Blatt & Ford, 1994; Blatt, Bondi, Sanislow, & Pilkonis, 1998), "...patients preoccupied with issues of self-definition, self-control, and self-worth (patients with an 'introjective' form of psychopathology) demonstrate significantly greater therapeutic gain in long-term intensive psychotherapy and in psychoanalysis than do anaclitic patients" (p. 738).

One's personality configuration may also have implications for responsiveness to treatment in general, regardless of modality and length. Results from the NIMH Treatment for Depression Collaborative Research Program (TDCRP), which compared three different brief therapies, showed that all three treatments were not significantly effective among highly self-critical, introjectively-depressed patients (Blatt et al., 1998). In contrast, patients with low levels of perfectionism or self-criticism showed significantly demonstrable improvement regardless of modality (Ibid).

Another interesting result from the TDCRP is that among those patients with higher levels of perfectionism (i.e., the more introjective), therapeutic progress basically stopped in the second half of the 16 wks of treatment (wks 9-16), while those who were identified as "low" in perfectionism (i.e., the less introjective), continued to have significant clinical improvement (Blatt et al., 1998). Moreover, it is curious that despite the lack of therapeutic progress, the more perfectionistic patients were *less* likely to terminate treatment prematurely (Ibid).

Zuroff, Blatt, Sotsky, Krupnik, Martin, Sanislow, & Martin, (2000) analyzed the data further and suggested that therapeutic alliance played an important role in this attenuated response to treatment among these more perfectionistic, or introjective, patients. They found that over the 16 weeks of treatment, patient-ratings of positive therapeutic alliance (i.e., constructive, cooperative, collaborative relationships with their therapist) were greater among those who were less perfectionistic; the more perfectionistic patients demonstrated smaller to no increases in therapeutic alliance. In summarizing, Zuroff et al. write that “the negative relation between perfectionism and outcome was explained (mediated) by perfectionistic patients’ failure to develop stronger therapeutic alliances” (2000, p. 114).

In explaining these findings, Zuroff et al. (2000) suggest that perhaps perfectionistic patients are less able to develop “open collaborative relationships” (p. 120), or perhaps that they take a longer time to develop a strong therapeutic alliance. This dovetails well with the suggestion by Blatt, Shahar & Zuroff (2001) that strengthening therapeutic alliance is particularly difficult among introjective patients because they tend to have punitive, harsh representations of self and others, which are likely to be projected onto their therapist. This speculation was corroborated in a unique “N-of-two” study in which an unequivocally introjective patient indicated a relatively low and static level of therapeutic alliance compared with an anaclitic patient (Kemmerer, 2004).

Another explanation for this possible difficulty that introjective patients may have with therapeutic alliance relates to the natural ebb and flow (i.e., disruptions)

that occurs in the relationship between patient and therapist. It has been suggested that it is the successful repairs of these alliance disruptions, or “ruptures,” that ultimately strengthens the alliance and has a relationship to positive therapeutic outcome (Safran & Muran, 1996). Based on this supposition, Zuroff et al. (2000) suggest that introjective patients may be less able to respond well to such ruptures, thus impacting negatively the evolving therapeutic alliance, and so, treatment outcome.

Still another seminal study of differences in therapeutic change between anaclitic and introjective patients is Blatt & Ford’s (1994) Riggs—Yale Project. In this study 90 seriously disturbed treatment resistant patients received long-term intensive treatment at an inpatient treatment center that included psychoanalytically-oriented psychotherapy at least 4 times a week. After, on average, 15-months of treatment, a differential pattern of change began to emerge between anaclitic and introjective patients. As indicated by independent ratings of case reports, and by tests of intelligence and tests of emotional functioning (e.g., Rorschach) given at the beginning and near the end of treatment, the introjective patients demonstrated significantly *greater* improvement compared with the anaclitic patients (Blatt & Ford, 1994). Introjective patients changed more quickly, and this improvement manifested itself primarily in intensity of clinical symptoms. Anaclitic patients improved more slowly, and this change was generally expressed in their quality of interpersonal relationships (Ibid). While this particular finding may *seem* to suggest that introjectives are more responsive to treatment, the therapy this highly disturbed

sample of inpatients was receiving was both long-term and quite intensive. Thus, it is worth considering whether such a result would be replicable among a less disturbed group of outpatients receiving a more brief psychotherapy.

With all of this emphasis on illuminating differential treatment-response patterns between anaclitic and introjective patients, it is curious that there has not been much research among patients who manifest *both* anaclitic *and* introjective preoccupations. While it was long theorized that patients tend to be preoccupied with issues of one domain—to the relative exclusion of the other—recent research has suggested that some patients are not so easily dichotomized and demonstrate preoccupations with both interpersonal relatedness and self-definition (Shahar, Blatt & Ford, 2003). It has been proposed that these “mixed-type” patients have not achieved a consolidated personality organization and defensive structure. That is, they are vulnerable to both sets of concerns—those of interpersonal relatedness and self-definition (Ibid).

Given this speculation of heightened vulnerability, Shahar, Blatt & Ford (2003) re-examined data from the Riggs—Yale Project, with a reclassification of some patients as mixed-types. They hypothesized that these mixed-types would show greater clinical impairment before treatment and, likewise, they would be less responsive to psychoanalytically-oriented treatment. Interestingly, while results did show that this group was more clinically disturbed (e.g., more psychiatric symptoms, greater problems with cognitive functioning, greater reliance on maladaptive defense mechanisms), they were actually the *only* group that showed significant improvement

in symptom-picture and cognitive functioning (Ibid). Neither pure anaclitic or pure introjectives showed such improvement from treatment. In making sense of these findings, the authors summarize that

...clearly organized anaclitic and introjective patients appear to have achieved a defensive consolidation that facilitates their apparent adaptation but that also seems to limit their capacity to respond to therapeutic intervention. Mixed-type individuals, in contrast, seem to have a less consolidated defensive structure and therefore are initially more symptomatic but are also more accessible to intervention and change...The lack of consolidation of a well-articulated defensive organization may make the mixed-type inpatients more accessible to therapeutic intervention. Subsequent research is needed to confirm and elaborate this interpretation (2003, pp. 98-99).

To summarize all of these different outcome studies, anaclitic, introjective and mixed-type patients appear to demonstrate different types of change in response to different lengths and types of psychotherapy. Poorer outcome has been shown among introjective patients in brief, time-limited psychotherapy—arguably because of their particularly negative mental representations of self and others. However, when therapy is long-term, intensive, and psychoanalytically-oriented, introjective patients seem to improve more than their anaclitic counterparts. These differential responses could be related to the patients' perception of the therapeutic alliance, with evidence suggesting that clearly defined introjective patients tend to have a more difficult time establishing a positive therapeutic alliance. More recent research that has looked at seriously disturbed inpatients who manifest preoccupations with *both* interpersonal relatedness and self-definition, suggests that these mixed-type patients are more clinically impaired and more vulnerable prior to treatment (when compared with



either pure anaclitics or pure introjectives), but that they improved significantly more in long-term (15-months) psychoanalytically-oriented treatment.

While these findings suggesting treatment differences among anaclitic, introjective, and mixed-type patients are illuminating, they are inherently limited by the fact that the various dependent measures of outcome and therapeutic alliance were only assessed at two, or, at best, a few points in time. As Bryk & Raudenbush (1987) note, “Much of the research on change has been based on data on individual status at two time points, for example scores on pretest and posttest. In general, two time points provide an inadequate basis for studying change” (p. 147). Likewise, Willett, Singer, & Martin (1998), in discussing development and psychopathology, insist that “to measure individual change well, a truly longitudinal perspective must be adopted—a sample of people must be followed over time allowing the researcher to collect multiple waves of data at sensible spaced intervals” (p. 397).

Indeed, general patterns of functioning prior to and through treatment with differently-configured patients are still fuzzy; it is unclear how therapeutic alliance and symptomatology tend to develop and change over time in each of these types of patients. In addition, all of this previous research (with the exception of TDCRP) has looked at treatment that was long-term, intensive, and among a seriously disturbed sample of inpatients. One wonders if the results are replicable in shorter-term, weekly therapy with outpatients.

It would also be worthwhile to examine whether there are differences between anaclitic, introjective and mixed-type patients in terms of the possible effect of

simply deciding to seek treatment. As Howard, Kopta, Krause, & Orlinsky (1986) note, about 15% of patients show measurable improvement before attending the first session of psychotherapy. They speculate that this decrease in distress could be related to the patient feeling a sense of reassurance that help is on the way. It could be that this reassurance is more potent among those with strong anaclitic concerns, since they are theoretically more invested in the prospect of making an interpersonal connection and more likely to be comforted by the possible fantasy of being “taken care of.” In the anaclitic—introjective case comparison study by Kemmerer (2004), the anaclitic patient demonstrated just such a decrease in symptoms during the period after her initial intake but before therapy began, while the introjective patient did not. This difference is worth examining further in a larger sample.

### ***Time Series and Hierarchical Linear Modeling to Study Growth***

The use of single-subject time series design in psychotherapy outcome research addresses this important issue of knowing what really varies and changes between pretreatment and termination. Traditionally, “N-of-one” or “case studies” have garnered little support in psychotherapy outcome research—and for some good reasons, too. Kazdin, (1992) highlights many of these limitations: alternate explanations can often account for change that is otherwise inferred to be because of a specific intervention; case studies are subject to bias problems insofar as anecdotal information about a patient is often cited; and, probably one of the biggest criticisms, information from case studies are difficult to generalize beyond that individual.

However, single subject or small-n research can be truly experimental in nature (Borckardt & Nash, 2002; Kazdin, 1992).

Instead of comparing performance differences between *groups* who differ in a single fundamental regard (e.g., those who receive X treatment vs. those who do not), the modern time series single case design allows one to make just as powerful inferences about variables responsible for change “by comparing different conditions presented to the same subject over time” (Kazdin, 1992, p. 158). The uniqueness of the time series design lies in the fact that the assessment is *continuous* and that these points of “observation” occur at equal intervals (e.g., every day, or at the least, every week). This continuous, evenly-spaced, assessment allows the researcher to examine the pattern and stability (or lack thereof) of the dependent variable (e.g., a symptom) in relation to the intervention. Of course, any inference of effect is still only applicable to that one subject. However, multiple measurements over time, from multiple individuals, can be pooled through the use of hierarchical linear modeling (HLM) in order to examine differences in outcome *between* groups of individuals who share something unique in common (e.g., personality configuration). As will be elaborated on in the Procedure section, the data in this study is hierarchical: measurements (over time) are nested in individuals, who are nested within groups.

### ***The Present Study***

The published outcome research among anaclitic, introjective and mixed-type patients is limited in two major ways. First, it is based on measurements taken at only

a few points in time, and secondly, it has mainly focused on long-term intensive treatment of inpatient populations. Thus, the present study aggregates individual time series data via HLM to examine patterns of change among differently-configured outpatients in shorter-term, less intensive psychotherapy. Levels and trends of patient functioning will be examined in the context of open-ended weekly therapy that lasts between 7 and 35 weeks. This study is the first extension of Blatt and colleagues' work to an outpatient sample exposed to non-manualized, and nonspecific—though generally psychodynamically-informed—psychotherapy.

Given the limitations and questions that have arisen from previous work, the following hypotheses will be tested: It is hypothesized that (1) those individuals classified as either pure introjectives or mixed-type, will stay in therapy longer than pure anaclitics.<sup>2</sup> This hypothesis is based on the notion that patients who are preoccupied with introjective themes (i.e., introjectives and mixed-types) tend to be more perfectionistic, self-critical, and concerned with achievement, success, and looking good in the eyes of others, which would arguably compel them to “stay-the-course” regardless of whether they feel they are improving or not. Put another way patients who are preoccupied with introjective concerns arguably have a greater sense of overwrought-duty or stubbornness (often reflective of their concerns with guilt and/or achievement) than their anaclitic counterparts, thus rendering them less likely to quit therapy.

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<sup>2</sup> “Pure” is synonymous with “clearly defined” or “heavily loaded.” It describes a personality configuration that does not have characteristics of both types—namely the “mixed-types.” However, for the sake of brevity, hereafter such patients will simply be referred to as introjective or anaclitic.

Next, it is hypothesized that (2) anaclitic and mixed-type patients who attend at least seven weeks of therapy will evidence higher mean ratings of therapeutic alliance compared with introjectives. This hypothesis is based on the notion that those preoccupied with issues of dependency, abandonment, and feelings of helplessness are more invested in connection, and nurturing a collaborative relationship with their therapist—indeed it is through the lens of *relationship* (as opposed to *self-definition*) that they see themselves and navigate their world. Put another way, in the relative absence of anaclitic preoccupations (i.e., among introjectives), one would arguably be less compelled to cultivate and invest in a collaborative relationship.

In an attempt to replicate—among outpatients—the findings of Shahar, Ford & Blatt (2003), it is further hypothesized that (3) prior to beginning psychotherapy, mixed-type patients will demonstrate a greater degree of clinical distress,<sup>3</sup> in comparison with anaclitic and introjective patients. Since mixed-type patients are struggling with preoccupations in *both* interpersonal relatedness *and* self-definition, it is reasonable to suspect that prior to therapy they will present as a more poorly functioning and symptomatic group (Ibid.).

It is also hypothesized that (4) anaclitic and mixed-type patients will demonstrate more pre-therapy clinical improvement than introjective patients. That is, baseline-phase slope among these patients should hypothetically show a significantly greater trend of improvement compared with that of introjectives. It is

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<sup>3</sup> clinical distress/symptomatology/improvement—these are all terms used throughout this paper and, unless otherwise mentioned, refer to patient-functioning as measured by the Outcome Questionnaire-45 (OQ-45) (M. J. Lambert et al., 1996)—the main dependent variable of this study.

reasonable to imagine that the distress among patients with anaclitic concerns (i.e., anaclitics and mixed-types) could be assuaged some prior to treatment by simply initiating contact and beginning a process that presupposes interpersonal connection.

The last two hypotheses relate to potential differences in therapeutic outcome among the groups. Thus, first the broad question will be addressed as to whether there is any effect for treatment—both in the whole sample of treated patients as well as in each of the three groups of patients. Regardless of any *significant* treatment effect, it is hypothesized that (5) mixed-type patients will show more clinical improvement after therapy intervention than anaclitic or introjective patients. This hypothesis is derived from the notion that these patients do not have a clearly defined defensive organization and, as such, they are more accessible to therapeutic intervention (Shahar, Ford & Blatt, 2003).

Finally, it is hypothesized that (6) the pace of clinical improvement in therapy among introjectives will be more gradual than that of anaclitics. In other words, the treatment phase slope among introjectives is expected to show a significantly less steep downward trend (downward indicating improvement), with regard to symptomatology ratings, compared with anaclitics. This hypothesis is based on the idea that the high degree of self-criticism and perfectionism inherent in those with strong and clearly-defined introjective preoccupations will make change much harder to come by. It is possible that their harshness is likely to be projected onto the therapist, making the establishment of a positive therapeutic alliance more difficult—which in turn would theoretically stultify therapeutic progress (Zuroff et al., 2000).

## Chapter 2

### Method

#### *Design*

This study included an A-B type within-subject bivariate time domain design, combined with a between subjects design. The A-phase was the pre-therapy, or baseline, phase and the B-phase was the therapy phase. Self-reported measures of patient-functioning (see OQ-45, under *Measurements*, below) were administered twice per week, at evenly spaced intervals, continuously, from baseline through treatment. A patient-reported therapeutic alliance measure (see CAS-3, under *Measurements*, below) was administered with the same temporal resolution during the therapy phase. In order to obtain a clear clinical picture of patients' pretreatment functioning, the baseline phase lasted a minimum of two-and-a-half weeks (five observations). The treatment phase was open-ended, but required at least seven weeks of participation (14 observations).

Beyond the within-subjects design, a between-subjects design was employed to test whether the various hypothesized patterns of change and outcome varied significantly as a function of patients' personality configuration.

#### *Participants*

Participants were adult outpatients from the University of Tennessee Psychological Clinic, a sliding-scale mental health clinic serving both students, as well as members of the community who are typically of lower SES. This clinic is a

training facility for students who are in at least their second year of a doctoral program in clinical psychology.

From March, 2002 through May, 2004, all adults (18 years of age and older) seeking weekly psychotherapy who were nonemergent, without an organic brain disorder, and without psychosis, were asked during their initial intake interview to participate in the clinic's time-series study. It was explained that this study involved completing some brief questionnaires both prior to and during therapy. If the individual agreed, and they completed questionnaires for at least five baseline points (two-and-a half weeks), and 14 therapy-phase points (seven weeks) they were included in the study.

Forty-five patients agreed initially to participate in the study. Eighteen of them dropped-out of the study. The remaining 27 in this sample comprise 20 females and 7 males, ranging in age from 20 to 51 years ( $M = 32.26$ ,  $Mdn = 29$ ,  $SD = 9.2$ ).

### ***Measures***

#### The Outcome Questionnaire–45 (OQ–45; Lambert, Hansen et al., 1996)

The OQ–45 is a 45-item standardized self-report questionnaire that was specifically designed for tracking outpatient symptomatology on a weekly basis. These 45 items are composed of three main subscales: subjective discomfort (OQ-SD) (mainly related to anxiety and depressive symptoms), interpersonal relationships (OQ-IR) (as assessed by friend and family relations), and social role functioning (OQ-SR) (work adjustment and quality of life). Each item is rated on a 5-point scale



(0-4, with 0 as “never” and 4 as “almost always”), yielding a total score (OQ-TOTAL) range of 0-180—with higher scores indicating poorer functioning.

The OQ–45 has adequate internal consistency ( $r = .93$ ) and satisfactory 3-week test—retest value ( $r = .84$ ) (Lambert, Hansen, & Finch, 2001). In addition, it has concurrent validity, significant at the .01 level, with a variety of other widely-used and psychometrically-sound instruments, such as the Symptom Checklist—90 (Derogatis, 1983), and the Inventory of Interpersonal Problems (Horowitz et al., 1988) (Ibid.). The OQ–45 is particularly well-suited for this study because it has been shown to be sufficiently resilient to test—retest artifact effects (test-retest coefficients range between .70 and .80) (Ibid.). Moreover, it has been shown that OQ–45 scores are sensitive to change among patients receiving psychotherapy, yet stable among those who are not treated (Lambert et al., 2001; Vermeersch, Lambert, & Burlingame, 2000).

It is estimated that if an individual scores 64 or above, s/he is likely to have a level of functioning that is consistent with a clinical population; below 64 suggests a nonclinical level of functioning. Finally, the OQ–45 has a reliable change index of 14 points; patients whose scores change by 14 points or more in either direction are considered to have made “clinically meaningful change” (Lambert et al., 2001).

The Combined Alliance Short Form, Patient Version-3 (CAS-3; Hatcher & Barends, 1996

The CAS-3 is a 33-item patient-report measure that was designed to assess the range of elements of what has broadly, and often non-specifically, been called therapeutic alliance. It was created out of the factor-analysis of three other widely-used alliance scales—the Working Alliance Inventory (Horvath & Greenberg, 1989), the Penn Helping Alliance Questionnaire (Alexander & Luborsky, 1987), and the California Psychotherapy Alliance Scales (Gaston, 1991). By drawing from all three of these measures, the CAS-3 encapsulates a more comprehensive measurement of alliance. Indeed, the CAS-3 includes items that tap the following six major factors: (1) the patient’s confidence in and commitment to a therapeutic process that feels promising and helpful (Confident Collaboration); (2) confidence in the therapist (Confident Collaboration-2); (3) the patient’s belief that s/he shares similar goals and tasks with the therapist (Goals and Tasks); (4) the patient’s feeling that s/he is liked and accepted by the therapist (Bond); (5) the patient’s feeling of helpful collaboration with the therapist, as well as his/her sense of disagreement with the therapist (Idealized Relationship); and (6) the patient’s level of dedication, such as the degree to which the s/he feels s/he keeps important thoughts and feelings to him/herself as opposed to sharing them with the therapist (Dedicated Patient). The items that comprise these six subscales are answered on a scale of 1-7 (with 1 as “never” and 7 as “always”). The CAS-3 is considered to have adequate reliability and validity;

alpha coefficients range from  $r = .84$  (for the Idealized Relationship subscale) to  $.91$  (for the Bond subscale) (Ackerman, Hilsenroth, Baity, & Blagys, 2000).

The Depressive Experiences Questionnaire (DEQ; Blatt, D'Afflitti, & Quinlan, 1976):

The DEQ is a 66-item, Likert-type self-report measure that assesses feelings about the self and interpersonal relationships that are thought to be related to a variety of experiences of nonclinical and clinical depression. The items do not assess manifest depressive symptoms, per se, but are related to the phenomenological experiences of people who report dysphoric affect (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982). It was developed to differentiate among the various types of experiences associated with depression, so that clarity could be gained with respect to different subtypes of depression (i.e., anaclitic vs. introjective). Principal components factor analysis on data from Blatt's (1976) original study of undergraduates who were administered the DEQ resulted in 3 major factors in both males and females: Dependency, Self-Criticism, and Efficacy. These same three factors were highly replicable in a larger, subsequent study ( $r$ 's  $> .91$  for all factors across both sexes), and they were not correlated (i.e., the scales remained orthogonal in the replication) (Zuroff, Quinlan, & Blatt, 1990).

The Dependency factor comprises items that tap anaclitic themes, such as dependency, helplessness, loneliness, abandonment, and rejection (e.g., item 23, "I often think about the danger of losing someone who is close to me."). The Self-

Criticism factor comprises items that tap introjective themes, such as, guilt, inadequacy, hopelessness, inferiority, and self-blame (e.g., item 7, “I often find that I don’t live up to my own standards or ideals.”). The Efficacy factor loads on items related to “goal-oriented strivings and feelings of personal accomplishment” (Blatt et al., 1976, p. 385). In short, this third factor measures a sense of well-being (Blatt et al., 1982).

To assess whether the Dependency and Self-Criticism factors scores of the DEQ are indeed operationalizations of anaclitic and introjective *styles*, stability of the DEQ was examined as a function of time and of receiving potentially state-altering feedback (school exam results) at time of retest. The stability of mean scores was reasonable, with no significant group X time interactions ( $p$ 's > .22). While a significant effect for time was found for Dependency, the magnitude was only .20 of the standard deviation. With regard to the stability of the ordering of the subjects, test-retest correlations for each group were all significant, ranging between .68 and .89. The authors conclude that “consistent with Blatt’s (1974) claim to have identified stable personality variables, the DEQ measures demonstrated high levels of temporal stability. The phenomenological correlates of Dependency and Self-Criticism were generally consistent with Blatt’s descriptions of anaclitic and introjective depression” (Zuroff, Moskowitz, Wielgus, Powers, & Franko, 1983, p. 239).

In another study, 12-month test—retest reliability of  $r = .79$  was found for both the Dependency and Self-Criticism scales (Zuroff, Igraja, & Mongrain, 1990). The DEQ scales also have high internal consistency. When administered to 779

female college students, Cronbach's alpha was .81, .75, and .73 for Dependency, Self-Criticism, and Efficacy, respectively. Among the 373 males in this sample, these alphas were .80, .77, and .69 (Zuroff, Quinlan, & Blatt, 1990). In comparing the scales with regard to sex, Tucker's coefficients of factor congruence were .97 for Dependency, .94 for Self-Criticism, and .92 for Efficacy. As such, it is justifiable (and recommended) to use common scoring for both men and women—based on the larger, female sample of college students<sup>4</sup> (Zuroff, Quinlan & Blatt, 1990).

### ***Procedure***

At time of intake, as part of usual data collection, patients completed the self report measure of symptomatology/patient-functioning (OQ-45), and the measure to assess anaclitic—introjective personality configuration (DEQ). If patients met inclusion criteria (outlined in the *Participants* section), then they were asked to be in the study. It was explained that their participation would involve the ongoing completion of some short questionnaires asking them about how they are feeling and functioning and about their perceptions of the therapy.

Consenting patients were given six copies of the OQ-45 each in a sealable yellow (indicating baseline) envelope. It was explained that they would be reminded by telephone to complete the measure three and-a half days from today, and again four days after that (one week from intake)—and so forth, for two to three weeks

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<sup>4</sup> It is reasonable to ask if college student data from the DEQ should be used to evaluate DEQ data in a clinical population. Blatt et al., (1982) suggest that it is, by noting that many researchers (e.g., Beck, 1967; Metcalfe & Goldman, 1965; Klein & Seligman, 1976) have found that the similarity between college students and patients' scores on depression measures suggests that differences between depression in these two populations is mainly a matter of degree or intensity.

prior to beginning therapy<sup>5</sup>. The patient was told that a therapist would be calling them shortly to schedule their first appointment. In the cases where a therapist was not available to see a patient three weeks from the intake date, they were mailed enough additional copies of the OQ-45 to sustain them until their first appointment. The goal was to have consistent, evenly-spaced measurements with no gap in measurements between baseline and treatment.

Therapy commenced on one of the two designated measurement days and remained the same throughout therapy. By having them come for therapy on one of the measurement days, they simply completed that day's measurement at the clinic, thus maximizing the likelihood they would complete the measure and minimizing the frequency of having to call them at home. When the patient came for his/her first therapy session, s/he turned in her accumulated sealed and dated baseline measurement packets to the clinic receptionist, who gave him/her two more packets—another yellow one (containing the usual OQ-45) to complete there in the waiting room before the therapy session, and also a white packet (indicating therapy had begun) to take home and complete, as usual, half a week later. This white packet included not only the OQ-45 symptomatology measure, but the CAS-3 therapeutic alliance measure as well.

From this point forward, the patient completed these white packets in the same fashion—at the clinic immediately before the therapy appointment, and then

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<sup>5</sup> While hierarchical linear modeling does not necessitate such regularly collected, evenly spaced measurements, data was collected in this fashion to satisfy temporal resolution requirements to run time series analyses on individual patients in other studies in this clinic-wide project. While not necessary, these more rigorous data-collection requirements add to the study's statistical power and ability to factor in greater nuances in patient functioning over time.

again half a week later at home. So, for example, a patient who came for therapy on Mondays would turn in his/her sealed packet from the previous Thursday to the receptionist, who then gave the patient two new packets. The patient would complete one of them right then at the clinic before his/her session and give it to the receptionist. S/he would then take the other packet home and complete it on Thursday (reminder call made to patient on that day), and bring it back the following Monday, and so forth.

All consenting adults who produced at least two-and-a-half weeks worth of baseline data (five data points<sup>6</sup>) and who stayed in therapy for at least seven weeks of therapy (14 data points) were included in this study. This seven-week criterion is based on the recommendation of Howard et al. (1986). Following the lead of pharmacological studies, which deem effective exposure to a drug as the dosage to which 50% of subjects respond, Howard and colleagues suggested that, likewise, sufficient therapy exposure should be the number of sessions to which 50% of patients respond. They found that this 50% dose-response is six to eight therapy sessions, and concluded that anything less than that would suggest insufficient exposure.

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<sup>6</sup> Less than 5 observations in baseline seriously compromises the power needed for a time series analysis. Most importantly, for the purposes of this study using HLM, anything less than the 2.5 weeks would arguably not create an adequate picture of baseline functioning.

## *Data Analysis*

### Determining one's personality grouping:

In order to determine one's personality configuration as anaclitic, introjective or mixed-type, factor-derived scale scores from the DEQ were computed for each patient. Scores for the Dependency (anaclitic) and the Self-Criticism (introjective) factors were calculated with a widely-used SPSS-based scoring program (see Zuroff, Quinlan & Blatt, 1990) that uses the factor coefficients, item means, and standard deviations from the original female sample of Blatt et al., (1976).<sup>7</sup> Typically, as recommended by Blatt et al., (1982) researchers and clinicians use a median-split procedure to determine whether one is high or low on the Dependency and the Self-Criticism factors, and then categorize patients accordingly. Those high on Dependency and low on Self-Criticism are considered pure anaclitic; those high on Self-Criticism and low on Dependency are considered pure introjectives; and those high on both factors are considered mixed-types (Viglione, Clemmey, & Camenzuli, 1990). However, Zuroff, Quinlan, & Blatt, (1990) noted that a potential drawback to this median-split approach is that the medians used to divide the subjects are sample-dependent. To address this problem, Zuroff and colleagues offer normative data based on their large-scale replication study, and recommend that researchers use this standardized sample as a reference for categorizing patients as anaclitic, introjective or mixed-type. Thus, in this study, the suggested median split procedure will be used

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<sup>7</sup> Zuroff, Quinlan & Blatt (1990) note that most research using the DEQ employs scoring parameters from the 1976 all-female sample, even though most studies include men, because this sample is large. Moreover, they deem common scoring reasonable based on evidence showing high congruence between male and female factors.



to determine personality configuration, but instead of using the DEQ scores from this small sample of 27 patients to determine the median, Zuroff, Quinlan & Blatt's (1990) sample will be used as the benchmark for determining one's percentile ranking—and, so, their categorization as anaclitic, introjective, or mixed-type.

It is uncommon for individuals in a clinical sample to score low (i.e., below the median) on *both* the anaclitic and introjective factors, but it is obviously possible. If patients score low on both factors, the forced-classification procedure will put them in the mixed-type category.<sup>8</sup>

#### Testing for differences between personality groups:

With the exception of hypothesis 1, which is testing for differences in treatment duration, the main dependent variable of the therapy outcome portion of this study is patient functioning, as assessed by the OQ-45. The biweekly measurements from the 27 patients in this study resulted in 1008 OQ-45 observations and 147 missing points. Therapeutic alliance measurements from the therapy phase resulted in 783 CAS-3 observations and 126 missing points. All of these data are hierarchical, or nested. That is, the observations collected belong to (i.e., are nested within) the individual patients, and the patients themselves exist within (i.e., are also nested within) larger categories—one of which is personality configuration. In this

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<sup>8</sup> One might question the classification of patients who are low on both factors, but for whom there is, nevertheless, a clear disparity in scores, with one of the factors approaching the median. For example, while a patient with percentile rankings of 05 and 10 on the anaclitic and introjective factors, respectively, can be thought of as unequivocally “low-low” (mixed), what about the hypothetical patient whose rankings are 05 on anaclitic and 45 on introjective? Would it really make sense to say that both these patients are mixed-types, simply because they are both below the median on both factors? To address this potential issue, it was decided *a priori* that if there are cases where the disparity in factor scores is more than 30 percentile points and one of the factors is within merely 5 points of the median, the individual will be classified in the category they are approaching.

study, change over time *within* groups of individuals, and *between* these groups, will be examined using a specialized regression technique called hierarchical linear modeling (HLM)—sometimes referred to as multilevel modeling.

Observations that come from hierarchical structures tend to be more similar to each other than observations taken from the population at large (Bryk & Raudenbush, 1987; 1992). In this case, it is likely that observations within-patients will be more homogenous than those between-patients over time, thus violating the assumption of independence of observations associated with conventional statistics. When this assumption is violated, the regression coefficients may be biased leading to erroneously-small standard errors, which can lead to increased risk of inferring a significant effect when there is none. HLM takes this violation of independence of observations into account (Ibid).

In addition, the integrity of HLM is not compromised by randomly distributed missing data points—an issue inherent in this study since there were times when patients did not show up for their appointment or occasionally forgot to fill out a measure at home. Since typical within-subject ANOVA procedures require both independent observations and no missing cells, such traditional kind of analysis is inappropriate (Cohen & Cohen, 1983). In short, HLM has been shown to address appropriately nested models with serially dependent data points and randomly distributed missing values (Bryk & Raudenbush, 1987; 1992; Draper, 1995; Hoffman & Gavin, 1998; Nezlek & Zyzanski, 1998). Moreover, the use of HLM is becoming quite popular among clinicians and social scientists since it is flexible and

appropriate for the data these researchers typically encounter (de Ruijter & Huffman, 2003; Griffen, 1997; Guo & Hussey, 1999; Kuo, Mohler, Raudenbush, & Earls, 2000; Sliwinski & Hall, 1998; Vancouver, 1997). Indeed, HLM models can be designed to include phase variables at the individual level in order to test for effects of an intervention on growth rate.

HLM typically involves a two-level conceptualization, allowing for unique modeling of variables at the individual, or “within-person” level (level-1) and at the broader organizational or “between-person” level, to which each individual belongs (level-2) (Willett, Singer & Martin, 1998). This is often called a two-level “school effects” model (i.e., students nested within classes, and/or, classes nested within schools (Bryk & Raudenbush, 1987; 1992).

Traditionally, at level-1, observed development is modeled as a function of the subject’s growth trajectory plus random error, with the trajectory being predicted by a set of individual parameters. At level-2, the parameters of the individual growth-trajectories are modeled as a function of measurable background or contextual differences between subjects (Bryk & Raudenbush, 1987; Singer, 1998; Willett, Singer & Martin, 1998).

HLM will be conducted in this study using the SAS PROC MIXED procedure, which expresses the patient/individual level outcome using a pair of combined models—one at the individual level and the other at the group level (Singer, 1998, Singer & Willett, 2003, Willett, Singer & Martin, 1998). Given that this study uses *continuous* multiple measurements at the individual level (versus just

a few observations), the HLM models used here differ slightly from a “school-effects” model (Singer, 1998). The level-1 model is actually an individual linear growth model (observations over time, nested within *each* of the individuals) and the level-2 model expresses change in individuals *as a whole group* over time (Henderson, 1999). That is, the level-2 model expresses variation in intercept and slope in the individual model as “random effects unrelated to any person-level covariates” (Singer, 1998, p. 340). In sum, the multilevel models used in this study have a *fixed part* comprising (1) two fixed effects (that of the intercept and that of time), and a *random part* comprising (2) three random effects (for the intercept, time slope, and within person residual (Henderson, 1999; Singer, 1998, Singer, 2003). Results from the two-levels are combined in a model expressing change in individuals as a group over time; the overall model combines intercepts and slopes of all individuals in the group, yielding an “average” intercept and slope for the group as a whole (e.g., the group of all patients, or the group of anaclitics, etc.).

Next, as articulated by Singer (1998), and Singer & Willett (2003), a person-level covariate will be added. Indeed, we are interested primarily in whether/how the background characteristic of personality type (anaclitic, introjective, or mixed-type) has an effect on patient change. This addition of a covariate to the two-level model will yield two more fixed effects—that of personality type and that of the interaction between personality type and time (Henderson, 1999). This time variable will be further specified to reflect the two phases of this study: baseline and therapy. In other words, there will be a baseline-time factor and a therapy-phase-time factor.

An important element to consider when using HLM is the type of model (e.g., quadratic, linear, piecewise linear) to use when fitting the individual-level (level-1) data. When specifically examining phenomenon that are limited to one phase, like therapeutic alliance, a simple linear model makes sense. But a piecewise linear model is better when it is anticipated that an intervention or manipulation of some sort (e.g., the onset of therapy) at a known point in time may result in a shift in the growth trajectory (Willett, Singer & Martin, 1998). Moreover, a piecewise model is recommended when rates of change among individuals in one period may be highly variable whereas those in the other phase may be relatively homogenous (Seltzer and Svartberg, 1998). As Seltzer and Svartberg summarize well: “Piecewise models for individual growth provide a means of dividing a time series into meaningful segments, and capturing key features of change in each segment” (1998, p. 5).

Thus, the testing of hypotheses 4 – 6 will employ a piecewise linear model for growth at the individual level. Testing hypothesis 2 will require a *simple* linear model, since therapeutic alliance is only measured during the therapy phase. The testing of hypothesis 3 will also require a simple linear model, with data from the baseline phase only, because it is specifically looking at mean level differences between the personality groups, and using the SAS PROC MIXED procedure with the *piecewise* model in this study would necessarily produce level scores that span both phases.

Finally, proper coding of the time variable in all of these growth models is important so that the resulting intercept is meaningful (Singer, 1998). For example,

by coding time beginning with zero for the first observation of a phase, the intercept represents *initial* level. Or, by centering time, the intercept represents the *average* level (Ibid). Time will be centered for the models used in hypotheses 2 and 3, since they are both examining average level differences between personality groups. In the model used for hypotheses 4-6 the time variable begins at zero, so the resulting intercepts and slopes refer to when patients began baseline (baseline time) or when they began therapy (therapy time). In this fashion we are able to model (and see) the course of change for each group from the beginning to the end of each phase.

In summary, the growth models used to test hypotheses 2 – 6 will have results indicating (1) an overall intercept, reflecting the level-status of the typical patient of a group; (2) overall slope value(s), reflecting the phase trend(s) of the typical patient of a group; (3) any effect for personality (telling us about mean level differences between groups of patients); and (4) any effect for the interaction of personality by time (telling us about slope or trend differences between groups of patients).

The testing of hypothesis 1 will employ either a parametric or nonparametric test of between-group differences in mean length of time in therapy.<sup>9</sup> It is worth noting that seven patients in the study asked to stop participating after some sustained period of time, but continued to come regularly for treatment. For these patients, their “length of time in therapy” was (for obvious rationale) determined when therapy ended, not when they decided to end their participation in the study.

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<sup>9</sup> The use of parametrics or nonparametrics will be determined by results from tests of normality and equal variances in the data.

## Chapter 3

### Results

#### *Personality Configuration and Phase-Length Descriptives*

DEQ factor-derived scaled scores for each of the 27 patients were computed and then his/her percentile rankings were determined for the Dependency Scale (anaclitic personality) and the Self-Criticism Scale (introjective personality), using the normative data of Zuroff, Quinlan, & Blatt, (1990). Using the modified version of Blatt's (1982) median-split procedure, each patient was then categorized as introjective, anaclitic, or mixed-type. Results yielded 13 introjectives, 6 anaclitics, and 8 mixed-types.

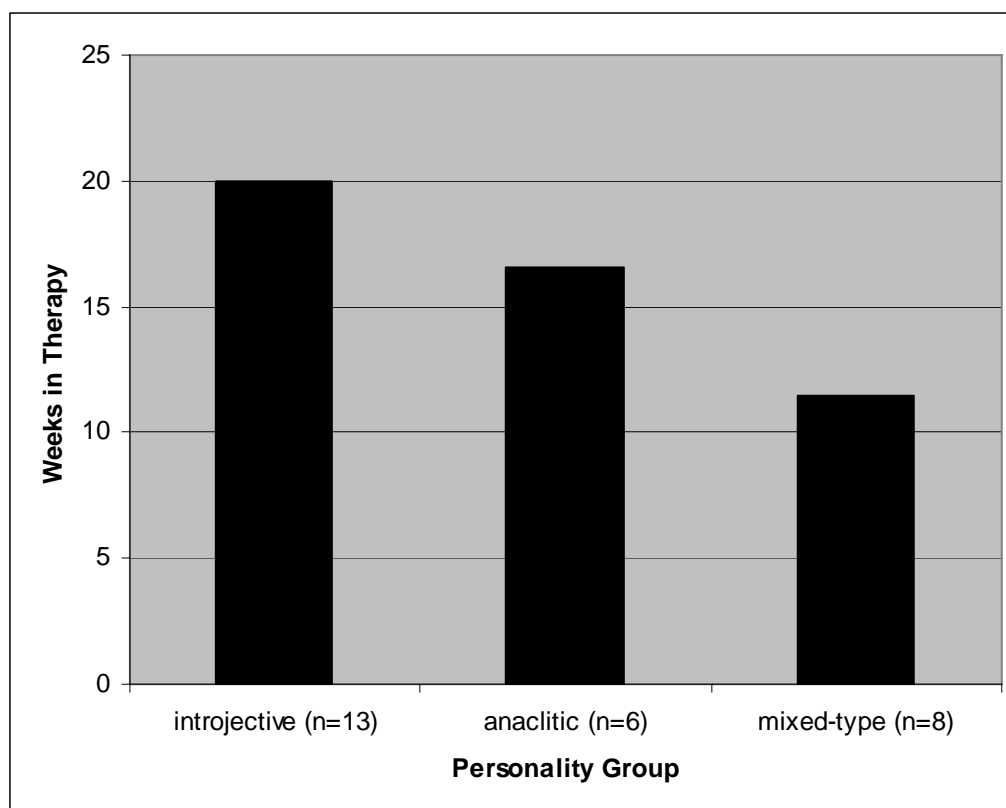
Because patients completed measures evenly spaced, twice a week, time-in-the-study was measured in half-week intervals or units. In this whole sample of patients, baseline-phase duration ranges between 5 and 18 units;  $M = 8.81$ ,  $Mdn = 8$ ,  $SD = 3.48$ . Thus, the average baseline duration is about four weeks. Therapy phase participation ranges between 14 and 90 units;  $M = 34.44$ ,  $Mdn = 32$ ,  $SD = 18.14$ . So, the average therapy-phase participation-in-study is about 16 weeks.

#### *Hypothesis 1*

Hypothesis 1 is that *those individuals classified as either introjectives or mixed-type, will stay in therapy longer than anaclitics*. Table 1 presents the descriptive statistics for patients' therapy duration, listed by personality group. Figure 1 illustrates the median number of weeks in therapy for each of the three groups.

**Table 1:** Duration-in-therapy for each personality group. Values are in number of weeks.

<u>Personality</u>	<u>Range</u>	<u>Mean</u>	<u>Median</u>	<u>Std Dev</u>
Anaclitic (n=6)	7 to 122	37.83	16.5	45.23
Introject (n=13)	8 to 86	27.92	20	23.26
Mixed-type (n=8)	7 to 102	32.75	11.5	40.10



**Figure 1:** Median number of weeks in therapy for each personality group.



SPSS Q-Q plots indicate that the therapy duration data is not normally distributed, making it more appropriate to examine the median number of weeks in therapy in order to test this hypothesis. A Mann-Whitney U Test indicates that introjectives ( $N = 13$ ,  $M = 27.92$ ,  $Mdn = 20$ ,  $SD = 23.26$ ) do not stay in therapy significantly longer than anaclitics ( $N = 6$ ,  $M = 37.83$ ,  $Mdn = 16.5$ ,  $SD = 45.23$ ),  $U = 33.5$ ,  $p = ns$ . Likewise, mixed-types ( $N = 8$ ,  $M = 32.75$ ,  $Mdn = 11.5$ ,  $SD = 40.10$ ) do not stay in therapy significantly longer than anaclitics either ( $N = 6$ ,  $M = 37.83$ ,  $Mdn = 16.5$ ,  $SD = 45.23$ ),  $U = 21.5$ ,  $p = ns$ . We are unable to reject the null hypothesis of no significant differences in therapy duration between anaclitics and introjectives, or anaclitics and mixed-types.

### ***Hypothesis 2***

Hypothesis 2 is that *anaclitic and mixed-type patients who attend at least seven weeks of therapy will evidence higher mean ratings of therapeutic alliance compared with introjectives*. This hypothesis was examined by testing for a significant effect for personality, with introjectives as the reference group, and CAS-3 score as the outcome variable, using a simple linear HLM model fitted to data from the therapy phase (780 observations across 27 patients). Importantly, in this model the therapy-phase time variable is centered so that the intercept and personality-type effect meaningfully refer to the “average status” for each group (Singer, 1998). To clarify, this hypothesis is *not* focused on the alliance ratings at the beginning of therapy (i.e., initial status), but rather on average across the whole therapy-phase.

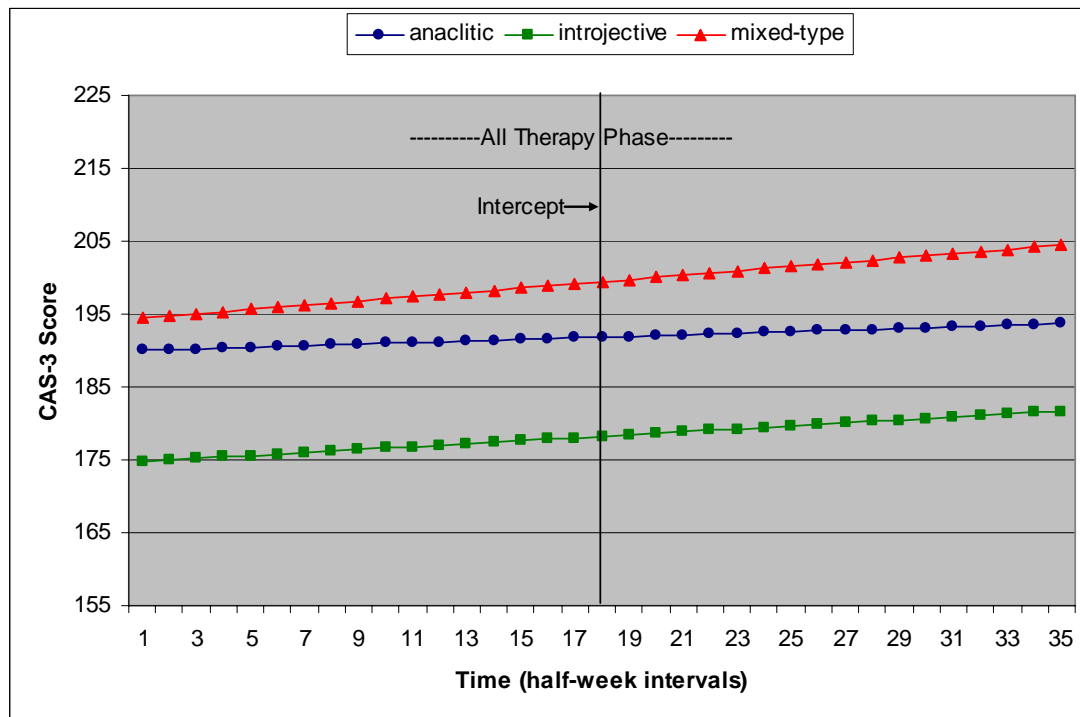
Figure 2 graphically illustrates the results of this HLM model predicting therapeutic alliance (as assessed by the CAS-3). The graph shows the relative differences in level and slope among the three personality groups.

Table 2 displays the results of this model, with estimates for intercept and slope, and for the effects of personality, and time-by-personality interaction. The results relevant for testing this hypothesis (the effect of personality, which refers to mean differences in level between groups) are in bold.

Results of this time-centered HLM model indicate there is no statistically significant difference in mean alliance scores across therapy between anaclitics and introjectives [ $t(753) = 0.78, p = .43$ ], nor between mixed-types and introjectives [ $t(753) = 1.34, p = .18$ ]. We are unable to reject the null hypothesis.

### ***Hypothesis 3***

Hypothesis 3 is that *prior to beginning therapy, mixed-type patients will demonstrate a greater degree of clinical distress in comparison with anaclitic and introjective patients*. This hypothesis was examined by testing for a significant effect for personality, with mixed-type patients as the reference group, and OQ-45-score as the outcome variable, using a *simple* linear HLM model fitted to data from the baseline phase (228 observations across 27 patients). Here also, in this model the time variable is centered so that the intercept and personality-type effect meaningfully refer to the “average status” for each group (Singer, 1998).



**Figure 2:** Average status growth curves for therapy-phase therapeutic alliance. Higher CAS-3 score indicates greater therapeutic alliance.

**Table 2:** Therapy-phase simple model results for therapeutic alliance. Results are predicting CAS-3 score, showing relative differences among the personality groups.

<u>Effect</u>	<u>Coefficient</u>	<u>SE</u>	<u>t-ratio</u>	<u>Probability</u>
Intercept	178.24	9.76	18.25	<.0001
Therapy Time (slope)	0.20	0.05	4.13	<.0001
<b>Personality (mean level)</b>				
<b>Anaclitic</b>	<b>13.60</b>	<b>17.37</b>	<b>0.78</b>	<b>.43</b>
<b>Mixed-type</b>	<b>21.22</b>	<b>15.83</b>	<b>1.34</b>	<b>.18</b>
<b>Introjective</b>	<b>Reference</b>	<b>----</b>	<b>----</b>	<b>----</b>
<b>Therapy Time x Personality</b>				
Anaclitic	-0.10	0.07	-1.33	.16
Mixed-type	0.09	0.08	1.14	.25
Introjective	Reference	----	----	----

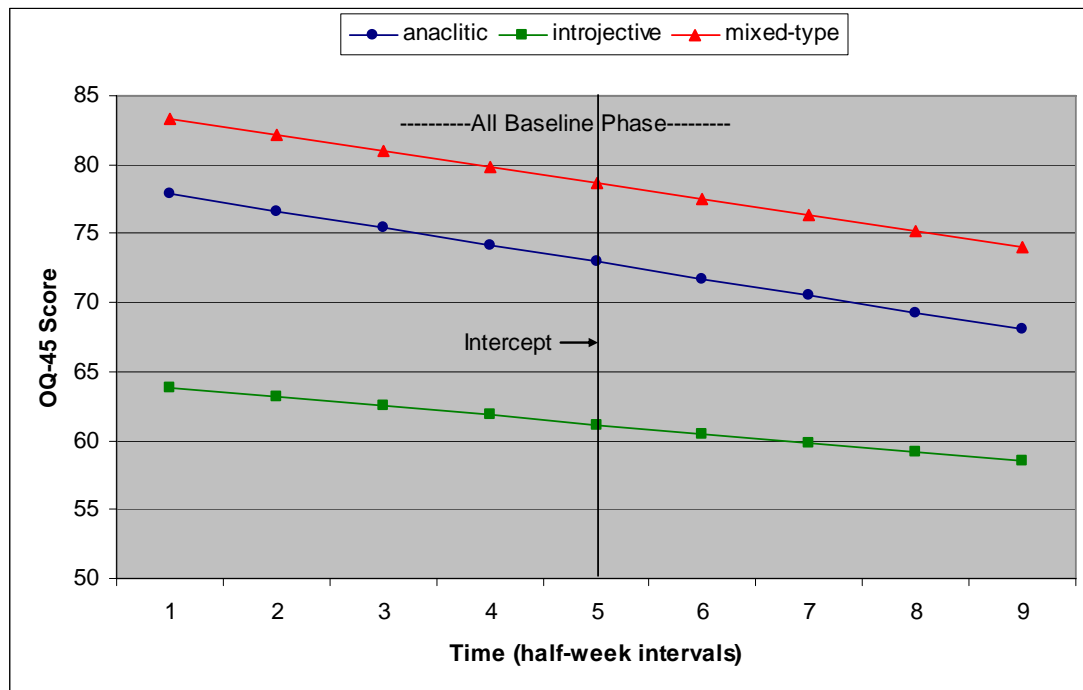
Figure 3 graphically illustrates the results of this HLM model predicting patient-functioning. The graph shows the relative differences in OQ-45 level and slope among the 3 personality groups.

Table 3 displays the results of this baseline phase HLM model, with those directly relevant for this hypothesis (the effect of personality) in bold.

Model results indicate that the average anaclitic patient scores a mean of 5.74 points lower on OQ-45-score during baseline, compared with the average mixed-type patient—however, this is not a statistically significant difference [ $t(198) = -0.43, p = .67$ ]. The average introjective scores a mean of 17.52 points lower than that of the average mixed-type. This difference does not reach statistical significance either [ $t(198) = -1.58, p = .12$ ]. However, it is worth noting that it *approaches* significance. In sum, we are unable to reject the null hypothesis of no difference in average baseline OQ-45 score between mixed-types and anaclitics, or mixed-types and introjectives.

#### ***Hypothesis 4***

Hypothesis 4 states that *anaclitic and mixed-type patients will demonstrate more pre-therapy improvement than pure introjective patients*. This hypothesis focuses on whether, indeed, baseline-slope among anaclitics and mixed-types shows a significantly greater trend of improvement when each is compared with that of introjectives. Specifically, this was examined by testing for a significant interaction between time in baseline phase and personality group, using the *piecewise* HLM model with introjectives as the reference group. In this model time is not centered,



**Figure 3:** Average status growth curves for baseline-phase patient-functioning. Lower OQ-45 score indicates greater improvement in patient-functioning.

**Table 3:** Baseline-phase simple model results for patient-functioning. Results are predicting OQ-45 score, showing relative differences among the personality groups.

<u>Effect</u>	<u>Coefficient</u>	<u>SE</u>	<u>t-ratio</u>	<u>Probability</u>
Intercept	78.68	8.73	9.01	<.0001
Baseline Time (slope)	-1.17	0.35	-3.34	.001
<b>Personality (mean level)</b>				
<b>Anaclitic</b>	<b>-5.74</b>	<b>13.33</b>	<b>-0.43</b>	<b>.67</b>
<b>Introjective</b>	<b>-17.52</b>	<b>11.08</b>	<b>-1.58</b>	<b>.12</b>
<b>Mixed-Type</b>	<b>Reference</b>	<b>----</b>	<b>----</b>	<b>----</b>
<b>Baseline Time x Personality</b>				
Anaclitic	-0.06	0.50	-0.13	.89
Introjective	0.51	0.40	1.26	.21
Mixed-Type	Reference	----	----	----

but begins at zero—thus creating an intercept that appropriately refers to “initial status” or score at intake (Singer, 1998).

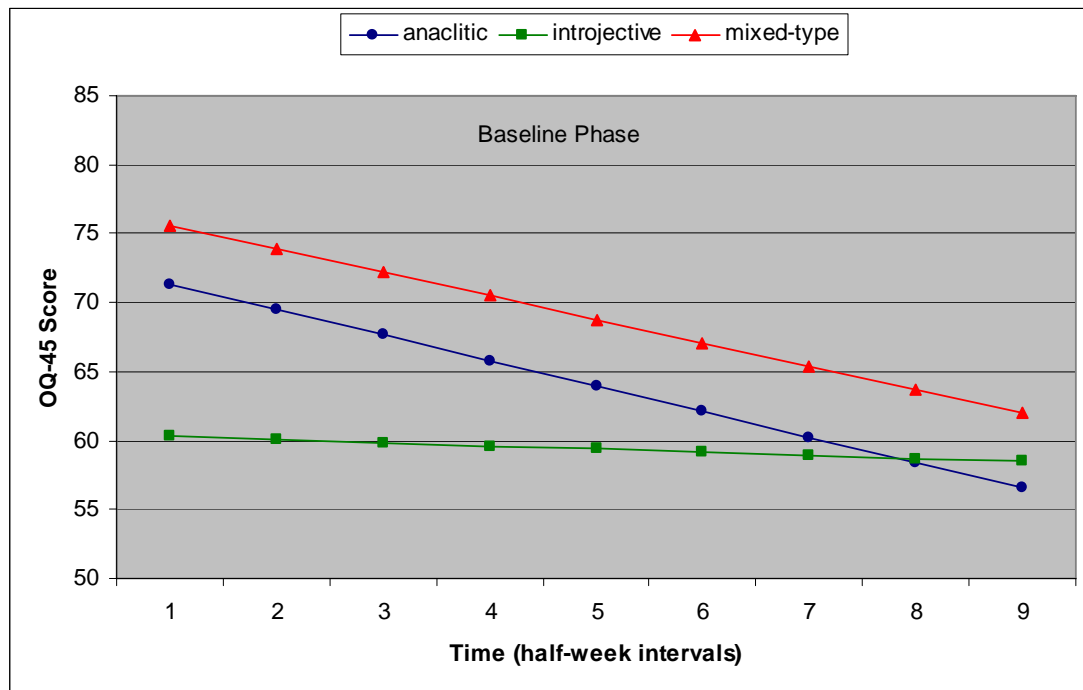
Figure 4 graphically illustrates the longitudinal model predicting patient-functioning for the 3 personality groups during baseline phase. It is the relative *slopes* of the three groups that are of interest here (versus *levels*, in hypothesis 3).

Table 4 displays the results of this model, with those directly relevant for testing this hypothesis (the baseline time by personality interaction) in bold.

The interaction between baseline time and personality group, supports both parts of hypothesis 4. There is a significant time by *anaclitic* personality interaction, such that compared with the average introjective patient, the average anaclitic improves in clinical functioning (i.e., decreases in OQ-45 score) 1.62 points more per half week [ $t(975) = -4.33, p < .0001$ ]. Likewise, there is a significant time by *mixed-type* personality interaction, such that relative to the average introjective patient, the average mixed-type improves 1.46 points more per half week [ $t(975) = -3.86, p = .0001$ ]. In sum, we can reject the null hypothesis of no difference in pre-therapy improvement trend between *anaclitics* and introjectives, as well as *mixed-types* and introjectives.

### ***Overview of Therapy Outcome—Preface to Hypotheses 5 and 6***

With regard to patient symptomatology, up to this point the focus has been just on baseline-phase phenomena. While hypotheses 5 and 6 address specific therapy-phase phenomena between groups of patients, an important and interesting



**Figure 4:** Initial status growth curves for baseline-phase patient-functioning. Lower OQ-45 score indicates greater improvement in patient-functioning.

**Table 4:** Baseline-phase piecewise model results for patient-functioning. Results are predicting OQ-45 score, showing relative differences among the personality groups.

<u>Effect</u>	<u>Coefficient</u>	<u>SE</u>	<u>t-ratio</u>	<u>Probability</u>
Intercept	60.30	6.26	9.63	<.0001
Baseline Time (slope)	-0.22	0.19	-1.20	.23
Personality (mean level)				
Anaclitic	11.04	11.19	0.99	.32
Mixed-Type	15.24	10.19	1.50	.13
Introjective	Reference	----	----	----
<b>Baseline Time x Personality</b>				
<b>Anaclitic</b>	<b>-1.62</b>	<b>0.37</b>	<b>-4.33</b>	<b>&lt;.0001</b>
<b>Mixed-Type</b>	<b>-1.46</b>	<b>0.39</b>	<b>-3.86</b>	<b>.0001</b>
<b>Introjective</b>	<b>Reference</b>	<b>----</b>	<b>----</b>	<b>----</b>

preface to these tests is to examine whether there is an overall effect for therapy in this sample as a whole, and in the groups separately. Figure 5 graphically illustrates the two-phase unconditional growth model curves for patient-functioning in the sample as a whole, and by each personality group.

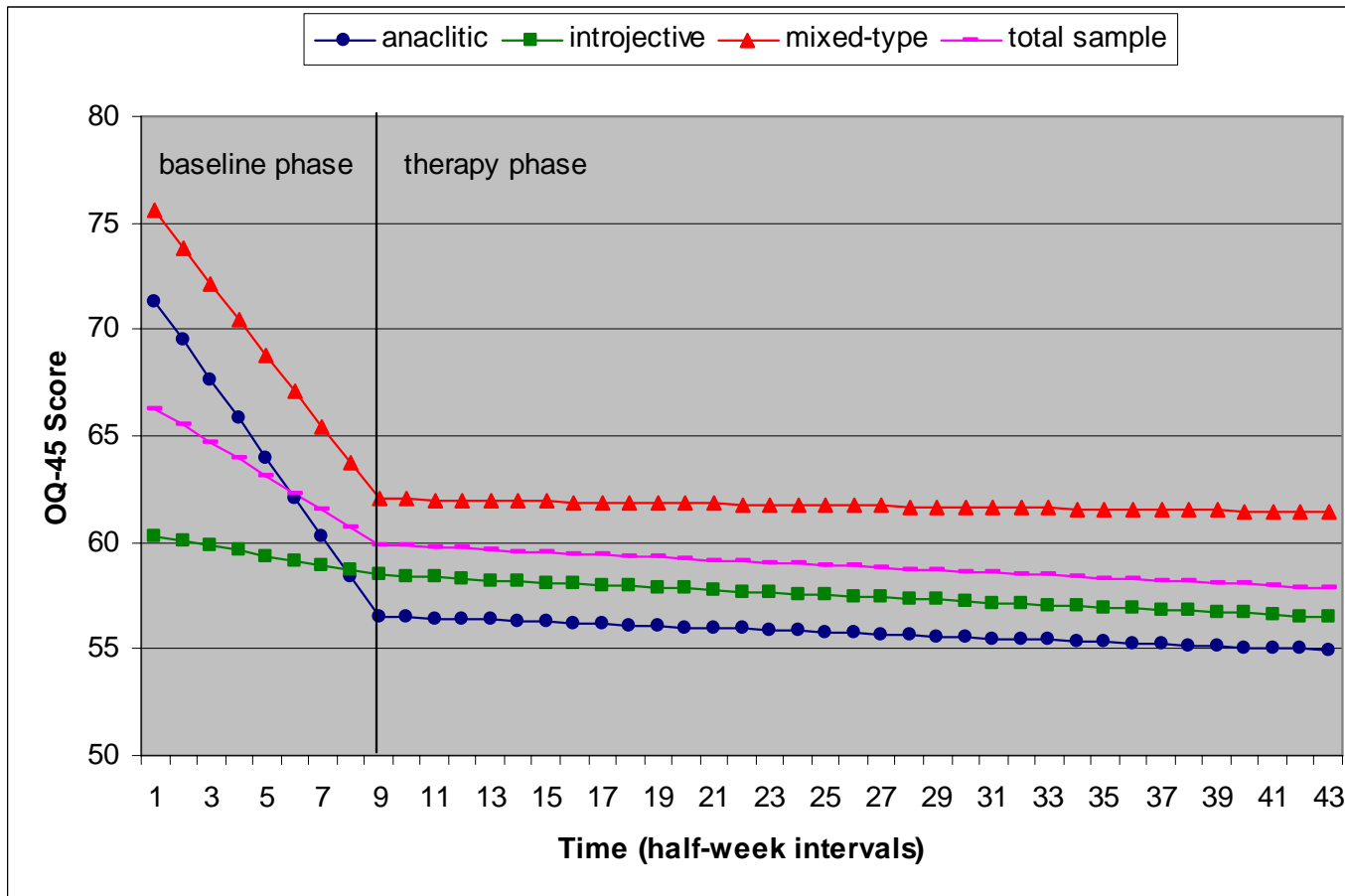
Table 5 summarizes the trends depicted graphically in Figure 5, and from which treatment effect inferences are made. More specifically, they are the results, by group, of the fixed effects for OQ-45-predicted intercept, baseline- and therapy-phase time—as well as results of an added between-phase level-effect test.<sup>10</sup> With the exception of the between-phase level results, what is presented in Table 5 comes from the unconditional linear growth model portion of the whole HLM model. That is, the portion that reports simply the intercept and slope for the *average* person (in HLM-parlance) of some designated group (e.g., anaclitics). In the full model, which includes the between-group covariate, this designated group becomes the benchmark against which other groups are compared (e.g., introjectives and/or mixed-types). This examination of each group one by one allows for an *overall* view of patients' growth in this study, before delving into hypotheses 5 and 6, which more specifically test for significant differences in treatment phase slopes *between* groups.

Beginning with the total sample, results indicate that the average patient starts out at intake with an OQ-45 score of 66.3. During baseline s/he decreases in score

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<sup>10</sup> This refers to a test for change in mean level between baseline and therapy phases. While a treatment effect is usually inferred by virtue of a significant improvement in therapy-phase slope, a more rigorous examination includes testing for a between-phase level effect as well. These level-test results come from an unconditional linear growth model that simply predicts OQ-45 across the entire time span and includes phase as a dichotomous covariate.





**Figure 5:** Initial status growth curves for two-phase patient-functioning. Lower OQ-45 score indicates greater improvement in patient-functioning.

**Table 5:** Overall unconditional model results for patient-functioning. Results are predicting OQ-45 score in both baseline and therapy-phase for all personality groups, and include a between-phase test of level differences.

<u>Group</u>	<u>Effect</u>	<u>Coefficient</u>	<u>SE</u>	<u>t-ratio</u>	<u>Probability</u>
<b>All Patients</b>	Intercept	66.30	4.19	15.81	<.0001
	Baseline slope	-0.80	0.15	-5.48	<.0001
	Therapy slope	-0.06	0.03	-2.24	.03
	Btwn phase level*	-10.88	1.39	-7.82	<.0001
<b>Anaclitics</b>	Intercept	71.25	8.35	8.53	.0004
	Baseline slope	-1.83	0.39	-4.66	<.0001
	Therapy slope	-0.05	0.06	-0.89	.38
	Btwn phase level*	-19.41	3.46	-5.61	<.0001
<b>Introjectives</b>	Intercept	60.28	7.42	8.13	<.0001
	Baseline slope	-0.22	0.16	-1.39	.16
	Therapy slope	-0.06	0.03	-1.66	.10
	Btwn phase level*	-1.84	1.76	-1.05	.29
<b>Mixed-Types</b>	Intercept	75.42	5.40	13.95	<.0001
	Baseline slope	-1.66	0.34	-4.88	<.0001
	Therapy slope	-0.02	0.06	-0.35	.72
	Btwn phase level*	-18.62	2.57	-7.26	<.0001

\* This between-phase level test is HLM model-derived, but it is not from the main piecewise HLM model used in this study.

(i.e., improves in functioning) by .80 points per half week [ $t(979) = -5.48, p < .0001$ ]. As can be seen in Figure 5, this improvement changes dramatically once therapy begins, but this average patient continues to improve at a rate of .06 points per half-week [ $t(979) = -2.24, p = .03$ ]. With regard to between-phase level changes in OQ-45, there is a significant difference such that in baseline this average patient scores a mean of 10.88 points higher (i.e., more symptomatic) than in therapy phase [ $t(978) = -7.82, p < .0001$ ]. In sum, there is an effect for both baseline and therapy phase slopes. Overall, patients in this total sample of 27 show statistically significant improvement in both phases, but compared with baseline, the improvement is negligible once therapy begins; most of the improvement occurs during baseline.

The average anaclitic patient starts out at intake with an OQ-45 score of 71.25, improves significantly in baseline by 1.83 points per half-week [ $t(244) = -4.66, p < .0001$ ], and then shows no improvement in therapy phase [ $t(244) = -0.89, p = .38$ ]. Also, the average anaclitic shows a significant OQ-45 *level* effect between phases, such that s/he scores a mean of 19.41 points higher during baseline [ $t(243) = -5.61, p < .0001$ ].

The average mixed-type patient starts out at intake with an OQ-45 score of 75.42, improves significantly in baseline by 1.66 points per half-week [ $t(240) = -4.88, p < .0001$ ], and then shows no improvement in therapy phase [ $t(240) = -0.35, p = .72$ ]. Also, the average mixed-type shows a significant OQ-45 *level* effect between phases, such that s/he scores a mean of 18.62 points higher during baseline [ $t(239) = -7.26, p < .0001$ ].

The average introjective patient starts out at intake with an OQ-45 score of 60.28 and does *not* improve significantly in baseline [ $t(491) = -1.39, p = .16$ ] nor in therapy phase [ $t(491) = -1.66, p = .10$ ]. Moreover, there is no significant difference in between-phase OQ-45 level in the average introjective patient [ $t(490) = -1.05, p = .29$ ]. To summarize, there is no significant effect for therapy phase slope in *any* of the three personality groups. Unlike the average introjective patient, both the anaclitic and mixed-type demonstrate significant pre-treatment slope improvements; and they both show significant differences in OQ-45 level between phases, such that they are more symptomatic in baseline.

### ***Hypothesis 5***

Hypothesis 5 states that *mixed-type patients will show more improvement in therapy-phase than anaclitic or introjective patients*. This hypothesis tests whether, in fact, the baseline slopes of anaclitics and introjectives each show a significantly weaker trend of improvement (i.e., decreasing slope) when compared with that of mixed-types. Specifically, Hypothesis 5 was examined by testing for a significant interaction between therapy-phase time and personality group, with mixed-types as the reference group, and OQ-45 score as the outcome variable, using the piecewise HLM model.

Again, Figure 5 illustrates the results of this model, showing the relative difference in therapy-phase slopes among the three groups. Table 6 displays these results, with those of the relevant interaction test in bold.

**Table 6:** Piecewise model results for patient-functioning, referencing mixed-types. Results are predicting OQ-45 score in both baseline and therapy-phase, showing relative differences among the personality groups.

<u>Effect</u>	<u>Coefficient</u>	<u>SE</u>	<u>t-ratio</u>	<u>Probability</u>
Intercept	75.55	8.04	9.40	<.0001
Baseline Time (slope)	-1.69	0.330	-5.10	<.0001
Personality (mean level)				
Anaclitic	-4.21	12.27	-0.34	.73
Introjective	-15.25	10.19	-1.50	.13
Mixed-type	Reference	----	----	----
Baseline Time x Personality				
Anaclitic	-0.160	0.464	-0.34	.73
Introjective	1.46	0.379	3.86	<.0001
Mixed-type	Reference	----	----	----
Therapy Time (slope)	-0.018	0.055	-0.33	.74
<b>Therapy Time x Personality</b>				
<b>Anaclitic</b>	<b>-0.029</b>	<b>.071</b>	<b>-0.40</b>	<b>.69</b>
<b>Introjective</b>	<b>-0.040</b>	<b>.068</b>	<b>-0.58</b>	<b>.56</b>
<b>Mixed-type</b>	<b>Reference</b>	<b>----</b>	<b>----</b>	<b>----</b>

There is no significant therapy time by anaclitic personality interaction [ $t(975) = -0.40, p = .69$ ], nor therapy time by introjective personality interaction [ $t(975) = -0.58, p = .56$ ]. Thus, we cannot reject the null hypothesis of no significant difference in OQ-45 therapy-phase slopes between mixed-type and introjective patients, or mixed-type and anaclitic patients.

### ***Hypothesis 6***

Hypothesis 6 states that *the pace of improvement during therapy-phase among introjectives will be more gradual than that of anaclitic patients*. As in hypothesis 5, this hypothesis tests for a significant interaction between therapy-phase time and personality group, with OQ-45 score as the outcome variable in the piecewise HLM

model. The results are, in essence, the same. However, for this hypothesis, anaclitics are the reference group,<sup>11</sup> leading to the appropriate adjustment in reported coefficients.

Again, Figure 5 visually shows the relative difference in slopes between anaclitics and introjectives (appearing nearly the same). Table 7 displays these results, with those directly relevant for testing this hypothesis, in bold.

**Table 7:** Piecewise model results for patient-functioning, referencing anaclitics. Results are predicting OQ-45 score in both baseline and therapy-phase, showing relative differences among the personality groups.

<u>Effect</u>	<u>Coefficient</u>	<u>SE</u>	<u>t-ratio</u>	<u>Probability</u>
Intercept	71.34	9.27	7.69	<.0001
Baseline Time (slope)	-1.84	0.326	-5.67	<.0001
Personality (mean level)				
Mixed-type	4.21	12.27	0.34	.73
Introjective	-11.04	11.19	-0.99	.32
Anaclitic	Reference	----	----	----
Baseline Time x Personality				
Mixed-type	0.16	0.46	0.34	.73
Introjective	1.62	0.38	4.33	<.0001
Anaclitic	Reference	----	----	----
Therapy Time (slope)	-0.05	0.05	-1.04	.30
<b>Therapy Time x Personality</b>				
Mixed-type	0.03	0.07	0.40	.69
<b>Introjective</b>	<b>-0.011</b>	<b>0.061</b>	<b>-0.18</b>	<b>.86</b>
<b>Anaclitic</b>	<b>Reference</b>	<b>----</b>	<b>----</b>	<b>----</b>

<sup>11</sup> Introjectives could just as arbitrarily be used as the reference group for testing this hypothesis—the important point is that it is not mixed-types, as was the case in testing hypothesis 5.

There is no significant therapy time by introjective personality interaction [ $t(975) = -0.18, p = .86$ ]. Thus, we cannot reject the null hypothesis of no significant difference in OQ-45 therapy phase slopes between anaclitic and introjective patients.

## Chapter 4

### Discussion

Drawing from a host of theoretical perspectives, S. J. Blatt and colleagues (e.g., Blatt, 1974; Blatt, 1995; Blatt & Blass, 1996; Blatt & Shichman, 1983) have developed a theory of personality and psychopathology that suggests individuals develop and function along two basic lines—that of interpersonal relatedness (anaclitic) and that of self-definition (introjective). Throughout the lifespan, they suggest that individuals develop normally in an oscillatory fashion along each of these lines—at times investing more in interpersonal strivings, related to dependency, loving and *being loved*; and at times investing more in self-definitional strivings, related to autonomy, achieving and *being lovable*. (Blatt & Shichman, 1983; Blatt, 1995). When investment in either of these lines becomes *enduringly* over-emphasized, or the achievement of one (or even both) becomes particularly frustrated, these configurations of personality become configurations of psychopathology.

Individuals with anaclitic psychopathologies tend to be plagued by feelings of helplessness and weakness, they tend to have fears of being abandoned, and they have strong wishes to be cared for, protected, and loved. They tend to have a *depleted* sense of self in which their symptoms express over-compensatory efforts to repair disruptions in interpersonal relations. They are often experienced by others as needy, clinging, and demanding individuals; and they frequently rely on more avoidant defenses (e.g., somatization and denial) (Blatt & Shichman, 1983; Blatt, 1995).



Individuals with introjective psychopathologies tend to be plagued by feelings of guilt, self-criticism, inadequacy, inferiority, and worthlessness. Rather than depleted, they tend to have a *distorted* sense of self in which their symptoms express over-compensatory efforts to be separate, to achieve, and to rectify feelings of failure and disappointment. They are often experienced by others as highly perfectionistic, duty-bound, and overly-competitive individuals; and they frequently rely on more counteractive (as opposed to avoidant) defenses (e.g., intellectualization and doing/undoing) (Blatt & Shichman, 1983; Blatt, 1995).

A number of studies have examined whether and how different types of treatment impact those with anaclitic vs. introjective disorders. And, recently (Shahar, Blatt & Ford, 2003) there has been research examining treatment of “mixed-type” patients who evidence significant problems in *both* domains. In general, poorer outcome has been shown among introjective patients in brief, time-limited psychotherapy—arguably because of their particularly negative mental representations of self and others (Blatt, 1998; Blatt, Shahar & Zuroff, 2001). However, when therapy is long-term, intensive, and psychoanalytically-oriented, introjective patients have been shown to improve more than their anaclitic counterparts (Blatt, 1992) These differential responses could be related to the patients’ perception of the therapeutic alliance, with evidence suggesting that highly introjective patients tend to have a more difficult time establishing a positive therapeutic alliance (Zuroff et al., 2000). The more recent research looking at mixed-type inpatients suggests they are more clinically impaired and more vulnerable prior

to treatment (when compared with either pure anaclitics or pure introjectives), but that they improve significantly more in long-term psychoanalytically-oriented treatment (Shahar, Blatt & Ford, 2003).

In all of this work that has been done to illuminate psychotherapy outcome in differently-configured patients, no known published research in this area has examined the impact of simply deciding to seek treatment. As Howard et al. (1986) note, about 15% of patients show measurable improvement before attending the first session of psychotherapy. They speculate that this decrease in distress could be related to the patient feeling a sense of reassurance that help is one the way. It could be that this reassurance is more potent among those with a predominantly anaclitic personality, since they are theoretically more invested in the prospect of making an interpersonal connection.

Thus, one of the aims of this study was to expand on the aforementioned simple pre-post research that has been conducted with primarily seriously disturbed inpatients in long-term therapy. To that end, the present study used a form of hierarchical linear modeling (HLM) to examine patterns of change in both therapeutic alliance and symptomatology among outpatients with anaclitic vs. introjective vs. mixed-type pathologies, in relatively short-term open-ended treatment. Of no less importance to this study, which adds to its uniqueness, is the examination of levels of distress and patterns of change *prior* to therapy, during a minimum 2.5 week baseline period.

### ***Overall Findings***

Overall, results were not supportive of most of this study's hypotheses. But some of the findings were quite interesting nonetheless, and warrant further investigation. Before discussing the results of the six hypotheses specifically, it is worth discussing the more general findings regarding treatment outcome, based on the piecewise model used in this study.

Controlling for personality type, there was equivocal evidence of an overall significant treatment effect in the sample as a whole. While there was a significant trend of improvement in *both* baseline and treatment phases, the former was quite significant at  $p < .0001$ , while the trend after therapy began was comparatively rather small—significant at the level of .03. Accounting for the large number of observations that comprise this sample, it makes sense to be wary of making much meaning of this treatment phase significance—especially in light of the rate of change in the therapy phase, which is only -0.06 points per half week.

To put this in more perspective, the average patient in the whole sample started out at intake with an OQ-45 score of about 66—just above 64, the cutoff for what is considered a level of symptomatology consistent with a clinical population (Lambert, Hansen, & Finch, 2001). As the baseline-phase progressed, the average patient reported improvement of 0.8 points per half-week before ever beginning psychotherapy. Once therapy began, the model shows that reported improvement leveled off to 0.06 points per half week. This leveling off, combined with the significant difference of nearly 11-points in mean OQ-45 score between baseline and

therapy phases indicates that most of the improvement in patient-functioning occurred during baseline. These baseline—therapy differences are markedly evident in Figure 5. In short, it can be said that when controlling for personality type, patients in this sample of 27 show significant statistical improvement during baseline—an improvement that suggests a move from a clinical to subclinical level of functioning—but after therapy begins the further improvement is negligible (even if statistically significant).

This brings up the issue of considering the reliable change index (RCI) when looking at all of these results. For the OQ-45 it is 14 points that constitutes such “clinically meaningful change” (Lambert et al., 2001). Examined as a whole, the average patient does not make such reliable change. However, they do change from a technically “clinical” level of functioning (above 64) to one that is not—and paradoxically this seems to occur during the baseline period.

When looking at patients by personality type, this baseline improvement followed by no meaningful change during therapy is even more pronounced among anaclitics and mixed-types. Indeed, results indicate that the average anaclitic and mixed-type patient presented for intake well within the domain of clinical impairment, with mean OQ-45 scores of approximately 71 and 76, respectively, and showed no significant improvement in therapy phase. Both also showed unequivocally-significant improvement during baseline of 1.83 and 1.66 points, respectively, per half-week. The significantly higher baseline-phase level for each group further highlights the degree to which change occurred prior to psychotherapy

intervention—as does the finding that no improvement was reported during therapy. Moreover, it can be said that the average anaclitic and mixed-type patient in this study made not only clinically meaningful change during baseline, since on average they improved by more than 14 points, but that this change moved them from the clinical range to that of the nonclinical range (i.e., below 64). The average introjective patient, on the other hand, presented at intake with a *subclinical* OQ-45 score of about 60, demonstrated no significant improvement trend in either baseline or therapy phases, and showed no difference in mean level of symptomatology between phases.

Perhaps what is most interesting about these results is that one cannot infer among any of these groups that psychotherapy, *per se*, had any effect on patients' functioning. It would be easy and reasonable to conclude that there simply was no "treatment effect"—as a whole, or by group. However, at least among anaclitics and mixed-types, it is arguable that there in fact *was* a treatment effect of some sort, but it was just not the intervention we imagined it would be (i.e., psychotherapy), but instead something that occurred during the baseline phase. This line of thinking will be explored further as the results of the 6 specific hypotheses are discussed.

### ***Specific Hypotheses***

Results were not supportive of the first hypothesis—that those with introjective preoccupations (i.e., introjectives and mixed-types) would stay in therapy longer compared with anaclitics. The rationale behind hypothesis 1 rests on the

supposition that the very kinds of preoccupations of those who have introjective propensities (e.g., perfectionism, sense of duty and obligation) would compel them to stay in therapy longer than those who are not as consumed with such issues (i.e., anaclitics). This was not the case in this sample of patients.

Results were not supportive of hypothesis 2—that those with strong anaclitic concerns (i.e., anaclitics and mixed-types) would have higher ratings of therapeutic alliance compared with introjectives. It was thought that being particularly invested, theoretically, in creating and maintaining satisfying intimate relationships would be reflected in a higher reporting of “satisfying” and “collaborative” feelings with one’s therapist. However, results indicated no such significant differences in alliance levels between the groups, while controlling for slope differences. More generally, there is a significant, but relatively modest, increasing trend of 0.20 points per half week in the average introjective patient, and no significant differences in slopes among the three groups. The average anaclitic increases 0.10 points per half-week and the average mixed-type improves 0.29 points per half-week.

Hypothesis 3—that mixed-type patients would show a higher level of clinical distress prior to therapy than introjectives or anaclitics—sought to replicate Shahar, Blatt & Ford’s (2003) finding, except in an *outpatient* sample of patients seeking less intensive psychotherapy. They suggest that mixed-types are likely to show greater clinical distress due to a lack of a clearly defined and consolidated mode of coping. This level-of-distress hypothesis was not supported when comparing mixed-types with anaclitics. However, the lack of a clearly significant difference in level between

the average mixed-type and *introjective* patient in this model is curious given the approximate 18-point difference between them—the fact that it approaches significance, makes it worthwhile to consider retesting this hypothesis with a larger sample of patients.

The lack of support for the first part of hypothesis 3, and the *possible* notion that introjectives score lower during baseline on the OQ-45 raises the interesting possibility that there may be something about being “purely” introjective—or, put another way, something about *not* having strong anaclitic “leanings,” so to speak—that is associated with lower reported-symptomatology prior to beginning therapy. Indeed, recall that both the average mixed-type and anaclitic presented for intake above the threshold for being considered in the “clinical” range of functioning, while the average introjective did not. It is a good question for future research to ask why it may be that pure introjectives present as the least distressed of the 3 personality types. It would be interesting to test whether this suggestion bears out with objective and/or projective measures, as opposed to self-report measures. One possibility for this apparent difference among introjectives is the notion that “purely” introjective patients tend towards self-reliance (in their exaggerated attempts to carve out an identity), which may in turn come with difficulty acknowledging (i.e., on a self-report) to a more full extent their distress and difficulties to another person and/or themselves.

Hypothesis 4 was the only fully supported one. It sought to examine whether those with anaclitic preoccupations (i.e., anaclitics and mixed-types) might, in fact, be

more assuaged of some clinical distress prior to therapy than introjectives would be, as evidenced by significant slope differences. The fact that both the average anaclitic and mixed-type patient showed a significant downward (i.e., improving) slope with regard to their reported symptomatology, and that this improvement was significantly different from that of the average introjective patient, supports the notion that simply the prospect of embarking on a therapeutic process that is *inherently interpersonal* can be particularly relieving to those patients with anaclitic preoccupations. Indeed, theory would suggest this to be the case given the anaclitically-inclined patient's affiliative and nurturant longings.

Results from hypotheses 5 and 6 are perhaps the most interesting of this study—and paradoxically so—since these hypotheses were not supported. Indeed, the treatment-phase time by personality interactions yielded no support for between-group differences in therapy-phase patient-functioning trends. Moreover, there was no support for the implicit hypothesis that therapy would in fact have an effect. Indeed, as Figure 5 illustrates well, all three groups' therapy phase slopes of symptomatology are nearly flat, showing no improvement or worsening in therapy. What is just as striking in these models is the significant effect for slope in *baseline*, with the exception of the introjective group. And, when looking at all the patients as a whole, this pre-treatment improvement followed by virtually no improvement in therapy also exists.

This is not the kind of finding that many clinicians, who champion their craft as helpful and mutative, would like to hear since it may suggest that what they



specifically do as a therapist is not associated with improvement—but that something else is. These results suggest that the “something else” is not even what has been called “nonspecific” or “common factors” of therapy (cf. Stein & M.J. Lambert, 1995), since the change is occurring *before* therapy even begins. It could be “expectancy” (cf., M. J. Lambert & Barley, 2001), which the results of hypothesis 4 suggest is particularly salient among anaclitic and mixed-type patients.

Another factor that may be at work in explaining this significant pre-therapy improvement is what M. J. Lambert & Barley (2001) note as “extratherapeutic factors,” such as spontaneous remission, chance events, and simple social support. Indeed, drawing from exhaustive reviews of psychotherapy-outcome literature, these authors suggest that such extratherapeutic factors comprise 40% of what influences patient-outcome (and common factors, expectancy, and specific techniques comprise the rest, at 30%, 15%, and 15%, respectively) (Ibid.).

Another similar idea that could explain this pre-therapy-improvement is what W. Lambert & Bickman (2004) call the “clock-setting” cure. These authors used a computer simulation program to demonstrate that natural history could account for initial symptom improvement in children who receive ineffective treatment <sup>12</sup>. They call it the clock-setting cure because when individuals come for treatment (whether we are talking about medical treatment for a cold, or psychotherapy for depression), they tend to come when they are feeling their worst and, as such, over time they will

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<sup>12</sup> this is not to say that the cohort of children these authors make reference to in their study received ineffective treatment—but rather that it seems that the initial improvement seen in the longitudinal outcome curve was a function of natural improvement as opposed to treatment.

likely *not* feel at their worst. As the authors note, this is exemplified well by the fact that when someone has a cold and they drink hot lemonade they in fact usually feel better in a week—the time for a cold to remit naturally anyway.

The fact that, as a whole, patients in this sample seemed to improve in baseline and reported no overall further clinically meaningful improvement in therapy may not actually be such a discouraging fact to those practicing psychotherapy; therapists may be providing an essential maintenance component. Indeed, the individuals in this sample did not seem to get worse after getting better either—they just stayed improved. The apparent fact that symptom-improvement in much of this sample began “once the clock started” (i.e., at intake) and not once the therapy began, does not necessarily mean that the therapy was ineffective—it just may mean that we need to study further what it is about the therapy process that may be helpful and sustaining of improved symptomatology.

### ***Study Limitations***

While the relatively frequently-collected measurements yielded a sufficient amount of statistical power for the models, the overall sample of 27 patients was relatively small. And when making comparisons between subsets of these patients, one of which only includes six individuals (anaclitics), this is an even further disadvantage. With such a small sample size, the multitude of other varying factors in this “real-world” effectiveness study is likely to have significant impact on the results. For instance, the therapists from this clinic had varying years of training, and

while coming from a generally psychodynamic program, there was surely variation among therapists in terms of how much support, direction, and interpretation was given to patients. With a larger sample size, these therapist-differences would become less significant, allowing for a more accurate and reliable examination of whether differences (or lack thereof, as the case may be) in treatment duration, outcome, and patterns of change can be attributed to one's personality configuration.

Another limitation in this study is the lack of a control group, which would have allowed for more meaningful comparisons and allowed for more definitiveness about whether there was a treatment effect overall.

It is also worth noting the possibility that the study protocol was overly-demanding of the patients' time and energy, which could lead to careless, rote completion of the questionnaires. While the OQ-45 was designed to be robust to the effects of multiple administrations over time, the fact that it was given twice a week (and in combination with the 33-item CAS-3 measure), may have been too rigorous an expectation. Indeed, anecdotally, several patients noted to their therapist they felt this process was cumbersome.

A closely related limitation in this study is the fact that nearly 25% of the patients participating asked to stop after a sufficient period of time, but continued in therapy. Results of this study may have been quite different if data were available for the entire course of their therapy.

Future outcome and/or time series studies, some of which are already in progress, would arguably be less cumbersome and more efficient if patients spent less

than a minute at the end of each day to respond to just a few items quite specific to their unique difficulties, and then completed a standardized measure like the OQ-45 on a monthly-basis, as a complementary component. Other ideas include complementing shorter self-report measures with ratings by the therapist, and/or administering pre-post projective tests. While this would be more time consuming for the investigators, it would yield important *other*-reported and implicitly-based data to assess whether and how patients change. To be sure, the sole-reliance on self-report measures in this study is arguably one of its biggest limitations.

### ***Conclusion***

This study sought to replicate and extend ideas suggested by Blatt and colleagues about ways in which those with anaclitic, introjective and mixed-type preoccupations change as a function of initiating and going through psychotherapy. In general, results of this study were not what was expected. With the exception of one original hypothesis that *was* supported (suggesting that those with anaclitic preoccupations would show more pre-therapy improvement compared with pure introjectives), all other hypotheses in this study were not fully supported. Duration of treatment and ratings of therapeutic alliance did not differ among patients. Patients did not differ clearly in levels of distress during baseline, either. Although, there was some evidence to suggest that, on average, during baseline introjectives tend to report being less symptomatic compared with anaclitics or mixed-type patients. Moreover,

results suggest that introjectives as a group may tend to present at intake with a subclinical level of distress, whereas anaclitics and mixed-types tend not to.

Beyond the specific hypotheses tested here, what *was* found was that when examining this sample as a whole, there was significant improvement in baseline, after initiating the process of coming for treatment, but before actually beginning psychotherapy, proper. Much of this overall baseline improvement was driven by the particularly strong improvement in the anaclitic and mixed-type groups, and attenuated by the lack of improvement in the introjective group. Once psychotherapy began, patients as a whole, and by group, did not report any meaningful change in symptomatology. Several possible explanations for such a phenomenon are suggested.

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