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A Task Analysis of Metacommunication in Time-Limited Dynamic Psychotherapy

by

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DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of Psychology in the Department of Clinical Psychology of Antioch University New England, 2011

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A TASK ANALYSIS OF THERAPIST METACOMMUNICATION
IN TIME-LIMITED DYNAMIC PSYCHOTHERAPY

presented on April 19, 2011

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Stand in the wind as the carousels spin
Wear out your welcome again
Stand on the silence of mountains
And take a look down to the sea.

-*Stuart Adamson*

Dedicated to my sister, Jessica

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Table of Contents

Dedication....iii

Acknowledgments....iv

List of Tables....ix

List of Figures....x

Abstract....1

Introduction....3

Definition....3

Metacommunicative Principles....5

Little Research on Effective Metacommunication....7

Function of Metacommunication....8

Task Analysis....9

Time-Limited Dynamic Therapy....9

Purpose of the Study....11

Literature Review....11

Relevant Research on Metacommunication....11

Metacommunication and immediacy....12

Metacommunication as self-involving statements....14

Metacommunication as interpersonal feedback....17

Metacommunication in interpersonal therapies....19

Relational therapy and stage-process models....21

Metacommunicative Principles....22

A Functional Approach to Studying Change: Task Analysis....27

Method 30
Study Design 30
Participants 31
Determining Session/Metacommunicative Quality 32
Session Impacts Scale 32
Therapist Appraisal Questionnaire 33
Client Appraisal Questionnaire 34
Client/Therapist Thought-Listing Questionnaire 34
Session Selection Procedure for Empirical Analysis 35
Exclusion of sessions with inadequate data 35
Ranking session quality 36
Exclusion of more than two sessions of identical dyads 38
Screening sessions for metacommunication 48
Selection procedure for sessions with multiple instances 48
Task Analysis: Procedure 52
Step 1: Description of the task 52
Step 2: Explicating the cognitive map 53
Step 3: Specifying and evaluating the potency of the task environment 53
Step 4: The rational task analysis/constructing a rational model 54
Step 5: Conducting an empirical task analysis 54
Step 6: Synthesizing a rational-empirical model 57
Results 59
Step 1: Identifying Markers and Sequences 59

Step 4: Constructing a Rational Model 60

Step 5: Empirical Modeling 65

Shared metacommunicative sequences in HQ sessions 65

Shared metacommunicative sequences in LQ sessions 67

Creation of the empirical model 68

Step 6: Synthesis of the Rational-Empirical Model 70

Discussion 74

The Rational-Empirical Model: Features and Clinical Implications 75

The Rational-Empirical Model in Light of Existing Principles 80

Limitations of the Study 82

Directions for Future Research 84

Personal Reflection 85

References 87

Appendixes 96

Appendix A. Session Impacts Scale 97

Appendix B. Therapist Appraisal Questionnaire 100

Appendix C. Client Appraisal Questionnaire 101

Appendix D. Therapist Thought-listing Questionnaire 102

Appendix E. Client Thought-listing Questionnaire 103

Appendix F. Resolution Diagrams of HQ Sessions 104

Appendix G. Resolution Diagrams of LQ Sessions 110

Appendix H. Combined and Abstracted Sequences Across HQ Sessions 116

Appendix I. Combined and Abstracted Sequences Across LQ Sessions 120

Appendix J. Shared Components of Metacommunication in HQ Sessions 124

Appendix K. Shared Components of Metacommunication in LQ Sessions.........................125

List of Tables

Table 1. Sorting Procedure for Selecting HQ Sessions for Empirical Analysis 41

Table 2. Sorting Procedure for Selecting LQ Sessions for Empirical Analysis 42

Table 3. Common Therapist-Client Dyads in Both HQ and LQ sessions 43

Table 4. Process Measure Subscale Values of Six Highest-Ranked TLDP Sessions 44

Table 5. Process Measure Subscale Values of Six Lowest-Ranked TLDP Sessions.............45

Table 6. Means and Standard Deviations of All Ratings for Sessions with Multiple MET Attempts 50

Table 7. Completeness and Relevancy Ratings for Sessions with Multiple MET Attempts 51

Table 8. Summary of Abstraction/Combination Procedures 58

List of Figures

Figure 1. H and L values of sessions selected for analysis 47

Figure 2. H and L rank values for sessions selected for analysis 47

Figure 3. Rational model of working metacommunication in TLDP.....................................61

Figure 4. Empirical model of working metacommunication in TLDP...................................69

Figure 5. Rational-Empirical model of working metacommunication in TLDP 74

Abstract

This study examined how successful metacommunication unfolded in time-limited dynamic psychotherapy (TLDP) using the task-analytic paradigm developed by Greenberg (2007). Specifically, the purpose of the study was to discern the elements, themes, and temporal sequences that were common to effective metacommunication. In accordance with the paradigm, this was accomplished by the creation of a rational model, which combined existing theoretical literature on metacommunication and anecdotal clinical evidence. Next, the distilled components of metacommunication in six high-quality (HQ) sequences were contrasted to the distilled components of six low-quality (LQ) sequences in order to generate an empirical model. These sequences were selected from 66 audiotaped TLDP training sessions and selected for analysis via an aggregate score on several client- and therapist-completed process measures. The empirical model was then integrated with the initial rational model to generate the final rational-empirical model, which can be viewed as a five-component series of essential "tasks" that the therapist-client dyad must complete. The most important client task was clients' ability to identify their own contributions to, or feelings about, their depictions of thematically repeated interpersonal conflict. The most important therapist tasks involved allowing for the emergence of a pattern in clients' interpersonal difficulty before making the metacommunicative statement, as well as establishing an empathic, encouraging tone throughout the metacommunicative sequence. The presence of client-therapist mutuality (a shared sense of regard and working together) was deemed to be an essential component of successful metacommunication as well. Study findings suggest that therapists practice "patience" in allowing clients' depictions of interpersonal or relational conflicts to become thematically established before offering a metacommunicative statement; additionally, therapists should incorporate supportive and encouraging elements into

these statements. Lastly, therapists should be cautious of using metacommunication to explore clients' self-criticism in the context of a poor therapeutic alliance. The absence of a reliable measure of metacommunication with which to select metacommunicative instances for analysis, as well as the possibility of difficult client interpersonal styles which might negatively impact therapists' metacommunicative attempts are discussed as limitations to the study. Finally, a personal reflection is offered on a misguided metacommunicative intervention.

A Task Analysis of Metacommunication in Time-Limited Dynamic Psychotherapy

It is without the slightest bit of irony that several psychotherapy process researchers have described the use of therapeutic metacommunication as an "asocial" way of communicating during the intimate process of psychotherapy (e.g., Kiesler, 1988; Kiesler & Van Denburg, 1993). Yet, metacommunication—often in the form of therapist self-involving disclosures used to make explicit their reactions to client patterns—is often used in a therapeutic setting to facilitate communication between therapist and client by bringing to awareness and clarifying those thoughts, feelings, and reactions that would otherwise remain implicit (Hill & Knox, 2002). Thus, metacommunication can be seen as a therapist skill that makes implicit communication between client and therapist explicit and more available for conjoint exploration.

Despite its singular transtheoretical purpose, metacommunication has been discussed in various ways across the extant literature. For instance, metacommunicative interventions have been described as a means of providing a sense of "immediacy" in the here-and-now of therapy (Hill & O'Brien, 1999; Yalom, 1995), as a skill to facilitate client insight into dysfunctional interpersonal patterns (Kiesler, 1996; Levenson, 1995; Strupp & Binder, 1984), and as a method by which interpretations are guided in psychoanalysis (Nuttall, 2000). Indeed, in one of its more sophisticated uses, metacommunication has even been identified as the "vehicle" by which strains or ruptures in the therapeutic relationship are explored, processed, and resolved, thereby providing a valuable opportunity for client insight and growth (Safran & Muran, 2003).

Definition

Metacommunication "qualifies or comments on communication… it can be a nonverbal act, or it can be a statement that comments on the process of communication" (Gottman, 1987). Often portrayed as simply "talking about talking," metacommunication occurs whenever

conversational partners' verbal and/or nonverbal communication becomes the topic of communication itself. This understanding of the term is reflected in a contemporary dictionary definition, which defines metacommunication as "communication that takes place with, or underlies, a more obvious form of communication" ("Metacommunication," Oxford English Dictionary, 1989, p. 666). These broad definitions, however, do not adequately capture the uniqueness of therapeutic metacommunication—specifically, its usefulness in fostering an atmosphere of therapist-client collaboration while exploring implicit feelings regarding interpersonal transactions, either between the client and important others or between the client and the therapist. As such, metacommunication is defined in this study as instances when the therapist takes a step back from the content of the client's depiction of an interpersonal transaction (or the therapist-client interaction itself) and makes an attempt to place it into some type of meaningful therapeutic context.

One means of framing metacommunication has been to discuss it as a transtheoretical counseling "microskill." For example, Teyber (2000) discusses how "process interventions" (p.221) benefit the therapeutic process by making the therapist-client interaction explicit and available for ongoing exploration. Brems (2000) discusses metacommunication in terms of "here-and-now process comments" (p. 247) that highlight current interactions and facilitate change outside of the therapy session.

In addition to its transtheoretical use as a microskill, metacommunication is often discussed as a key feature of interpersonal and relational psychotherapies, where the identification and exploration of the unfolding relationship between the therapist and client is thought to hold important information about the client's view of him- or herself and his or her relationships with others. This literature has often framed metacommunication as "interpersonal

feedback" – that is, information provided to the client about his or her behavior or its effects, which may contain both descriptive and evaluative components (Claiborn, Goodyear, & Horner, 2001).

Safran and Muran (2003) highlighted the mindful use of metacommunication in relational therapy to reflect on, discuss, and therapeutically process strains and fractures in the therapeutic relationship. In this model, in which such ruptures are seen as inevitable, the therapeutic work performed around rupture repair is considered central to therapeutic change. These authors developed stage-process models of rupture repair, where the skillful use of metacommunication was found to be an essential component of the characteristic ways in which alliance ruptures are resolved. Here, the metacommunicative principles found to be common to successful resolution are discussed in depth, and share many elements with the principles discussed by other theorists (e.g., Kiesler, 1996; Teyber, 2000).

Metacommunicative Principles

Despite the modest amount of empirical research on what constitutes effective metacommunication, a copious amount of theoretical literature exists on the essential components of metacommunicative feedback as well as the principles that guide its application. Most prominent in this literature are Kiesler's (1988, 1996) extensive frameworks. Consistent with interpersonal formulations related to client reenactment of interpersonal difficulties within the therapy setting, metacommunication is framed as the provision of "impact disclosure," which "offers metacommunicative feedback to the patient that describes the patient's style and its self-defeating interpersonal consequences" (p. 29). As such, the most overarching recommendation is that the therapist's metacommunication reflect the multidimensionality and complexity of the client's style—that is, by emphasizing both the "negative" and "positive"

aspects of the therapist's reaction to the client. Kiesler's ten specific principles of metacommunication highlight the importance of therapists' being confrontational as well as supportive, the necessity of a facilitating attitude in the therapist, the ability to be direct and unambiguous, and the importance of introducing metacommunicative feedback early in therapy, among others.

Likewise, Safran and Muran (2003) outline seventeen metacommunicative principles, discussed in three general areas—how the therapist should relate to the client, what the therapist should attend to in metacommunicative attempts, and what the therapist should expect while mobilizing metacommunication to work through a therapeutic impasse. Furthermore, these authors propose an additional fifteen specific principles across two areas: developing therapists' awareness of their own experience before the metacommunicative event, as well as offering specific tips on crafting metacommunicative utterances. Considered as a whole, these principles highlight many of the features of brief relational therapy, which emphasizes therapist subjectivity, focuses on the here-and-now of therapy, and encourages in-depth exploration of the patient's experience in the context of the therapeutic relationship.

Teyber (2000) discussed how effective metacommunication is often hindered by therapists' fears that clients will perceive direct and honest metacommunicative feedback as too direct or confrontational. Although the author discusses how this style of discourse is typically not found in extra-therapeutic settings and can initially be perceived as awkward by clients as well as therapists, he reassures readers that fears of long-term client discomfort are unfounded. Nevertheless, Teyber encourages therapists to speak directly to their clients about metacommunication at the beginning of treatment, and supports the notion such an introduction

to metacommunicative discourse will put both members of the therapy dyad at ease when it is subsequently used.

Little Research on Effective Metacommunication

Although several psychotherapeutic orientations stress the importance of therapeutic metacommunication, there are few empirically informed models of its use despite a substantial body of theoretical guidelines (e.g., Kiesler, 1996; Safran & Muran, 2003; Teyber, 2000). In part, this can be attributed to methodological difficulties, as metacommunicative exchanges typically transcend the content-based categorical rating systems commonly used to characterize therapist and client utterances (Hill & O'Brien, 1999).

However, three important general themes of effective metacommunication have arisen from research that largely agrees with theoretical guidelines. First, several studies (e.g., Hill, Mahalik, & Thompson, 1989; McCarthy & Betz, 1978; Reynolds & Fischer, 1983) found that "self-involving statements"—therapist metacommunicative utterances that were "direct present expressions of the counselor's feelings about or reactions to the statements or behaviors of the client" (McCarthy & Betz, 1978, p. 251)—kept the focus of the interaction on the client and maintained this focus in the present, which tended to generate "here-and-now" themes relevant to clients' interpersonal difficulties.

Second, several other studies emphasized the importance of placing metacommunicative interventions within a positive or hopeful context. For instance, research has shown that when the self-involving statements described above are delivered in a reassuring manner (rather than delivered in a challenging one), such metacommunication is more likely to be accepted and processed by the client (Hill et al., 1989). Similarly, it has been demonstrated that the most important factor in clients' acceptance of therapist metacommunication was the presence of a

positive "valence" or general tone (Critelli & Neumann, 1978); indeed, even client acceptance of negative interpersonal feedback (one type of metacommunication) has been shown to increase if bracketed by positive feedback (Hill et al., 1989; Morran, Stockton, Cline, & Teed, 1998; Stockton & Morran, 1981; Rose & Bednar, 1980). Similarly, metacommunication that contains an element of encouragement is experienced as more helpful than those feedback statements that do not (DeVoge, Minor, & Karoly, 1981).

Finally, research findings demonstrate that therapist feedback tends to be more readily accepted in later sessions of therapy (Morran, Robison, & Stockton, 1985) suggesting that metacommunication is more helpful as relationships are given time to mature. Additionally, the presence of a high-quality working alliance has been associated with increased acceptance of negative feedback (Claiborn et al., 2001), again emphasizing the importance of a facilitative interpersonal context. Further, another study emphasized the converse; namely, that hostile clients tend to evoke therapist metacommunicative utterances that convey blame, thereby damaging the alliance (Henry, Strupp, Butler, Schacht, & Binder, 1993).

Function of Metacommunication

One means of deepening the understanding of therapists' effective use of metacommunication is through a focus on "process in context" (Greenberg, 2007, p. 16)—in this case, by conceptualizing metacommunication through the therapeutic function it is meant to serve. Despite subtle differences in the purpose of metacommunication across various psychotherapeutic approaches—as well as use for different purposes within a given approach—the overarching function of metacommunication is to transform the implicit (i.e., tacit or unspoken) into the explicit (i.e., understood, available for further exploration) in order to elicit client self-awareness, reflection, and encourage further processing of clinical material. With this

in mind, metacommunication can be viewed functionally—that is, as a contextually dependent, goal-directed process in which therapist and client both play equal parts. Such a view has important implications for studying the use of therapeutic metacommunication, as through this functional lens, metacommunication becomes a clinically meaningful and circumscribed therapy task involving both therapist and client. Here, the notion of participant (i.e., therapist and client) performance becomes important, with successful performance resulting in meaningful therapeutic change.

Task Analysis

As an investigative methodology that seeks to provide "a detailed understanding of a participant's performance in completing a complex change task" (Pascual-Leone, Greenberg, & Pascual-Leone, 2009, p. 527), task analysis is ideal for studying metacommunication from a functional perspective—that is, via discovering and characterizing the context-dependent performance of both therapist and client in the transformation of the implicit to the explicit in service of enhanced client self-awareness, reflection, and change. This methodology has been applied to a variety of psychotherapeutic tasks across varying theoretical orientations (see Greenberg, 1984; Greenberg & Johnson, 1988; Joyce, Duncan, & Piper, 1995; Scioli, 2006; Safran, Muran, & Samstag, 1994) with the goal of discovering the "process of change by identifying the affective and cognitive components of resolution of the task" (Greenberg, 2007, p. 17). In the interactive process of therapeutic metacommunication, it is important to take into consideration both client and therapist contributions to the identification of successful metacommunication components and processes.

Time-Limited Dynamic Therapy

An essential step of the task-analytic paradigm is the grounding of the phenomenon of

interest in a general theory of psychotherapy that enables the investigator to declare his or her assumptions and understanding of change (Greenberg, 1984, 2007). Time-Limited Dynamic Psychotherapy (TLDP), originally conceived by Strupp and Binder (1984) and later expanded upon by Levenson (1995, 2003), is a popular brief therapy that combines psychodynamic and interpersonal notions of client change in a framework that specifies metacommunicative interventions as a key component of the therapy.

TLDP relies on accurate and sensitive metacommunicative feedback to highlight interactions between client and therapist (Strupp & Binder, 1984). Specifically, the therapist's interactions with the patient are thought to "contribute significantly to maintaining the dysfunctional interaction between patient and therapist" (Levenson, 1995, p. 88). The "way out of this interactive rut" (p.88) is through an "unhooking" process via metacommunication, which provides a context to discuss the therapist's own reactions to the interaction as well as the patient's contribution. Thus, therapist metacommunication—through "self-involving statements" and "countertransference disclosure"—become essential TLDP elements in permitting the exploration of dysfunctional interpersonal dynamics.

However, the delivery of metacommunication in TLDP is a skill that therapists in training often struggle with, especially when working with clients whose interpersonal styles are particularly challenging, or with those clients who react to metacommunicative interventions negatively (Levenson, 1995; Raue, Goldfried, & Barkham, 1997; Safran & Muran, 2003). In light of research showing that poorly delivered metacommunication (i.e., metacommunicative attempts that are perceived by the client as blaming or belittling) can overwhelm previous positive therapeutic work (Henry et al., 1993), identifying and characterizing those instances

where metacommunication has enhanced therapy process has important implications for both understanding its relationship to therapy outcome and the training of skilled therapists.

Purpose of the Study

Therapeutic metacommunication has been discussed in various contexts, from a transtheoretical microskill to a highly detailed, prescribed theory-specific intervention. However, little research has characterized the elements, themes, and temporal sequences of successful metacommunicative exchanges as they occur in therapy sessions. As such, the primary question of the proposed study is: How does effective metacommunication unfold in TLDP? Specifically, what are the elements, themes, and temporal sequences that are common to effective metacommunication? And to what extent does effective metacommunication comport with theoretical models?

Literature Review

This section begins by summarizing the theory and research across different frameworks of therapeutic metacommunication. It then considers an alternate approach to investigating metacommunication through viewing the intervention functionally—that is, by emphasizing metacommunication as a goal-directed task that seeks to resolve a particular therapeutic problem. Other studies that have explored similar tasks in psychotherapy using this approach are highlighted, and the current project is described in this light.

Relevant Research on Metacommunication

Because metacommunication encompasses a broad spectrum of interventions, interactional sequences, and speech acts, it has been discussed across the literature using various terms. These include “impact disclosure” (Kiesler, 1988, p. 40), “interpersonal feedback” (Claiborn et al., 2001, p. 401), “process commentary” (Teyber, 2000, p. 222), “here-and-now

commentary" (Brems, 2001, p. 267), and, "talking in the here-and-now about the here-and-now" (Yalom, 1995, p. 129). Despite these distinctions in terminology, however, all share a common psychotherapeutic function of transforming the tacit to the explicit.

Research on metacommunication has been similarly performed across different investigatory frameworks. As such, relevant investigations are summarized here, beginning with a discussion of research framing metacommunication as a basic, transtheoretical therapist skill (i.e., metacommunication as provision of "immediacy"), then by summarizing research that begins to incorporates basic interpersonal principles (i.e., research on therapist self-disclosing statements and feedback) and ending with research on metacommunication in the theory-dependent context of interpersonal and relational therapies.

Metacommunication and immediacy. Several scholars have framed metacommunicative interventions as a basic, transtheoretical counseling technique that is included in the arsenal of therapist "microskills." These are common and transtheoretical therapist comments or questions designed to "draw the clients' attention to a feeling, thought, behavior, need, conflict, or coping response expressed in the relationship with the clinician right here and right now" (Brems, 2001, p. 267). Teyber (2000) discusses how such "process interventions" (p.221) benefit the therapeutic process by making the therapist-client interaction explicit and available for ongoing exploration. Brems, who echoes Yalom's (1995) emphasis on highlighting current interactions, discusses metacommunication in terms of "here-and-now process comments" (p. 247) that highlight current interactions and facilitate change outside of the therapy session. Finally, Galvin and Ivey (1981) described metacommunication-as-microskill (often referred to as "immediacy" in this literature) as an important quality of therapist empathy.

Empirical investigation into the benefits of immediacy has been limited in that metacommunicative statements do not neatly "fit" into the content-based categorical rating systems used to quantify and characterize therapist and client utterances (Hill et al., 1989). For instance, Hill et al. (1988) classified nine content-based therapist "response modes" (i.e., interpretation, self-disclosure, paraphrase, approval, open question, confrontation, information, direct guidance and closed question) and assessed clients' views of helpfulness of each one of these modes. In this classification scheme, instances of metacommunication might be found across several modes (e.g., self-disclosure, approval, or confrontation) or could be conceptualized as a qualitatively different therapist response mode altogether.

To remedy this methodological limitation, researchers have either developed their own rating scales of therapist immediacy (e.g., Hill et al., 2008) or used a single-case, qualitative methodology to investigate the intervention (e.g., Kasper, Hill & Kivlighan, 2008). In these studies, therapist immediacy—defined as "disclosures within the therapy session of how the therapist is feeling about the client, him - or herself in relation to the client, or about the therapy relationship" (Kasper et al., p. 281)—was found to elicit client expression of feelings, enable client exploration of concerns, increase the client's feeling of "closeness" with the therapist, and enable successful relational negotiation between client and therapist. However, Kasper et al. also found that therapists' use of immediacy sometimes caused clients to experience feelings of awkwardness, vulnerability, and even hurt. This potential for either positive or negative effects of therapist immediacy on the therapeutic process reflects the cautionary tone of several basic-skills psychotherapy authors (e.g., Brems, 2001, Dillon, 2003, Yalom, 1995) who encourage the mindful use of therapist metacommunicative disclosures that are offered in a tentative manner.

Metacommunication as self-involving statements. One means of encouraging immediacy is through therapists' provision of their own personal response to client statements, emotions, or reactions, which is one form of therapist self-disclosure. McCarthy and Betz's (1978) seminal study explored the differential effects of therapist self-disclosing statements versus therapist self-involving statements, terms first elucidated by Danish, D'Augelli, and Hauer (1980). McCarthy and Betz defined self-disclosing statements as "referring to the past history or personal experiences of the counselor," (p. 251) whereas they define therapist self-involving statements as "direct present expressions of the counselor's feelings about or reactions to the statements or behaviors of the client," (p. 251). Clearly, self-disclosing statements are statements that reveal biographical (factual) information about the therapist, whereas self-involving statements are a type of metacommunicative utterance.

In this study, undergraduate student raters listened to one of two audiotapes of nearly identical scripted counseling session between a male therapist and a female client, who was expressing her dissatisfaction with her lack of friends and her problems relating to her parents. On one tape, the counselor made ten self-disclosing statements, whereas on the second tape the counselor made ten self-involving statements. Other than these differences, therapist and client utterances were identical between the two tapes. The last statement on each tape was that of the therapist making either a self-involving or self-disclosing statement, with no client response so that the student raters could provide their own written response as if they were the client.

Students rated the self-involving therapist as significantly more trustworthy and expert as compared to the self-disclosing therapist. Additionally, self-involving statements tended to generate more responses focusing on the present interaction in therapy, whereas self-disclosing statements tended to generate questions about therapists' past, detracting from the therapeutic

process by shifting focus away from the client and the present "in the moment" client-therapist interaction.

In a subsequent study, Dowd and Boroto (1982) again used college student volunteers to watch one of five types of simulated therapy sessions on videotape. These simulated sessions were identical to one another (as well as to the simulated sessions in the McCarthy and Betz [1978] study) save for the last few minutes, during which the "therapist" would offer one of five scripted sequences, namely: (a) self-disclosure based on present events of a personal nature, (b) self-disclosure focused on past personal events, (c) self-involving statements, (d) a dynamic interpretation, or (e) a summary of the session. In this study, the authors did not find any difference in perceived expertness, attractiveness, trustworthiness, or students' willingness to work with the therapist between those therapists who used self-disclosure (both past and present) and those therapists who used self-involving statements.

Early studies on therapist self-disclosure also focused on the overall positive or negative valence (content) of the therapist metacommunicative statement in relation to their effectiveness. Reynolds and Fischer (1983) used the same audiotaped scripts used by McCarthy and Betz (1978) but slightly modified the ending to reflect a positive/negative dimension to the self-disclosing/self-involving dimension. In this study, positive disclosures were defined as a therapist's positive reactions or feelings to client statements or behavior; negative disclosures were defined as the therapist's negative feelings or reactions to the statement or behaviors of the client. In this study, undergraduate raters did not perceive any significant differences in therapist expertness, trustworthiness, or attractiveness between those therapists who used positive disclosures versus those who used negative disclosures. Additionally, few differences were found along these three dimensions for the self-disclosing/self-involving axis (specifically, only

female therapists were rated as more professional when using self-involving statements rather than self-disclosing statements). Perhaps most central to the Reynolds and Fischer study, however, is the qualitative finding that self-involving therapist statements kept the focus of conversation on the client and self-disclosing statements tended to shift focus to the therapists.

In another important study on therapist self-involving disclosure, Hill et al. (1989) sought to address the limitations of previous studies' analog designs on therapist self-disclosure by investigating therapist self-disclosure in eight cases of brief psychotherapy (12 to 20 sessions) with anxious and depressed female clients. In addition to rating therapist disclosing statements as either self-involving or self-disclosing, Hill et al. also coded the "tone" (either challenging or reassuring) of therapists' disclosures. The authors looked at these variables in the following manner: first, upon the completion of treatment, therapists used their clinical judgment in selecting disclosing interventions for review by both themselves and the client (i.e., client and therapist would both watch the videotape of the intervention simultaneously but could neither see nor speak to one another). Then, both therapists and clients were instructed to try to recall what they were experiencing at the moment of the intervention and subsequently measured "helpfulness" of selected self-involving/self-disclosing utterances with a preexisting scale. Likewise, expert judges measured client "experiencing" (i.e., client level of involvement in therapy, from superficial/impersonal to fully experiencing emotion in the present interaction) during these sequences. Other expert judges were used to classify tone and type of disclosing statement.

In this study, Hill et al. (1989) found no support for their hypothesis that self-involving disclosures would be experienced as more helpful than the self-disclosing disclosures; rather, it was only in the interaction with the reassuring dimension that self-involving statements were

experienced as more helpful. Additionally, judges rated higher levels of experiencing in clients who received reassuring disclosures of either type (i.e., self-involving/self-disclosing) compared to clients who received challenging disclosures. Besides the obvious effects of making clients more comfortable, the authors emphasize that reassuring disclosures enable clients to "experience themselves at deeper levels, indicating that they led to client progress" (p. 294).

To summarize, while studies consistently find that immediacy tends to focus clinical conversation on the client in the present moment, there is little agreement on how its use impacts clients' views of the therapist. These differences may be attributed to the analog methodology of most of these investigations. In the one study that used actual therapy sessions (i.e., Hill et al. [1989]), investigators found that self-involving disclosures were more helpful and led to greater client experiencing only when delivered with a positive, reassuring tone by the therapist.

Metacommunication as interpersonal feedback. Claiborn et al. (2001) provided a basic definition of feedback as information provided to a person from another source about the person's behavior or its effects. These authors expand upon the reciprocal nature of feedback, clearly placing it within the metacommunicative domain:

> Any instance of feedback begins with an observation of another person's behavior. Thus, the therapist's feedback to the client is a response to the client's prior behavior. The client then responds to the feedback in some way (e.g., agreeing or disagreeing, correcting, distorting, incorporating, etc.). These client responses constitute feedback to the therapist about the feedback he or she has just delivered. This sequence makes both parties simultaneously givers and receivers of feedback. (p. 401)

Thus, characterizing effective feedback delivery is important for therapists, as Morran et al. (1985) note that feedback—by having both descriptive and evaluative components—has the

potential to stimulate an emotional response that may either augment or impede the (presumably) corrective potential that the feedback process is meant to provide.

Four studies have been performed that discuss feedback as a distinct intervention in individual therapy. Perhaps the most relevant study was conducted by Leitenberg, Agras, Allen, Butz, and Edwards (1975), who combined five single case studies on the effect of feedback on women with specific phobias. In this study, simple feedback was both added to and withheld from the provision of praise to the study participants regarding the feared object or situation (e.g., “that was a great effort!” vs. “that was a great effort, and you spent 62 seconds looking at the knife!”). In the trials where feedback was provided with praise, participant performance (time spent with feared object or in a feared situation) rose dramatically. In this study, the authors emphasize the importance of “measurement feedback” (progress) in therapeutic situations, offering three reasons for client progress when such feedback is provided: (a) feedback serves as a reminder of the goals of therapy, (b) learning is facilitated when objectives are defined and reached; and (c) client knowledge of prior success enables future success.

Likewise, in another case study, DeVoge et al. (1981) examined the use of feedback with a severely agoraphobic client. In this study, the authors tracked four variables (car mileage, client-assessed anxiety level, positive self-appraisal, and number of Valium pills ingested) across four consecutive treatments: relaxation via audiotape, self-instruction of relaxation, cognitive restructuring, and feedback. Here, the feedback was primarily evaluative (rather than descriptive) and focused on both positive and negative aspects of the client’s behavior, although it maintained an encouraging tone regardless of focus. DeVoge et al. found that the feedback produced the most change of any of the other interventions. Specifically, the client drove dramatically more during the feedback phase, self-reported anxiety decreased while positive self-appraisal

increased, and Valium intake decreased by half. These gains appeared to hold steady when the client was contacted 16 months later. It should be noted, however, that the client was provided the feedback treatment only after the three previous treatments were already delivered; thus, it is possible that gains made by the client with feedback were facilitated by prior treatment modalities.

Thelen and Lasoki (1980) examined the effects of video playback ("mirroring feedback"), therapist focusing ("behavioral description feedback") and behavioral rehearsal in sessions of assertion training for women. The authors found that therapist focusing—where the therapist provides direct and immediate feedback on clients' performance during an assertion task—was the most effective in shaping client assertiveness.

Lastly, Rapee and Hayman (1991) investigated the role of video playback on socially anxious clients' perceptions of their own performance—that is, how such clients would rate their own performance when confronted with such "objective" data, as these individuals typically rate their own social behavior more negatively than third-party observers. When such video playback was watched, clients rated their performance higher than would be otherwise rated (without video playback) and social anxiety was decreased. The authors speculate that the tendency to underrate one's performance plays a central role in the maintenance of social anxiety disorder, and that unbiased feedback plays a positive disconfirming role. The authors discuss clinical implications by emphasizing the "anxiety reducing effects of performance feedback by combining video with other methods of feedback such as input from therapist, group, or significant others" (p. 321).

Metacommunication in interpersonal therapies. The use of metacommunication is among the most important features of interpersonal models of psychotherapy. The general

interpersonal orientation focuses on the interaction between client and therapist (rather than the content of what is discussed) and the identification and exploration of the interpersonal sequences and themes between the therapist and client, which is presumed to hold important information about the client's view of him- or herself and his or her relationships with others.

In this tradition, interpersonal theorists maintain that therapy can be viewed as a three-stage process involving: (a) the establishment of a "complementary" relationship between client and therapist (i.e., a relationship whereby the clients' personality dynamics emerge and are subsequently maintained by the unique interactional nature of the therapist-client dyad); (b) the emergence of some type of therapeutic conflict, often caused by the therapist's recognition of becoming embedded within the complementary role; and (c) the resolution of the conflict (Tracy, 1993). In this therapeutic framework, Kiesler (1996) emphasizes the importance of metacommunicative feedback in two important therapeutic tasks: the therapist's attempts at getting "unstuck" from the complementary role and in resolving the conflict. Thus, throughout therapy, metacommunication becomes an essential means of discussing the client's "evoking style and its self-defeating consequences… as a springboard to collaborative exploration with the patient" (p. 283). In the interpersonal framework, metacommunication is conceptualized as an important therapist tool used for a variety of purposes—to discuss the ebb and flow of the therapist-client relationship, to highlight the client's (presumably dysfunctional) way of relating to others, and to explore and validate reasons for the client's use of these maladaptive interpersonal strategies.

Although a rich body of theoretical literature exists on the use of metacommunication in interpersonal psychotherapy (e.g., Kiesler, 1982, 1988, 1996; Kiesler & van Denburg, 1993; Tracy, 1993), Kiesler (1996) points out that few empirical studies exist that can assist therapists

with metacommunicative delivery in individual psychotherapy. Additionally, even these few studies refer to investigations performed outside of the context of interpersonal theory and research (i.e., studies discussed above), or refer to research that is tangential to therapeutic metacommunication (e.g., an exploration of self-disclosure between friendly peer dyads [Critelli & Neumann, 1978]).

Relational therapy and stage-process models. In this paradigm, a featured use of metacommunication is to highlight, discuss, and process strains and fractures in the therapeutic relationship. As such ruptures are seen as inevitable, the therapeutic work performed around rupture repair is considered an important element of therapeutic change (Safran, 1993a, 1993b; Safran & Muran, 2003). Metacommunication is discussed in this context as a means of stepping outside of the therapist-client "enactment" of the client's recurring interpersonal difficulties and treating this enactment as the object of therapeutic work.

Safran, Muran, and Samstag (1994), using Greenberg's (1984) model, conducted a task analytic investigation of therapeutic alliance rupture resolution in which metacommunication was identified as an integral resolution component. This investigation sheds light on *when* metacommunication is effective in this therapeutic process, as opposed to *what* effective elements of metacommunication may be; the timely delivery of metacommunication becomes as important as the content of the metacommunicative utterance in this relational framework.

In this study, Safran et al. (1994) selected rupture events using client, therapist, and third-party responses on a preexisting measure of working alliance (i.e., the Working Alliance Inventory). Rupture resolution events were identified when there was agreement that the alliance was strong at the beginning of a session, deteriorated towards the middle, and once again was strong at the end of session. Four therapy process measures (the Structural Analysis of Social

Behavior, the Patient Experiencing Scale, the Therapist Experiencing Scale, and the Client Vocal Quality Scale) were then used to operationalize the components of this repair process for the formal empirical analysis.

Using task analysis, Safran et al. (1994) developed a preliminary model of successful resolution attempts, which contained therapist-client metacommunication at key points in the process. Specifically, the researchers determined that therapists used metacommunication in the process of rupture resolution in order to disembed from and draw attention to the rupture, to help explore the rupture experience, and take responsibility for their role in the rupture. Two pilot studies in the Safran et al. (1994) study changed little of the proposed four-component resolution model, and served to strengthen the claim that metacommunication is integral in the initial phases of therapeutic alliance rupture repair.

Metacommunicative Principles

Although there has been little research guiding the effective use of metacommunicative interventions, a substantial body of literature exists regarding how such interventions should be generated. These include detailed guidelines for conceptualizing, crafting, offering, and tracking the effects metacommunicative offerings.

In one of the earliest guides for shaping facilitative metacommunication, Villard and Whipple (1976) state that metacommunication should incorporate six features. First among these is that it should be descriptive, and should not incorporate evaluative elements. Next, metacommunication should be empathic in tone, as opposed to neutral or even critical. Metacommunication should be problem-centered – that is, it should be offered in response to some sort of client conflict. Spontaneity is encouraged (the “strategic” use of metacommunication is specifically not recommended). The authors suggest that

metacommunication should maximize equality between therapist and client, rather than establish the superiority of the therapist. Finally, the provisional nature and tentative delivery of effective metacommunication is discussed.

Perhaps the most well known theoretical recipe for metacommunication is Kiesler's (1996) model, wherein the metacommunicative task occurs only after two distinct stages have taken place. First, the "hooked" stage occurs, where, from the very beginning of therapy, the client's interpersonal style "pulls for" a certain set of covert (emotional and cognitive) and overt (behavioral) responses from the therapist. The therapist's reaction is assumed to be similar to those responses the client elicits from others outside the therapy setting, and can be considered "complementary" to the client's interpersonal style. Here, the therapist "cannot *not* be hooked or sucked in by the patient… because the patient is superior to the therapist in shaping the direction of their relationship" (p. 287).

As the therapist remains "hooked," he or she experiences the full intensity of the client's style and associated "impact messages" (feelings, fantasies, cognitive attributions, etc) and continues, perhaps with greater intensity, to offer the complementary response (e.g., becomes increasingly dominant with a passive client who seems to ask for guidance). As such, the first of four of Kiesler's (1996) fifteen metacommunicative principles are "stage-setting" principles that encourage the therapist to notice and label (to him- or herself) those "pulls" from the client and begin to discontinue any complementary response. It is only after this that the therapist can use metacommunication to help the client "interrupt" or at least temporarily suspend his or her interpersonal style, and talk directly to the client about what is taking place. Note that the use of metacommunication is not necessary in these preliminary steps, and that, rather than an

evolutionary, two-step sequence invoking some sort of final "unhooked" state, the therapist can go back and forth between "hooked" and unhooked" at any given point.

Once this disengaged stage is attained, the remaining metacommunicative principles come into effect. These are designed to promote "successful, supportive, and growth-enhancing use of therapeutic metacommunication" (Kiesler, 1996, p. 291). In this vein, the next three principles address the "spirit" in which the therapist should deliver metacommunication. The first two of these emphasize that metacommunication should be confrontive yet supportive, and delivered with a helpful, facilitative attitude and intent. Special emphasis is placed on the third of these "spirit" principles, which emphasizes the direct, open, and completely unambiguous communication to the client about the "pulls" the therapist experiences while simultaneously stressing the subjectivity of the therapist's reactions—that is, the therapist must be ready to acknowledge his or her own contribution to the unique relational cycle.

The remainder of Kiesler's (1996) principles addresses the content and mechanics of metacommunication in an interpersonal context. These include: (a) emphasizing both a positive and negative polarity in the same metacommunicative utterance; (b) being specific in feedback, as effectiveness decreases when metacommunication is delivered in a "cloak of generalities" (Morran et al., 1985, p. 64); (c) alternating between exploring the client's maladaptive style as it plays out in session as well as how it may be relevant in terms of the client's relationship with others; (d) importance of therapist awareness of the strength of the working alliance and client personality differences when delivering feedback; (e) encouragement of therapist metacommunication early in session; (f) encouraging therapists' labeling of perceived "wants" from the client should the therapist find him- or herself in the "hooked" stage again; (g) emphasizing therapist use of fantasy or metaphor as the least threatening way of disclosing

reactions to clients; and (h) exploring the implications on the working relationship when clients include references to the therapist in their statements about relationships with others.

Safran and Muran (2003), in their guide to brief relational psychotherapy, propose an extensive set of metacommunicative principles that generally echo those of Kiesler (1996). However, in accordance with the authors' emphasis on the progression of therapy via exploration of strains in the therapeutic relationship, metacommunication here is discussed around the therapeutic task of rupture resolution. As such, several important theoretical distinctions arise between the two sets of principles.

Throughout the 17 "general" principles of metacommunication discussed by Safran and Muran (2003), the emphasis on therapist subjectivity emerges as an overarching theme. This is perhaps the most salient theoretical difference between metacommunication as delivered in relational therapy and metacommunicative interventions in an interpersonal context. Specifically, Kiesler (1996) makes the assumption that clients' maladaptive (or "duplicitous" [p. 282]) communication style with the therapist generalizes to his or her important relationships outside of therapy. As such, interpersonal metacommunicative interventions are designed to heighten clients' awareness of these patterns. In a brief relational framework, however, such relational "parallels" are not assumed, but rather held in abeyance in order to convey a non-blaming stance that encourages clients (and therapists) to take responsibility for their contributions to the therapeutic interaction.

Mutuality emerges as a second important thread that can be found throughout Safran and Muran's (2003) general principles. In establishing a sense of "we-ness" (p. 115), problems (and resolutions) regarding the therapeutic relationship are framed as a shared experience. Clients'

sense of being “stuck together” (p. 115) in this regard engenders clients’ sense of validation, which in turn enables clients to access their inner experience in a more genuine fashion.

While themes of subjectivity and mutuality are thus echoed across several general principles that orient the therapist to the contextual “ground” of the metacommunicative task, the “figure” can be found in the 11 specific principles discussed in shaping metacommunicative delivery. Similar to Kiesler’s (1996) principles involved in “stage-setting” before the metacommunicative task can occur, Safran and Muran (2003) begin by emphasizing the importance of therapist self-awareness during metacommunicative interventions, as such awareness must precede accurate metacommunicative feedback to the client. In the relational context, however, therapists’ focus on their own experience becomes the overarching principle of effective metacommunication throughout all stages of the intervention.

Included in the general theme of awareness is Safran and Muran’s (2003) emphasis on therapist awareness of client “markers,” or specific and repeated patient behaviors or communications that evoke internally experienced therapist reactions. Therapist identification of such markers enables therapists to step away from the current interaction, making their own feelings more available for reflection. This emotional accuracy becomes important as the authors encourage therapists to link their feelings to the interpersonal marker in metacommunicative delivery, which allows for greater metacommunicative “accuracy” (e.g., “I’m feeling kind of confused right now, and it seems to me that it had something to do with the way you kind of shut down and crossed your arms when we started talking about…”)

Taking a step back from the depth and breadth of the metacommunicative principles discussed by Kiesler (1996) and Safran and Muran (2003), several common themes emerge that also converge with guidance put forward by Villard and Whipple (1976) and Teyber (2000).

First, guidelines on therapeutic metacommunication emphasize spontaneity and discourage its premeditated use. Second, metacommunication should encourage a sense of mutuality, a "we-ness," or "we're stuck in this together" sensibility. Third, metacommunicative utterances should be provisional and open to modification (or even rejection) by the client. These three broad themes become an important conceptual starting point for the following investigation of the transactional elements that constitute effective metacommunication.

A Functional Approach to Studying Change: Task Analysis

Across contexts, the singular, transtheoretical purpose of metacommunication is to make the implicit explicit. With this in mind, what characterizes this transformation in terms of client-therapist themes, operations, and interactional sequences? What are the differences between successful transformations and unsuccessful ones? Seen through this functional lens, it is possible to study metacommunication via rigorous analysis of single cases to discern what is essential in a successful metacommunicative task "performance."

Task analysis is a pluralistic research method that combines qualitative and quantitative methods (as well as rational and empirical modeling approaches) in order to discover and validate models of psychotherapeutic change in a detailed manner (Greenberg, 1984; 2007). The most basic assumption underlying this method is that psychotherapy can be broken down into a series of client-therapist "tasks" that, when resolved, advance the course of therapy and result in client change. In an "ongoing oscillation between theory building and empirical analysis" (Safran et al., 1994, p. 227), the specific steps involved in the successful resolution of a therapeutic task can be identified.

The programmatic nature of task analysis is based on the notion that scientific progress occurs through the development of research programs where knowledge is accumulated over

time (Greenberg, 2007). As such, task analysis proceeds in two distinct phases—a "discovery" phase, which combines observation and theory to develop a model from which subsequent measures can be derived, and an empirical "validation" phase, which works within a justification paradigm and uses traditional methods pertaining to hypothesis testing, group design, and statistical testing on a separate sample from the discovery phase (Greenberg, 2007, Pascual-Leone et al., 2009). The present study focuses solely on the discovery phase.

Task analysis has been used to discover the process of change in a wide array of psychotherapeutic tasks. As mentioned, task analysis was the means by which the process of successful alliance rupture resolution was discovered and modeled (Safran et al, 1994). Additionally, this methodology has been used to explore how forgiveness unfolds between partners in couples therapy (Meneses, 2006), how dominant-submissive cycles are resolved in couples therapy (Sharma, 2007), how individuals recover from schizophrenia (Klein, 2005) as well as identifying the features of successful facilitative interpretations in short-term dynamic psychotherapy (Joyce, Duncan, & Piper, 1995).

Greenberg (2007) outlined six distinct steps during the discovery phase of task analysis. The first step of *specifying the task* involves formulating a precise and thorough behavioral description of the "affective-cognitive task" or problem to be studied. This must be a circumscribed and clinically meaningful client-therapist interaction—that is, there is an identifiable beginning point, a working-through process, and a distinct end point. The beginning of the event is characterized by a *marker*—a client or therapist utterance, series of speech acts, or key behavior that signify that the particular event of interest is occurring.

The second step of task analysis is *explicating the researcher's cognitive map*. Given that this first phase of the task analysis is discovery-oriented, it is necessary to elucidate the

"cognitive map" of the investigator as explicitly as possible (that is, the discovery process relies on observation, which is viewed as theory-based in the task-analytic paradigm rather than originating from the perspective of a "naïve observer."). This includes the listing of implicit assumptions, theoretical perspectives, and preconceived ideas regarding therapeutic change. Greenberg (1991) emphasizes that this explicative process maximizes the chance of finding therapeutically interesting and important phenomena.

The next step in Greenberg's (2007) guide to task analysis involves *specifying the task environment*. As the resolution of a specific psychotherapeutic task occurs within a context, this environment must be specified and described. Additionally, before a time-consuming study of a particular change event occurs, a determination must be made that change actually does occur within the task environment (i.e., the researcher must be certain that change is possible within this environment).

Fourth, researchers are instructed to *construct the rational model*. This entails generating hypotheses regarding how the particular therapeutic problem of interest is "solved" by the participants (i.e., the therapist and the client). These hypotheses are summarized in a diagram of client-therapist performance that make explicit the steps believed to exist in resolving the problem. This step has been designated as a "thought experiment" (Sharma, 2007) or a "creative thinking task" (Meneses, 2006) that distills the basic features of resolution performance and generates both a framework for understanding actual client-therapist performance and an initial model against which future observations can be compared. This rational model is generated from theoretical literature, clinical experience, experiences of other clinicians, and any other relevant and informed sources of input regarding the task under investigation.

At the heart of the task-analytic paradigm is the *empirical analysis*, which constitutes the

fifth step of the discovery phase. The purpose of this step is to distill the essential sequences of task performance as well as to develop a means of measuring these sequences. This entails the rigorous observation of actual client-therapist performances of successful problem resolution via audio- or videotape and associated transcripts. Detailed, sequential descriptions of client-therapist performance are generated with the aim of identifying key components of the resolved state. This is done by first describing the features of the resolved state and then describing the observable steps the dyad makes in moving from the initial marker to the resolved state. This procedure is repeated in an iterative fashion over successfully resolved cases. Likewise, a similar description is generated for "unresolved" cases, and a diagram is drawn to thematically represent the essential components that distinguish examples that reach resolution from those that have not resolved the task in question.

Finally, *synthesizing the rational/empirical model* can occur. Upon completion of the empirical model, it is compared to the rational model. Deviations of the rational model from actual client-therapist performance are noted and changes are subsequently made to the rational model to more thoroughly reflect therapist-client performance, resulting in a synthesized model that is based on both theory and empirical findings. This rational/empirical model serves as an empirically grounded hypothesis for subsequent validation.

Method

Study Design

The current study identified the characteristics of successful therapeutic metacommunication in TLDP sessions via several steps. First, both "high-quality" (HQ) and "low-quality" (LQ) sessions were selected for the empirical analysis stage of the task analysis using a number of psychotherapy process measures completed by both client and therapist at the

end of every (or every other) session. Next, HQ and LQ sessions were screened for metacommunicative exchanges, and identified exchanges were ranked to select the most complete and clinically relevant metacommunicative utterance in each session. Then, via the latter steps of the task-analytic paradigm (Greenberg, 1984, 2007), salient themes, processes, and transactional patterns were identified and consolidated into a preliminary empirical model. Finally, this empirical model was compared to the rational model to form the first rational-empirical model of how effective metacommunicative exchange unfolds in TLDP.

The study used archival, audiotaped sessions collected from therapist/client dyads at the Antioch University New England (ANE) Psychological Services Center (PSC) in Keene, New Hampshire. The PSC is an outpatient mental health training clinic offering psychotherapy, psychological testing, and psychology-related services to community members as well as ANE students from programs other than clinical psychology.

Participants

Participants were thirteen (11 female, 2 male) European-American therapist-trainees (hereafter referred to as "therapists") and fourteen (10 female, 4 male) clients. Therapists were in their second, third, or fourth year of doctoral study and volunteered to participate in an 18-week TLDP training program in which they explored the application of TLDP to one or two training cases. The primary training methods were didactic instruction, demonstration, and small group case consultation and supervision. The training was conducted by a PSC clinical supervisor and experienced TLDP practitioner. Therapist clinical experience ranged from no therapy experience prior to placement at the PSC to several years of therapy experience. Educational attainment of therapist participants ranged from Bachelor's to Master's degrees.

Clients were referred to TLDP treatment based on exclusion (e.g., severe mental illness, substance abuse, repeated suicide attempts) and inclusion criteria (e.g., presence of emotional discomfort, capacity to experience basic trust, willingness to consider problems in interpersonal terms, willingness to examine feelings, and capacity to relate to the therapist in a meaningful way) as discussed by Levenson (1995). Clients were seen for a maximum of 15 sessions.

Determining Session/Metacommunicative Quality

Presumably, instances of effective metacommunication are more likely within more effective TLDP sessions. As such, the current study employed multiple session process and outcome measures completed by both client and therapist in order to discriminate more effective (HQ) from less effective (LQ) sessions. These five aforementioned session outcome measures assessed: (a) client perception of treatment progress, (b) appraisals of the therapist by the client, (c) appraisals of the client by the therapist, (d) therapist thoughts during session, and (e) client thoughts during the session.

Session Impacts Scale. The Session Impacts Scale (SIS; Elliot & Wexler, 1994) is a 17-item self-report measure of clients' perceptions of treatment progress, the therapy relationship, and features of the therapy that serve to hinder the therapy process. These are reflected in the three SIS scales, which were developed based upon previous studies that examined client descriptions of significant events in therapy sessions and were categorized into three areas: Task Impacts (measuring positive aspects of the session whereas the client feels as if progress was being made on presenting concerns), Relationship Impacts (measuring positive aspects of the session related to clients' positive interpersonal experiences with the therapist), and Hindering Impacts (HI; describes negative aspects of the session, such as client perception of feeling misunderstood or frustrated with a lack of progress). Two of these scales (Task Impacts

and Relationship Impacts) consist of five items each whereas the third scale (Hindering Impacts) consists of six items. All items are rated on the same Likert-type scale (1=not at all, 2=slightly, 3=somewhat, 4=pretty much, and 5=very much).

The SIS has been shown to predict engagement in therapy as well as premature therapy termination (Tyron, 1990) in addition to predicting the formation of a strong working alliance and general treatment outcome (Mallinckrodt, 1993). It has demonstrated very good internal consistency (reported alpha coefficients ranging from .90 to .91) as well as strong construct validity (Elliot & Wexler, 1994; Stiles et al., 1994). The SIS has demonstrated strong convergent reliability via comparison with the Session Evaluation Questionnaire (SEQ; Stiles, 1980). In addition, Eliot and Wexler demonstrated discriminant validity via comparison with SEQ items pertaining to client post-session arousal. See Appendix A for SIS items and scales.

Therapist Appraisal Questionnaire. The Therapist Appraisal Questionnaire (TAQ; Fauth & Hayes, 2006) was designed to measure therapists' emotional reactions to the client during the therapy session. Developed from a measure originally designed by Cooley and Klinger (1989) to measure academic stress, TAQ consists of 20 items across of a six point Likert-style scale (0=not at all, 1=slightly, 2=somewhat, 3=moderately, 4=quite a bit, 5=a great deal). The TAQ consists of three scales: Challenge (seven items; measures the presence of emotions such as hopeful, eager, exhilarated, happy, energetic, excited, etc.), Threat (four items; measures emotional responses which include worried, fearful, anxious, and confident), and Harm (five items; measures emotional responses such as sad, angry, disappointed, and disgusted). Based upon prior research (see Fauth & Hayes, 2006), the Threat and Harm scales are combined to form a Negative Stress scale.

TAQ Challenge and Negative Stress scales demonstrate fair to excellent internal consistency, with alpha coefficients ranging from .71 to .90 (Cooley & Klinger, 1989; Fauth, Hayes, Park, & Freedman, 1999). The TAQ also demonstrates construct validity, as the Challenge and Negative Stress scale are correlated in the expected directions with several variables including therapist self-efficacy and hesitance during sessions (Fauth & Hayes, 2006, Fauth et al., 1999). Items 17-20 of this version of the TAQ consist of experimental items with no known validity or reliability data, and address emotional responses related to frustration, disinterest, boredom, and indifference. As several theorists have posited that poorly-delivered metacommunicative feedback can generate similar emotions (e.g., Kielser, 1996, Strupp & Binder, 1984), these experimental items will be included in the characterization of "good" versus "poor" sessions. See Appendix B for TAQ items and scales.

Client Appraisal Questionnaire. The Client Appraisal Questionnaire (CAQ; Mathisen, 2007) is the client version of the TAQ, designed to measure clients' emotional reactions to the therapy session. As with the TAQ, it consists of 20 items on a six-point Likert-style scale (0=not at all, 1=slightly, 2=somewhat, 3=moderately, 4=quite a bit, 5=a great deal) and consists of three scales: Challenge (measures the presence of emotions such as hopeful, eager, exhilarated, happy, energetic, excited, etc.), Threat (measures emotional responses which include worried, fearful, anxious, and confident), and Harm (measures emotional responses such as sad, angry, disappointed, and disgusted). In a first study of CAQ validity, Mathisen found that therapists' self-reported negative in-session emotions are predictive of client self-reported negative in-session emotions. See Appendix C for CAQ items and scales.

Client/Therapist Thought-Listing Questionnaire. The Client Thought-Listing Questionnaire (CTQ; Fauth, Smith, & Mathisen, 2005) and the Therapist Thought-Listing

Questionnaire (TTQ; Fauth, Smith, & Mathisen) were developed to assess clients' and therapists' thoughts during a particular therapy session. Immediately following a session, both clients and therapists alike were asked to list up to 10 thoughts that occurred to them during that session (see appendices D and E). Clients/therapists were instructed to list thoughts without regard to content, valence (positive, negative, or neutral) or referent (i.e., listed thought was about self, or about therapist/client). Clients/therapists were also instructed to write down only the thoughts that were going through their minds during the time of the therapy session. In a previous analysis (Mathisen, 2007), both client and therapist thoughts were quantified into both a positive and negative Thought Index (TI), defined as the number of positive (or negative) thoughts divided by the total number of thoughts for each therapist-client session.

This thought-listing technique is believed to be the most effective means to access session thought content retroactively (Clark, 1988, Coyne & Gotlieb, 1983). Additionally, Heimberg (1994) found that listed thoughts have been shown to change positively over the course of therapy for anxiety disorders. Research in the field of anxiety disorders has also highlighted the measure's criterion-related validity, such as Cacioppo, Glass, and Merluzzi's (1979) study showing that listed thoughts of a negative nature covary with negative self-evaluations. See Appendixes D and E for TTQ/CTQ items, respectively.

Session Selection Procedure for Empirical Analysis

Exclusion of sessions with inadequate data. Six variables (i.e., Task and Relationship Impacts on the SIS, Challenge scale on both the TAQ/CAQ, and the positive TI on both the TTQ/CTQ) were used to select HQ sessions. Although many sessions possessed an associated set of five completed process measures (i.e., SIS, TAQ, CAQ, TTQ, CTQ), some sessions were missing one or more of the measures. In this investigation, it was important to represent as wide

a range as possible of metacommunicative quality; as such, consideration was given to sessions with missing process measures. However, as the SIS was considered here to be the "cornerstone" measure of therapeutic progress, sessions without SIS data were not considered. Additionally, in order to strengthen the presumed association between high-quality metacommunication as reflected by multiple process measures, at least one measure completed by the therapist and at least one measure completed by the client (besides the SIS) had to be present to include a given session for consideration.

Of the 128 sessions represented in the complete dataset, 46 either did not have accompanying audiotapes or could not be used due to damaged or incomplete tapes. Of these 82 remaining sessions, 16 did not have the required minimum set of completed process measures and were subsequently excluded. These excluded sessions were primarily attributable to the bi-weekly, alternating administration of the CAQ/TAQ and CTQ/TTQ in the first year of data collection (i.e., the former measures were administered on weeks 1, 3, 5, etc. while the latter were given on weeks 2, 4, 6, etc.) This yielded 66 psychotherapy sessions from which to select HQ and LQ sessions for the empirical analysis.

In the task-analytic paradigm, analysis of three to six instances each of "resolved" and "unresolved" events of interest are considered sufficient in order to generate the empirical model (Greenberg, 2007; Pascual-Leone, A., Greenberg, & Pascual-Leone, J, 2009). That is, analysis of further events is unlikely to add meaningful information to the emerging model. As there were a relatively large number of events (metacommunicative events within sessions) from which to select HQ and LQ sessions, six of each were selected for subsequent intensive analysis.

Ranking session quality. Thus, for each session with (a) an existing audiotape, (b) completed SIS, and (c) at least one therapist-completed measure and one client-completed

measure besides the SIS, a simple weighting procedure took place as follows in order to rank HQ sessions. First, all values of the available variables were summed and divided by the maximum possible value of each variable in order to generate values from zero to one. Note that both Positive and Negative Thought Index scores already exist as a ratio and needed no transformation. Next, these values were added together and then divided by their possible maximum value (i.e., the number of variables summed) to generate another number from zero to one. This final value (hereafter referred to as the "H" value) was then ranked to select the six highest rated TLDP sessions to analyze for metacommunicative exchange.

For instance, in selecting HQ sessions, hypothetical session "A" has complete associated session outcome data – namely, Task and Relationship Impacts (both on the SIS) scores of 18/25 and 20/25, respectively; Challenge scores of 21/35 and 15/35 on the TAQ and CAQ, and positive TI scores of .75 and .5 on the TTQ and CTQ. Thus, a single score of 3.8 is generated as a sum of the transformed numbers (.72 + .8 + .6 + .43 + .75 + .5). As all six measures are represented, a final H value of .63 is generated (3.8/6).

Session "B," on the other hand, has incomplete associated session data. In this case, along with the SIS, the only available measures represented are the Therapist and Client Appraisal Questionnaires. Session B's Task Impact and Relationship Impacts scores are10/25 and 13/25, respectively, and Challenge scores of 21/35 and 19/35 on the TAQ and CAQ. Thus, the single score of 2.06 is generated for Session "B" (.4 + .52 + .6 + .54) and a final H score of .52 is generated (2.06/4). Between these two sessions, "A" would rank higher than "B."

LQ sessions were chosen in parallel fashion using a different set of scales. Specifically, LQ sessions were identified on the basis of seven variables (i.e., the HI scale on the SIS, Negative Stress scale on both the TAQ/CAQ, cumulative scores of items 17-20 on the

TAQ/CAQ, and the negative TI on both the TTQ/CTQ). Again, to be considered for the analysis, the following must have been present: (a) an associated audiotape, (b) the presence of a completed SIS, and (c) at least one other process measure completed by both client and therapist. Selection of these sessions proceeded in a similar manner to the selection of high-quality sessions albeit with different measure subscales to generate the "L" value. Note that the variables discussed in the selection of these cases reflected the presence of some type of negative therapeutic process, thought content, or emotional valence, so variable values rose accordingly (i.e., higher L values represented increasingly lower-rated sessions).

Exclusion of more than two sessions of identical dyads. Initial ranking of sessions produced an unanticipated result. In the HQ sorting procedure (where sessions were ranked in decreasing order of the "H" variable), one therapist-client dyad was over-represented in the highest-ranked sessions, appearing in four of the top six sessions. Although an important feature of the task-analytic paradigm in this study is to discern the resolution components of metacommunication in highest-rated TLDP sessions, a determination was made that no more than two of the same therapist-client dyads would be chosen for subsequent intensive analysis.

The rationale for this decision was based along both pragmatic and conceptual concerns. In terms of the former, a closer examination of the actual (paper) process measures for dyads that tended to be over-represented in the top of the HQ sort revealed that both therapists and clients almost always endorsed the maximum value for those items that reflect positive process and tended to endorse the minimum value for items that reveal negative therapeutic process, with few intermediate values circled. Additionally, very few negative thoughts were listed for these dyads in the C/TTQ. Although it is possible that these cases proceeded through the course of therapy with such positive process reflective of these elevated scores, it can also be surmised that these

therapists and clients were either hesitant to be “critical” of one another or simply raced through the administration of the measure. That being said, an informal survey of these sessions (i.e., listening to several sessions of these dyads in entirety throughout the course of therapy) did tend to reveal strong alliances and positive feelings between therapist and client. Thus, such dyads were allowed to proceed to the formal empirical analysis, albeit with no more than two sessions each.

A conceptual reason for limiting the number of sessions from the same dyad has to do with the possibility of idiosyncratic therapist metacommunicative abilities. For instance, it is possible that a particular therapist is over-represented at the “top” of the HQ sorting procedure because he or she possesses an eccentric or otherwise unconventional metacommunicative style that, while effective, is not representative of typical TLDP therapists in accordance with their understanding of the supporting theory. While it would be of value to incorporate components of such a style into a final rational-empirical model, “flooding” the empirical model with such data would not likely represent mainstream TLDP practitioners, and would be even less likely to epitomize TLDP trainees.

As indicated, the same determination was made for the LQ sort—namely, that no more than two sessions from the same dyad would be included for subsequent analysis. Although this was not as much of a concern in the ranked LQ sessions (with only one such repetition), the rationale for this decision is similar to those mentioned above, albeit in the “opposite” direction. Specifically, the pragmatic concern was that therapists and clients who were struggling with negative process might be averse to endorsing anything but the most negative scores on process measures, and a more conceptual issue was the possibility that one therapist might “flood” the empirical model with unconventionally poor quality metacommunication.

Thus, both HQ and LQ sessions were ranked based upon their corresponding H and L variables and sessions were subsequently selected for the empirical task analysis if they contained at least one metacommunicative exchange. Listening for at least one exchange proceeded "down" HQ and LQ rankings until six of each was selected. Table 1 illustrates the sorting procedure for HQ dyad/session selection, depicting how each session was selected for the empirical analysis and subsequently re-named in accordance with their new ranks ("H1," "H2," etc.) Table 2 depicts LQ session selection. Table 3 displays the therapists or therapist-client dyads that were represented more than once in the final twelve sessions. Tables 4 and 5 depict the rankings and relevant process measure variable values of the top six HQ and LQ sessions in which metacommunicative utterances were present.

Table 1

Sorting Procedure for Selecting HQ Sessions for Empirical Analysis

Dyad	Session#	H Value	L Value	H Rank	L Rank	Met?	Designation*
A-1	**5**	**0.97**	**0.05**	**1**	**65**	**Yes**	**H1**
B-2	**9**	**0.96**	**0.05**	**2**	**66**	**Yes**	**H2**
A-1	9	0.88	0.08	3	63	No	
A-1	4	0.85	0.12	4	58	No	
B-2	**13**	**0.84**	**0.11**	**5**	**61**	**Yes**	**H3**
A-1	3	0.83	0.13	6	55	No	
B-2	11	0.82	0.14	7	54	Yes	
C-3	**5**	**0.82**	**0.08**	**8**	**64**	**Yes**	**H4**
B-2	6	0.81	0.15	9	53	Yes	
B-2	4	0.77	0.20	10	44	Yes	
A-1	6	0.77	0.20	11	43	No	
B-2	12	0.74	0.12	12	59	Yes	
B-2	15	0.74	0.16	13	51	Yes	
B-3	14	0.73	0.13	14	56	Yes	
D-4	**6**	**0.72**	**0.18**	**15**	**49**	**Yes**	**H5**
E-5	**5**	**0.72**	**0.22**	**15**	**41**	**Yes**	**H6**

*Dyad: letter designates therapist, number; client. Met? = presence of at least one metacommunicative exchange.

Table 2

Sorting Procedure for Selecting LQ Sessions for Empirical Analysis

Dyad	Session#	H Value	L Value	H Rank	L Rank	Met?	Designation*
F-6	**5**	**0.21**	**0.53**	**65**	**1**	**Yes**	**L1**
G-7	4	0.53	0.53	37	2	No	
B-8	**9**	**0.21**	**0.47**	**64**	**3**	**Yes**	**L2**
B-8	**7**	**0.18**	**0.45**	**66**	**4**	**Yes**	**L3**
C-3	**6**	**0.52**	**0.44**	**39**	**5**	**Yes**	**L4**
H-9	**3**	**0.43**	**0.42**	**45**	**6**	**Yes**	**L5**
I-10	1	0.43	0.42	46	7	No	
F-6	**7**	**0.22**	**0.42**	**62**	**8**	**Yes**	**L6**

*Dyad: letter designates therapist, number; client. Met? = presence of at least one metacommunicative exchange.

Table 3

Common Therapist-Client Dyads in Both HQ and LQ sessions

Commonality	Dyad	Session#	Position
Same dyad in 2 LQ sessions	F-6	1	L1
	F-6	7	L6
Same dyad in 1 HQ and 1 LQ session	C-3	5	H4
	C-3	6	L4
Same therapist in 2 HQ sessions with one client	B-2	9	H2
	B-2	13	H3
…and 2 LQ sessions with a different client	B-8	9	L2
	B-8	7	L3

Table 4

Process Measure Subscale Values of Six Highest-Ranked TLDP Sessions

Rank	SIS		TAQ	CAQ	TTQ	CTQ	H Value
	TI	RI	Tchal	Cchal	Tpos	Cpos*	
H1	25	25	29	35	1.00	1.00	**0.97**
H2	23	25	30	34	1.00	1.00	**0.96**
H3	21	25	19	32	.75	1.00	**0.84**
H4	22	25	21	28			**0.82**
H5	22	24	21	18	.86	.50	**0.72**
H6	24	23	18	21	.57	.75	**0.72**

*H1…6 = ;TI/RI = SIS Task/Relationship Index scales (25 max score); Tchal/Cchal = TAQ/CAQ Challenge scales (35 max score); Tpos/Cpos = TTQ/CTQ Positive Thought Index scales.

Table 5

Process Measure Subscale Values of Six Lowest-Ranked TLDP Sessions

Rank	SIS	TAQ		CAQ		TTQ	CTQ	L Value
	HI	TNS	17-20	CNS	17-20	Tneg	Cneg*	
L1	20	8	3	30	8	.75	1.00	**0.53**
L2	13	11	2	25	6	.75	1.00	**0.47**
L3	9	6	1	17	12	.75	1.00	**0.45**
L4	6					.67	.50	**0.44**
L5	11	17	13			.78	.75	**0.42**
L6	17	7	2	15	5	.60	1.00	**0.42**

*L1…6= ; HI = SIS Hindering Impacts scale (35 max score); TNS/CNS = TAQ/CAQ Negative Stress Scales (35 max score); 17-20 = items 17-20 on either the TAQ or CAQ (20 max score); and Tneg/Cneg = TTQ/CTQ Negative Thought Index.

Finally, Figures 1 and 2 display the values of HQ/LQ designated sessions in graphical format, both in terms of the session's associated H/L value as well as the session's ordinal ranking in the dataset (i.e., before duplicate therapist-dyad sessions, sessions that contained no metacommunication, or sessions with no corresponding audiotape were deleted but after the deletion of sessions that did not have sufficient associated process measures). Although the process measure subscales used to generate LQ and HQ rankings were orthogonal, we expected that the sorting and ranking procedures used would identify different sessions as either HQ or LQ, with no overlap between the ranked HQ and LQ sessions. Furthermore, we expected to find a large distance between HQ and LQ sessions when ranked by H or L variables, respectively—that is, when ordered by H variable, one would expect to find LQ sessions to exist at the bottom of the sort, and vice versa. This is intuitive, given that sessions that were ranked poorly by both therapist and client were unlikely to be ranked positively on a different set of process measure subscales. This selection process—which produced a wide degree of separation between HQ and LQ sessions—was critically important for the subsequent empirical analysis, in which the presumed differences and styles in metacommunication between HQ and LQ sessions were compared and contrasted to form the empirical model.

Figure 1. H and L values of sessions selected for analysis.

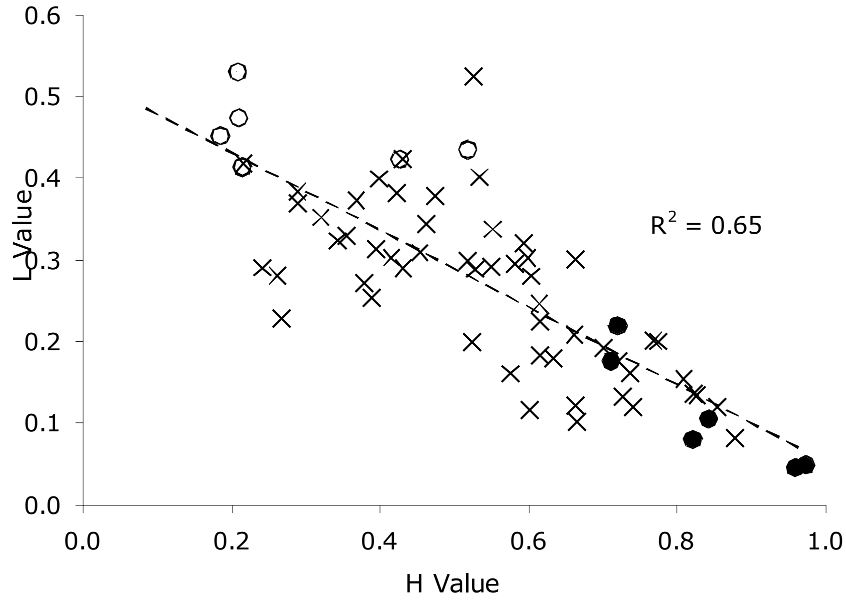
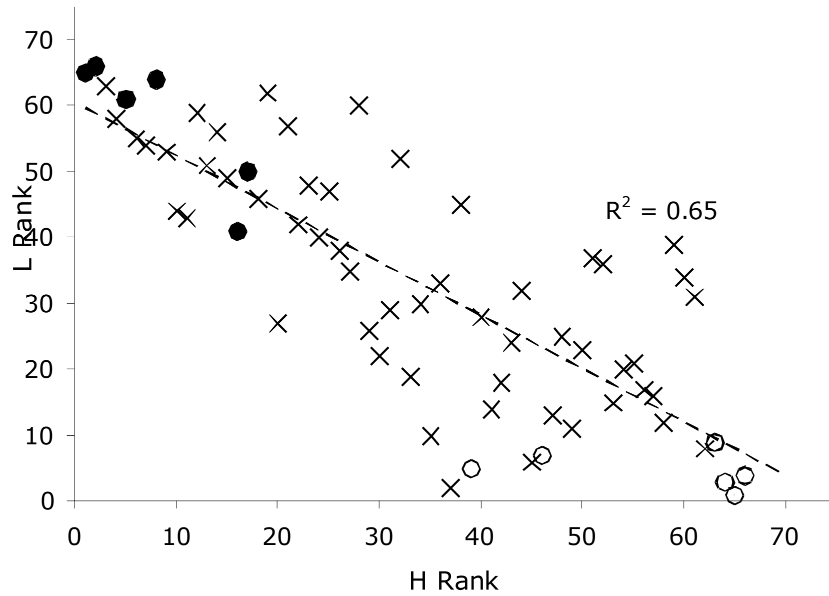


Figure 2. H and L rank values for sessions selected for analysis.



In both figures 1 and 2, HQ-designated sessions are depicted as solid circles; LQ-designated sessions depicted as open circles; sessions not selected for analysis depicted as Xs.

Screening sessions for metacommunication. Each of the selected sessions was screened for instances of at least one metacommunicative exchange; if no exchange existed, the session was rejected and the next-highest ranked session was selected. This was repeated until the six highest-ranking sessions (of both HQ and LQ sessions) with at least one metacommunicative exchange were selected for the empirical analysis. These exchanges were identified using two simple criteria. First, there must have been an explicit reference (by either therapist or client) to a current or previous therapeutic interaction. Next, this reference then must become the subject of conversation between therapist and client—specifically, after the explicit reference is made, an utterance of acknowledgement must come from the other member of the dyad. Note that even a simple expression of acknowledgement was enough to meet this criterion.

Selection procedure for sessions with multiple instances. Although several sessions contained no metacommunication, six of the selected twelve contained at least two instances. In these sessions, a procedure was designed to select the most complete and relevant exchanges for further analysis. Two high-quality sessions and four low-quality sessions contained multiple metacommunicative exchanges (2 each for sessions H4, H6, L2, L3, and L4; four were found in session L6). Per session, each complete exchange was played back in random order (i.e., not necessarily in temporal sequence) while the primary investigator and a second rater (a predoctoral clinical psychology student) read the associated transcript. The two raters then judged each exchange on two six-point Likert-style scales of "completeness" and "relevancy to clinical material" independently of one another. The exchange with the highest combined score was subsequently selected for empirical analysis. Across all sessions with multiple metacommunicative attempts, raters displayed consistency with one another on which exchange

was to be selected. Refer to Table 6 for means and standard deviations of the ratings and Table 7 for full rating results.

Table 6.

Means and Standard Deviations of All Ratings for Sessions with Multiple MET Attempts

	HQ Sessions (2 sessions)	LQ Sessions (4 sessions)
Completeness	4.0 (1.66)	2.75 (1.27)
Relevancy	5.0 (0.93)	3.90 (1.70)

Table 7.

Completeness and Relevancy Ratings for Sessions with Multiple MET Attempts

Session		H4		H6		L2		L3		L4		L6	
Rater		R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2
Meta. #1	Com.*	**6****	**6**	1	2	2	2	2	2	**2**	**3**	3	1
	Rel.	**6**	**5**	4	3	4	5	4	2	**2**	**2**	2	3
Meta. #2	Com.	5	4	**5**	**4**	**4**	**6**	**4**	**3**	1	2	**6**	**5**
	Rel.	5	4	**6**	**5**	**2**	**6**	**6**	**5**	1	1	**6**	**6**
Meta. #3	Com.											5	3
	Rel.											3	5
Meta. #3	Com.											2	1
	Rel.											5	2

*Meta. #1… #3: Com = completeness rating; Rel. = relevancy rating
**Highlighted ratings indicate exchange was selected for empirical analysis.

Task Analysis: Procedure

A task analysis was conducted to discriminate the features of metacommunication as seen in high-quality sessions of TLDP as opposed to metacommunication in low-quality TLDP sessions. This analysis was largely be guided by the step-by-step process set forth by Greenberg (1984, 2007) and expanded upon by Pascual-Leone et al. (2009) and proceeded in the following manner:

Step 1: Description of the task. The task for both therapist and client in this study is to transform implicit or hidden feelings, thoughts, or reactions into explicit communication via the process of metacommunication. Consistent with Greenberg's (2007) guide to conducting a task analysis of therapeutic change, behavioral markers of the above-mentioned task were discerned in a discovery-oriented process whereby three examples of metacommunication were chosen at random from sessions not selected for the empirical analysis. From these sessions, verbal/behavioral sequences that discriminated metacommunication from the stream of non-metacommunicative therapeutic discourse were identified.

Thus, three sessions not included in the 12 sessions selected for empirical analysis were chosen at random. Each was screened to define the marker, or starting point, of metacommunicative exchange in order to clearly "anchor" the start of metacommunication in the subsequent empirical analysis. Additionally, the marker of resolution—that point at which the metacommunicative task was resolved—was defined. Commonalities among these exchanges were noted and another three tapes chosen at random were screened and common marker features of these exchanges were integrated with the first three. At this point it was clear that a point of saturation had been reached and no further tapes were screened.

Step 2: Explicating the cognitive map. As discussed above, a task analysis of therapeutic change requires that my framework of understanding metacommunication must be made explicit. This is accomplished by detailing any theoretical perspectives, assumptions, and preconceived ideas with which I entered this discovery process.

I came to this study of metacommunication with the following general assumptions, influenced by the core principles of interpersonal/relational theory (e.g., Kiesler, 1996, Kiesler & van Denburg, 1993): (a) clients' tacit (unspoken) material—thoughts, feelings, and reactions—is important to bring to awareness via metacommunication; (b) this material is often of an interpersonal nature—that is, such material relates to the client's interactions with others outside of therapy, or with the therapist him- or herself; (c) metacommunication regarding such interpersonal themes often leads to clinically meaningful insight; and (d) such insight can be consolidated and used outside of the therapy relationship to engender more adaptive ways of relating.

I also assumed that effective metacommunication would be characterized by the following: (a) client acknowledgement of the therapist's metacommunication attempt, with client perception of accuracy an important determinant of acknowledgement (that is, client provides some information that the therapist is "on the right track" or "in the ballpark"); (b) some type of emotional expression by the client after the metacommunicative utterance is made by the therapist (e.g., a sigh, tearfulness, expressed anger, etc); and (c) a willingness by both the client and the therapist to continue with the metacommunication beyond the therapist's initial metacommunicative utterance is made.

Step 3: Specifying and evaluating the potency of the task environment. As discussed previously, the goal of this stage was twofold. First, the environment in which the therapeutic

task occurs was characterized; next the "potency" of the task environment was specified by making a reasonable determination that the therapeutic event of interest had some type of therapeutic effect within a single session. Here, the context for metacommunicative exchange in the current study is TLDP. Although no known measures have been developed to track moment-to-moment metacommunicative processes within TLDP, numerous authors (e.g., Levenson, 1995; 2003; Levenson & Strupp, 1999; Strupp & Binder, 1984) have discussed how the intervention of metacommunication successfully acts as a vehicle for client insight and change in TLPD.

Step 4: The rational task analysis/constructing a rational model. This phase of the task analysis integrated several sources of input regarding the metacommunicative task. These included my understanding of the components involved in this process based upon the existing theoretical literature, information made salient via the explication of my own cognitive "map" regarding the metacommunicative process, relevant personal clinical experience, and informal discussion with other clinicians. Taken together, these sources of data explicated the sequence of presumed essential therapist-client performance tasks thought to be representative of transforming implicit or hidden thoughts, feelings, or reactions into explicit utterances available for conjoint exploration via metacommunication. This was sketched into a simple rational model, which served as a theoretical "backdrop" that was bracketed during the empirical analysis and subsequently integrated with it to produce the final rational-empirical model.

Step 5: Conducting an empirical task analysis. Once the rational model was developed, the empirical portion of the task analysis began. The goal of this most important step was to determine the essential components of resolution performance by characterizing the events and tasks the therapist-client dyad must resolve in each session in order to complete the

metacommunicative task. This was repeated across sessions until an empirical model was diagrammed that shows the necessary components of effective metacommunication in TLDP.

Although Greenberg (2007) identifies sixteen sub-procedures within this step, they can be thematically condensed into two broad phases. First, the process of *characterizing the unfolding states and processes* involved in successful metacommunication commenced. This initial part of the empirical analysis distilled client and therapist contributions within each selected metacommunicative exchange by first summarizing and abstracting each therapist and client speaking turn and subsequently diagramming each exchange from marker to resolution. This is done in order to break down the conversational stream into distinct parts (Greenberg, 2007) through the identification of client and therapist utterances into broad categories (e.g., emotions, wishes, needs, memories, perspectives, etc). Thus, therapeutic conversation from marker to resolution was tracked and a basis for comparison between sessions could be generated.

Specifically, this was accomplished by separating distinct components of meaning within a speaking turn, summarizing these components, and distilling the "gist" of each component into a clearly-understood, higher-order semantic unit. Next, each abstracted sequence was diagrammed in order to better visualize and compare/contrast essential shared components and sequences across high- and low-quality sessions (see Appendixes F and G for these diagrams). These diagrams depict therapist (shaded) and client summarized speech units across the four distinct components of metacommunicative delivery: pre-marker, therapist marker, client marker, and resolution phases. Note that several sequences of speech units are too long to depict on one horizontal stream and are depicted across two levels. In these diagrams the therapeutic stream progresses first from left to right and then downwards.

Next, the phase of *iterative analysis* was reached. Here, the rational model was

"bracketed" while each metacommunicative exchange was diagrammed across both HQ and LQ sessions—that is, as each instance was diagrammed, the rational model was kept in mind as a template or theoretical basis for ongoing comparison. However, in order to develop over-arching categories that captured the moment-by-moment processes of working metacommunication, a process was used that first compared and abstracted metacommunication in similar-quality sessions and then contrasted these two models to one another to generate a final empirical model. Importantly, this process maintained the primacy (weights) of higher-ranked sessions over lower-ranked sessions in developing these models, and proceeded as follows:

After abstracting/categorizing the highest-ranked categories (H1 and L1), the abstracted categories from second- and third-highest ranked exchanges (H2, H3 and L2, L3) were compared with one another (i.e., H2 to H3, L2 to L3) and overarching categories were noted within each of the four stages of metacommunicative delivery. The last procedure of this first step involved comparing the three lowest-ranked exchanges in each subset (H4, H5, H6 and L4, L5, L6) and producing an additional set of overarching categories. Thus, at the end of this initial procedure, six distinct sets (three each for HQ and LQ sessions) of compared/combined abstracted products existed that reflected the decreasing weight of successively ranked exchanges.

These abstracted products were designated A, B, and C along with the appropriate prefix (i.e., HA, HB, HC and LA, LB, and LC). Represented fractionally, and using only HQ sessions as an example, session H1 (product HA) therefore represents one-third of the HQ model. Similarly, although combined sessions H2 and H3 (product HB) represent a second third of the HQ model, each session contributes one-sixth towards the total. Finally, the combined sessions H4, H5, and H6 (product HC) contribute the last third to the HQ model, although each session alone contributes one-ninth of the total. In this way, higher-ranked exchanges have more

influence in the construction of the HQ and LQ models. Refer to Appendixes H and I to view the combined and abstracted sequences across HQ and LQ sessions, respectively.

Next, combining and abstracting the three products discussed above generated the HQ and LQ models. This was accomplished by grouping the combined/abstracted products together and discerning shared components across each stage of metacommunicative delivery in a sequential fashion. Only components that are clearly shared across the three products are included in subsequent diagramming of the HQ and LQ models. Note that if two clear pathways were discovered, such divergences were noted in the diagrams. Refer to Appendixes J and K for the HQ and LQ preliminary models.

Next, preliminary models were compared and contrasted to one another to generate the empirical model of effective metacommunication in TLDP. Note that in this model, shared processes/components in both HQ and LQ sessions are not included, as it can be surmised that common components are not essential to working metacommunicative delivery. However, if subtle differences in quality or nature existed between these shared components, they were included in the final rational model (for instance, “expresses negative emotion” was a common component, but the object of the expression—to self, therapist, or other—differed.)

Step 6: Synthesizing a rational-empirical model. Finally, the rational and empirical models were compared and contrasted to synthesize the rational-empirical model. Consistent with the task-analytic paradigm (Greenberg, 2007), changes are made to the rational model to more accurately reflect in-vivo client performances; however, if a radical departure was noted in the empirical model from the rational model, the former was given primacy in accordance with the paradigm. A diagram of overall model development is depicted in Table 8.

Table 8

Summary of Abstraction/Combination Procedures

Lower-Level Session	Abstract/Combine To	Contribution to HQ/LQ Models
1	Product HA/LA	1/3 each
2,3	Product HB/LB	1/6 each
4,5,6	Product HC/LC	1/9 each

Mid-Level Product	Abstract/Combine To Higher-Level Product
HA, HB, HC	HQ Model
LA, LB, LC	LQ Model

Higher-Level Product	Abstract/Combine To Final Models
HQ, LQ Models	Empirical Model
Empirical, Rational Model	**Rational-Empirical Model**

Results

Results are reported here in accordance with each step of the task analysis, where appropriate (i.e., steps 2 and 3 are largely conceptual and are discussed in full in the Methods section). Whereas the Method section highlighted the activities performed within each task-analytic step, the Results section presents an overview of the output or product of each identified step.

Step 1: Identifying Markers and Sequences

As discussed above, the initial step of the task-analytic procedure entails identifying and defining behavioral markers (starting points) of the particular therapeutic task. This was accomplished through listening to TLDP sessions not selected for the empirical analysis and then discerning shared features and components of metacommunicative progression identified in these tapes.

Indeed, sequences shared consistent features across sessions. First, clients tended to elicit metacommunicative utterances from the therapist by discussing an extra-therapeutic interpersonally- or relationally-oriented problem or predicament that was often emblematic of a larger pattern. Although such client speaking turns alone could not be used as the “marker” of metacommunication (as few overall were followed by a therapist metacommunicative utterance), for the purposes of this study, the client speaking turn that immediately precedes the therapist metacommunication will be included in the sequence as a “pre-marker,” as it becomes thematically relevant to the therapist’s subsequent process comment.

Second, therapists initiated all metacommunicative utterances; no client-initiated metacommunication was noted during this screening process (or, for that matter, throughout the entire study). Third, therapists typically initiated metacommunication with the use of a simple

process comment—for instance, *I'm noticing that* (perhaps most commonly used), *I'm sensing that*, or *it seems to me as if*. Fourth, therapists usually followed this utterance with some type of "invitation" to the client to provide his or her input about the therapist observation—typically, "does it seem that way to you?" or "what do you make of that?" In most cases, such sequences were briefly stated over one or two sentences with little verbal elaboration. The last noted sequence in terms of marker commonality was the client's (usually brief) initial acknowledgement of the therapist's utterance (e.g., expressions of acceptance, surprise, skepticism, ambivalence, or rejection) before the therapist once again spoke to further explore the metacommunicative utterance noted above. In this way, a concrete "therapist marker" (metacommunicative utterance and invitation) and "client marker" (initial acknowledgement) could be defined within the stream of conversation.

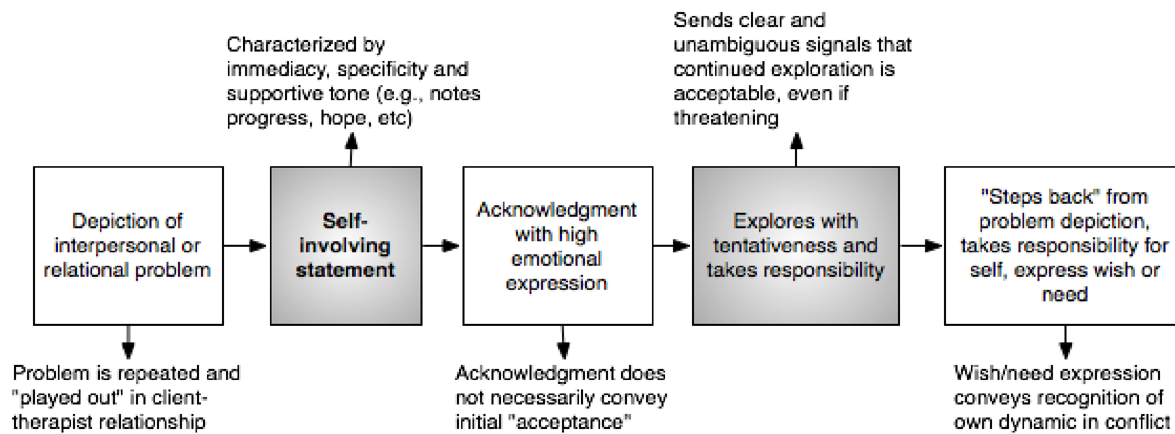
Resolution was reached when either therapist or client "moved on" to a different conversational topic—specifically, with the first utterance of a qualitatively different, off-topic theme. Note that, for this study, metacommunication is considered "resolved" even if the client emphatically rejects a therapist's metacommunicative offering but the therapist and client continue to discuss the metacommunication past the therapist-client marker. In this way, metacommunication can be conceptualized into four sequential phases: pre-marker, therapist marker, client marker, and resolution.

Step 4: Constructing a Rational Model

An essential feature of the task-analytic paradigm is the condensing of theoretical perspectives, personal experience, and viewpoints from other practitioners into a rational model, which serves as an initial "best guess" of how successful metacommunication proceeds in TLDP.

As such, a diagram was constructed (see Figure 1) depicting this initial model – a benchmark against which the empirical model was later compared.

Figure 3. Rational model of working metacommunication in TLDP.



Grey shaded boxes denote therapist elements of performance; no shading indicates client elements.

Here, as with all successive diagrams, significant units of client speech are depicted as white boxes, and important therapist speaking turns are depicted as grey boxes. Only those components hypothesized to be "essential" are depicted in Figure 1 (i.e., other elements may be present but are thought to be unnecessary to the delivery of working metacommunication). The sequence of speech turns unfolds sequentially (temporally) from left to right.

In this rational model, the first essential component is thought to be the client's depiction of an interpersonal or relational problem, which prompts the metacommunicative utterance from the therapist. As noted in Keisler's (1988, 1996) principles of metacommunication and supported by the clinical experience of the investigator, therapist metacommunication is typically elicited by clients' depiction of an extratherapeutic interpersonal problem which is stereotypical of a

larger pattern of relational difficulties. In many cases, the client may even be aware that the problem being depicted is similar to previous interpersonal struggles but either cannot identify his or her own contribution to the ongoing dynamic or voices hopelessness or helplessness regarding change.

Next, the therapist makes a self-involving statement characterized by immediacy (i.e., is reflective of the therapist's present experience), specificity (avoids vague or ambiguous statements), and an overall supportive or encouraging tone. Although the use of such statements is an essential element of TLDP (see Levenson, 1995; Strupp & Binder, 1984), the incorporation of a positive, supportive tone in self-involving statements is not specified in this literature. Rather, "clinical honesty" (Levenson, p. 89) is encouraged in therapists' conveyance of his or her emotions regarding the client during the metacommunicative attempt. However, the rational model incorporates research indicating that clients more readily internalize feedback when it is delivered with (or at least prefaced with) praise or encouragement. This is not to say that such metacommunicative expressions would be clinically "dishonest" – rather, it presumes that even "difficult" metacommunication that conveys negative therapist emotions can be done in a supportive, encouraging manner.

An important feature of this first therapist component is that, through the use of a self-involving statement, the therapist is able to step back from the content of the client's speech, setting the tone of subsequent discussion – namely, moving towards a more "decentered" examination of the context of what is being said. As this initial therapist metacommunication can be viewed as an essential step that "sets the stage" for the quality of subsequent client exploration, an encouraging tone becomes important.

The next component of the rational model summarizes clients' reception of and immediate response to the therapist's initial self-involving statement. Here, the model incorporates McCullough et al.'s (1995) findings, in which 66 percent of the variance of therapy outcome for Short Term Dynamic Psychotherapy (Mann, 1973; Malan; 1979; Sifneos, 1979; Davanloo, 1980, as discussed in McCullough) and Brief Adaptation Oriented Therapy (Pollack & Horner, 1985, as discussed in McCullough) is accounted for by two therapy interactional sequences: therapist interpretation followed by patient affect (positively related to outcome) versus interpretation followed by defense (negatively related to outcome). With this in mind, the rational model surmises that clients will respond to therapist self-involving statements by verbally registering the meaningfulness of the therapist statement with some type of "affective responding" (McCullough, p. 528). Note that such responding can convey "negative" emotions such as anxiety, frustration, or even anger, as long as it does not involve a defensive component, or those responses that are seen as "patient statements that represent various mechanisms to avoid or resist facing difficult issues" (McCullough, p. 528). For instance, a client who replies to a therapist self-involving statement with "what you just said makes me feel angry for some reason, and I don't know why" does not convey the defensiveness of "what you just said makes me feel angry! I always get blamed for everything!"

The first therapist speech turns after the metacommunicative statement are exploratory in nature, again maintaining a hopeful or supportive tone even if the feelings offered during the metacommunicative delivery were critical or otherwise negative. An important feature of this component is the therapist's ability to proceed with the intervention despite his or her own uncomfortable feelings and send clear, unambiguous signals to the client that continued exploration is not only acceptable but will likely result in therapeutic gains. That is, as therapist

self-involving statements often are perceived as “threatening to therapists because they felt vulnerable in sharing part of themselves with clients” (Hill et al., 1989, p. 294), it is essential that the therapist at this step continue with the metacommunicative task, together with whatever discomfort might arise.

During this step, many of the tenets of metacommunicative exploration set forth by both Keisler (1996) and Safran and Muran (2000) are noted; namely, the therapist’s subsequent exploration of the initial metacommunicative utterance will be characterized by taking responsibility for his or her own feelings and reactions (i.e., not implying that his or her reactions and feelings are “caused” by the client). Additionally, a tentative tone will be noted in the therapist during this discussion, which allows for a greater degree of co-construction of whatever new understanding the client gains from the metacommunication.

Finally, the last sequence of the rational model is reached. Similar in nature to the first therapist component, here the client noticeably “steps away” from the depiction of the interpersonal difficulty that was noted at the beginning of the model and acknowledges the interaction in a qualitatively different manner, made possible by the therapist metacommunication. Usually, this involves clients’ conceding some sort of responsibility for the negative interaction or recognizing that interaction as part of a larger interpersonal pattern.

Similar to the last component of Safran and Muran’s (2000) stage-process models of rupture resolution, this is when a wish or a need is expressed – for instance, a client may verbalize that she wishes she could assert her needs directly with her therapist without equivocation or guilt, and that her therapist would understand. Such wishful expressions underlie the vulnerability that clients experience at the end of the metacommunicative intervention, and more authentic expressions of need will typically follow as clients begin to recognize their own

contributions to the repeated and maladaptive cycle that was discussed in a more superficial manner at the outset of the metacommunicative process.

Step 5: Empirical Modeling

Shared metacommunicative sequences in HQ sessions. As depicted in Appendix J, combining and abstracting the three HQ products generated several commonalities across the four stages. In the pre-marker stage, clients typically prompted therapists' metacommunicative utterances by describing some type of out-of-session interpersonal problem or conflict, which in most cases contained explicit expressions indicating the repeated nature of the problem. In several instances, a high degree of expressed emotion was noted in this depiction. Towards the end of the pre-marker stage, clients often expressed positive emotion (trust or faith) towards the therapist. Often, such a statement would be combined with an acknowledgment that the initial depiction of interpersonal conflict was causing more distress than initially noted, leading to a process whereby the client would add some type of greater meaning to the noted problem. Throughout this stage, therapists characteristically said little, offering only the occasional prompting to continue, or stating a brief affirmation.

A point of divergence was noted at the beginning of the therapist marker stage, as therapists in HQ sessions tended to either begin the metacommunicative utterance with an acknowledgment of the client's (presumably changed) behavior in the "here-and-now" of therapy, or through therapists' recall of a previous therapeutic interaction that served as an example of positive change. These two divergent paths, however, then tended to continue along a similar sequence: first, therapists expressed reciprocal (positive) feelings to the client (i.e., in response to the client's expressions of positive emotions and statements of trust/faith in the pre-marker stage); next, therapists inquired about clients' emotions regarding the present

therapist-client interaction and from this point made links to extra-therapeutic events or relationships.

In terms of content, the client marker stage in HQ sessions was characterized by two general themes; however, these tended to proceed via a similar process. Namely, clients either profitably explored the interpersonal problem, or discussed their avoidance regarding this same issue. Typically, this process was first characterized by an acknowledgment of the therapist's metacommunicative attempt, often expressed with agreement or "mutuality"—i.e., some statement that indicated being on board the metacommunication. Next, clients either voiced ambivalence about change (usually with self-directed negative emotional expression) or conveyed expressions of gratitude, relief, and/or and acknowledgement of the positive effects of treatment. In most HQ sessions, positive emotion or an expression of trust was once again directed towards the therapist. The client marker stage typically finished with either an acknowledgement of a dysfunctional interpersonal pattern (often, with an explicit wish to be different or with the client's recognition of his or her avoidance regarding changing the identified pattern.

Finally, an initial therapist statement of understanding or encouragement marked the beginning of the resolution stage in HQ sessions, typically followed by therapists conveying their own reactions to the client's expressions during the client marker phase. This often involved therapists voicing their own conflict regarding how they should proceed in treatment. Clients responded to this with understanding, again routinely conveying how treatment had been beneficial. Following this, clients often returned to discussing the original problem, often expressing a deeper level of emotional pain in the process of questioning their interpersonal pattern or avoidance of change. Heightened emotional expression was noted in several clients

during this component of the model. Simple therapist queries and/or affirmations and client self-affirmations marked the end of the resolution phase. Often, the entire metacommunicative sequence would end with the client expressing a need or wish regarding change before the topic of conversation would shift.

Shared metacommunicative sequences in LQ sessions. As seen in Appendix K, combining and abstracting the three products for the LQ model displayed distinctive commonalities as well. As with the HQ model, the pre-marker phase typically commenced with the depiction of some type of interpersonal difficulty or struggle. However, across the LQ sessions, a much greater degree of self-directed negative emotion (anger, shame, guilt, self-blame) was noted, expression of which tended to arise repeatedly throughout the pre-marker sequence. Similar to the HQ pre-marker phase, therapists tended to advance therapy via simple reflections and inquiries. However, across LQ sessions, therapists inquired specifically about clients' negative pronouncements about themselves, often resulting in yet more client self-directed negative emotion. Finally, several clients in this group were observed to provide their own rationale for problematic interpersonal problems, seemingly independent of the therapeutic work taking place.

To begin the marker phase, therapists characteristically offered self-involving statements that were similar in form to the self-involving statements offered by therapists in HQ sessions – that is, by recalling some sort of previous in-session event or interaction. However, in the LQ sessions these recalled events were consistently marked by the recollection of something "negative" in tone—for instance, a prior discussion of suicidal ideation or a recollection of in-session conflict. This overall negative tone could be discerned throughout the therapist marker

stage, often culminating in a frank discussion of the therapeutic relationship (or proposing new therapeutic goals) in light of the discussed material.

The client marker sequence in LQ sessions typically began with an expression of denial or confusion about the preceding therapist statement(s), or agreeing with the therapist in a tangential or "concrete" manner indicating a misunderstanding of the intent of the therapist's metacommunicative utterance. This was typically followed by an expression of uncertainty or more self-directed negative emotion. In response to therapists' suggestion of new therapeutic goals, clients in LQ sessions were seen to note problems with such proposals, and in at least two cases independently offered their own strategies to resolving their interpersonal difficulties.

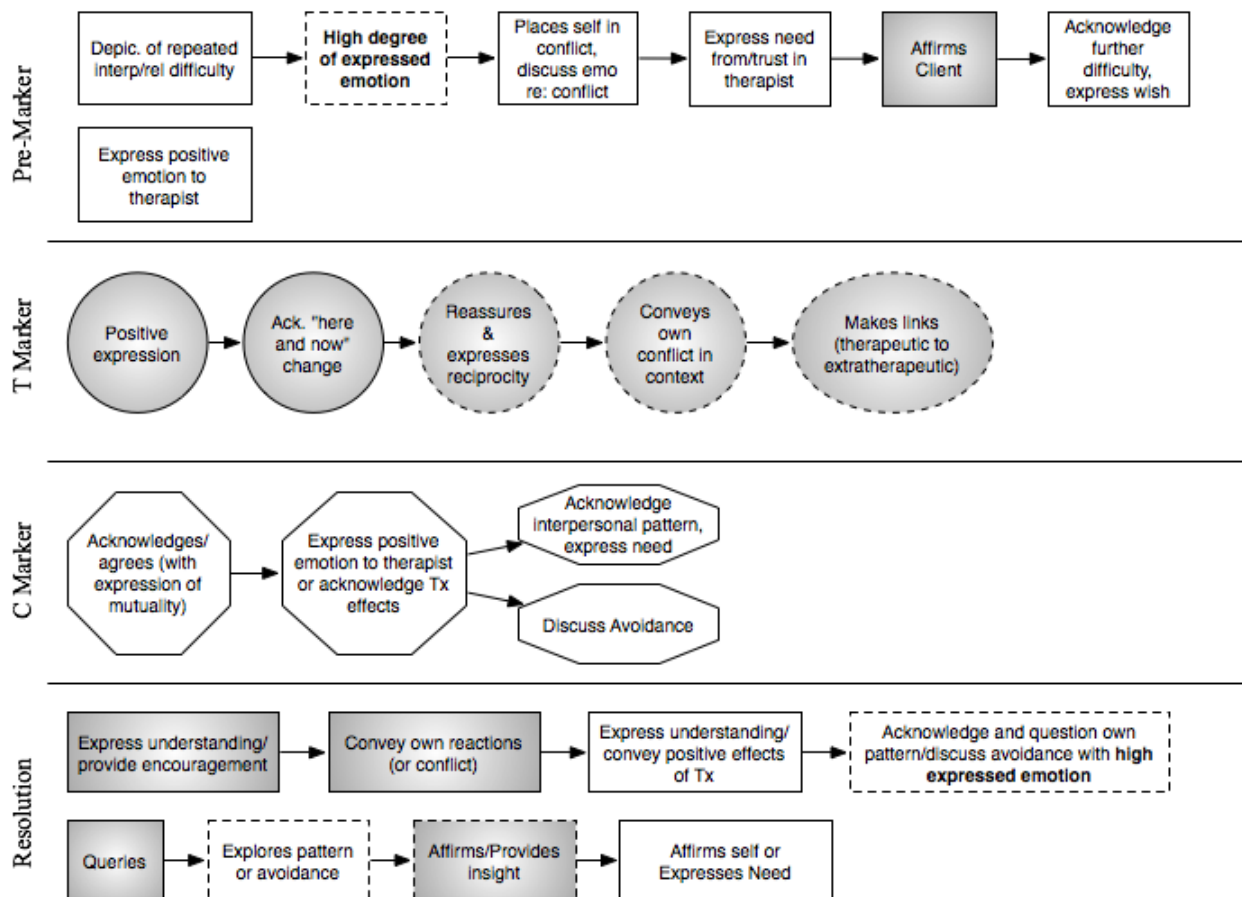
Abstracted client and therapist speech units during the resolution stage of LQ sessions followed two clear paths. In two cases (L4 and L5), no resolution was observed—that is, no discussion took place after the initial client acknowledgment of the therapist's metacommunicative delivery and before the focus of conversation shifted to a different topic. In one case, this was due to the client's repeatedly interrupting and talking over the therapist, prompting the therapist's curt metacommunicative response.

The second path was characterized by clients' continued self-criticism or negative emotions directed towards themselves. This tended to elicit reciprocal therapist negative emotions towards the client (as typified in one therapist's statement of "sometimes I feel not so connected to you either, and I think that's something that we need to work some more on") or negative comments regarding therapeutic progress. In all cases in this second pathway, clients finished the sequence with some type of self-criticizing statement.

Creation of the empirical model. In accordance with Greenberg's (2007) task-analytic guide, the first step of the construction of the empirical model (see Figure 2) entailed examining

both HQ and LQ models and discerning which components were shared. Only those components depicted in the HQ model were incorporated into the empirical model, and shared components (i.e., components within a given stage common to both HQ and LQ models) were not included. Again, the deletion of shared features does not indicate that these components did not occur. Rather, in order to distill the purest examples of effective metacommunication in TLDP, identical sub-components seen across both HQ and LQ cases can be seen as nonessential components of resolution that need not be depicted in the final rational-empirical model.

Figure 4. Empirical model of working metacommunication in TLDP.



Grey shading denotes therapist components; no shading denotes client components. Solid borders indicate essential steps of metacommunicative performance; dashed borders indicate important but unessential elements of performance.

Several shared components were observed across the two preliminary models. The most salient of these was the client's depiction of an interpersonal problem to begin the metacommunicative sequence. Others included simple therapist reflections and inquiries and client processes related to expressing negative views of the self.

The second step in creating the rational model was to look at each HQ metacommunicative exchange to determine whether each component of the initial empirical model was present in some form across all HQ cases. If not, the component in question was presumed to be "important but not essential" (Greenberg, 2007, p. 20) in the delivery of effective metacommunication and is depicted in the empirical model by a dashed-line border. As such, the final empirical model depicts components of effective metacommunicative delivery that are presumed to be essential, as well as those components that are presumed to be important but nonessential.

Step 6. Synthesis of the Rational-Empirical Model

Once the empirical model was delineated, it was compared to the rational model and used to "corroborate, elaborate, or modify" (Greenberg, 2007, p. 23) this initial product. If the empirical model displayed a radical departure from the rational model, that component of the rational model was rejected in favor of that element which was observed in real-world performances. In the current study, although the rational model maintained its overall five-component sequence and no wholesale deletions/substitutions were made in light of empirical findings, the nature of each rational-empirical model component was either altered considerably or expanded upon in light of empirical findings. See Figure 3 for the rational-empirical model of working metacommunication in TLDP.

The rational-empirical model's first component, "places self in conflict/discuss emotions

regarding conflict" is more specific compared to the rational model's first element, "depiction of interpersonal or relational difficulty." Rather than a "true" (i.e., observed) discrepancy between the rational model and the empirical model, this difference arises from a procedural effect of the task-analytic paradigm. Namely, in both LQ and HQ sessions, clients' depictions of interpersonal or relational difficulties did indeed appear to initiate therapists' metacommunicative sequences. However, only "essential components of resolution performance" (Greenberg, 2007, p. 22) are of interest in the empirical model. Shared components, viewed as being non-essential, are not included. That is, while such components may be common to all observed performances, they cannot be considered essential if shared between presumed high- and low-quality examples of the phenomenon. As such, this component of metacommunicative competence was not included in the empirical model, and is subsequently not depicted in the rational-empirical model.

With this in mind, the most striking difference between this model and the rational model was the significant alteration of the client's performance in the pre-marker phase. Although client self-criticism was noted in both HQ and LQ sessions, clients in HQ sessions tended to spontaneously transform self-criticism through self-reflection and insight, whereas clients in LQ sessions remain mired in repeated self-blame, and resisted therapists efforts to explore it. For instance, in session H3, the client was self-critical regarding her tendency to be over-concerned about what others thought of her, but spontaneously (i.e., without therapist intervention) proceeded to discuss how she was aware of this tendency in therapy but had a hard time maintaining this perspective in her daily life. However, in session L2, the client repeatedly expressed her own worthlessness as the primary source of her marital strife.

Another notable finding in the pre-marker phase was the heightened emotional expression of several clients in HQ sessions (e.g., raised voice volume and pitch indicating

frustration with self, or speaking in a slower, quieter manner that belies the client's recognition and subsequent pride that she engaged in a different relational pattern with a friend), which was absent in LQ sessions.

Other alterations to the rational model resembled "assimilation" rather than "accommodation" (that is, themes discovered through empirical analysis were incorporated into the fabric of the rational model, as opposed to changing the structure of the rational model to accommodate the empirical findings). To begin, therapist self-involving statements were a hallmark of the therapist marker stage and were indeed crafted with immediacy, specificity, and an overall positive tone. However, the empirical analysis and model also indicate that, as observed in actual performance, therapists then tended to make links between client in session behavior and client out-of-session behavior (or, at least, the possibility of extra-therapeutic change). Additionally, therapists at this point typically elucidated some type of conflict they were experiencing at the present time (for example, voicing wanting to gratify a client's request to know her diagnosis while articulating how doing so might play into the client's dynamic of needing to know how she is perceived by others); however, this was uniformly done in a hopeful, supportive tone.

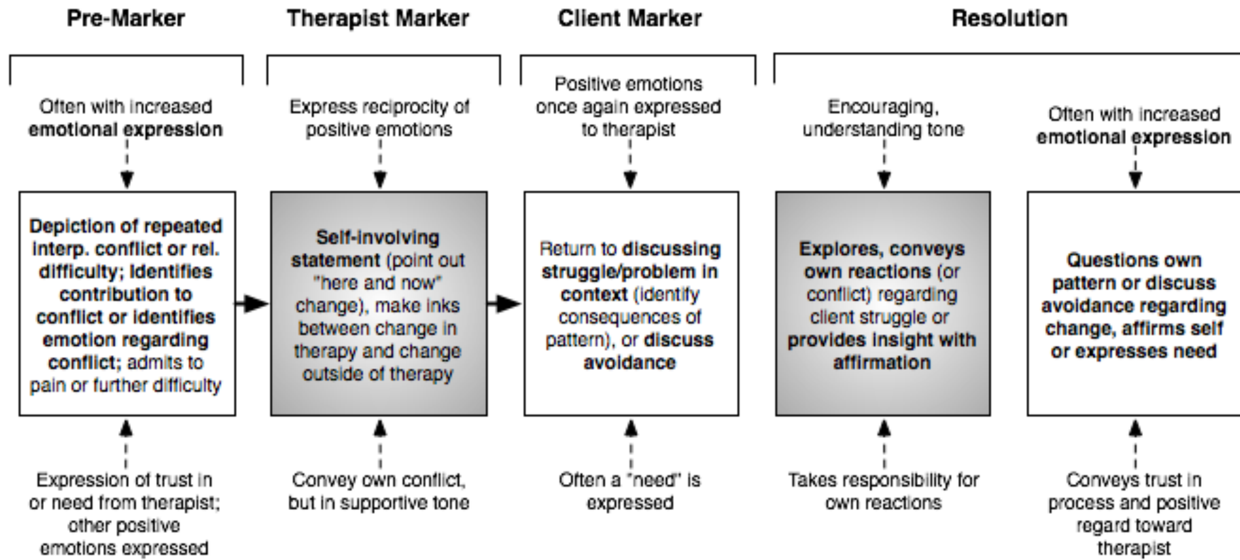
In the rational model, "acknowledgement with high emotional expression" was expected to be the essential task in the client marker phase, even if the client did not necessarily "accept" the therapist's metacommunicative utterance. Such heightened emotion was not observed to be essential in the HQ cases, however. The defining feature of this part of the sequence was clients' returning to discussing the original problem with "deeper" meaning, such as identifying the negative consequences of the pattern or motivations for avoiding change. Typically, statements of trust in the therapist or other indications of a positive therapeutic alliance were voiced during

this time, and often clients were observed to make "need" statements towards end the client marker stage (i.e., clients expressed increased readiness for change).

As depicted in this model, the final two squares represent grouped therapist and client tasks, respectively, across the resolution phase. While the general themes of exploring the interpersonal/relational dynamic, taking responsibility for one's reactions, and "stepping back" from the depiction of the initial problem in order to facilitate therapeutic exploration as depicted in the rational model were supported, several elements from the empirical model were integrated. First, the task of therapists' expressing encouragement and voicing support throughout the resolution phase was evident in HQ cases and infused within the model. Second, therapists often continued to discuss their own reactions to clients' interpersonal struggles or conflicts; however, these were almost always discussed in an encouraging and supportive tone. Finally, therapists typically provided some degree of insight regarding potential reasons for clients' reactions to the conflict.

Heightened emotional expression was noted in clients for the second time during the resolution phase. Additionally, several clients were observed to question their previously identified pattern, or admit to their avoidance of change. In several instances this occurred in a back-and-forth fashion, with clients first expressing the need for change, and then alternatively articulating the relative safety of avoiding change. Again, throughout this process were statements of trust or positive feelings regarding the therapist or trust in the process of therapy. In almost every HQ metacommunicative instance, the final client utterance was an expression of self-affirmation or need, making this the last component of the resolution task.

Figure 5. Rational-Empirical Model of Working Metacommunication in TLDP.



Grey boxes indicate therapist performance component; unshaded boxes indicate client performance.

To summarize, the rational model appears to have served as an adequate initial structure suitable for "receiving" the empirically derived data. The most significant modification involved deleting "depiction of interpersonal or relational problem" from the major pre-marker component (due to its commonality in both HQ and LQ models) and replacing it with the more specific modifier ("provides initial insight into struggle/problem"). The other changes were smaller and assimilative in nature.

Discussion

This study formed an initial model of the sequential components of working therapist metacommunication in TLDP through the task-analytic paradigm, which combines a theoretically-grounded "best guess" of how optimal client-therapist metacommunicative performance unfolds with repeated observation of real-world task performance. The purpose of the study was threefold: first, to independently characterize working metacommunication in naturalistic settings to better understand which elements and processes appear to be essential to

this transtheoretical intervention; second, to provide a preliminary empirical foundation with which to either corroborate or de-emphasize features of existing theoretical guidelines for therapeutic metacommunication; and third, to better equip TLDP trainees and practitioners in the use of metacommunication.

As such, this section begins with a discussion of the components and clinical implications of the rational-empirical model. Next, the model is discussed in the context of existing guidelines for metacommunicative use. Limitations of the study and areas of potential future research are discussed. Finally, a personal reflection is offered, in which the findings of this study are discussed in light of a personal experience of a poorly-performed metacommunicative intervention.

The Rational-Empirical Model: Features and Clinical Implications

As discussed in Greenberg (2007), the rational-empirical model, while depicted in flow-diagram form, should not be thought of as a series of rigid "steps" through which the therapist-client dyad must proceed in a lockstep fashion. Rather, "given the complexity of human performance" (p. 23) the model should be viewed as representing roughly sequential "components of competence" (p. 23). That is, the model must be viewed as units of performance (or subtasks) which the therapist-client dyad must attain before the next component can be successfully undertaken.

With this in mind, the most important task in the pre-marker component is the client's ability to identify their own contributions or feelings within their depictions of their interpersonal conflict. Note that such identification was not observed to be particularly profound or incredibly insightful; rather, clients accomplished this task simply by included themselves in their

depictions of conflict or elucidated their current emotions regarding the conflict. For example, in session H2, a client discussed conflict she had during the week with a friend:

> [c] I don't feel I can hold it against her because she's proven helpful in a lot of other ways […] she's been a solid piece in a lot of really turbulent change recently […] I feel like I have to let it go, because if it sits on my shoulder then it will be, like it will cast too much of a shadow. When do I get to hold on to something? You know, because I let things go all the time.

Clients' ability to identify their own contribution and/or feelings regarding the interpersonal/relational difficulty—even if stated in a manner that falls short of taking full responsibility for their contribution to the conflict, or elucidated in a cursory manner—appears to provide a "stepping-off point" for further, mutual exploration of the difficulty in the subsequent stages of metacommunication. It appears this client marker signals to the therapist that the client is open to further exploration through metacommunication. This signal was absent in LQ sessions, in which clients typically remained mired in self-criticism rather than self-reflection; this more defensive client stance made for hostile territory for metacommunication.

Recall that the initial task in the rational model is "depiction of interpersonal or relational problem" that is "repeated and 'played out' in the client-therapist relationship." Given the unfamiliarity with previous session content, it was not possible to directly determine if client utterances in the analyzed sessions were manifestations of "central thematic interpersonal problems" (Kiesler, 1996, p. 284), nor was there a means to determine if these were "played out" in the therapeutic relationship. However, it is noteworthy that many of these depictions of conflict contained explicit references to repetitive thematic content (e.g., "again, we have this repeated thing," "that reminds me of a pickle we got into around session six or seven," "…over

and over again.") Phrases such as these appear in five HQ sessions, but only one LQ session (in which the therapist curtly directs the client's attention to the fact that the client tends to repeatedly interrupt her).

Thus, another important feature in the pre-marker phase is the acknowledgement (either from the client or the therapist) that there is a recurring nature to the conflict under consideration. While self-reflective depictions of conflict appear to provide a "way in" for therapists to metacommunicate, recognition of repetitive patterns (by either client or therapist) also provides fertile ground for therapist metacommunicative statements. As witnessed in several LQ instances, when these pre-marker features were absent, metacommunicative attempts are met with confusion, denial, or superficial responding. Thus, another important therapist task appears to be one of "therapeutic patience" in allowing for the development and elucidation of such a pattern before proceeding to metacommunication.

As depicted in the model, the essential task in the therapist marker component is therapists' ability to construct a self-involving statement that is supportive and encouraging, even if it also highlights client ambivalence or conflict. For example, a therapist states the following to initiate the therapist marker task component in a HQ session:

> [t] …this reminds me of a pickle we that got into in probably like session 6 or 7… remember when you asked me if you were crazy [c: yes] do you remember that? [c: yeah] … and I feel sort of, not that it's exactly the same thing, I feel like [client name] if I say "you are fine, there's no major worries," what does that do for you in terms of this deeper issue, which is looking for somebody else to tell you you're okay? [c: I know…]

Such empathic yet challenging therapist self-involving disclosures can be contrasted with therapist marker sequences in LQ sessions, in which clients' pre-marker narratives of self-

criticism or self-blame (i.e., regarding the depicted conflict) often prompted therapists to inquire about the client's here-and-now experience of conveying the negative emotions. Subsequent to the client's elucidating yet more negative emotions in response (such as frustration with treatment or the therapist, or voicing yet more self-blame or self-criticism), therapists uttered the self-involving statement. For example, one client began the pre-marker sequence with a discussion of his self-critical tendencies:

> [c] I don't know whether it is honest to say that I'm really being self-critical because I don't change anything, you know? I don't allow that criticism to make for major changes in my behavior, so… unless there's some sort of masochistic pleasure, I don't know... I mean maybe I like being self-critical. Or I get some pleasure out of criticizing myself.

To this, the therapist responded "what's it like sitting here today and talking about this with- with me, what's this like for you right now?" To which the client answered, "I'm not uncomfortable with you but I am uncomfortable with this situation and this description of this situation." It is after this initial metacommunicative exchange that the therapist offered his own self-involving disclosure (voicing a sense of feeling "stuck" with therapeutic progress), which was arguably negatively influenced by the initial client criticism.

Such self-involving disclosures in LQ sessions tended to be met with superficial responding by the client. Often, this precipitated another round of therapists' attempts to process emotions in the here-and-now, which were similarly unproductive. The result of such recursive metacommunicative attempts tended to further entrench therapists and clients into "adversarial" positions (i.e., therapists' attempts to elicit some type of clinical exploration, met by clients' attempts to avoid it). Perhaps, because Levenson (1995) as well as Strupp and Binder (1984) discuss metacommunication as a means to facilitate new corrective new experiences with others,

therapist-trainees use metacommunication in a sincere attempt to explore emerging strains in the therapeutic alliance. When such attempts are met with client ambivalence, denial, or criticism, some TLDP trainee-therapists, in accordance with their understanding of the goals of metacommunication, re-double their efforts to metacommunicate, which only serves to elicit more of the same.

The rational-empirical model demonstrates that therapist-client mutuality (reciprocated positive emotions combined with a sense of being “in sync” with one another) facilitates the therapeutic work performed in the resolution phase. That is, the client's expressions of trust or faith in the therapist (or the therapeutic process in general), combined with the therapist's expressions of hopefulness, pride, or encouragement, engenders important client insight in this phase. Specifically, clients were noted to more thoroughly examine their own role in the interpersonal or relational conflict, or discussed their tendency to avoid thinking about such problems.

This model also provides important information regarding the consequences of therapists’ attempts to metacommunicate in the absence of such mutuality. TLDP therapist-trainees’ attempts to metacommunicate during times of alliance strain were largely unproductive and may even have contributed to (rather than alleviated) negative therapeutic process. This is particularly significant, given that TLDP endorses the use of therapeutic metacommunication as the means by which therapists can escape the “interactive rut” (Levenson, 1995, p. 88) of becoming a participant in the client’s “dysfunctional dynamic interaction” (p. 88). Although metacommunication is not discussed in the TLDP literature specifically as a means to explore a strained or deteriorating alliance, TLDP therapist-trainees often appear to use the intervention in this fashion, or as an attempt to extricate themselves from uncomfortable or difficult moments.

Indeed, evidence supporting this hypothesis can be found in the qualitatively different thematic content of metacommunication in HQ and LQ sessions. Specifically, while the content of the former is exploratory and focused mainly on the client's experience, the latter displays more metacommunication focused on present (often conflicted) aspects of the client-therapist relationship.

This finding is consistent with a study performed by Phillips (2009) on the same dataset that determined that ratings of the quality of therapeutic alliance rupture repair (as elucidated by Safran and Muran [2000]) were not related to session outcome. Review of these overlapping datasets reveals that Phillips identified alliance ruptures in all but one of the LQ sessions. While therapists' inopportune or unskilled use of metacommunication might contribute to clients' perception of feeling misunderstood or frustrated with a lack of progress, it can also be that therapists are equally frustrated with difficult clients, resulting in metacommunicative attempts that can appear forced or even aggressive. Indeed, this latter scenario appears to have modest support throughout the empirical analysis, as none of the metacommunication in the LQ sessions contained the supportive, encouraging tone of the metacommunication seen in the HQ sessions.

The Rational-Empirical Model in Light of Existing Principles

The rational-empirical model of therapeutic metacommunication should be viewed as the first step in developing an empirically derived model of what "works" in therapeutic metacommunication *in vivo*; as such, it provides a useful model with which to begin to compare existing theoretically derived guidelines and principles (i.e., Kiesler, 1996; Safran & Muran, 2000; Teyber, 2000; Villard & Whipple, 1976). As discussed, the consistent presence of mutuality and empathy across stages is the most consistent feature across the rational model. And indeed, genuinely empathic therapist expressions (such as voicing pride in clients' handling

of reported interpersonal conflict in a different way, conveying a respectful tone in regards to what would otherwise seem to be a trivial extra-therapeutic occurrence, or acknowledging client pain or difficulty) can be found throughout each of the rational-empirical model's therapist components, and appear to be an important facilitating factor for subsequent client exploration and emotional processing. In other words, while it is important that metacommunication be delivered in an empathic manner, it will likely only be effective within a generally positive, empathic, and solidly established therapy alliance. The presence of mutuality as a precondition for effective metacommunication arises as perhaps the most important overarching metacommunicative principle.

Other rational model principles did not fare as well upon empirical analysis. For example, the importance of spontaneity in metacommunication (along with the purported pitfalls of its "strategic," or pre-crafted, use) is discussed across all of the guidelines in the literature. However, in this study, there were several examples of metacommunication that were, to some degree, "pre-crafted," as judged by both subjective analysis and grammatical content (e.g., "what I really want to do [this session] is kind of get at what you're feeling…"). Such examples were found across HQ- and LQ-rated sessions; additionally, client enthusiasm and willingness to continue did not appear to be related to whether the metacommunication appeared to be spontaneous or strategic.

The rational model incorporates the findings of McCullough et al. (1991) regarding therapist interpretation – specifically, that there was a significant relationship between the presence of client affect in response to therapist interpretation with client improvement at termination. This finding was cited by Levenson (1995) as an important determination in judging the effectiveness of therapist self-involving statements in TLDP. Although such emotional

expression was indeed noted in the resolution phase of HQ sessions, it was just as frequently seen in the pre-marker phase (i.e., before the therapist metacommunicative statement). Thus, it seems likely that therapist metacommunication in HQ TLDP sessions was delivered in the context of heightened client affect, rather than eliciting such an affective response *per se*.

Finally, the rational model noted that therapists' self-involving statements should be characterized by "immediacy, specificity, and supportive tone." This first characteristic was chosen due to its prominence in the theoretical literature (e.g., Kiesler, 1996; Safran & Muran, 2000), and emphasizes the importance of "focusing on the here-and-now of the therapeutic relationship and the present moment, rather than on events that have taken place in the past" (Safran & Muran, p. 117). The tendency to take the emphasis off here-and-now interaction, the authors argue, is a natural tendency to avoid anxiety-provoking feelings but comes at the expense of client insight. However, in several HQ metacommunicative instances, the past was brought up specifically by the therapist (e.g., a previous session or interaction, or a prior extra-therapeutic interaction) during a metacommunicative statement in order to point out positive client change in the present. Thus, the characteristic of "immediacy" was not included in the rational-empirical model's therapist marker phase, as empirical modeling demonstrated that therapists often reference prior instances of client behavior as a means of encouraging and reinforcing change in the present.

Limitations of the Study

One limitation of this study was the lack of availability of a direct measure of metacommunicative quality, and the subsequent necessity of using indirect indicators instead. The use of the measure would allow us to more directly, and perhaps validly, differentiate between high and low quality metacommunicative exchanges. Ideally, a pilot study would have

been performed in order to generate a measure of therapist metacommunicative quality. Trained third-party raters could then score all identified metacommunicative episodes across every taped session in order to generate a single score of metacommunicative quality, which would then be used to select high and low quality metacommunicative exchanges for empirical analysis.

A second limitation can be found in terms of heterogeneity of client interpersonal styles, and the resulting possibility that it was these client characteristics that were primary to the quality of the metacommunicative exchange. While clients were referred to TLDP treatment based on TLDP exclusion (e.g., presence of panic disorder, substance abuse, or a history of repeated suicide attempts) and inclusion criteria (e.g., presence of emotional discomfort, capacity for basic trust, willingness to consider problems in interpersonal terms, willingness to examine feelings, capacity to relate to others in a meaningful way) (Levenson, 1995), such criteria do not necessarily exclude client-participants with challenging interpersonal styles. Indeed, while several of the clients in HQ sessions came across as insightful, open, and appreciative, most of the clients in LQ sessions appeared to be more challenging (i.e., taciturn, walled-off, or even hostile). This may have created a scenario in which therapists within LQ sessions were "at their worst" with "difficult" clients, while therapists within HQ sessions were "at their best" with "easy" clients. Although the task-analytic paradigm calls for comparing dichotomized outcomes as a basis for the empirical model, it does so with the intention of "starting with" roughly similar initial treatment characteristics, then tracking divergences leading to different outcomes over time (Pascual-Leone et al., 2009). However, the degree to which these "starting points" should be similar has not been specified. At the same time, some of the same clients, therapists, and dyads were represented in both HQ and LQ sessions, thereby attenuating this concern, to some degree.

A third and final limitation has to do with issues related to systematic classification of client and therapist speech components in the empirical analysis. Although Greenberg (2007) encourages breaking down speech acts into "meaningful units of common process that capture the point of what is occurring in a given passage of transcript" (p. 20), other authors have opted to categorize such units into existing classification schemes. For instance, in the task-analytic paradigm, Stern (2001) used Benjamin's (1974) Structural Analysis of Social Behavior to classify, quantify, and statistically analyze essential components of a parent-adolescent reattachment task in family therapy. Using such valid and reliable coding schemes decreases the likelihood that the investigator will unwittingly affix his or her own meaning to an event of interest; additionally, it lends definitional precision when abstracting speech acts.

Directions for Future Research

As discussed previously, a methodologically complete task analysis involves two broad phases: the discovery phase (performed here) and the validation phase, which tests the rational-empirical model through the creation of a measure. Specifically, the measure would discern if "the components of the model discriminate between resolved and unresolved performances" in a separate dataset (Greenberg, 2007, p. 26). The creation of such a valid and reliable measure that incorporates the components of the rational-empirical model discerned in this study would be the next step in more completely characterizing therapeutic metacommunication from both therapist and client perspectives. Although there is at least one qualitative study on therapists' experience of the overall helpfulness of therapeutic metacommunication (Beam, 2006), a systematic investigation regarding clients' experience of metacommunication would be helpful to understand this intervention from a client-therapist dyadic viewpoint. Lacking client data of the

intervention, the broad picture of what constitutes effective metacommunication remains incomplete.

Personal Reflection

This study traces its lineage back to an externship placement years before I had settled on a dissertation topic. In my clinical work with a college student, I noticed that the productive atmosphere of the first few sessions was diminishing on a session-to-session basis, replaced by a seemingly superficial conversational tone and my client's reluctance to return to the constructive atmosphere we had previously experienced. With my nascent knowledge of TLDP theory and technique, I began to metacommunicate with her regarding the impasse. When this attempt was met with some defensiveness, I continued with the metacommunicative attempt, albeit on a higher level – in retrospect, I was attempting to "meta-metacommunicate" in an attempt to understand my client's initial reluctance to process the original metacommunicative intervention.

The result was, to put it clinically, a sub-optimal outcome. My client terminated treatment, but did come in for one more session. Over the course of this last therapy hour, I learned that, although she had experienced herself as being in a bit of a rut, she had spent the last few weeks processing the initial, productive sessions and stated that she needed the seemingly "unproductive" space to let her new insights settle in. She explained that she had every intention of coming back to different therapeutic material once she had completed this period of processing. My attempts to continue productive exploration via metacommunication were experienced as mis-timed and off-putting. Listening to the audiotape after the termination session, I agreed with her.

Although this vignette perhaps has to do more with clinical inexperience than what makes metacommunication "work," I have returned to this episode repeatedly, wondering how

this unique intervention—the only intervention in which therapists expose their own feelings, thoughts, and innermost reactions to the client, often *about* the client—can best be brought to bear in psychotherapy. Taking a step back from this study, it comes as little surprise that many of the empirically discerned themes of effective metacommunication (e.g., hopefulness, an expressed pride in our clients' efforts in taking a different tack in response to repeated challenges, a supportive tone, etc.) are no different than the personal characteristics of Kotter's (1991) "compleat" therapist, respected and admired for

> …the excitement they exude, the wonderment and insatiable curiosity they convey about the world, about people, and about what makes us the way we are. This enthusiasm is transmitted by the sense of drama in the stories we tell. It is communicated in the elation we can barely contain during a moment of stunning insight or shared connection. It is felt by the genuine caring we show, our intense desire to be helpful. (p. 82)

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Appendixes

Appendix A: Session Impacts Scale

Therapist ID:	Session Date:
Client ID:	Session #:

DIRECTIONS: Please respond to these items **based on your internal reactions to the therapist's responses to you**. Rate each item on the basis of the descriptor which best fits your experience of your therapists' interventions and responses.

Not at all 1	Slightly 2	Somewhat 3	Pretty Much 4	Very much 5

1.	**Realized something new about myself.** As a result of the session, I now have new insight about myself or have understood something new about me; I see a new connection or see why I did or felt something. (Note: There must be a sense of "newness" as a result of something which happened during the session). (T)	1	2	3	4	5
2.	**Realized something new about someone else.** As a result of the session, I now have new insight about another person or have understood something new about someone else or people in general. (T)	1	2	3	4	5
3.	**More aware of or clearer about feelings, experiences.** As a result of this session, I have been able to get in touch with my feelings, thoughts, memories, or other experiences; I have become more aware of experiences which I have been avoiding; some feelings or experiences of mine which had been unclear have become clearer. (Note: Refers to becoming clearer about what you are feeling rather than why you are feeling something). (T)	1	2	3	4	5
4.	**Definition of problems for me to work on.** As a result of this session, I now have a clearer sense of what I need to change in my life or what I need to work toward in therapy (or counseling), what my goals are. (T)	1	2	3	4	5
5.	**Progress toward knowing what to do about problems.** As a result of this session, I have figured out possible ways of coping with a particular situation or problem; I have made a decision or resolved a conflict about what to do; I now have the energy or resolve to do something differently. (T)	1	2	3	4	5
6.	**Feel my therapist understands me.** As a result of this session, I now feel more deeply understood, that someone else (my therapist) really understands what is going on with me or what I'm like as a person. (R)	1	2	3	4	5

7.	**Feel supported or encouraged.** As a result of this session, I now feel supported, reassured, confirmed, or encouraged by my therapist; I feel better about myself, or have started to like myself better; I have come to feel more hopeful about myself or my future. (R)	1	2	3	4	5
8.	**Feel relieved, more comfortable.** As a result of the session, I now feel relief from uncomfortable or painful feelings; I feel less nervous, depressed or guilty, or angry in general or about therapy. (R)	1	2	3	4	5
9.	**Feel more involved in therapy or inclined to work harder.** As a result of this session, I have become more involved in what I have to do in therapy; my thinking has been stimulated; I have started working harder; I have become more hopeful that what I have to do in therapy will help; I now feel that I can be more open with my therapist.(R)	1	2	3	4	5
10.	**Feel closer to my therapist.** As a result of this session, I have come to feel that my therapist and I are really working together to help me; I am more impressed with my therapist as a person, or have come to trust, like, respect, or admire her/him more; a problem between us has been overcome. (R)	1	2	3	4	5
11.	**More bothered by unpleasant thoughts or more likely to push them away.** The session has made me think of uncomfortable or painful ideas, memories, or feelings that weren't helpful; it has made me push certain thoughts of feelings away or avoid them. (H)	1	2	3	4	5
12.	**Too much pressure or not enough direction from therapist.** As a result of the session, I now feel too much pressure has been put on me to do something, either in therapy or outside it; I have come to feel abandoned by my therapist or too much left on my own. (H)	1	2	3	4	5
13.	**Feel my therapist doesn't understand me.** As a result of the session, I now feel misunderstood; that my therapist just doesn't or can't understand me or what I was saying. (H)	1	2	3	4	5
14.	**Feel attacked or that my therapist doesn't care.** As a result of the session, I now feel criticized, judged, or put down by my therapist; I feel she/he is cold, bored, or doesn't care about me. (H)	1	2	3	4	5
15.	**Confused or distracted.** As a result of the session, I now feel more confused about my problems or issues; I feel thrown off or side-tracked from the things which are or were important to me. (H)	1	2	3	4	5
16.	**Impatient or doubting value of therapy.** As a result of the session, I now feel more bored or impatient with the progress of therapy or with having to go over the same old things over and over again; I have started to feel more that my therapy is pointless or not going anywhere. (H)	1	2	3	4	5

17.	**Other important impacts.** Please describe and rate any other important impact that may have occurred as a result of this session.	1	2	3	4	5

T = Task Impacts, R = Relationship Impacts, H = Hindering Impacts

Appendix B: Therapist Appraisal Questionnaire

Therapist ID:	Session Date:
Client ID:	Session #:

Directions: Please complete the sentence "When working with my client today, I felt..." according to your reactions in your session toward this particular client. It is important that you rate the items based on the therapy session you just conducted with this particular client, rather than on your feelings about therapy in general or any of your other clients.

Please indicate your agreement with each item according to the following scale:

Not at All	Slightly	Somewhat	Moderately	Quite a bit	A Great Deal
0	1	2	3	4	5

When working with my client today, I felt...

1.	Happy. (C)	0	1	2	3	4	5
2.	Confident. (T)*	0	1	2	3	4	5
3.	Angry. (H)	0	1	2	3	4	5
4.	Energetic. (C)	0	1	2	3	4	5
5.	Disappointed. (H)	0	1	2	3	4	5
6.	Eager. (C)	0	1	2	3	4	5
7.	Worried. (T)	0	1	2	3	4	5
8.	Disgusted. (H)	0	1	2	3	4	5
9.	Excited. (C)	0	1	2	3	4	5
10.	Exhilarated. (C)	0	1	2	3	4	5
11.	Fearful. (T)	0	1	2	3	4	5
12.	Sad. (H)	0	1	2	3	4	5
13.	Hopeful. (C)	0	1	2	3	4	5
14.	Pleased. (C)	0	1	2	3	4	5
15.	Anxious. (T)	0	1	2	3	4	5
16.	Guilty. (H)	0	1	2	3	4	5
17.	Frustrated.	0	1	2	3	4	5
18.	Bored.	0	1	2	3	4	5
19.	Indifferent.	0	1	2	3	4	5
20.	Disinterested.	0	1	2	3	4	5

C = Challenge, T = Threat, H = Harm. * = reverse scored item.

Appendix C: Client Appraisal Questionnaire

Therapist ID:	Session Date:
Client ID:	Session #:

Directions: Please complete the sentence "When working with my therapist today, I felt..." according to your reactions in your session toward your therapist. It is important that you rate the items based on the therapy session you just participated in with this particular therapist, rather than on your feelings about therapy in general.

Please indicate your agreement with each item according to the following scale:

Not at All	Slightly	Somewhat	Moderately	Quite a bit	A Great Deal
0	1	2	3	4	5

When working with my therapist today, I felt...

#	Item							#	Item						
1.	Happy. (C)	0	1	2	3	4	5	11.	Fearful. (T)	0	1	2	3	4	5
2.	Confident. (T)*	0	1	2	3	4	5	12.	Sad. (H)	0	1	2	3	4	5
3.	Angry. (H)	0	1	2	3	4	5	13.	Hopeful. (C)	0	1	2	3	4	5
4.	Energetic. (C)	0	1	2	3	4	5	14.	Pleased. (C)	0	1	2	3	4	5
5.	Disappointed. (H)	0	1	2	3	4	5	15.	Anxious. (T)	0	1	2	3	4	5
6.	Eager. (C)	0	1	2	3	4	5	16.	Guilty. (H)	0	1	2	3	4	5
7.	Worried. (T)	0	1	2	3	4	5	17.	Frustrated.	0	1	2	3	4	5
8.	Disgusted. (H)	0	1	2	3	4	5	18.	Bored.	0	1	2	3	4	5
9.	Excited. (C)	0	1	2	3	4	5	19.	Indifferent.	0	1	2	3	4	5
10.	Exhilarated. (C)	0	1	2	3	4	5	20.	Disinterested.	0	1	2	3	4	5

C = Challenge, T = Threat, H = Harm. * = reverse scored item.

Appendix D: Therapist Thought-listing Questionnaire

Therapist ID:	Session Date:
Client ID:	Session #:

I am interested in what went through your mind during the therapy session that just ended. Please list these thoughts, whether they were about you, the client, or anything else and whether they were positive, neutral, or negative. Any case is fine. Just remember to write down what you were thinking while you were in the therapy session and not the ideas that occur to you now. Please be completely honest. Your responses will be anonymous. Ignore spelling, grammar, and punctuation. Simply write down the first thought that came to mind in the first box, the second thought in the second box, etc. for up to 10 thoughts. Please put only one idea or thought in a box.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Appendix E: Client Thought-Listing Questionnaire

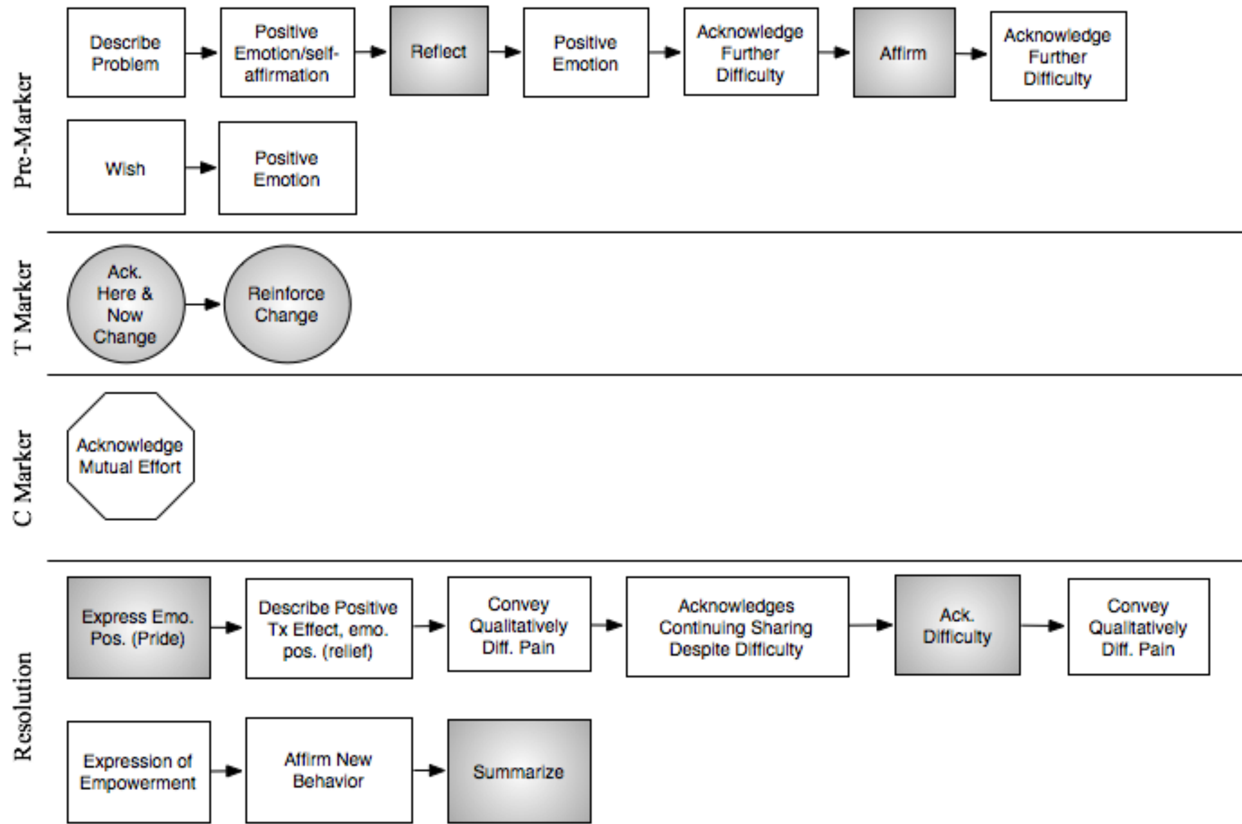
Therapist ID:	Session Date:
Client ID:	Session #:

I am interested in what went through your mind during the therapy session that just ended. Please list these thoughts, whether they were about you, the therapist, or anything else and whether they were positive, neutral, or negative. Any case is fine. Just remember to write down what you were thinking while you were in the therapy session and not the ideas that occur to you now. Please be completely honest. Your responses will be anonymous. Ignore spelling, grammar, and punctuation. Simply write down the first thought that came to mind in the first box, the second thought in the second box, etc. for up to 10 thoughts. Please put only one idea or thought in a box.

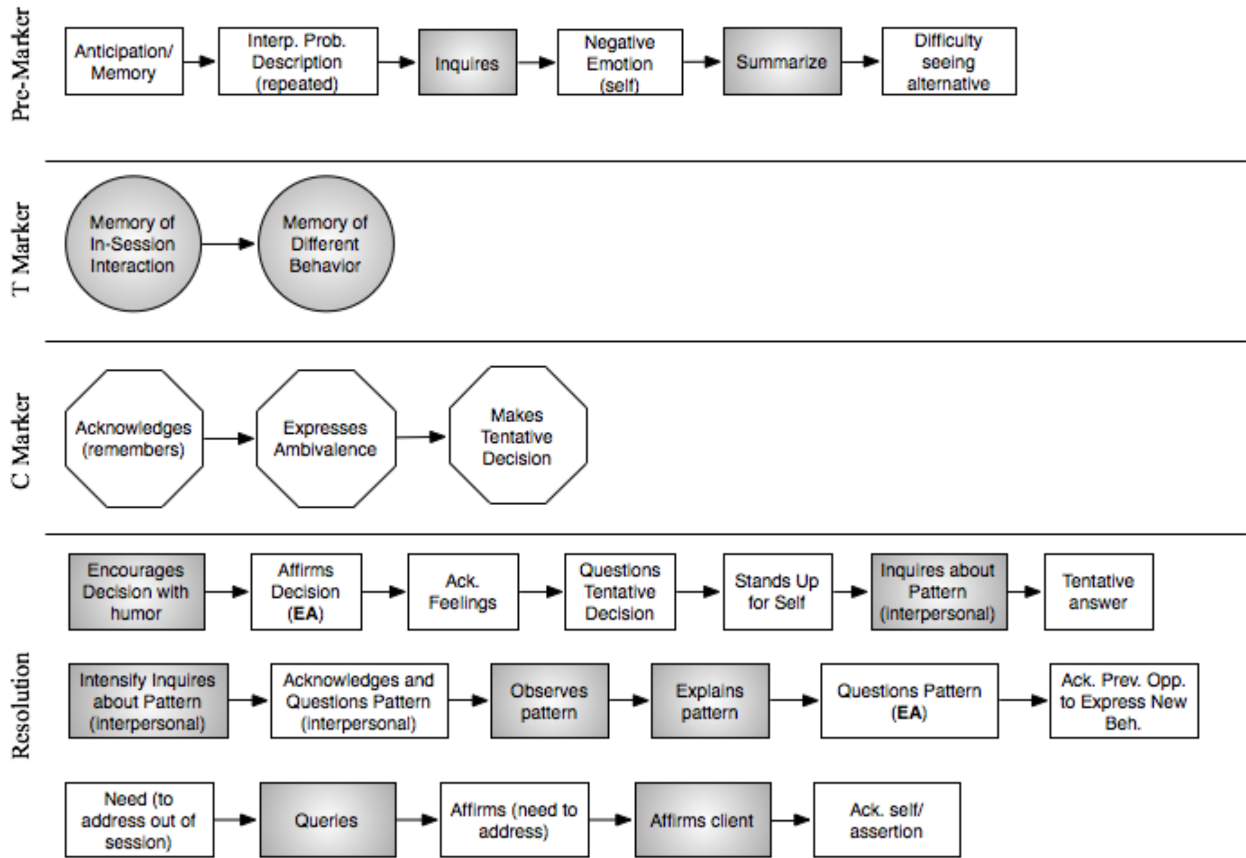
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Appendix F: Resolution Diagrams of HQ Sessions

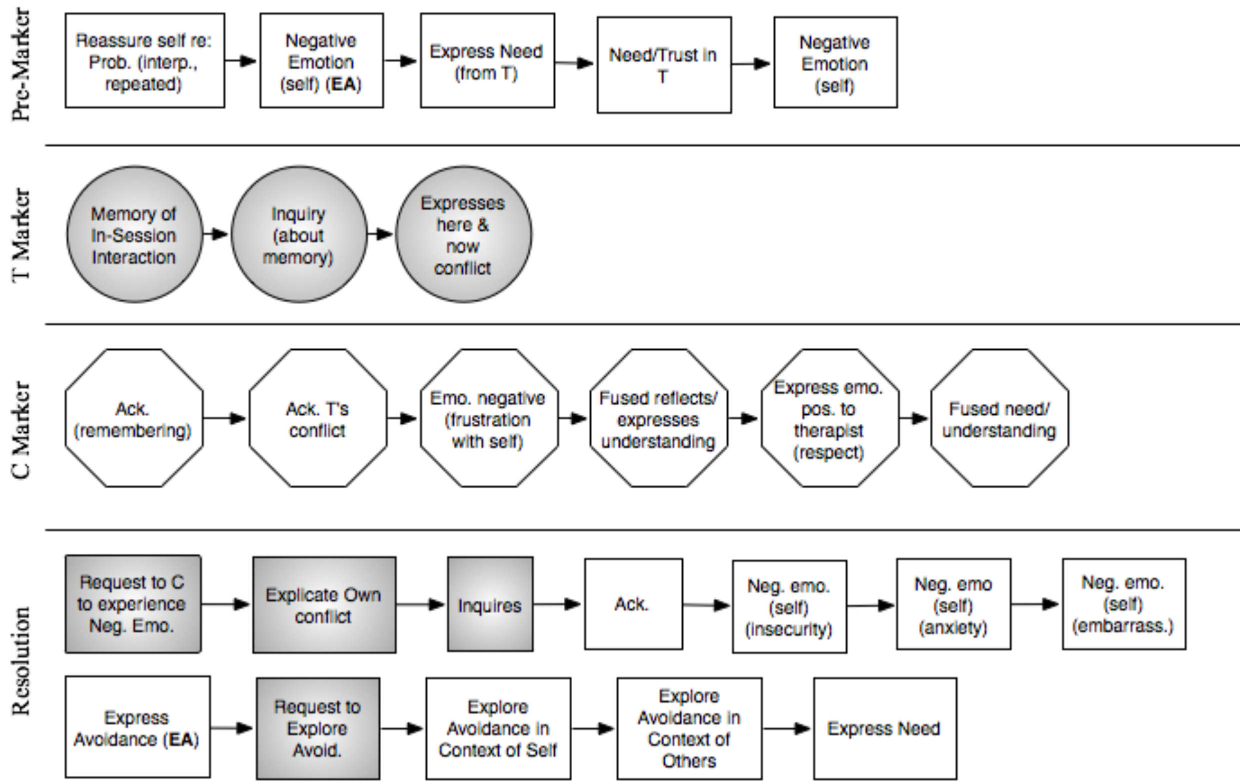
Dyad H1



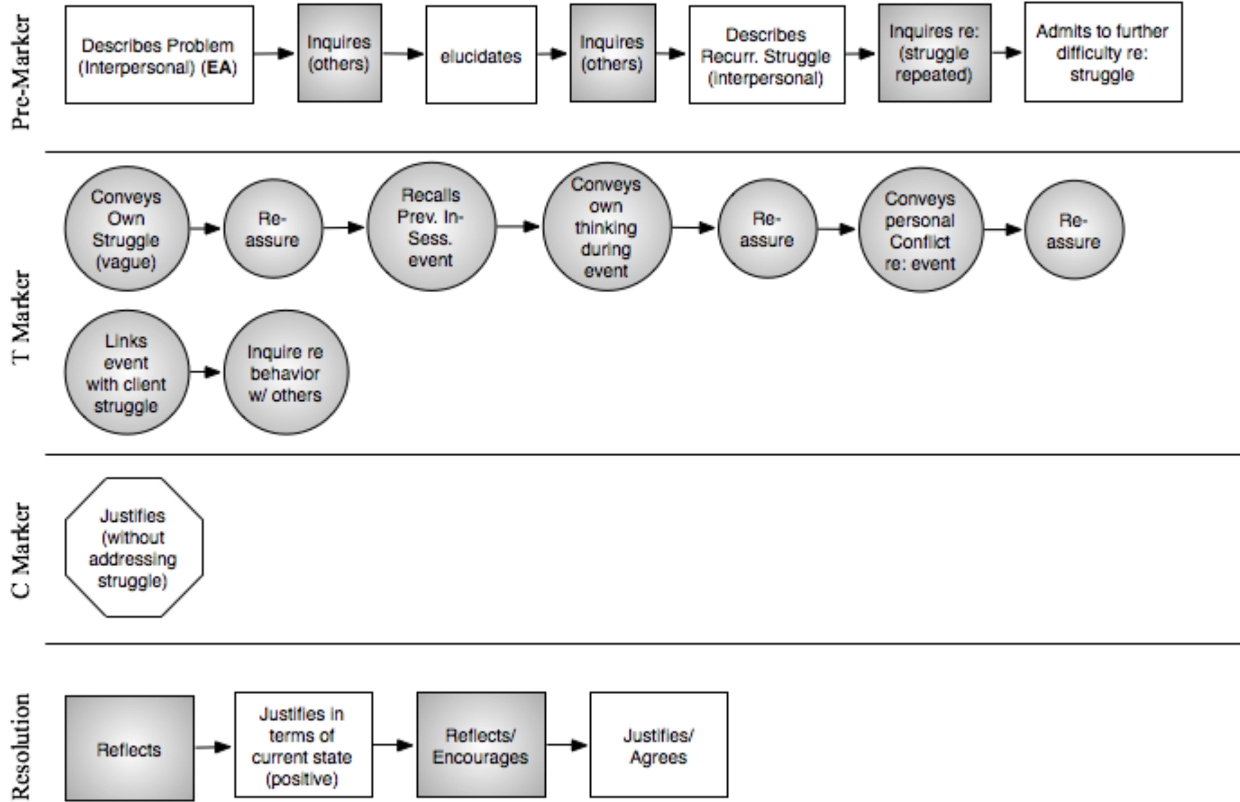
Dyad H2



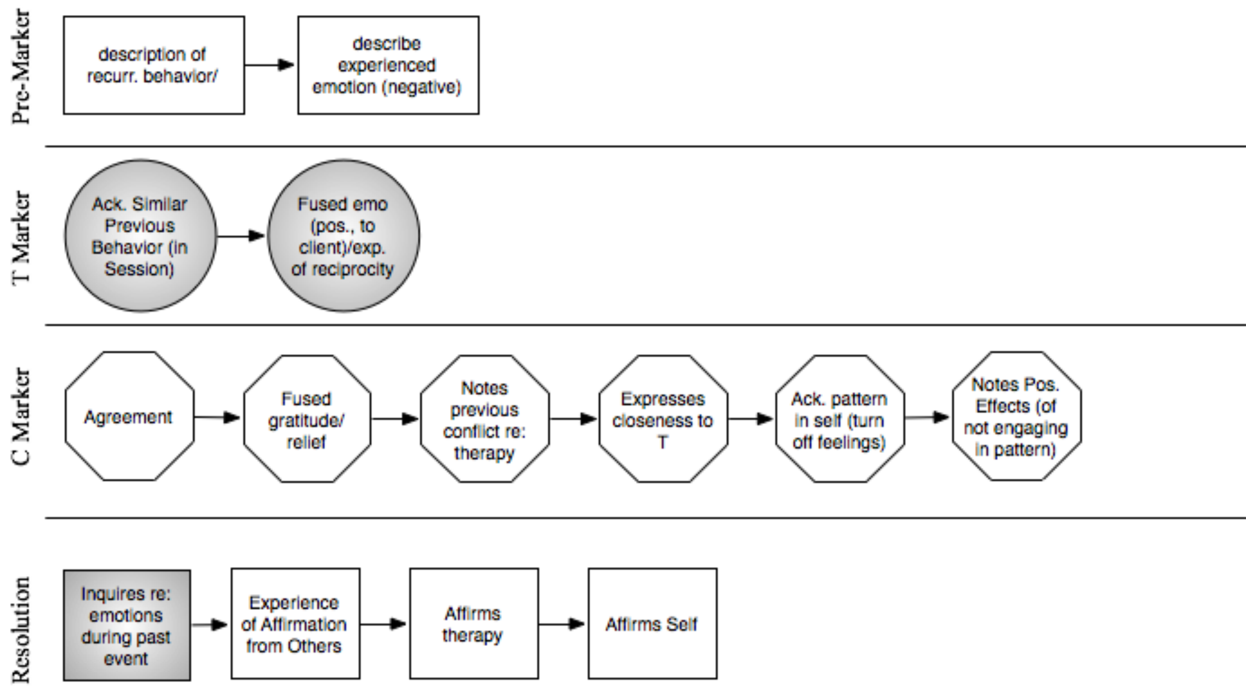
Dyad H3



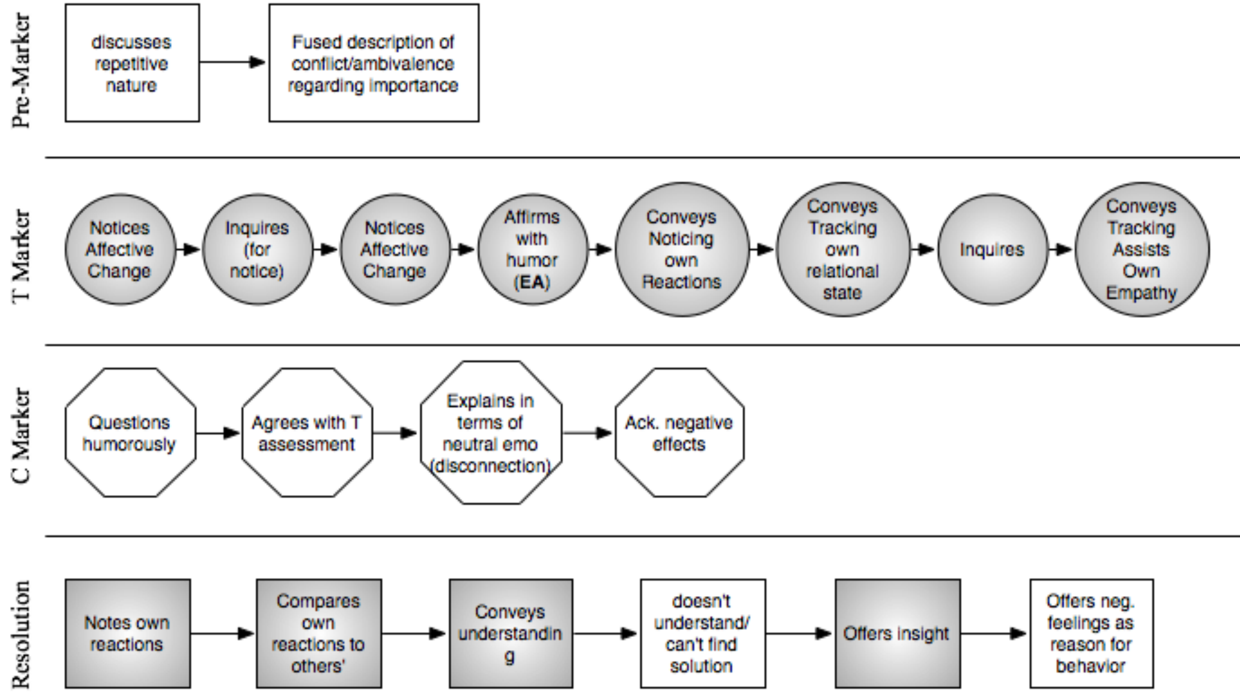
Dyad H4



Dyad H5

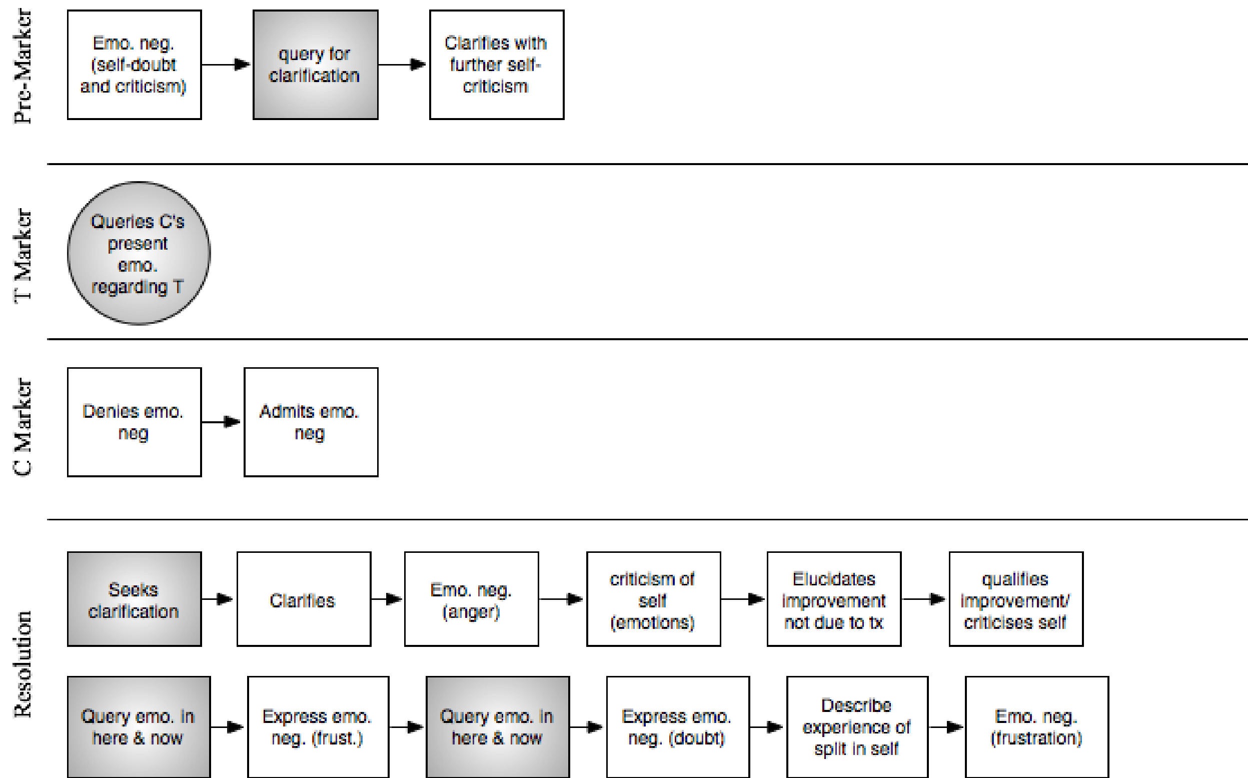


Dyad H6

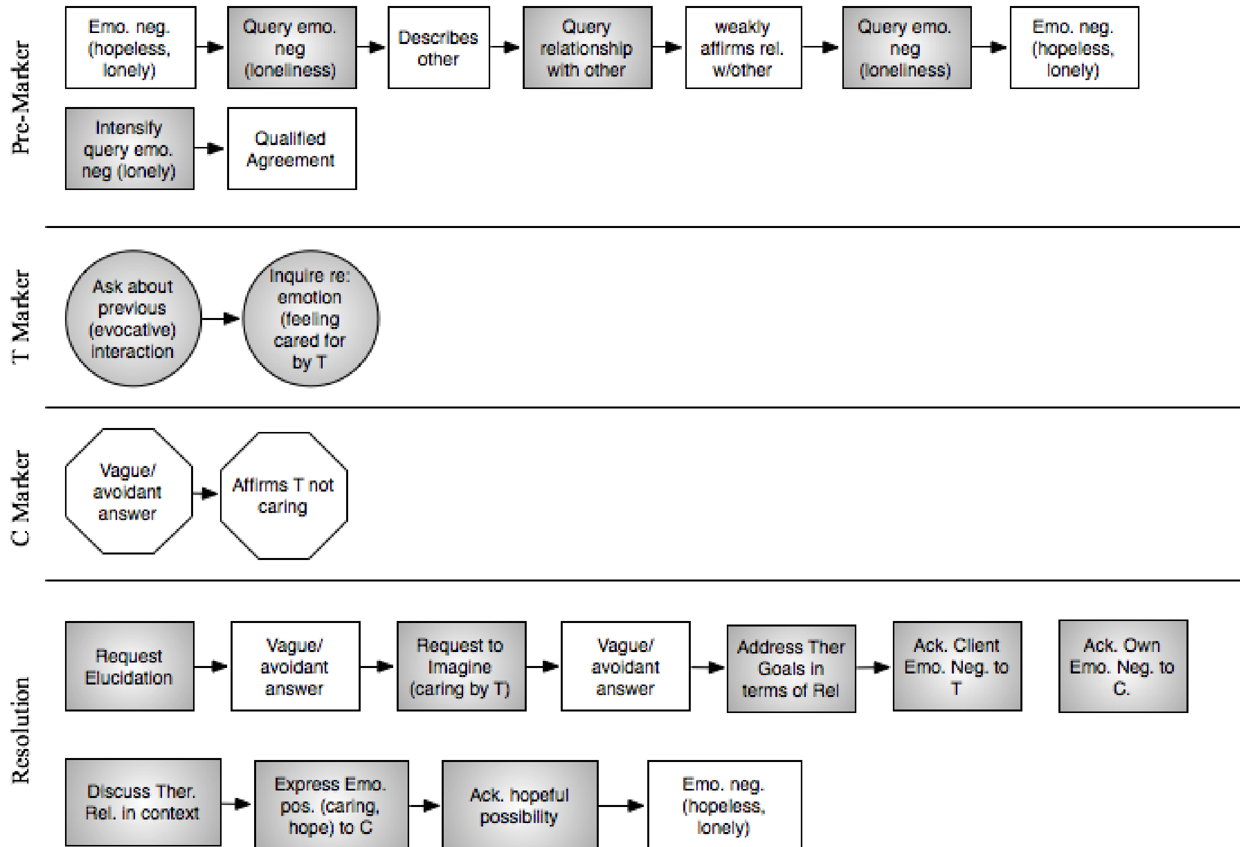


Appendix G: Resolution Diagrams of LQ Sessions

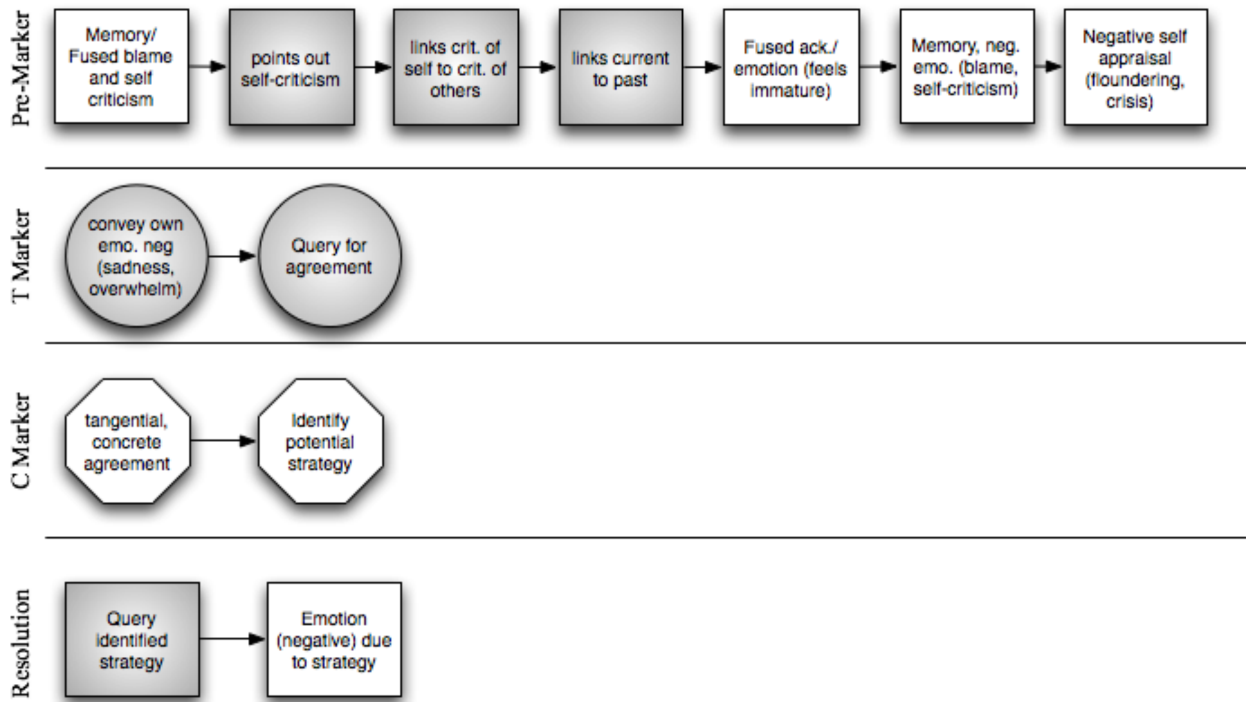
Dyad L1



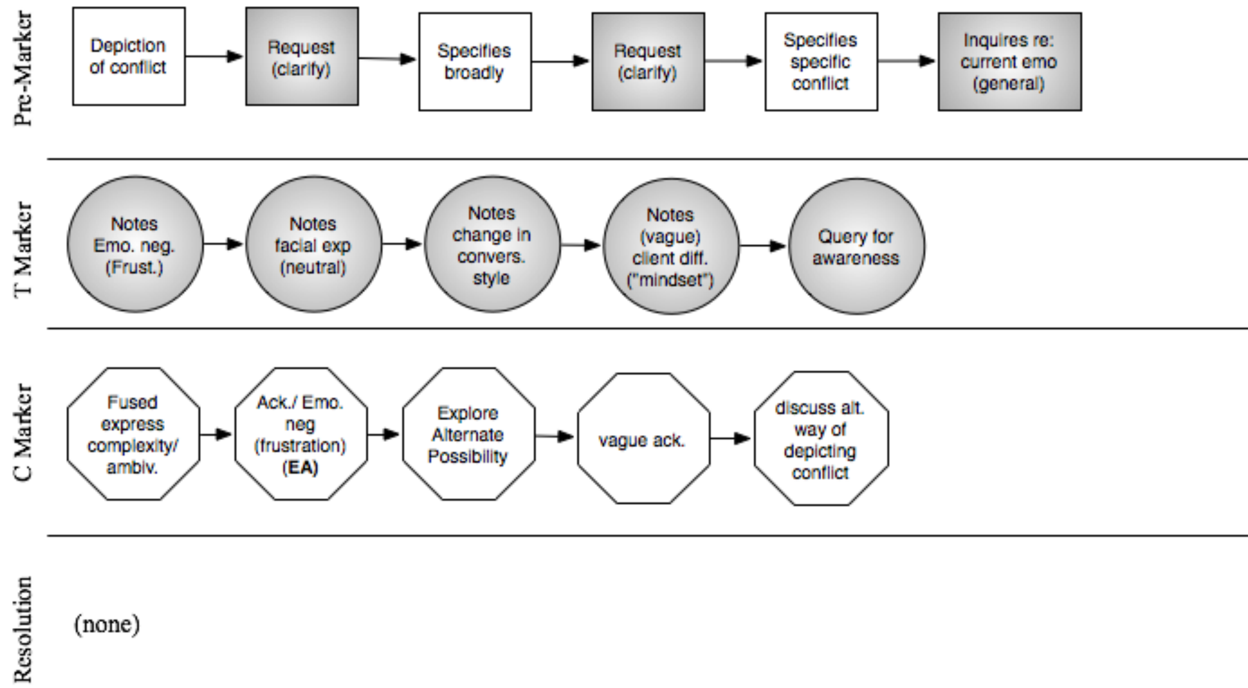
Dyad L2



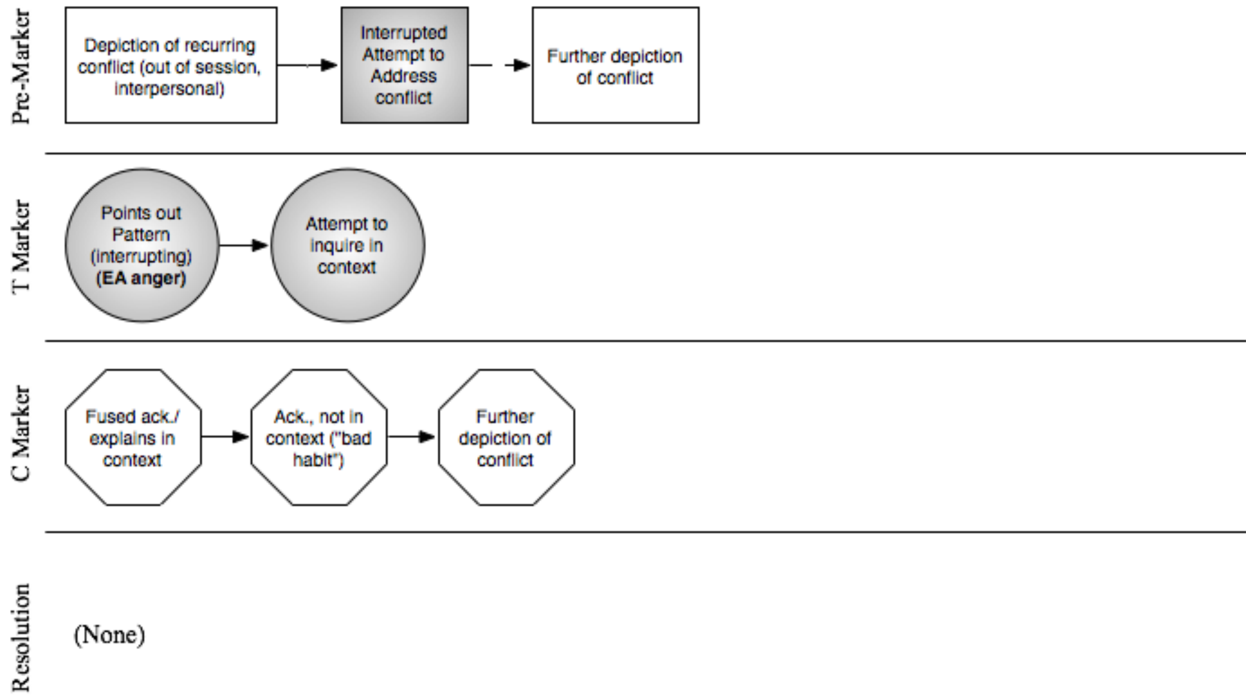
Dyad L3



Dyad L4

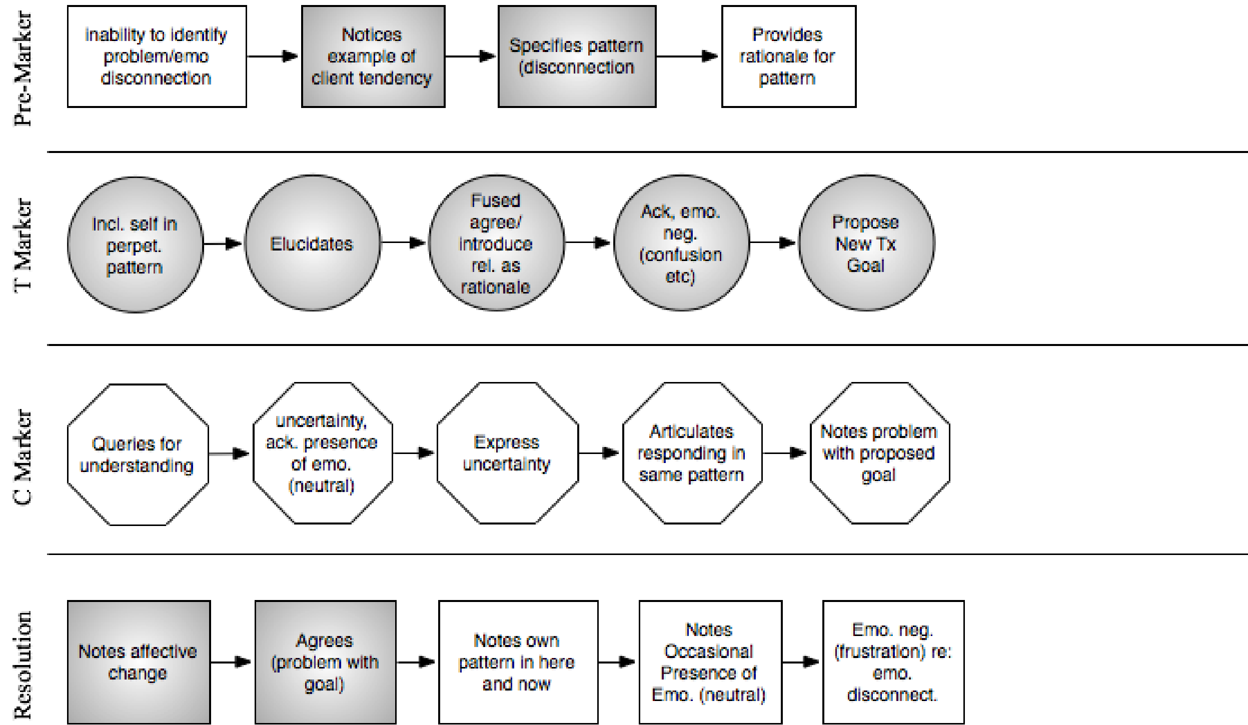


Dyad L5



(None)

Dyad L6



Appendix H: Combined and Abstracted Sequences Across HQ Sessions

Session H1 (Product HA)

	H1	Abstracted Product HA
Pre-marker	Describe problem (personal) (repeated)	Problem description repeated
	Pos emo (self-affirmation)	w/emo pos (to self)
	Reflect	Reflect
	Ack further difficulty	Ack further diff. with pos emo. To therapist
	Pos emo to T (gratitude)	
	Affirm	Affirm C
	Ack further difficulty	Ack further difficulty
	Wish	Wish
	Positive emotion	Express pos emo to T
TM	Ack here & now change	Ack and reinforce here and now change
	Reinforce change	
CM	Ack mutual effort	Ack mutual effort
Resolution	Express emo pos	Express emo positive (pride)
	Pos Tx, emo pos (relief)	Convey pos Tx effects
	Convey Qual. Diff. Pain	Ack diff in sharing qualitatively different emotion
	Ack Sharing despite difficult	
	Ack difficulty	Ack difficulty
	Convey qual diff pain	Affirm new behavior/empowerment
	Expression of empowement	
	Affirm new behavior	
	Summarize	summarize

Sessions H2 & H3 (Product HB)

<table>
<tr><th></th><th>H2</th><th>H3</th><th>Abstracted Product HB</th></tr>
<tr><td rowspan="6">Pre-marker</td><td>Fused anticipation/mem of problem</td><td>Reassures self (prob interp. repeat)</td><td rowspan="2">Description of prob (interpersonal) w/neg emo to self (high EA) repeated</td></tr>
<tr><td>Problem desc interp. repeated</td><td>Neg emo to self (high EA)</td></tr>
<tr><td>Inquires</td><td>Express need from T</td><td>Inquires</td></tr>
<tr><td>Neg. emo towards self</td><td>Need/trust in T</td><td>Express need from/trust in T</td></tr>
<tr><td>Summarize</td><td></td><td>Difficulty seeing alternative w/neg emo to self</td></tr>
<tr><td>difficulty seeing alternative</td><td>Neg emo (felt towards self)</td><td>summarize</td></tr>
<tr><td rowspan="3">TM</td><td>Memory of in session interaction</td><td>Memory of in session interaction</td><td>Memory of in session interaction/diff behavior</td></tr>
<tr><td>Inquiry about memory</td><td>Memory of different behavior</td><td>Inquires about memory/behavior</td></tr>
<tr><td>Express here and now conflict</td><td></td><td>Express here and now conflict</td></tr>
<tr><td rowspan="6">CM</td><td>Ack T memory</td><td>Ack T memory</td><td rowspan="2">Ack/express understanding of T memory or conflict</td></tr>
<tr><td>Express ambivalence</td><td>Ack T conflict</td></tr>
<tr><td>Make tentative decision</td><td>Emo neg towards self</td><td>Express ambivalence with emo neg to self</td></tr>
<tr><td></td><td>Reflects/understands</td><td>Emo pos to T</td></tr>
<tr><td></td><td>Emo pos to therapist</td><td rowspan="2">Express need/understanding</td></tr>
<tr><td></td><td>Needs/understands</td></tr>
<tr><td rowspan="16">Resolution</td><td>Encourage with humor</td><td>Request to C to exp emo neg</td><td>Encourage w/humor/inquire</td></tr>
<tr><td>Affirm decision (EA)</td><td>Explicate own conflict</td><td rowspan="2">Request to C to exp neg emo/explic conflict</td></tr>
<tr><td>Ack own feelings</td><td>Inquires</td></tr>
<tr><td>Questions tentative decision</td><td>Acknowledge</td><td rowspan="2">Questions tent decision, express neg emo to self</td></tr>
<tr><td>Stands up for self</td><td>Express neg emo to self</td></tr>
<tr><td>Inquires about interpersonal pattern</td><td>Express neg emo to self</td><td>Inquire about interpersonal pattern</td></tr>
<tr><td>Intensify inquiry interp. Pattern</td><td>Express neg emo to self</td><td>Ack and observes pattern, express avoidance (EA)</td></tr>
<tr><td>Observes pattern</td><td>Express avoidance (EA)</td><td rowspan="2">Observes/explains pattern, request to exp. avoidance</td></tr>
<tr><td>Explains pattern</td><td>Request to explore avoidance</td></tr>
<tr><td>Questions pattern (EA)</td><td>Explore avoidance in context of self</td><td rowspan="2">Explore avoidance or previous opportunities in context</td></tr>
<tr><td>Ack prev. opportunity to expl. beh.</td><td>Explore avoid in context of others</td></tr>
<tr><td>Need</td><td>Express need</td><td>Queries/affirms client</td></tr>
<tr><td>Queries</td><td></td><td>Asserts self/expresses need</td></tr>
<tr><td>Affirms need</td><td></td><td></td></tr>
<tr><td>Affirms client</td><td></td><td></td></tr>
<tr><td>Ack. self/asserts self</td><td></td><td></td></tr>
</table>

Sessions H4, H5, & H6 (Product HC)

	H4	H5	H6	Abstracted Product HC
Pre-marker	Describes event (**EA**)	Description of out of session behavior/emotion repeated	Description of repeated conflict/ambivalence [reg importance]	Description of interpers difficulty repeated
	Asks about others			Query about difficulty
	Describes event			Places struggle in context
	Asks about others			Query about context
	Describes struggle in context			Admits to struggle (pattern)
	Inquires about struggle			
	Admit to further diff re struggle			
TM	Conveys own struggle	Ack previous similar behavior in session	Notices affective change	Convey similar ther struggle req noted similar behavior w/humor
	Reassures		Inquires	
	Recalls prev therapy event	Emotion (closeness), expression of reciprocity	Notices affective change	Reassures, pos emo to C w/expression of reciprocity
	Conveys thoughts during event		Affirms with humor	
	Reassures		Notes own reactions	Notices present client change
	Conveys conflict re: event		Conveys tracking own relational state	Convey own confl and notes own reactions
	Reassures		Inquires	Explitizes tracking own reactions
	Links event with own struggle		Conveys tracking assists empathy	Makes links
	Links struggle w/C's behavior			
CM	Justifies behavior not in context of struggle	Agrees	Questions with humor	Agrees with humor
		Fused gratitude and relief	Agrees	Expression of gratitude/pos Tx effects/relief
		Notes pos tx effects	Explains in terms of disconnected emotion	
		Expresses closeness to T		Expresses closeness to T
		Acknowledges int pattern	Acknowledges negative effects	Ack pattern and neg effects of pattern
		Notes pos extra-therap effects		Discuss avoidance or justify behavior
Resolution	Reflects	Inquires about emo during event	Notices own reactions	Convey understand and inquire re: emo
	Fused justify/convey current state	Affirmation from others	Compares own reactions to others'	Convey own reactions and make links
		Affirms therapy	Conveys understanding	Agrees with T assessment
	Reflects/encourages	Affirms self	Not understand/cant find solution	Notes affirmation from others, affirms self
	Justifies/agrees with assessment		Provides insight	Affirms Tx, conveys pos current state
			Discuss neg emo as reason for beh.	Provides insight
				Discuss avoidance

Combine/Abstract of HQ Products H1, H2, and H3

	H1 (Product HA)	H2, H3 (Product HB)	H4, H5, H6 (Product HC)	Abstracted Product
Pre-marker	Problem description repeat with pos emo to self	Depic of interpersonal prob rep. with neg emo to self (EA)	Desciption of interpersonal diff rep.	Desc of interp problem repeated (**EA**)
			Query about difficulty	Reflects/inquires further
	Reflect	Inquires	Places struggle in context	Places struggle in context
	Ack further diff w/pos emo to T	Express need from/trust in T	Query about context	Express need from/trust in T
	Affirm C	Difficulty seeing alternative w/neg emo to self	Admits to struggle (pattern)	Affirms
	Ack further difficulty			Ack further difficulty, express wish
	Wish	summarize		Express positive emotion to T
	Express pos emo to T			
TM	Acknowledge and reinforce here and now change	Mem of in-sess interaction/beh	Convey similar struggle reg beh w/humor	Ack here and now change
		Inquires about interact/beh	Reassure, pos emo to C w/reciprocity	Mem of prev ther interact w/pos emo
		Express here and now conflict	Notice present client change	Reassure, express reciprocity w/pos emo
			Convey own conflict and note own react.	Inquires re T-C interaction
			Explitize tracking own reactions	Conveys own conflict in context
			Makes links	Makes links
CM	Acknowledge mutual effort	Ack/express understanding of T mem or conflict	Agrees with humor	Ack/agree with expression of mutuality
			Express gratitude/pos Tx/Relief	Express ambiv with neg emo to self
		Expres ambiv w/neg emo to self	Express closness to T	Exp gratitude/relief/post Tx effects
		Emo pos to T	Ack pattern and neg effects of pattern	Express pos emo to T
		Express need/understanding	Discuss avoidance or justify beh	Ack interpersonal pattern, express need
				Discuss avoidance
Resolution	Express pos emo (pride)	Encourage w/humor, inquire	Convey understand, inquire re: emo	Exp understand, encourage w/pos emo
	Convey post Tx effects	Ask C to experience neg emo/ explicate own conflict	Convey own reactions, makes links	Convey own reactions/conflict
	Ack diff in sharing qual diff pain		Agrees with T assessment	Expres understand/convey pos Tx FX
	Ack difficulty	Q own decision with neg emo	Notes affirm from others, asserts self	Express qual diff emo pain
	Affirm new beh/empowerment	Inquire about interp. pattern	Affirms Tx and conveys pos state	Ack and quest own patt, avoidance (**EA**)
	summarize	Q patt, express avoidance (**EA**)	Provides insight	Queries
		Exp patt, request explore avoid	Discuss avoidance	Explore avoidance
		Exp avoid, or prev opp to explor		Affirms/provides insight
		Queries/affirms client		Asserts self/expresses need
		Asserts self/express need		

Appendix I: Combined and Abstracted Sequences Across LQ Sessions

Session L1 (Product LA)

	L1	Abstracted Product LA
PM	Emo neg (doubt, self-criticism)	Neg emo (self)
	Seeks clarification	Inquires
	Clarifies and criticizes self	Clarifies with further criticism
TM	Queries present emotions	Queries emotions in the here and now
CM	Denies neg emo (discomfort with T)	Denies neg emo to T
	Admits neg emo (discomfort w/material)	Admits neg emo to Tx
Resolution	Seeks clarification	Seeks clarification
	Clarifies	Clarifies with further neg emo to self
	Emotion (anger, no direction)	Notes improvement not due to TX
	Criticism (of emotions)	Qualifies improvement
	Improvement not due to Tx	Queries emotions in here and now
	Qualifies improvement, criticizes self	Express emo neg (no direction)
	Queries emotions in here and now	Experience split in self
	Express emotion (frustration)	
	Queries emotions in the here and now	
	Expresses doubt	
	Experiences split in self	
	Emotion (frustration)	

Sessions L2 & L3 (Product LB)

	L2	L3	Abstracted Product LB
Pre-marker	Fused hopelessness/loneliness	Fused memory, blame of parents	Memory (neg) or expression of neg emo to self
	Asks about loneliness	Points out self-criticism	Inquire about or point out neg emo
	Describes other	Links (self crit to others' crit)	Makes links
	Asks about extrather relationship	Links current to past	Expression of hopeless/lonely/self-blame
	Weakly affirms this relationship	Fused ack/emo (feeling of immat.)	Queries loneliness, extra-ther relationships
	Asks about loneliness	Fused memory/blame	Qualified agreement
	Fused hopelessness/loneliness	Negative appraisal	Negative self appraisal
	Asks about loneliness (intensifies)		
	Qualified agreement		
TM	Asks about previous evocative in-session interaction	Emo (sadness and overwhelmed)	Recalls previous neg and evocative therapy event
			Express emo in here and now, neg (to C)
		Query for agreement	
CM	denies	Tangential, concrete areement	denial
		Identify potential strategy (stop talk)	Tangential, concrete agreement
			Identify potential strat to problem (independent of T)
Resolution	Request to imagine T caring	Query identified strategy	Request to imagine pos emo from T
	Vague/avoidant	Emotion (anger) due to strategy	Query strategy
	Address therapy goals in terms of rel		Vague/avoidant or emo neg to self
	Ack client emo (disconnection)		Address therapy goals in context of relationship
	Ack own emo (disconnection)		Ack client neg emo
	Discuss ther rel in context		Ack own neg emo
	Express caring/hope		Express caring/hope/pos. possibility
	Ack hopeful possibility		Emotion – anger, to self
	Hopeless/lonely		

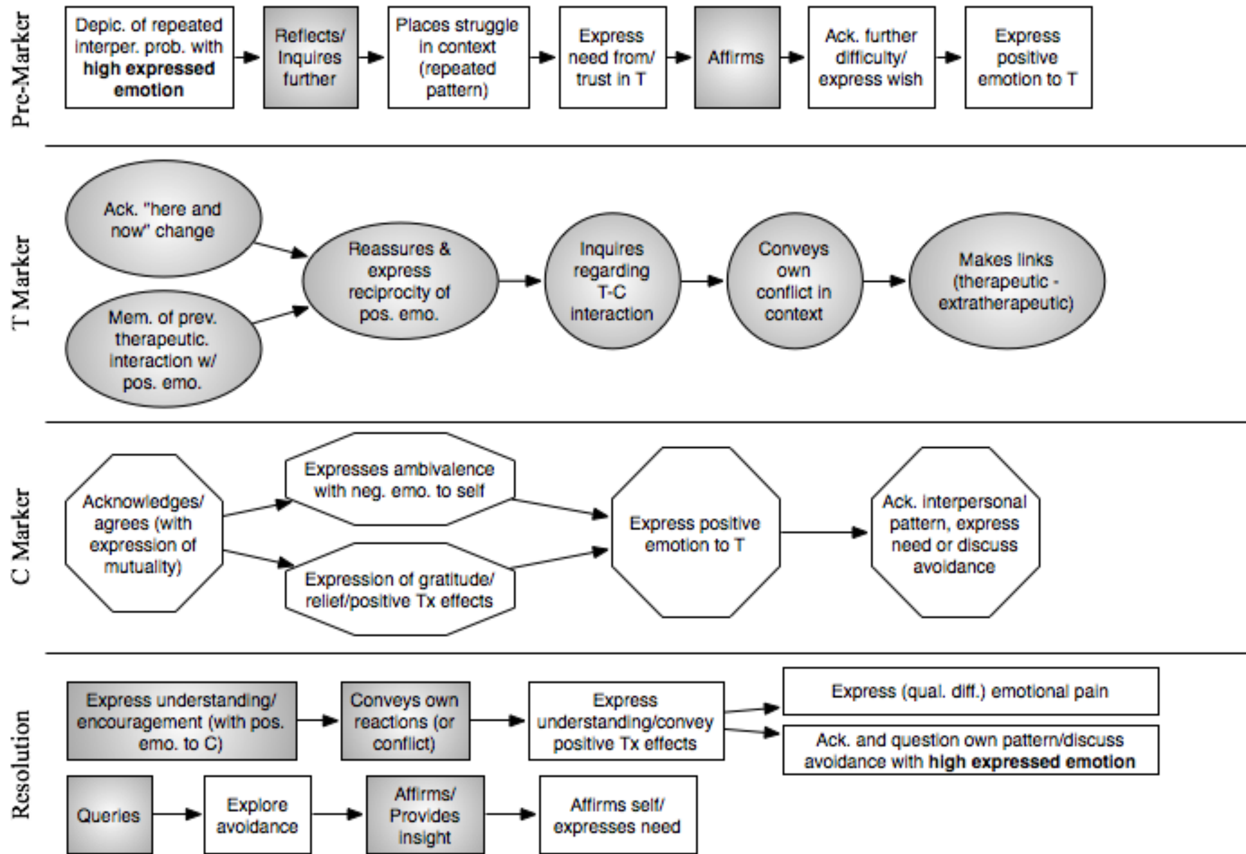
Sessions L4, L5, & L6 (Product LC)

	L4	**L5**	**L6**	**Abstracted Product LC**
Pre-marker	Depic of extra-ther conflict	Desc recur conflict with mother	Inability to ID prob/emo disconnect	Depiction of interpersonal conflict
	Request to be more clear	Interrupted while IDing pattern	Noitices example of tendency	Points out pattern/tendency (or interrupted while doing so)
	Specifies broad conflict	Desc recur conflict with mother	Specify pattern (emo disconnect)	
	Request to be more clear		Provide rationale for pattern (emo disconnect)	Specifies conflict
	Specifies specific conflict			Request/inquire re: current emo
	Inquires current emotiony			Provide rationale for pattern (not due to tx)
TM	Notices client emo (frustration)	Points out pattern in tx (interrupt) (**EA**)	Includes self in perpetuating pattern	Makes note of C emo/expression/change
	Notices client expression		Elucidates	Points out pattern (**EA**)
	Notices change in convers. style	Inquires re: pattern in tx	Agree/intro of ther rel as rationale	Includes self in pattern w/neg emo
	Points out current difference		Uncertain/confused/frustrated	Discuss ther rel as rationale for pattern
	Queries for awareness		Proposes new therapeutic goal	Propose new therapeutic goal
CM	Fused expressed complex/ambiv	Fused ack, explains in context (mother)	Queries for understanding	Doesn't understand
	Fused ack/frustration (**EA**)		Doesn't know/ack presence of emo	Ack pattern with frustration (**EA**)
	Explores alternate possibility	Acknowledge pattern	Express uncertainty	Describes conflict
	Vague acknowledgement	Desc recur conflict with mother	Articulate stuck-ness (wants to respond with same pattern)	Expresses uncertainty
	Discuss alt way of depicting conflict			Notes problem with new goal
			Notes problem with proposed goal	Discuss alt way of coping (not due to tx)
Resolution	(none)	(none)	Notes affective change	NONE or agrees
			Agrees re: prob with proposed goal	Notes affective change
			Notes pattern in moment (H&N)	Note pattern in moment (here and now)
			Notes occasional presence of emo	Experiences emo not due to tx
			Emo neg to self, convey current process ("commentary")	Emo (neg) due to current process

Combine/Abstract of LQ Products L1, L2, and L3

	L1 (Product LA)	L2, L3 (Product LB)	L4, L5, L6 (Product LC)	Abstracted Product
Pre-marker	Neg emo to self	Mem (neg) or express of neg emo to self	Depiction of interp conflict	Depic or mem of interper conflict with neg emo to self
	Inquires		Points out pattern/tendency (interrupt)	
	Clarifies with further criticism	Inquire/point out neg emo	Specifies conflict	Inquire/point out pattern or tendency
		Links neg emo to self w/neg emo from others	Request/inquire re:current emo	Clarify with self-crit or neg emo to self
			Provide rationale for pattern (not due to Tx)	Queries H&N emo or neg emos to self
		Expres hopeles/lonely/selfblame		Qualified agreement with neg self-apprais.
		Q loneliness, extra-ther rels		Prov rationale for pattern (not due to Tx)
		Qualified agreement		
		Negative self-appraisal		
TM	Queries emos in here and now	Recalls previous negative evocative therapy event	Makes note of C emo/express/change	Recalls prev neg and evocative ther event
			Poitns out pattern (**EA**)	Points out pattern (**EA**)
		Express emo in here and now, negative to T	Includes self in pattern w/neg emo	Queries emos in here and now
			Discuss ther rel as rationale for patt	Conveys own emos in here and now
			Propose new therapeutic goal	Discuss ther rel/new ther goal
CM	Denies neg emo to T	Denial	Doesn't understand	Denies/doesn't understand/tangential concrete agreement
	Admits neg emo in terms of Tx	Tangential, concrete agreement	Ack pattern with frustration (**EA**)	
		Identify potential strategy to problem independent of Tx	Describes conflict	Deny neg emo to T/Admit neg emo to Tx
			Expresses uncertainty	Express uncertainty or interper conflict
			Notes problem with new goal	ID new strategy not due to Tx
			Discuss alt way of coping (not due to Tx)	Notes problem with goal suggested by T
				Discuss alt way of coping not due to Tx
Resolution	Seeks clarification	Req. to imagine pos emo from T	NONE or agrees	NONE
	Clarify with further neg emo (to self and no direction)	Query strategy	Notes affective change	Agree/query strat or seek clarification
		Vague/avoid or neg emo to self	Notes pattern in moment (H&N)	Improvement not due to Tx
	Improvement not due to Tx	Addr ther goal in context of rel	Expereinces emo (unspecified) not due to tx	Vague/avoid with neg emo to self
	Qualifies improvement	Ack client neg emo		Emo neg due to current process (Tx)
	Queries emos in here and now	Ack own neg emo	Emo neg due to current process	Ack client and own emo on H&N
	Express emo neg (no dir)	Expres caring/hope/possibility		Express emo neg (self and undirected)
	Experience split in self	Emo neg to self		Express hopeful possibility
				Emo neg to self

Appendix J. Shared Components of Metacommunication in HQ Sessions



Appendix K. Shared Components of Metacommunication in LQ Sessions