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RUNNING HEAD: PATIENT'S AND THERAPIST'S VIEWS OF ALLIANCE

Patient's and Therapist's Views of Early Alliance Building in Dynamic Psychotherapy:

Patterns and Relation to Outcome[1]

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Author Note

Abstract

Patients and therapists have somewhat divergent perspectives of alliance. Usually in psychotherapy research, the focus is laid on the patient's view of alliance, predicting parts of outcome. This study questions this hypothesis by applying Shape-of-Change procedure to patient's and therapist's view of alliance-building processes in Dynamic Psychotherapy. The results of this naturalistic study indicate that none of the three patient patterns is related to outcome at the end of psychotherapy, but a specific therapist's pattern – out of two - is linked to positive symptom change. These results are discussed in the context of current research on therapeutic alliance, especially in terms of level and process, its measurement and potential in predicting outcome in Dynamic Psychotherapy.

Key-Words: Therapeutic alliance, Outcome, Dynamic Psychotherapy, Process Study, Shape of Change

Patient's and Therapist's Views of Early Alliance Building in Dynamic Psychotherapy:

Patterns and Relation to Outcome

The question of the rater's perspective in therapeutic process scores has been addressed by a number of authors (Fitzpatrick, Iwakabe, & Stalikas, 2005; Horvath, 2006; Horvath & Symonds, 1991; Hoyt, 2002; Luborsky, 1994). Classically, in these studies, three perspectives are differentiated, the patient's, therapist's and observer's view of alliance and outcome. The patient's view of alliance is more interesting in terms of link with outcome, explaining most consistently outcome variance (Horvath, 2005; Luborsky, 1994). In the present study, we will concentrate on the patient's and the therapist's ratings of alliance-construction processes in Dynamic Psychotherapy and their links with outcome. We are particularly interested in identifying patterns of alliance building and not only in isolated alliance measures.

Divergent perspectives on alliance

Studies report that the patient's alliance rating is usually higher and more stable than the therapist's (Fitzpatrick et al., 2005; Hatcher, Barends, Handell, & Gutfreund, 1995; Kivlighan, & Shaughnessy, 1995; Mallinckrodt, & Nelson, 1991; Tichenor & Hill, 1989). According to Horvath (2000), these differences are due to their different interactional stances and roles in psychotherapy: the patient rates alliance based on his previous interpersonal experiences, the patient's alliance being thus intimately related to transference issues in the therapeutic setting (Gelso, & Carter, 1994), whereas the therapist rates alliance as a function of his theoretical assumptions and his clinical experience, the therapist's alliance being thus embedded in a semantic network of professional know-how (Horvath, 2000).

Studies on divergent perspectives are mainly based on one-time evaluations of alliance (see also the studies included in the meta-analysis by Martin, Garske, & Davis, 2000). In previous research on brief psychodynamic intervention in four sessions, de Roten, Fischer, Drapeau, Beretta, Kramer, Favre, and Despland (2004) have suggested the importance of change of focus in alliance research: neither the third session nor the mean alliance score is the sole important factor, as patterns of alliance evolution may contribute to explaining further outcome variance. Two advantages result from this change of focus: (1) it becomes possible to describe in clinically relevant terms different alliance construction processes in the beginning of psychotherapy, (2) it becomes possible to look at alliance processes over the course of entire psychotherapies, by assuming for instance U-shaped patterns (high initial alliance, regression at midtreatment and again high alliance at the end; Kivlighan, Shaughnessy, 2000), as well as local V-shaped patterns (understood as rupture-resolution-cycles; Stiles, Glick, Osatuke, Hardy, Shapiro, Agnew-Davies, Rees, & Barkham, 2004). In our study, we will focus on the first point, alliance construction processes; the second has been addressed elsewhere (Kramer, Beretta. Michel, Despland, & de Roten, 2006). The study of patterns is more sensitive to variation of alliance scores across psychotherapy than general linear modeling, the latter describing general growth tendencies. Some authors even think that this variation prevents the description of patterns (Brossart, Willson, Patton, Kivlighan, & Multon, 1998), nevertheless, we think that process research on patterns needs to be carried further, especially with the idea of replication of previous studies.

Alliance and outcome

Convergence between the evolutions of patients' and therapist's alliance rating has been related to outcome; Kivlighan and Shaughnessy (1995) have shown that the disappearance of divergence over the course of psychotherapy is related to positive

therapeutic outcome; the more the patient and the therapist agree on the quality of their relationship at the end of therapy, the better the outcome. On the contrary, Fitzpatrick , Iwakabe, and Stalikas (2005)'s study has not found such convergence, which is not a hindrance for positive therapeutic change to be produced. Based on Gelso and Carter's (1994) contribution and psychoanalytic theory, Kivlighan and Shaughnessy (2000) have shown in a four-session-therapeutic-process that U-shaped patterns are predictive of outcome, in as much as momentary alliance strains (V-shaped, or sequences of rupture-repair, see also Safran, & Muran, 2000) are linked to positive therapeutic outcome.

We are aware of only one study so far which has taken into account alliance evolution including also therapist's views of alliance. Kivlighan and Shaughnessy (1995) have shown that it is the therapist's view, that predicts the best therapeutic outcome, as compared to the patient's view. This is in opposition to the aforementioned results, where the patient's perspective is more interesting in this regard. The latter results are based on one-time evaluations, which might explain the divergent results obtained by Kivlighan and Shaughnessy (1995). One could assume that research on alliance patterns concentrating on process yield alliance-outcome-links for the therapist's view, whereas research on one-time evaluations – the "alliance level" – yield alliance-outcome-links for the patient's. One has to note as a limitation to this study that the therapists had a low level of clinical experience.

Shape-of-Change

Recently, Stiles, Agnew-Davies, Hardy, Barkham and Shapiro (1998; Stiles, Glick, Osatuke, Hardy, Shapiro, Agnew-Davies, Rees, & Barkham, 2004) have defined a systematic procedure of computation of alliance patterns: the Shape-of-Change methodology, based on cluster analysis of within-subject regression coefficients predicting alliance ratings for each session. They argue that patterns of alliance reflect most reliably the clinical reality of

between-subjects-variation, as a function of client, therapist and process. Cluster analysis yielding patterns can therefore be seen as a method of choice for the investigation of alliance evolution and its link with outcome (Stiles et al., 2004). In their study, this methodology was applied to 8- and 16-session processes of interpersonal and cognitive psychotherapy and showed interesting results: in the eight initial sessions, four clusters were found (only from the patient's point of view). There were two linear increase patterns (cluster 1 & 2), one linear decrease (3) and one inverted U-shaped quadratic growth pattern (4). None of the patterns was related to outcome, but the linear decrease pattern (3) was related to higher over-involvement(or the position of high anxiety-ambivalence) in the patients' affective relationships (measured by a derived subscale of the Inventory of Interpersonal Problems, IIP; Hardy & Barkham, 1994). Unfortunately, the study by Stiles did not take the therapist's ratings into consideration, nor did it focus clearly on alliance building processes; in fact, processes of alliance building (initial 8 sessions of a total of 16) and whole psychotherapeutic processes (8 sessions in total) have been aggregated in their analysis. Unfortunately in Stiles' approach, the limits of cluster analysis are not fully appreciated and remedied by complementary higher-order statistical analysis, such as Hierarchical Linear Modeling (Bryk, & Raudenbush, 1987). This method controls better for missing data and thus allows the formalization of general alliance evolution.

The present study aims at replicating Stiles' study in a sample of Dynamic Psychotherapy processes, focusing on alliance construction processes from the patient's and the therapist's perspectives. For the purpose of replication, we will define alliance construction as a process taking place over the eight initial sessions of psychotherapy (see Stiles et al.) and thus consider only these data of each therapeutic process. In the present study, we will complete the analysis by the therapist's ratings of alliance which were analysed independently. Moreover, we aim at conducting HLM in 8 sessions for patient's and

therapist's ratings, in order to be able to compare results from these two different analyses of change over time. Based on the body of research, we formulate the following research questions (a) Do the patient's and therapist's alliance patterns differ? (b) Does the patient's or the therapist's - or both - alliance patterns predict outcome?

Method

Participants

The clients (N = 50) were self-referred university students at a French-speaking European university consultation center, consulting for various psychiatric difficulties, mainly Adjustment Disorder (28%), Depression (46%), Anxiety Disorder (38%) and other (27%); multiple diagnoses were possible, as well as 23% of Personality Disorders (clusters B & C). Their mean age was 24 years (SD = 4.3; range = 18-39); 35 (70%) were female. They were recruited after their intake session by research staff proposing the study to the patients. Upon approval, they were referred to one of the therapists. All participating clients gave written informed consent for their data to be used for research; the present study was approved by the ethical expert commission of the Department of Psychiatry involved.

The therapists (N = 13) were experienced psychiatrists and psychotherapists, all had over 10 years of clinical experience in the field of Psychodynamic Psychotherapy. The therapists did not have access to research data until the whole set was completed. This is also true for the two therapists who are at the same time co-authors of this article (LM and JND). As far as the distribution to these therapists-co-authors is concerned, one treated 10 patients (LM) and the second 5 (JND) of this sample.

Treatment

Short-Term Psychodynamic Psychotherapy (STDP) is a manual-based (Gilliéron, 1997), time-limited psychological form of therapy based on psychoanalytic theory and developed in order to respond to the increasing demand for short-term efficient treatments in psychotherapy (Malan, 1976; Sifneos, 1987; Gilliéron, 1997). Its efficacy has been established by a number of studies (Leichsenring & Leibing, 2003; Crits-Christoph, 1992; Beretta, de Roten, Kramer, Michel, & Despland, submitted). Our study includes psychotherapeutic treatments lasting up to 40 sessions, with a mean of 24 sessions (SD = 10.0, range 9 - 40; drop-outs not included in this study).

Measures

Helping Alliance questionnaire HAq – I (Alexander & Luborsky, 1986). This self-report 11-item questionnaire is rated by means of a 6-point-Likert scale (ranging from –3 "I strongly feel that this is not true" to +3 "I strongly feel that this is true"). The total score of HAq-I ranges theoretically from –33 to 33. Two factors have been identified in previous studies (Luborsky, 2000, for a review): the patient's experience of being helped and the patient's experience of joint effort with the therapist in order to overcome difficulties. According to Luborsky (2000), psychometric properties are as good as for other current alliance questionnaires. At the end of each session, the patient's and therapist's versions of the questionnaire were filled in. French validation study based on translation and back-translation was carried out by Bachelor and Salamé (2000). The therapist was not aware of the patient's rating and vice-versa. Internal consistency for the whole scale was for the patient alpha = .89, for the therapist alpha = .87.

Symptom Check List SCL-90-R (Derogatis, 1994). This questionnaire includes 90 items addressing various somatic and psychological signs of distress. These items are scored

using a Likert-type scale from 0 (not at all) to 4 (very much). Although the instrument is

composed of 10 subscales, our study used only the General Symptomatic Index (GSI, score

ranging from 0 to 4), which is a mean rated over all symptoms. French validation study has

been carried out by Pariente and Guelfi (1990), based on their translation and back-translation

of the original scale. Cronbach alpha for this sample was .96. Outcome in the beginning and at

the end of the therapeutic process was evaluated by the following questionnaires. This data

was analysed after computation of residual gains and controlling for the number of sessions

(see Stiles et al., 2004).

Results

Preliminary Analyses: Since the objective of this study is replication of Stiles et al.'s

study, possible dependency in the data (between patients and therapists) has been addressed

by additional preliminary analyses. More specifically, data dependency has been addressed by

using Intra-class Correlation Coefficients (ICC(1, 13)), computed separately for all four

Shape-of-Change parameters, for patient's and therapist's ratings (see below; Kenny, Kashy,

& Bolger, 1998). Finally, an additional level (third higher-order level) has been added to

Hierarchical Linear Modeling procedure (Bryk, & Raudenbush, 1987), focussing on patients

nested within therapists.

Intraclass Correlation Coefficients (1, 13) has yielded for patients' coefficients ranging

from -.05 to .10 (all non-significant), for therapist's coefficients ranging from -.08 to .22 (all

non-significant; see table 1). Due to limited number of observations per therapist as class,

analyses were underpowered (Kenny, Kashy, & Bolger, 1998). Nevertheless, it can be said

that data independency (between therapists and patient's/therapist's Shape-of-Change

parameters) tends to be acceptable for most ICCs in this sample. This is also true for the

independency testing of outcome. Finally, HLM on three levels focussing on patients nested

within therapists yields a significant therapist effect on patient's reported alliance slope (Estimate = .05; SE = .02; Z = 3.01; p < .00), thus data independency between therapist and patient for HLM parameters is not guaranteed.

Tests of Hypotheses. In order to address the first research question, we applied the Shape-of-Change procedure for the initial eight session, for investigation of early alliance building processes and replication of Stiles et al. (2004); performed cluster analysis (Borgen, & Barnett, 1987; Ward, 1963; Hair, & Black, 2000) yielding classification of therapeutic processes by their resemblance to the four Shape-of-Change parameters.

The Shape-of-Change methodology (Stiles et al., 2004; B. Stiles, 2005, personal communication) defines four basic parameters of change in alliance evolution over sessions: (1) intercept I, measured at midtreatment (centered sessions, here at 4.5), (2) slope S, describing the positive or negative linear trend, (3) curve C, representing the degree of quadratic U-shaped or inverted U-shaped trend and (4) variation ε, operationalized by the RMSE (the square root of the mean of the squares of the residuals from the regression equation). These parameters are calculated for each therapeutic process, in our study for patient's and therapist's ratings separately. They yield the following alliance curve estimation of y, where x represents the session:

$$y = I + Sx + Cx^2 + \varepsilon.$$

The four parameters for each process are introduced into ascendant hierarchical cluster analysis (Ward's method, Squared Euclidian Distance) yielding a number of clusters. For determining the number of clusters found, we applied the stopping rule by Hair & Black (2000; p. 184; "sudden jumps"). The mean of each parameter for each cluster can be represented as a graph, by means of a regression line for each cluster. Note that in the tables and figures depicting the results, raw (and not transformed) scores are reported in order to enhance meaningfulness of the reported data.

The patient's and therapist's patterns are reported in figure 1 and 2, the related parameters of change are shown in table 2.

We found three patterns based on the patient's scores and two on the therapist's. A total of 31 patients (62%) report a decreasing alliance evolution, starting out on a medium level of alliance (15 out of 33), presenting a relatively small slope and a negative curve; residuals are minimal. Moreover, 16 patients (32%) report an increasing evolution, starting out on a low level of alliance (7), presenting a moderate slope and a positive curve; residuals are moderate. Finally, 3 patients (6%) present a "stable" alliance evolution, on a low level of alliance (8), with a positive slope attenuated by a negative curve and high residuals (in accordance with Stiles et al.'s study, we chose to name the patterns following their progression, not their most salient characteristic which is for the third the high residuals). The therapist's ratings present two basic alliance patterns: growing and stable, both starting out on a low level of alliance. The former (n = 17) present high scores on slope and curve, whereas the latter (n = 33) moderate scores; residuals are higher in the former.

Pearson's correlations have been computed between patient's and therapist's Shape-of-Change, in order to investigate convergence and divergence between the parameters. Table 3 reports the findings: 19% of all correlations proved to be significant. More specifically, a moderate relationship between patient's and therapist's intercept ratings, slope ratings and variation ratings was found; no relationship was found for curve ratings. Chi-square test has been applied in order to test possible divergence or convergence between patient's and therapist's clusters (yielded by Shape-of-Change); marginal significance in favour of convergence of rater perspectives (Chi-Square = .053) resulted from the analysis.

Furthermore, we performed Hierarchical Linear Modeling (HLM; Bryk, & Raudenbush, 1987) on patient and therapist initial 8 sessions, a nested design where sessions are on level 1 and patients on level 2. This analysis yields the general alliance progression

(intercept and slope), while checking for missing values as necessary. The extent of the concordance of the data with the HLM model is also calculated, and tests of significance are performed on the two parameters (program MixReg; Hedecker, & Gibbons, 1996).

HLM assumes a general variable progression and yields the following coefficients (linear model): For the patients' ratings, overall intercept is estimated at 10.46 ($Z = 8.16$; $p<.00$), the slope at 0.40 ($Z = 1.84$; $p<.07$) and the residual variance at 23.72 ($Z = 11.96$; $p<.00$). For the therapists' ratings, overall intercept is estimated at 3.15 ($Z = 2.22$; $p<.05$), the slope at 0.77 ($Z = 3.05$; $p<.00$) and the residual variance at 44.40 ($Z = 3.72$; $p<.00$).

To explore the second research question, we performed correlation analyses and ANOVAs on alliance patterns and outcome (residual gain scores). In order to respond to our second research question, the two sources of early alliance ratings, patient and therapist, have been investigated separately with regard to differential links with outcome. Table 3 reports these results.

It appears that the therapist's stable pattern is the one related to most important positive symptom change ($F(1, 45) = 4.62$; $p < .05$; $d = 0.68$). No significant result has been found in the patient, based on the ANOVA on alliance patterns ($F(2, 45) = .21$; ns). Pearson's correlation between overall patient's mean alliance and patient-rated outcome (ΔGSI) is $r = .25$ ($p = $ ns).

<div align="center">Discussion</div>

Both procedures, Shape-of-Change and Hierarchical Linear Modeling, yield interestingly converging results, while being based on quite different assumptions and therefore, can be understood as complementary.

Stiles et al.'s methodology is remarkably appropriate for description of clinically relevant patterns and yields a limited number of them, for both the patient and the therapist.

Our overall comparison between patient's and therapist's views found rather similar patterns. We find well-known growing and stable patterns in alliance construction (see also de Roten et al., 2004; Kivlighan, & Shaughnessy, 1995), but also a decreasing alliance pattern in the patient. The latter case might prove to be a challenge for the therapist when adapting therapeutic techniques to the patient's individual way of entering into a relationship. Stiles et al. (2004) have also found such a pattern, which underlines its occurrence in different samples. However, they have not found a stable pattern (in our study an underpowered cluster characterized by high residuals). Therefore, we admit that the replication of Stiles et al.'s (2004) patterns over the first eight sessions of psychotherapy has succeeded. According to Hair and Black's (2000) position, the results of cluster analyses vary as a function of several methodological criteria (i.e., input variables, measures, standardization of scores, clustering procedures, the presence of outliers). All criteria being the same between Stiles et al.'s and our studies, except alliance measure and sample-specific variables, we can be confident about the possible generalizability of two alliance building processes in the patient: decreasing and increasing.

Investigating the links between patient's and therapist's views, we have found patients' and therapists' Shape-of-Change parameters correlate significantly in 19% of the cases, between three out of four corresponding parameters (see table 3), and a marginal link between clusters have been found by Chi-square statistics. These links are important information arguing in favour of the relevance of the disentangling of the four change parameters as done by Shape-of-Change methodology, as well as of the clustering. Even if overlap between patient's and therapist's perspectives may be limited in raw data (alliance means or any other measure), relationships between both perspectives yield significance level rather elegantly by using more sophisticated parameter-based process-evaluation.

With respect to alliance-outcome-link, addressed by our second research question, we have found no link of the patient's patterns and a quite strong effect of the therapist's patterns. The therapist's pattern described as stable is the most predictive of positive outcome. Thus, we were able to reproduce the absence of link in the patient's patterns (Stiles et al., 2004) and would suggest that the therapist's patterns of alliance construction best predict outcome. This result is in line with Kivlighan and Shaughnessy (1995). Thus, we are able to confirm our assumption in terms of therapist's alliance rating measuring the process, as opposed to the patient's alliance rating measuring the level of alliance (Martin, Garske, & Davis, 2000). The former, and not the latter, is related to outcome. This hypothesis is corroborated by "traditional" alliance measures (mean alliance and alliance at the third session representing the "level of alliance"; Horvath, & Symonds, 1991) being correlated with outcome, but only for the patient's view. For our sample, however, this link between the patient's mean alliance and outcome has only marginally been confirmed (r = .25; corresponding to a marginally significant effect of mean alliance). Since many studies have confined alliance measure solely to the patient's level of alliance, its impact on outcome may have been over-estimated. Our results indicate that alliance process research, i.e., by means of patterns as a result of the Shape-of-Change procedure, add an argument in favour of the relevance for outcome of the therapist's perspective on alliance. Stiles et al.'s absence of link between patient's patterns and outcome would support our statement. More studies are definitely needed to support this assumption.

Adding to the Shape-of-Change methodology, we included HLM methodology in order to be able to deal optimally with missing values and to have an alternative look at the formalization of alliance building processes. HLM should be capable of dealing with shortcomings of cluster analysis, such as the high dependency of the results from the set of variables introduced, its important sensitivity to outliers and the sensitivity of the Ward's

method to results yielded in the early stage of iterations. The overall (linear) growth in these data is significantly positive, as is the mean intercept calculated by HLM, which is true for the patient and the therapist; the latter displays a higher slope coefficient. This result indicates, on the one hand, that the patient's decreasing pattern found by the Shape-of-Change methodology might be an artefact of the very methodology used, based on the aforementioned possible biases. On the other hand, it might show the limits of HLM itself: by agglomerating the data, one might ignore the existence of differential evolutions over time, as is shown for the therapist's two patterns yielded by Shape-of-Change being related to outcome differentially.

Looking at dependency analysis based on intra-class correlations between patients' Shape-of-Change nested within therapists, a moderate dependency is found for the rating of the intercept, whereas for correlations on the level of patients' Shape-of-Change parameters, a low dependency is found. This means that the same therapist tends to rate all his/her patients' intercepts in a similar way, whereas the ratings of the latter do not necessarily depend on the therapist they see. The lack of differentiation as a function of patient for the therapists might be a real phenomenon, but might also reflect a therapist bias (i.e., the tendency to see the patient's alliance on a lower level than the patient does; Fitzpatrick, Iwakabe, & Stalikas, 2005). This different way of rating as a function of the therapist might somewhat illustrate the embeddedness of the therapist's ratings in a semantic network of professional know-how and experience (Horvath, 2000). Even if based on underpowered analyses, coefficients reported in table 1 (especially the ICC for outcome being zero) suggest the bias in significance testing with regard to outcome (as reported in table 4) be very small (for further elaborations see Kenny, Kasher, & Bolger, 1998). Moderate data dependency is also found with regard to HLM, where the therapist's is related to the patient's HLM slope. This methodological question of rater "bias" (Hoyt, 2002) and relative data dependency (Kenny, Kasher, & Bolger,

1998) is addressed for this sample more fully elsewhere, in a replication of the Fitzpatrick et al.'(2005) study (Kramer, de Roten, Beretta, Michel, & Despland, in revision).

To sum up, our application of Stiles et al.'s methodology and HLM to patient's and therapist's views of alliance building has yielded interesting results, which are conform to our hypotheses and open up to further research directions. The main challenges for further studies in this area with these two methodologies is certainly how to deal with the high residuals attenuating necessarily the relevance of results yielding from from HLM, but also in the Shape-of-Change methodology (also Stiles, 2006, personal communication) and to deal with data dependency. Comparing these two methods, it is important not to forget the subjective part in interpreting cluster solutions, whereas for HLM, it is essential not to forget the agglomeration of highly distinct evolutions over time, based on assumptions of Growth Modeling, and for both models, the methodological implications of a nested design.

Several clinical implications might ensue from this study: (1) the patient's ratings – when looked at longitudinally - of alliance construction are not necessarily the most accurate for the prediction of outcome; disentangling alliance level and alliance shape of change helps in this respect; (2) therapists might benefit from the awareness of their own alliance construction ratings – and its evolution -, compared to the ones done by the patients, in order to prevent overly positive therapist evaluations which do not seem to be helpful for the therapeutic process and outcome; (3) monitoring of alliance over the course of psychotherapy might help preventing negative outcome, especially in trainee-therapists, if done in an individual-centered paradigm implying elaborated feed-back given to the trainee-therapists with regard to relationship features if necessary (see Lambert, 2007, for feed-back given to "off-track" therapists with regard to outcome evolution).

Further research in this area should involve not merely alliance building processes, but also alliance over the course of the whole psychotherapy (Kramer, Beretta, Michel, Despland,

& de Roten, 2006; Kramer, de Roten, Beretta, Michel, & Despland, in prep.). Another field of investigation is the local V-shaped patterns. In fact, our methods are based on aggregated data on mean scores (eliminating intra-subject variation) which might hide singular – clinically relevant - rupture-repair sequences appearing from one session to another, where the process of reparation has been related to outcome (de Roten, Beretta, Kramer, & Despland, 2005). Regression to the mean (eliminating inter-subject variation) as a potential bias of the present study has already been mentioned. These sources of variation might partially explain the high residuals. Furthermore, outcome was only rated by means of self-report questionnaires; no therapist rating was included in our study. And the number of our observations is rather small, both overall and in some cases per cluster. Overall however, this study indicates that the approach by alliance monitoring is promising; it might contribute to an enlargement of perspective in the understanding of the formalization of alliance building processes and might hopefully stimulate other attempts of replication of the study. It would also be interesting to relate these patterns to different psychodynamic techniques in the sessions, such as explorative or supportive techniques. Such research might add an argument to the absence of link with outcome in the patient's ratings.

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Table 1

Data Dependency Analysis: Patient's parameters within Therapists

Shape-of-Change Parameters	Intra-Class Correlation Coefficient (1, 13)	
	Patient	Therapist
Intercept	.10	.22
Slope	-.02	-.08
Curve	-.05	.00
Variation	.00	-.02
Outcome (ΔGSI)	.00	--[1]

Note. [1]Outcome only assessed by patient

All ICC non-significant

Table 2

Parameters of change per cluster (M and SD in parentheses of raw scores reported)

Pattern	N	Intercept	Slope	Curve	Residuals
Patient					
Decreasing	31	15.28 (7.03)	-.38 (1.04)	-.14 (.33)	7.56 (4.24)
Increasing	16	7.61 (8.04)	.56 (1.35)	.13 (.45)	34.90 (15.20)
Stable	3	8.95 (7.49)	.63 (2.12)	-.05 (.32)	136.96 (47.00)
Therapist					
Stable	33	7.90 (9.02)	.64 (.87)	-.11 (.25)	20.71 (16.43)
Increasing	17	3.30 (.32)	1.01 (.98)	.23 (.67)	74.97 (15.45)

Table 3

Pearson's Correlations between patient's and therapist's Shape-of-Change parameters

Therapist	Intercept	Slope	Curve	Variation
Patient				
Intercept	.55**	.12	-.16	-.33
Slope	.07	.57**	-.04	-.14
Curve	-.27	.19	-.02	-.04
Variation	-.32	.06	.26	.38**

Table 4

Outcome (ΔGSI) as a function of alliance patterns for the patient and the therapist

source	Stable		Increasing		Decreasing		*F*	*PES*
	M	SD	M	SD	M	SD		
Patient	.31	.47	.44	.42	.36	.45	.21	.01
Therapist	.48	.40	.19	.45	-	-	4.62*	.10

Note. Two one-way ANOVAs have been performed, PES: Partial Eta Squared
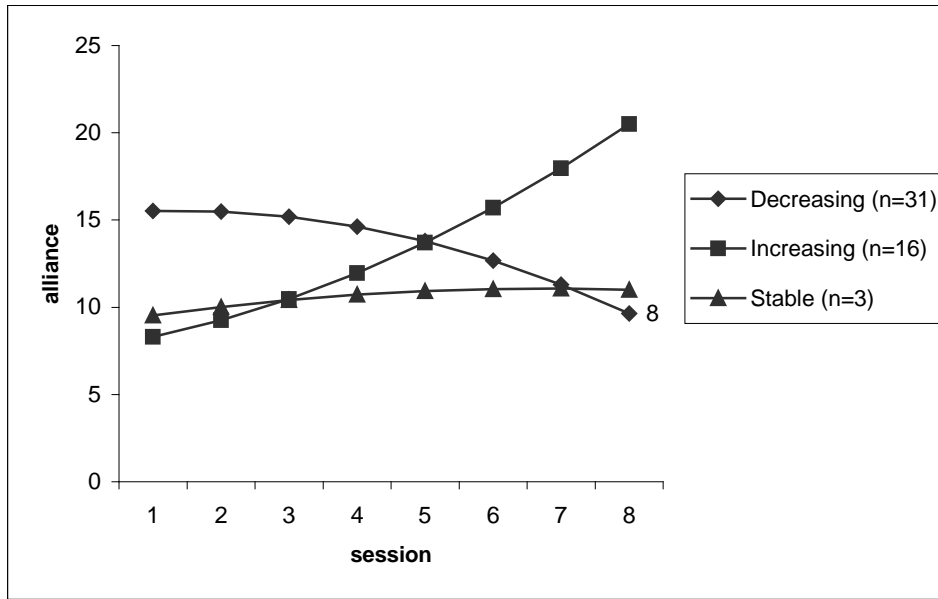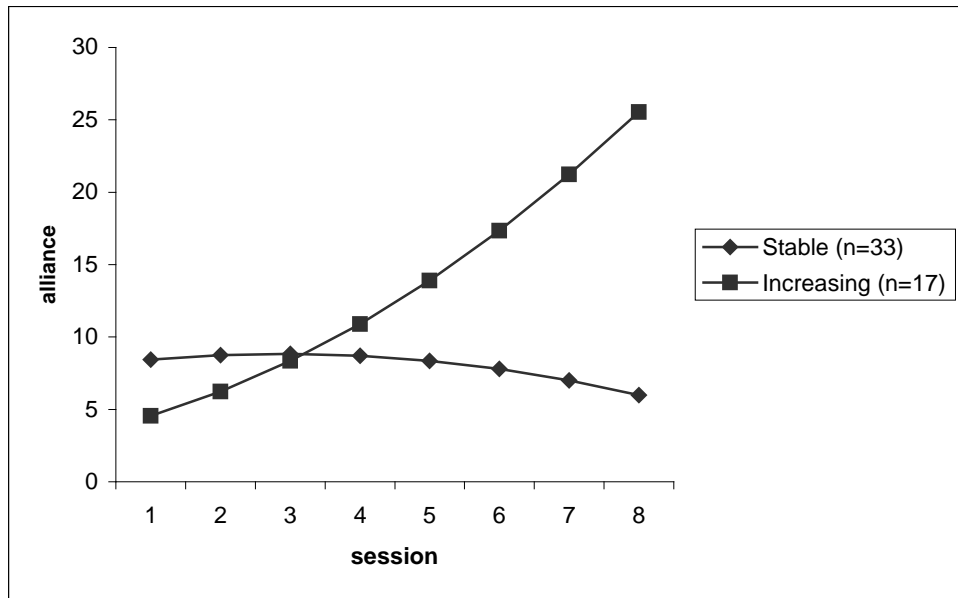
Figure 1

Figure 2

Figure Captions

Figure 1. Patient's patterns of alliance building over 8 initial sessions of dynamic

psychotherapy (N=50)

Figure 2. Therapist's patterns of alliance building over 8 initial sessions of dynamic

psychotherapy (N=50)