THE PATIENT’S CONTRIBUTION TO THE THERAPEUTIC PROCESS:
A Rogerian-psychoanalytic Perspective

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This article considers the importance of focusing on the patient’s experiential world in the treatment process. It also presents an evidence-based conceptual model of personality development and psychopathology that enabled investigators to introduce aspects of patients into research designs so they could explore patient-treatment and patient-outcome interactions—interactions that address complex questions such as what kinds of treatments are most effective with what types of patients and that suggest that different, but equally desirable, therapeutic outcomes occur through differing mechanisms of therapeutic action. Consistent with clinical experiences discussed in the earlier sections of this article, results from three studies of long-term, psychodynamically oriented treatment, and from a randomized clinical trial investigating several brief manual-directed treatments for depression, demonstrate the importance of focusing on the contributions of patients to the treatment process in both clinical practice and research.

Keywords: therapeutic process, patient’s contributions, empathy, countertransference, two polarities model

The emphasis in much of contemporary psychotherapy research and practice is on the techniques and tactics of therapy. We develop manuals specifying therapist’s interventions and conduct seemingly endless trials comparing different types of intervention with the hope of identifying evidence-based treatments. Relatively little attention, however, is devoted to examining the contributions of the patient to the treatment process in order to understand more fully the mechanisms or processes that lead to sustained therapeutic change. In contrast to the emphasis on the therapist and the techniques and tactics of
various treatments in contemporary psychotherapy research, this article is devoted to understanding the contributions the patient makes to the treatment process.

Initially, I address the importance of focusing on the patient’s experiential world, both within and outside the treatment process. I then consider the processes that occur within the patient that led to sustained therapeutic change. Then I summarize a theoretical model of personality development and psychopathology (e.g., Blatt, 2008) that can facilitate the introduction of central aspects of the patient into research designs, thereby allowing investigators to address more complex questions, such as what kinds of treatments are most effective with what kinds of patients, and that lead to different types of therapeutic action, possibly through different processes or mechanisms of therapeutic change. I summarize the results of four studies (three of long-term intensive treatment, and a randomized controlled trial of several brief, manual-directed treatments) that demonstrate the importance of differentiating between patients in psychotherapy research.

Early Influences on My Development as a Therapist

I began my career as a psychotherapist and psychoanalyst with training primarily in the client-centered tradition. As a beginning graduate student at The Pennsylvania State University with Dr. William U. Snyder, a predominant figure in client-centered therapy in the early 1950s, I first learned the importance of assuming the client’s frame of reference and the importance of “clarifying” the client’s feelings. In our psychotherapy seminars and practicum, Dr. Snyder relentlessly evaluated typescripts of our treatment hours, assiduously and authoritatively scoring each of the comments we made to our clients according to his definition of whether the comment was, on one hand, only a restatement of what the client had said, or an “interpretation,” on the other hand, or the highly sought-after “clarification of feelings” that Dr. Snyder believed was the essence of good psychotherapy—the core intervention of the client-centered approach. If at least 75% of your comments in the therapeutic hour were considered by Dr. Snyder to be “clarifications of feelings,” it was deemed an acceptable hour, provided, of course, your hour contained no more than 5% of interpretations—what Dr. Snyder considered an antitherapeutic intervention.

Being somewhat inquisitive and rebellious in the early years of my graduate training, I commented, rather provocatively, in seminar with Dr. Snyder, that it seemed to me that there was very little difference between a clarification of feelings and an appropriate interpretation. Using Carl Rogers’s terms, I went on to comment that both types of interventions, if done appropriately, should result in what Rogers called “catching the edge of awareness.” Dr. Snyder, as you might imagine, was dismayed, probably even appalled, by my lack of appreciation of this very important distinction and by my inability or unwillingness to repudiate the role of interpretation.

Through a complex and most fortunate series of events (see Blatt, 2006a), I subsequently enrolled as a doctoral candidate in the psychology department at the University of Chicago, where The Counseling Center was directed by none other than Dr. Carl Rogers, who also taught the graduate psychotherapy seminars. Naturally, I enrolled in Carl’s seminar, and, as the semester progressed, I decided to test fate once again and asked Dr. Rogers whether a good clarification of feelings was really very different from a good interpretation, in that both sought to capture the edge of the client’s awareness. Typical of Carl’s openness and thoughtfulness, he responded, “Of course not!”
In my 2 years of internship at the Counseling Center with Carl Rogers and his colleagues, I learned a great deal about psychotherapy and about myself, and much of what I learned in those early years is still central to my capacities as a therapist and analyst. First and foremost, I learned the importance of assuming the patient’s frame of reference—of seeking to give voice to the thoughts and feelings that the client was experiencing but was unable or unwilling to articulate. Still today, this emphasis on capturing and communicating the experiences of the patient is my cardinal goal as a therapist and psychoanalyst—to give voice to the subtle personal experiences that the patient is struggling to articulate. As a therapist and analyst, I therefore maintain this empathic immersion so that I can help the patient to discover something that is just outside his or her conscious experience—something that might be called, in older psychoanalytic terminology, preconscious (Freud, 1915) or, in more current thinking, unformulated (Stern, 1983). This emphasis on understanding the patient’s experiences has been a guiding principle not only in my clinical work but also in my research as well.

Heinz Kohut was also at the University of Chicago in the mid- to late 1950s, primarily at the medical school, which was located just a few blocks from Roger’s Counseling Center. Kohut gave a series of eight evening lectures from 1958 to 1959 on basic psychoanalytic theory. Those lectures greatly enriched my understanding of fundamental psychodynamic thought, so much so that my notes of these lectures were the basis of my lectures on psychoanalytic concepts early in my career at Yale. But as I recall, Kohut did not discuss the role of empathy in the treatment process in these lectures. But Kohut’s seminal 1959 paper on introspection and empathy had a profound impact on my emerging understanding of the treatment process, especially his opening lines in that article that we understand the physical world through our physical senses and the psychological world through our psychological senses—through introspection and empathy (Kohut, 1959; see also Kohut, 1982). In a detailed discussion of the contributions of Rogers and Kohut on empathy in the treatment process, Kahn and Rachman (2000) noted that Ferenczi was the first to discuss the role of empathy in psychoanalysis.

The Patient’s Experiential World in the Treatment Process

Based on my experiences with Rogers and influenced by Kohut’s (1959) article, I seek to view patients not from an external perspective from which I would make judgments about the nature of their pathology, the quality of their relationships, or their life more generally. Rather, I seek to be sensitive to patients’ struggles and try to capture conscious and unconscious aspects of their experiences, and to place these experiences into words that patients could hear and use effectively in their internal dialogue or exploration. I try to avoid, for example, commenting about a therapeutic impasse that the patient is “resistant” to dealing with a particular issue. Such an intervention, from an external perspective, primarily expresses the therapist’s judgment rather than capturing an aspect of the patient’s feelings and thoughts. Rather, I prefer to note how difficult it seems to think about or discuss a particular topic, with the hope that such an intervention recognizes and appreciates the patient’s struggles to express the thoughts and feelings he or she is seeking to articulate and communicate. Such an intervention identifies the particular issues central in the patient’s current concerns, as well as some of the experiential modes currently active around these issues. Similarly, to comment to a patient about his or her difficult current or past life circumstances could be experienced by the patient as sympathy (or pity), but articulating that the patient feels (or felt) overwhelmed by certain life circum-
stances could be experienced as empathic, as the therapist has given voice to the patient’s subjective experiences around particular events. Such an intervention from an internal perspective gives voice to aspects of the patient’s conscious and unconscious experiences, rather than objectively noting a realistic fact from an external perspective.

Interventions that give voice to the patient’s experiences facilitate the therapeutic process because they enable the patient to feel understood rather than judged or criticized. Accurate interventions from an internal perspective, a “clarification of feelings,” if you like, also enable patients to experience their thoughts and feelings as having a coherence and logic that can be understood and accepted by another person (Atwood & Stolorow, 1980; Blatt & Erlich, 1982; Rycroft, 1956). The goal of such interventions is to facilitate the patient’s internal dialogue or exploration. It is the facilitation of the internal dialogue that should be the criteria of the effectiveness of any intervention and of the progress of the therapeutic process more generally (Freud, 1937).

Placing partially articulated experiences into words enables patients to establish a sense of greater control over their experiences by providing a structure that enables them to think about and understand previously unarticulated experiences. Placing experiences into words sharpens the delineation between self and other, helps clarify cause-and-effect sequences, and enhances the sense of self as an active and effective agent (Horowitz, 1977). By placing partially conscious experiences and enactive modes into verbal form, the therapist provides organization and structure to experiences. Giving voice to partially conscious longings and fears facilitates the integration of these thoughts and feelings with current experiences. This organizing, restructuring interaction between patient and therapist, which occurs predominantly on the level of language, facilitates the differentiation, articulation, and integration of self and object representations so that these representations are no longer primarily linked to earlier unconscious experiences and repetitive enactments but are now more open to environmental input and modification (Horowitz, 1977, 1991, 1998).

In other words, the therapist participates in and facilitates the patient’s internal dialogue by empathically identifying with the patient and by constructing representations of the patient and of his or her world—representations that approximate the patient’s experiential world (Buie, 1981; Greenson, 1960, p. 423; Schafer, 1959). By articulating experiences that were just outside of the patient’s conscious experience (Sandler & Rosenblatt, 1962), both patient and therapist make increasingly subtle differentiations and distinctions of aspects of the patient’s intrapsychic and interpersonal world (Jacobson, 1964; Kernberg, 1966, 1976). The therapist’s parallel construction of an approximation of the patient’s experiences enables the therapist to understand the subtleties of the patient’s communications. It also enables the therapist to contrast the nuances of his or her constructions with what the patient reports, thereby enabling the therapist to question himself or herself and the patient when aspects of their representations are incongruent. The therapist can consider whether this incongruity was the result of the patient being unable or unwilling to consider certain possibly relevant aspects of a particular issue, or whether the therapist has an inaccurate construction that needs to be revised because of insufficient information or because of a countertransference distortion that interfered with the therapist accurately hearing the patient, or an expression of subtle defensive processes in the patient that the therapist has identified by noting the inconsistencies between his or her constructions and the patient’s experiences. In this sense, countertransference is a natural and inevitable part of the therapeutic process—one that can produce considerable insight into the patient’s experiential world. The therapist’s representations of the patient’s experiential world are constantly revised and reworked throughout treatment, eventually
becoming highly differentiated, rich, and diverse concepts and images of the patient’s past, present, and wished-for (and feared) future life. The continual refinement of these representations enables the therapist to more fully appreciate nuances of the patient’s subjective world.

The Experiential World of Patient and Therapist in the Treatment Process

The therapist’s understanding of the patient’s experiential world is often based on the therapist’s own experiences, especially early life experiences. We, like our patients, have gone through similar fundamental developmental sequences and challenges as we progress through life, though everyone’s life journey is always, in some way, unique. Despite individual and cultural differences, we all have struggled with two fundamental psychological developmental tasks: (a) a struggle for individuation, separation, and the development of an essentially positive and realistic sense of self or an identity; and (b) the establishment and maintenance of meaningful, reciprocal, mutually satisfying, interpersonal relationships (Blatt, 1990, 2006b, 2008; Blatt & Blass, 1990, 1996; Blatt & Shichman, 1983). Shared experiences and commonalities at various levels in these two fundamental developmental tasks enable therapists to understand the experiences of their patients, even though we may have approached these developmental tasks somewhat differently because of unique life circumstances and experiences (e.g., differences in sex, race, religion, and social class, as well as differences in personal events, especially with primary caretakers). The therapist, having dealt reasonably successfully with these developmental tasks in his or her own life and therapy, has a structure and organization for understanding the patient’s difficulties with these tasks and for finding ways to facilitate the patient’s dealing with them in the treatment process. The commonalities we share with our patients in dealing with the same fundamental developmental tasks enable us to construct increasingly accurate approximations of patients’ experiential world and, especially, to appreciate the patient’s experiences in the therapeutic process (see also Bowlby, 1988; Fromm-Reichman, 1951; Racker, 1957).

This transactional interpersonal process in the therapeutic situation involves a constant and subtle reciprocal influence between patient and therapist, each affecting and influencing the other in a myriad of complex ways. It is this transactional interpersonal process that makes therapy such an emotional experience, not just for the patient but for the therapist as well. We experience and reexperience important aspects of our own lives with each of our patients, and we use these usually brief and temporary reexperiences of our own fundamental life issues to understand the subtleties and nuances of our patient’s experiences. We use our own past and current life experiences, in direct and indirect ways, in the treatment process. Our experiences guide our thoughts and associations about the patient’s experiences. Thus, it is essential that we have examined in detail, and have resolved as fully as possible, our own needs and conflicts so that they do not distort our ability to listen to our patients and limit our capacity to respond primarily from the patient’s point of view. One’s own therapy, therefore, is a central part of becoming a therapist—not so much to become a paragon of mental health but, as research indicates (e.g., Geller, Orlinsky & Norcross, 2005; Macran, Stiles, & Smith, 1999; Orlinsky & Geller, 2011; Rizq & Target, 2008a, 2008b), to be reasonably certain that our basic tools in the therapeutic process—our empathic thoughts, feelings, and associations—are relatively objective and conflict free, and do not intrude upon and distort our capacity to use our past and current life experiences to understand the experiences of our patients. When
the therapist has an inaccurate construction of the patient’s experiential world, because of insufficient information or because of countertransference distortions, these inaccuracies reflect difficulties in establishing the shared understanding of therapist and patient that is essential in the treatment process.

**Empathy in the Treatment Process**

Rogers (1975, p. 4) defined empathy as a complex, demanding, strong, yet subtle and gentle ... process ... [of] entering the private perceptual world of the other and becoming thoroughly at home with it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person. ... It means temporarily living in his or her life ... without making judgments, sensing meanings of which he or she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening. It includes communicating your sensing’s of his or her world as you look with fresh and unfrightened eyes at elements of which the individual is fearful. ... To be with another in this way means that for the time being you lay aside the views and values you hold for yourself in order to enter another’s world without prejudice.

We are drawn into our patient’s life not only by the patient’s reenactment of his or her early conflictual experiences in the transference relationship but also by our temporary empathic identification with the patient in each therapeutic hour. This temporary empathic identification is usually relatively limited, ending with the close of each hour, to be reactivated once again on the patient’s return for the next session. On occasion, however, this empathic identification can be more intense and extend beyond the confines of the therapeutic hour. This can occur, on occasion, in a problematic way when countertransference reactions are no longer in the service of understanding the patient but begin to involve more personal needs of the therapist. The patient’s admiration for the therapist, for example, can become a source of narcissistic gratification for the therapist, and the patient’s anger might involve the therapist in enactments of his or her own experiences with things like punishment or rejection or humiliation. But these more intense countertransference reactions can also occur in more subtle ways and be a vital part of the treatment process.

I have noted occasions when my empathic identification with the patient is more intense and extends beyond the treatment hour, but is still in the service of the therapeutic process. Therapists often review or even dwell on a particularly difficult or significant therapeutic hour after the patient has left, as we consciously try to think through and sort out what the patient was trying to communicate or what was happening in the hour. This process of working through an hour, however, can also occur in much more subtle and unconscious ways. After a particularly compelling or perplexing hour, when I consciously or unconsciously feel troubled or puzzled by certain aspects of the session, I subsequently find myself doing, saying, thinking, or feeling—in a word, enacting (see also Aron, 1996, and Bromberg, 1998)—something that feels strange and ego alien. I may say something abrupt to my wife or children, or may have a set of thoughts, fantasies, or feelings that seem strange and incongruent. These thoughts, feelings, or enactments simply do not feel like me. On reflection, after such an experience, I have realized that I, unconsciously, have been carrying an issue within me that is directly relevant to something that had occurred in a perplexing or troubling therapeutic hour but that I did not, or could not, articulate at the time. The compelling nature of the issue and its centrality in the treatment process became apparent to me only upon reflection about my incongruent action, thought, or

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feeling, and only through this reflection did I gain an awareness of aspects of an hour that was previously unavailable to me. That an enactment was necessary to bring this material to my awareness also alerts me to more fully consider the special nature of this material for either the patient or myself. Intensive therapy, working several hours each week over extended periods of time with an individual, places considerable emotional demand on both patient and therapist. We balance our involvement through empathic identification with our capacity to disengage emotionally and to evaluate the therapeutic process relatively realistically and objectively. This balance of empathic engagement and disengagement is essential to maintain because our therapeutic efficacy requires us to also stand outside or apart from our patients’ struggles, but it is our capacities for empathic identification with the patient’s conscious and unconscious experiences that make it at all possible for us to help our patients in the first place.

The Impact of the Patient on the Therapist

We rarely consider the patient’s impact on us as therapists and the gratifications we gain from participating in the therapeutic process. Conducting a relatively successful treatment, for example, enables the therapist to grow in the sense of being an effective therapist. But participating in the therapeutic process through empathic identification—using one’s own personal life experiences as guides to understand aspects of the life experiences of the patient—often stimulates, in subtle ways, the therapist’s further clarification of his or her own personal issues. Certainly, the significance and intensity that the therapeutic process has for the therapist is different from the depth of meaning it can have for the patient. But the issues that patients raise and struggle with in intensive therapy, and the infinite ways they can relate to the therapist, require the therapist’s continual self-analysis (Blatt & Behrends, 1987). Allowing access to our own current and past personal experiences in order to elaborate our understanding of our patient’s experiences requires that we participate, more or less vicariously, in the patient’s explorations and resolution of conflicts. This participation in our patients’ dealing with important developmental processes and challenges forces us to reconsider, usually in very subtle ways, some of these issues for ourselves. This is why the therapist’s empathic participation in the therapeutic process, while contributing to the patient’s growth at the same time, albeit much more microscopically, can both directly and indirectly result in a subtle reworking and consolidation of the therapist’s personal issues as well.

Let me illustrate this point with a somewhat vivid clinical example. A young professional, in his early 30s, was referred to me by a colleague for psychoanalysis. The patient had worked with him in psychotherapy but was now interested in a more intensive therapeutic experience. Among his complex personal issues was his experiencing a progressively serious hearing loss because of increasing deterioration of his auditory nerves. He was, however, able to maintain adequate auditory discrimination with the use of hearing aids. Thus, I was able to conduct the analysis in the traditional way, using the couch, by speaking loudly and enunciating each word clearly and slowly. I also tried to state my interventions as briefly and succinctly as possible. Initially, it was difficult for me to adjust to speaking loudly and emphatically in the analysis—an earlier patient had commented in the closing hour of a 4-year analysis that she would always remember me as the “gentle voice”—but I soon became accustomed to these changes in my therapeutic style. I also decided at the outset of the analysis that I would never directly interpret his occasional misperception of what I had said, though I felt free to interpret his slips of tongue or his use of unique phrases or verbal constructions. In my interventions I avoided,
however, directly using any of his possible misperceptions that might have been caused by his hearing loss.

In the closing hour of a lengthy and relatively successful analysis, he thanked me for my thoughtfulness and sensitivity, especially my attention to articulating my comments carefully and slowly so that he could always hear me clearly. He was also very appreciative of my willingness to repeat things he might not have heard clearly and my occasional seeking alternate ways of stating comments that he had been unable to hear precisely. He then abruptly stopped and thoughtfully began to wonder why I had been so unusually sensitive and attentive to his hearing loss. I suddenly realized that my attentiveness was, in part, a consequence of my attempts to compensate for my lack of patience with my father’s serious and progressive hearing loss that began when I was in early adolescence. The patient’s question enabled me, for the first time, to realize explicitly that throughout this analysis I had been unconsciously working through important issues with my father. As Freud (1897, 1954, p. 234) noted, one’s own self-analysis can proceed by way of analyzing others.

Separation, Loss, and the Construction of Representational Structures
Termination is a complex process for both patient and therapist. Classically, termination is indicated when the patient has achieved a growing sense of autonomy, independence and mature relatedness, and has acquired a self-analytic or self-interpretive function, a function which he or she had previously depended on the therapist to provide. The patient, however, internalizes not only the interpretative function but also the therapist’s sensitivity, compassion, and acceptance as well. With these internalizations, the patient has also developed an increased capacity to tolerate painful experiences and affects. Hopefully and ideally, at termination, the patient can conduct the process of self-inquiry with the concern and empathy originally experienced with a caring parent or therapist, so that self-inquiry and examination is conducted with acknowledgment and acceptance of both one’s limitations and strengths (Blatt & Behrends, 1987). In addition, the experience of feeling accepted, understood, and cared for by another should enable the patient to feel, in turn, more capable of understanding and caring for others (Blatt & Behrends, 1987; Nacht, 1962). Much as a child learns to love by being loved by his or her parents, the patient can come to regard others with dignity and respect by having had such experiences in the therapeutic relationship—in sum, to develop mature reciprocal caring relationships. The analyst’s recognition of the patient’s subjectivity enables the patient, through experiencing a meeting of minds, to recognize and value his or her own subjectivity as well as the subjectivity of others (Aron, 1996; Auerbach & Blatt, 2001, 2002; J. Benjamin, 1995; Winnicott, 1971).

But there is always a fundamental indeterminacy for both patient and therapist in termination—both remain somewhat uncertain about whether the patient can now continue the exploration without the assistance of the therapist. Termination is not only a loss for the patient but also a loss for the therapist, and therefore a challenge to the therapist’s ability to bear painful experiences and emotions. The therapist feels confident about termination, however, when he or she has established a well-consolidated representation of the patient as being able to conduct the therapeutic exploration with skill, sensitivity, and compassion (Blatt & Behrends, 1987). In other words, successful termination requires not only the patient’s consolidation of his or her own self-representation, and his or her representation of the therapist, but also the consolidation of the therapist’s representation of the patient. The loss of the therapist at termination is a major factor in the patient’s
internalizations that consolidate the therapeutic gains achieved in the treatment process. As Freud (1923, 1925) noted in his conceptualization of the formation of the superego—the threat (or experience) of loss precipitates an attempt at recovery or restitution of the loss through identification with, or internalization of, the lost object. If loss is a major factor in the internalizations that occur at termination, then the experience or anticipation of loss should also play an important role throughout the treatment process. Therapeutic gains should be most manifest at separations—before, during, or after planned, as well as unplanned, interruptions of the treatment process.

I first became aware of the importance of separation and loss leading to the formation of representational structures in the treatment process early in my career, during the analysis of a very talented, physically attractive graduate student who sought analysis primarily because of interpersonal difficulties. She had been sexually abused when she was about 5 years old and again in early adolescence. More recently, she also had to deal with sexual advances by a member of the clergy in the religious institution with which she was affiliated and by the psychotherapist who she was seeing shortly before she sought analysis. Understandably, given the violations by people whom she should have been able to trust, the first year of analysis was filled with long periods of silence and a sense of apprehension. She spontaneously reported that she never dreamed.

Early in the second year of analysis, she requested a change in the time of our Friday morning appointment so she could attend a lecture that was relevant to her graduate studies. I, trying to maintain a “classic” approach to the psychoanalytic process early in my career, told her that the hour was hers and she could decide how she wanted to use it. She decided to attend the lecture. On her return to analysis on Monday morning, she reported, for the first time, that she had a dream. She could not recall any details of the dream other than that, though she did not see me in it, she sensed my presence. This sequence of events was a major turning point in a relatively successful 5-year psychoanalytic process.

It seemed that my presence in her mind and thoughts in her dream was a way of her coping with the loss she experienced in missing her usual Friday morning appointment. In addition, allowing her to make the decision about how to use the hour may have given her a sense of safety in my maintaining boundaries and in her having some control over how the analysis would proceed. But this experience dramatically called my attention to the importance of separations and loss in the treatment process.

Once the therapeutic alliance has been reasonably well established, patients seem to demonstrate therapeutic progress primarily around interruptions of the treatment process (see Jiménez, Kächele & Pokorny, 2006). Therapeutic progress early in treatment seems to occur primarily during or after an interruption (e.g., vacations, absences because of illness, absences over weekends, or even at the end of an hour). Much as a child develops object constancy to deal with the mother’s absence (e.g., Mahler, 1968), patients begin to establish, revise, and consolidate representations of self, the therapist, and of the therapeutic relationship, primarily when there is a disruption of the usual cadence of therapeutic sessions. Alternatively, changes in patients’ internal working models of the therapeutic relationship, and of relationships more generally, are more likely to occur when there are changes in the therapist’s provision of a secure base (Bowlby, 1988). Later in treatment, progress more often occurs in anticipation of separation, as the patient and therapist deal with anticipated loss in symbolic and verbal form rather than through its enactment. Throughout treatment, therapeutic gains appear to occur as a consequence of the resolution of a complex series of attachments and separations between patient and therapist (Blatt & Behrends, 1987), events similar to the sequence of affect matching, mismatching,
and repair that is central to the mother–infant dyad (e.g., Beebe & Lachmann, 1988, 1994; Gergely, 2002), although, of course, carried out in analysis at a much more mature level of symbolization and of mutual emotional need. But both attachment and separation are crucial therapeutic experiences in the internalization process that results in the progressive development of representations of self and of actual and potential relationships with significant others.

In considering the nature of therapeutic action in both clinical practice and research, we therefore must be attentive not only to the quality of the therapeutic alliance but also to the processes through which patients attempt to cope with separation and loss. The experience and anticipation of loss are crucial moments in the therapeutic process (Blatt, Auerbach, & Behrends, 2008). They are the moments at which both patient and therapist develop, revise, extend, and consolidate their representational structures. And it is these revised representational structures that are crucial elements of therapeutic change.

Adaptive Processes in the Transference

Many formulations of the mutative effects of the therapeutic process consider ways in which patients internalize “aspects of the analyst’s way of looking at things . . . [which become] a self-analytic function and probably a permanent new intrapsychic representation” (McLaughlin, 1981, p. 653). McLaughlin, for example, argues that analysis produces change “through the internalization, as new psychic structures, of attitudes and values experienced in the relationship to the analyst” (p. 655) and through the “intrapsychic transformation of old transferences into new and more adaptive transferences, organized around a new object, the analyst” (p. 657).

But research findings of changes in representations in the treatment process (Blatt, Auerbach, & Aryan, 1998; Blatt, Stayner, Auerbach, & Behrends, 1996; Blatt, Wiseman, Prince-Gibson & Gatt, 1991) raise some interesting questions about these traditional views of therapeutic action and the mutative forces in the treatment process. In one study, seriously disturbed inpatients in long-term, intensive, psychodynamically informed therapy were asked to describe each of their parents, themselves, a significant other, and their therapist at the beginning of treatment and every 6 months thereafter, until termination of treatment, which occurred, on average, some 18 months later. Analysis of some of these data indicated that increased cognitive sophistication and articulation of the representation of mother, father, self, and therapist were significantly correlated with independent clinical assessment of therapeutic gain. These findings forced us to consider the nature of the mutative factors in the treatment process, particularly what patients internalize in the therapeutic process.

It is often assumed that patients internalize the therapeutic attitudes, functions, and values of the therapist and of the treatment process. But if patients project aspects of their distorted and conflict-laden early interpersonal relationships with primary caregivers onto their therapists, it seems possible that patients also selectively construct and then identify with aspects of the therapist that are congruent with the patient’s fundamental needs and aspirations, and then more fully internalize these more adaptive elements through identification. Transference projections may express not only distorted and pathological enactments but also patients’ more adaptive efforts to find, in the therapist and in the therapeutic relationship, both consciously and unconsciously, strengths that they have had difficulty claiming as their own. Both pathological and adaptive attributes may be projected onto the therapist in the transference. Initially, more powerful pathological issues are usually projected onto the therapist, but as these pathological transferences are
resolved in the therapeutic process, the patient can begin to project more adaptive
c characteristics onto the therapist—characteristics that are then eventually reinternalized in
fuller, more mature, and consolidated form through identification. Thus, patients may not
just internalize the therapeutic attitudes, views, and functions of the therapist, but, in the
later phases of the therapeutic process, they may also selectively internalize constructed
aspects of the therapist that are congruent with their own fundamental needs, goals, and
aspirations. As Sutherland (1963, pp. 117–118) noted,

More often the inner object acts as a scanning apparatus which seeks a potential object in the
outer world. The subego of this system then coerces these people into the role of the inner
object. . . . The general aim of psychoanalysis . . . in terms of an object-relations model . . . [is]
initiating and maintaining a process whereby repressed relationship-systems are brought back
within the organizing system of the ego that then can be subjected to learning and adaptation.”

Similarly, Meissner (1980, p. 238), in discussing Fairbairn’s concepts of internaliza-
tion, noted that “the ego in a sense is thought to scan the outer world for potential objects
that fulfill . . . the role of inner objects,” and also stated, “External objects will be modified
. . . to conform to or to realize the characteristics of these inner objects.” The transitional
object, as discussed by Winnicott (1965, 1971), is constructed by the child by attributing
properties to the object that derive from the dynamics of the child’s inner life.

This process occurs in treatment as well. Identifications in therapy involve not
only the internalization of attributes of the therapist and the therapeutic process but
also the integration of those attributes that are congruent with preexisting qualities of
the patient—qualities that the patient then more fully takes as his or her own. In the
therapist, patients find or see adaptive qualities that the patient partially possesses, and
in a constructed representation of the therapist, patients eventually, through identifi-
cation, consolidate these more adaptive qualities as their own. By identifying these
qualities in the therapist, this process consolidates, at a higher development level,
width adaptive qualities that the patient has long desired and sought. In other words,
just as the infant is an active constructing agent in the mother–infant dyad (see, e.g.,
Beebe & Lachmann, 2002, and Stern, 1985), the patient is an active constructing agent
in the therapeutic process.

A Clinical Example of the Internalization of Adaptive Aspects of the
Transference

A summary of a clinical example previously presented in detail elsewhere (e.g., Blatt et
al., 1996) illustrates the process through which some patients not only internalize the activities
and attitudes of the therapist but also actively seek to identify mature and adaptive qualities in
the therapist that are congruent with some fundamental qualities or functions that the patient
has aspired to achieve—the expression of which has been thwarted by the patient’s distur-
bances and conflicts.

Alison, a 13-year-old adolescent, was admitted to a long-term, intensive, psychody-
namically oriented treatment facility because of severe affective lability, suicidal ideation,
substance (opiate) abuse, visual hallucinations, and delusions. Her diagnosis was psy-
chotic depression in a borderline personality disorder, with substance abuse. At admission
to the hospital, and every 6 months thereafter to termination about 18 months later, she
was asked by an independent examiner to describe each of her parents, herself, a
significant other, and her therapist. These descriptions were recorded verbatim.
Her self-description at admission was, "Depends on how I’m feeling. Sometimes I am outgoing but other times I’m withdrawn. I don’t know.” On nonspecific inquiry by the examiner, Alison noted that she did not want to describe herself because she gets upset when she does and that she is either too conceited or too modest to answer something like this.

At 6 months, Alison described herself: “I can’t describe myself—you describe me. It’s hard—no it’s easy. Vulnerable. Hurt. Lonely. Sort of happy. Getting more confident—no—please write gaining confidence. Considerate.” Upon inquiry, she elaborated on the word “vulnerable” as “I can easily be hurt.” Upon inquiry into the word “hurt,” she said, “Can’t say more.” “Lonely” was responded to as “I’m suffering from a lack of caring. I’m not cared about, the way I’d like to be.” “Considerate” was elaborated as “care about others’ feelings.”

Many features of these two self-descriptions are of interest, including Alison’s initial ambivalent and qualifying attitude about being outgoing or withdrawn, too conceited or too modest, and the task of describing herself as being too hard or too easy. This linguistic precision in Alison’s self-descriptions suggest a movement toward differentiation, which was also expressed at 6 months in her request to change the phrase “getting more confidence” to “gaining confidence.” At admission, Alison described her therapist as “sweet, supportive, trusting, and caring.” At 6 months, however, she said, “I can’t describe her because I don’t know her. Seems to care about me. That’s it.”

After about one year of treatment, Alison developed a brief transient psychotic transference to her therapist, in part derived from the emergence of very difficult material concerning paranoid ideation that her mother wanted to kill her, with Alison containing her fear by sleeping with a knife under her pillow to protect herself from her mother. As this material was dealt with in treatment, Alison once again began to feel closer to her female therapist. In this regard, it is interesting and important to note the patient’s description of her therapist at the termination of treatment:

I’m trying to think of a word: Tactful in approaching subjects. That wasn’t the word I was thinking of—not blunt—can say things in a better fashion. She can put things in a better way that doesn’t sound so intimidating or so cruel. She’s sweet, generous, and has high morals. She’s a nice person. Has high standards.

One of the fascinating aspects of Alison’s description of her therapist at termination is the emphasis on the therapist’s capacity to articulate things tactfully. In the patient’s description of this linguistic capacity in her therapist, the patient herself, as in her self-description at 6 months, is searching for the correct word to capture feelings and thoughts she is trying to communicate. It is impressive that Alison has constructed or identified characteristics of her therapist that are congruent with the very dimensions that she enacted and verbally demonstrated much earlier in the treatment process, at 6 months, in her self-description, and that she was still seeking to acquire at termination.

Alison illustrates how patients internalize and consolidate desired and wished-for functions by creating or identifying these qualities in a therapist—qualities that they have sought to obtain from someone else for awhile because they cannot provide these functions fully for themselves. Once these functions are experienced in the therapeutic relationship, patients seek to consolidate these functions as their own, through identification with the therapist, and thus can obtain them, enact them, or exchange them through more mature forms of relatedness. In this sense, needed, desired, and wished-for functions are projected onto the therapist and, eventually, through identification, made one’s own.
This process of externalization and internalization (projective or vicarious identification; Auerbach & Blatt, 2010) is a complex integration and synthesis that results in psychological structure formation through an awareness and acceptance of the eventual loss of the therapist (Meissner, 1981).

Attempts to understand the therapeutic process usually focus on aspects of the therapist and of therapeutic technique but tend to ignore attributes that patients bring to the treatment process. We assume that patients internalize aspects of the therapist in which we take pride—our therapeutic attitude, activities, skills, and our interpretations, as well as our capacity to establish a therapeutic relationship. But in our pride over, and preoccupation with, our therapeutic skills, we have tended to ignore that patients play an active role in the treatment process. Throughout treatment, and possibly beyond, patients construct representations of their therapist on the basis not only of the projection of primitive needs and conflicts but also of more adaptive fundamental needs and goals. Because of relative therapeutic neutrality, of the therapist’s relative capacity to balance immersion in the patient’s experiential world with a stance just outside of it, therapists exist as individuals for patients in limited but very special ways. This relative therapeutic neutrality—with it being understood that the analyst is never entirely free from his or her own therapeutic values and from the emotional pulls of the therapeutic relationship—allows, even encourages, patients to project onto us both pathological and adaptive qualities. These transference projections enable the therapist to understand important aspects of patient’s distorted life experiences. But our patients also project qualities onto us attributes they are seeking to make their own. In our relative neutrality, we not only encourage patients to express their pathological transferences but also allow our patients to locate more adaptive and constructive qualities within us—qualities that they are seeking for themselves and that, through processes of projection and identification, eventually come to consolidate as their own.

Introduction of Patient Dimensions into Psychotherapy Research

The active contributions of patients to the treatment process indicate that it is vital that patient dimensions be included in psychotherapy investigations. Numerous attempts to demonstrate the relative effectiveness of various kinds of psychotherapy usually yield essentially inconclusive results. Most comparative studies of different forms of psychotherapy generally indicate that “no one therapy has been shown to be overall significantly superior to any other” (Frank, 1979, p. 311). Extensive meta-analyses of comparative outcome studies have shown few differences between alternative forms of treatment (e.g., American Psychiatric Association Commission on Psychotherapies, 1982; Blatt & Zuroff, 2005; Blatt, Zuroff, Hawley, & Auerbach, 2010; Shapiro & Shapiro, 1982; M. L. Smith, Glass, & Miller, 1980). This lack of differences between the effectiveness of various forms of psychotherapy is, at least partly, a function of the failure to distinguish among patients, instead expecting all patients to be equally responsive, in the same way, to various forms of treatment. Frank (1979, p. 312), for example, early in the history of psychotherapy research, noted “that the major determinants of therapeutic success appear to lie in aspects of the patients’ personality and style of life.” He saw as crucial the development of criteria for assigning different types of patients to different therapies. Based on research findings (e.g., Malan, 1976a, 1976b), Frank proposed that “verbal, psychologically minded patients who have motivation for insight do well in insight-oriented therapies whereas action-oriented patients may do better in behavioral therapies.”
He also suggested that patients who conceptualize their subjective world in greater complexity may do better in unstructured situations, whereas less conceptually complex patients may respond better to more structured therapy. Horowitz, Marmar, Weiss, DeWitt, and Rosenbaum (1984), in one of the early studies to consider patient dimensions in their research, found, in brief therapy for bereavement, that patients with developmentally lower levels of self-concept responded to supportive treatment, whereas patients with developmentally more advanced self-concept responded to insight-oriented treatment (Blatt & Felsen, 1993).

The assumption of homogeneity among patients—that patients at the start of treatment are more alike than different, and that patients all experience the therapeutic process and change in similar ways—has been a major obstacle to the investigation of the processes of therapeutic change. Many psychotherapy investigators and research methodologists (e.g., Bergin & Suinn, 1975; Beutler, 1991; Blatt & Zuroff, 1992, 2005; Colby, 1964; Cronbach, 1958; Goldstein & Stein, 1976; Paul, 1969; Smith & Sechrest, 1991; Snow, 1991) have stressed the need to abandon this homogeneity myth and, instead, to include relevant differences among patients into research designs in order to address complex questions about whether different types of patients are responsive to different aspects of the therapeutic process and change in different, but possibly equally desirable, ways (Blatt & Felsen, 1993; Paul, 1969). Harkness and Lilienfeld (1997, p. 349), for example, noted that findings from research on individual differences “require the inclusion of personality trait assessment for the construction and implementation of any treatment plan that would lay claim to scientific status.” Thus, significant differences in sustained therapeutic change might occur in different treatments as a function of differences in patients' pretreatment personality.

This persistent failure to include patient variables in psychotherapy research designs is partially a function of the difficulty identifying relevant patient characteristics that might be central to the psychotherapeutic process (e.g., Beutler, 1991). One possible model that has been helpful in this regard, consistent with other object relations approaches to the treatment process (e.g., Blatt & Shahar, 2004; Høglend et al., 2008; Piper, Joyce, McCallum, Azim, & Ogrodniczuk, 2002), is the two-configurations model of personality development and psychopathology proposed by Blatt (1974, 2004, 2006b, 2008) and colleagues (Blatt & Blass, 1990, 1996; Blatt & Shichman, 1983). This model posits interpersonal relatedness and self-definition as basic dimensions underlying personality development, personality organization, concepts of psychopathology, and mechanisms of therapeutic change. This theoretical model, previously presented in detail (e.g., Blatt, 2006b, 2008) elsewhere, is summarized here to demonstrate its potential value in introducing relevant patient characteristics into psychotherapy research.

Two Configurations of Personality Development and Psychopathology

A wide range of personality theorists, from Freud (1930) to Bakan (1966), Wiggins (1991), and L. S. Benjamin (1995, 2003), propose that two dimensions—interpersonal relatedness and self-definition (or communion and agency)—are fundamental components of personality development and organization. Consistent with these views, Blatt (1974, 2004, 2008) and colleagues (Blatt & Blass, 1990, 1996; Blatt & Shichman, 1983) proposed that normal personality development evolves through a synergistic dialectical interaction between these two primary developmental dimensions across the life cycle. Throughout life, interpersonal relationships contribute to the development of a sense of
self, and refinements in the sense of self contribute to the development of more mature interpersonal relationships. Although most individuals try to maintain a balanced commitment to both of these fundamental dimensions of psychological existence and experience, individuals generally tend to place somewhat greater emphasis or value on one or the other of these two basic psychological dimensions. Extensive research (see summaries in Blatt, 2004, 2008; Blatt & Zuroff, 1992) indicates that this distinction defines two broad, normal types of personality organization, one focused primarily on interpersonal relatedness and the other primarily on self-definition, that engage and experience life differently.

Extensive research (see summaries in Blatt, 2004; Blatt & Zuroff, 1992) indicates that these two personality dimensions are also the source of vulnerabilities to depression: (a) disruptions of interpersonal relatedness (e.g., loss, abandonment, or a need for closeness), and (b) disruptions of self-esteem (e.g., feelings of failure, guilt, or unworthiness). Research (see summaries in Blatt, 2004; Blatt & Zuroff, 1992; Corveleyn, Luyten, & Blatt, 2005) indicates that personality characteristics of self-critical perfectionism are often central to the etiology, clinical course, and treatment of depression. Extensive research (see summary in Blatt, 2004) indicates that patients with these two types of depression have different early-life experiences (Blatt & Homann, 1992), are vulnerable to different types of stressful life events (Blatt & Zuroff, 1992) to which they respond and express their depression differently (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982), and are differentially responsive to different types of therapeutic intervention (Blatt, Zuroff, Quinlan, & Pilkonis, 1996).

Four major scales systematically assess these two personality dimensions: the Dysfunctional Attitudes Scale (DAS; A. N. Weissman & Beck, 1978), the Depressive Experiences Questionnaire (DEQ; Blatt, D’Afflitti, & Quinlan, 1976, 1979), the Sociotropy-Autonomy Scale (SAS; Beck, 1983), and the Personal Styles Inventory (PSI; Robins et al., 1994). All four of these scales measure an interpersonal or relatedness dimension, variously labeled “dependency,” “sociotropy,” or “need for approval,” and a self-definitional dimension, variously labeled “self-criticism,” “autonomy,” or “perfectionism” (Blaney & Kutcher, 1991).

The differentiation between individuals preoccupied with issues of relatedness or issues of self-definition has also enabled investigators to identify an empirically derived, theoretically coherent, taxonomy for the diverse personality disorders described in Axis II in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM–IV; American Psychiatric Association, 1994). Systematic empirical investigation with both inpatients and outpatients found that various Axis II personality disorders are meaningfully organized, in theoretically expected ways, in two primary configurations: one organized around issues of relatedness and the other around issues of self-definition. Even further, empirical investigations have found that individuals with a dependent, histrionic, or borderline personality disorder have significantly greater concern with interpersonal relatedness than with issues of self-definition, whereas individuals with a paranoid, schizoid, schizotypic, antisocial, narcissistic, avoidant, obsessive–compulsive, or self-defeating personality disorder usually have significantly greater preoccupation with self-definition than with issues of interpersonal relatedness (Clark, Steer, Haslam, Beck, & Brown, 1997; Cogswell & Alloy, 2006; Goldberg, Segal, Vella, & Shaw, 1989; Levy et al., 1995; Morse, Robins, & Gittes-Fox, 2002; Nordahl & Stiles, 2000; Ouimette & Klein, 1993; Ouimette, Klein, Anderson, Riso, & Lizardi, 1994; Overholser & Freiheit, 1994; Pilkonis, 1988; Ryder, McBride, & Bagby, 2008). These findings are further supported by attachment research that demonstrates that personality disorders can be similarly organ-
nized in two-dimensional space, defined by attachment anxiety reflecting relatedness concerns and attachment avoidance reflecting self-definition issues (Blatt & Luyten, 2011; Meyer & Pilkonis, 2005; Luyten & Blatt, in press).

Blatt (1990, 2004, 2006b, 2008) and colleagues (e.g., Blatt & Shichman, 1983) also conceptualize many major forms of psychopathology, in addition to depression and personality disorders, as involving one-sided, distorted, intense preoccupation with one of these two personality dimensions to the neglect or defensive avoidance of the other. Severe disruptions of the normal synergistic developmental process lead some individuals to seek stability by placing exaggerated and distorted emphasis on one of these developmental lines, either interpersonal relatedness or self-definition, with marked impairment in the other dimension. Disorders with excessive preoccupation with issues of interpersonal relatedness, at the expense of the development of a sense of self, are termed anaclitic because these individuals are preoccupied with leaning on others for emotional support (Blatt, 1974; Blatt & Shichman, 1983). These issues can be expressed at a very primitive level in experiences of fusion and merger, with a loss of boundaries between self and nonself in undifferentiated schizophrenia (e.g., Blatt & Wild, 1976); at a more intermediate level, around intense fears of abandonment and neglect, in borderline and dependent personality disorders; or at a more advanced reciprocal level, around conflicts with being able to give as well as receive love, in histrionic personality disorder (Marmor, 1953).

In contrast, self-definitional disorders with excessive preoccupied with the formation and protection of the self at the expense of the development of interpersonal relatedness are termed introjective because they often involve harsh self-criticism, perfectionism, and a need for control that have been internalized from similar such attitudes from parents or other caregiving figures. Struggles around self-definition can be expressed at a primitive level, in feeling persecuted (e.g., attacked or criticized) by others in paranoid pathology; at an intermediate level, in excessive behavioral and ideational control in obsessive–compulsive conditions; and at developmentally more advanced levels, in exaggerated concerns about self-worth in negative self-critical concerns in introjective depression, or in positive and sometimes grandiose preoccupations in narcissistic disorders. In general, the terms relational and self-definitional refer to these concerns in normal functioning, and the terms anaclitic and introjective refer to their respective decompensations in psychopathology. Blatt (2004; Blatt et al., 2010) also speculated that sustained progress in psychotherapy is expressed in a reactivation of the previously disrupted normal dialectic developmental interaction between relatedness and self-definition, such that anaclitic patients eventually become more agentic and assertive, and introjective patients eventually become increasingly invested in interpersonal relationships (Safran & Muran, 2000).

Thus, the developmental constructs of interpersonal relatedness and self-definition provide the basis for an empirically supported and theoretically coherent model of personality development and psychopathology that has demonstrated reliability and construct validity—a model for introducing patient variables into the investigation of the treatment process. In contrast to the atheoretical diagnostic system of the DSM (American Psychiatric Association, 1994), based primarily on manifest symptoms, the differentiation between anaclitic and introjective personality organization and psychopathology is based on dynamic considerations, including differences in primary instinctual focus (libidinal vs. aggressive), types of defensive organization (avoidant vs. counteractive), and predominant character style (e.g., emphasis on object vs. self-orientation and on affects vs. cognition; Blatt, 1991).
Investigations of Patient-Treatment and Patient-Outcome Interactions

The distinction between relational and self-definitional personality organization and anaclitic and introjective forms of psychopathology was made at acceptable levels of intrarater reliability in two investigations of long-term, psychodynamically oriented treatment—the Rigg’s-Yale Project (R-YP; e.g., Blatt & Ford, 1994; Blatt, Besser, & Ford, 2007), and the Menninger Psychotherapy Research Project (MPRP; e.g., Blatt, 1992; Blatt & Shahar, 2004). Findings in these investigations indicate that anaclitic and introjective patients come to treatment with different needs, respond differentially to different types of therapeutic intervention, and change in different ways—ways congruent with their basic personality organization.

Vermote and colleagues (e.g., Luyten, Lowyck, & Vermote, 2010; Vermote, 2005; Vermote et al., 2010) studied therapeutic change in a 9-month, psychodynamically oriented inpatient treatment program for personality disordered patients at the Kortenberg-Leuven Psychiatric Hospital (K-LS). Although Vermote et al. did not differentiate anaclitic and introjective patients in the K-LS at the outset of their investigation, they noted, in conclusion, that their findings were congruent with the differential therapeutic response of anaclitic and introjective patients in the R-YP and the MPRP investigations (Luyten et al., 2010; Vermote, 2005; Vermote et al., 2009, 2010). Vermote (2005) concluded that not only were specific patterns of change noted in these two different types of patients but also that different aspects of the therapeutic process seemed to have facilitated their change—that the “anaclitic group,” like in the MPRP, responded to support and structure, whereas the “introjective group” profited from the explorative dimensions of the treatment process. Vermote et al. also noted that the continued and sustained improvement of introjective patients in posttreatment was consistent with the findings of Bateman and Fonagy (1999, 2001) and with the consequence of their greater capacity for internalization in introjective patients (Blatt & Behrends, 1987). Vermote (2011, p. 4) found these results so convincing that he and his colleagues at Kortenberg reorganized their clinical services to now offer “classical psychodynamic group therapy for severe introjective patients (obsessive—compulsive, narcissistic, paranoid), while for anaclitic patients (borderline, histrionic, dependent) [they] offer more structured therapy like Mentalization Based Treatment, which is less based on insight and transference.”

These findings of therapeutic change in long-term, intensive, psychodynamic treatment in the R-YP, MPRP, and K-LS provide strong confirmation of Cronbach’s (1958, for example) and Frank’s (1979) formulations that patients’ personality characteristics influence therapeutic response, and that psychotherapy research needs to go beyond comparisons of various forms of treatment in the reduction of focal symptoms (e.g., depression or anxiety) to address more complex issues such as identifying mechanisms of therapeutic change and identifying what kinds of treatment are more effective, in what kinds of ways, with which types of patients (Blatt & Shahar, 2004; Blatt, Shahar, & Zuroff, 2002; Paul, 1969).

The differential response of anaclitic and introjective patients to different dimensions of the therapeutic process in long-term intensive treatment suggested that the well-established differentiation of dependent (anaclitic) and self-critically (introjective) depressed patients (Arieti & Bemporad, 1978, 1980; Beck, 1983; Blatt, 1974; Blatt et al., 1976, 1982) may be important in the systematic evaluation of different forms of brief psychotherapy in treating depression. Thus, this distinction of these two types of depression was introduced into further analyses of data from the extensive
and comprehensive Treatment of Depression Collaborative Research Program (TDCRP) sponsored by the National Institute of Mental Health (NIMH)—a remarkably extensive data set established by Elkin and her NIMH colleagues (Shea, Parloff, and Docherty) that compared 16 weeks of medication (Imipramine, the antidepressant medication of choice at that time) and a double-blind placebo with 16 sessions of manual-directed, carefully monitored, cognitive–behavioral therapy (CBT) or interpersonal psychotherapy (IPT) in the outpatient treatment of depression (Elkin, 1994). Eighteen experienced psychiatrists and 10 experienced PhD clinical psychologists saw patients at one of three treatment sites.

The basic findings of the TDCRP (e.g., Elkin, 1994) indicated that medication (Imipramine) led to a significantly more rapid decline in symptoms at midtreatment (at Session 8), but no significant differences were found in symptom reduction among the three active treatments at termination (the classic “dodo bird effect”). Shea and colleagues from the TDCRP, in an analysis of follow-up evaluations 18 months after termination, considered approximately 35% of the patients to have recovered because they had minimal or no symptoms for at least eight consecutive weeks following termination of treatment (Shea et al., 1992). Approximately 40% of these recovered patients, however, had relapsed by the 18-month evaluation. Thus, Shea et al. concluded that only approximately 20% of the 239 patients “fully recovered.” In sum, the TDCRP investigators found no significant differences among the three active treatments at termination, and found that all three active treatment conditions were relatively ineffective in producing therapeutic gain that was sustained through the 18-month follow-up period.

Based on the two factors of the Dysfunctional Attitudes Scale (DAS; Weissman & Beck, 1978), administered at intake and periodically throughout treatment in the TDCRP, Blatt, Quinlan, Pilkonis, & Shea (1995) explored the impact of the DAS Need for Approval (NFA) and Self-Critical Perfectionism (SC-PFT) scales on the treatment process in the TDCRP. Blatt and colleagues found that pretreatment levels of self-critical perfectionism (SC-PFT, an introjective personality trait), measured by the DAS (Weissman & Beck, 1978) significantly interfered with treatment outcome at termination across all four treatment conditions in the TDCRP. Pretreatment SC-PFT interfered dramatically with therapeutic gain primarily in the latter half of treatment, beginning in the 9th treatment session. Only patients with lower SC-PFT had significant therapeutic gain as they approached termination. Pretreatment SC-PFT was also significantly associated with poor therapeutic outcome at the 18-month follow-up (Blatt, Zuroff, Bondi, & Sanislow, 2000).

Using latent difference score (LDS) analysis, a structural equation modeling technique, Hawley, Moon Ho, Zuroff, and Blatt (2006) evaluated temporal coupled changes in symptoms and the introjective personality dimension, SC-PFT. They found that depressive symptoms diminished rapidly very early in the treatment with relatively little therapeutic intervention, but, in contrast, SC-PFT diminished gradually throughout treatment. Despite the remarkably rapid decrease in depressive symptoms early in the treatment process, significant unidirectional longitudinal coupling indicated that changes in patients’ SC-PFT predicted the decline in symptoms of depression throughout treatment. Thus, sustained therapeutic gain in the TDCRP, over all four treatment conditions, seems to be the consequence of changes in the personality factors involved in depression. These findings also indicate the need to further examine how these pretreatment personality factors impact on the treatment process.
Using the ratings established by Krupnick et al. (1996) of the degree to which patient and therapist contribute to the therapeutic alliance in the 3rd, 9th, and 15th treatment sessions in TDCRP, Zuroff et al. (2000) found that pretreatment SC-PFT significantly interfered with patients’ participation in the therapeutic alliance, especially in the last half of treatment.1 Shahar, Blatt, Zuroff, Krupnick, and Sotsky (2004) found that pretreatment SC-PFT also significantly impaired patients’ perceptions of their social relationships as supportive. Thus, pretreatment SC-PFT interfered with interpersonal relationships both in and external to the treatment process. The disruption of these interpersonal relationships accounted for almost all of the effects of pretreatment SC-PFT on treatment outcome at termination.

The quality of patients’ overall relationship with their therapist was assessed in the TDCRP at the end of the 2nd treatment session with the well-established (e.g., Gurman, 1977a, 1997b) Barrett-Lennard Relationship Inventory (B-L RI; Barrett-Lennard, 1962, 1985). The B-L RI, based on Carl Rogers’ (1957, 1959), “necessary and sufficient conditions” of effective therapy, assesses the degree to which patients experienced their therapist as warm, empathic and congruent. The B-L RI, very early in the treatment, was significantly related to a more positive therapeutic outcome at termination and at the 18-month follow-up. It was also significantly related to a decline in SC-PFT over the course of treatment—a change that, in turn, led to further therapeutic gain. It is impressive that the quality of the therapeutic relationship assessed so very early in the treatment process (at the 2nd treatment session) had a significant impact on treatment outcome both at termination and at follow-up, as assessed on a wide range of measures across all four treatment conditions (see also Blatt et al., 1996, and Kim, Wampold, & Bolt, 2006). Hawley, Moon Ho, Zuroff & Blatt (2007), in another LDS analysis, found that the strength of patients’ participation in the therapeutic alliance in the 3rd treatment session significantly influenced change in their level of SC-PFT, which, as noted earlier, significantly influenced the reduction of depressive symptoms.

Together, these findings clearly indicate that the quality of the early therapeutic relationship and the extent of to which the patient participated in the therapeutic alliance plays a crucial role in the reduction of depressive symptoms as well as the disruptive negative self-schema (SC-PFT; Zuroff & Blatt, 2006). Consistent with these findings, It is important to note that more effective therapists in the TDCRP, in comparison with moderately and less effective therapists, were significantly “more psychologically minded, eschewed biological interventions . . . in their ordinary clinical practice and expect outpatient treatment of depression to take longer” (Blatt, Sanislow, Zuroff, & Pilkonis, 1996, p. 1276).

In summary, the two-configurational model facilitated the introducing of crucial patient dimensions into the investigation of both long- and short-term treatment. The model also posits that a goal of treatment is to enable both dependent (anaclitic) and self-critical (introjective) individuals to reestablish the synergistic process so they can establish increasingly mature levels of both relatedness and self-definition. Research by

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1 It is especially important to note that Krupnick and colleagues (1996), using the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983), rated the contributions of both patients and therapists to the therapeutic alliance. Consistent with the basic premise of this article about the importance of attending to the patient’s contribution in the treatment process, Krupnick et al. found that only the contributions of the patients to the therapeutic alliance, and not those of the therapists, were significantly related to therapeutic gain at termination across all four treatment conditions in the TDCRP.
Safran and Muran (2000, for example) suggests that dependent and self-critical patients may approach this goal from somewhat different directions—through different transfer-ence expressions and enactments. Issues of unreliable and inconsistent caring experiences are expected to emerge with dependent patients, whereas self-critical patients will likely deal with issues of failure and transgression, and with harsh, critical, punitive, judgmental, intrusive, and overcontrolling early relationships. Dependent (anaclitic) patients will usually focus, at least early in the therapeutic process, on issues of separation and loss of gratifying relationships. The early focus of self-critical (introjective) patients will primarily be on establishing and maintaining a sense of self as separate, independent, and worthwhile. Exploration of these processes of therapeutic change await further investigation.

Conclusions
The findings and formulations presented in this article suggest that the contributions of the therapist must be multifaceted and in response to the basic personality organization of the patient. Thus, the unit of analysis in psychotherapy research should not be the patient or the therapist in isolation, but the patient–therapist interaction. The effectiveness of the therapist’s responses appears to be determined by whether it enables the patient to experience the therapist as empathic and congruent (as measured, e.g., by the B-L RI) and to participate more fully in the therapeutic process (as measured, e.g., by the Vanderbilt Therapeutic Alliance Scale; Krupnick et al., 1996) so that the patient can continue and extend the internal dialogue and exploration (Freud, 1937). Findings from long-term psychodynamic treatment (e.g., the MPRP and the K-LS) indicate that dependent (anaclitic) patients are responsive primarily to supportive interventions, whereas self-critical (introjective) patients are primarily responsive to exploratory interventions, Thus, the effectiveness of specific therapeutic interventions must be defined and evaluated not in isolation but from the perspective of the patient–therapist dyad. In sum, the findings and formulations presented in this article clearly indicate the importance of focusing, in both clinical practice and clinical research, on the patient’s contribution to the treatment process and on the conditions that facilitate this participation.

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