Deconstructing the therapeutic relationship in order to reconstruct it[1]

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In the last ten years many researchers have set out to investigate the existence of a common factor that is transversal to various treatment models, in order to explain most of the effectiveness of the psychotherapies. The relationship, or more precisely that aspect of the patient-therapist relationship that goes by the name "therapeutic alliance", has been identified as this common factor (Horvath & Symonds, 1991; Horvath & Bedi, 2002; Lingiardi, 2002; Martin, Garske, & Davis, 2000). Although the concept of therapeutic alliance has a relatively short history (Zetzel, 1958), its roots lie in the psychoanalytic tradition (Freud, 1912; Sterba, 1934) and it was in the 1970s that it started its shift into the field of empirical research.

After an initial period (1912-1965) of psychoanalytic theorizations (starting with the "irreprehensible positive transference" of Freud 1912) and a second period of empirical research with the construction of *ad hoc* instruments and studies aimed at the examination of the relation between alliance and outcome (1970-2000), came a third phase that can be called "of clinical research", characterized by the study of the relational dynamics of the alliance, in particular the episodes of disruption and repair, and of their subjective components[2].

Today's interest in the clinical dynamics associated with the quality of the therapeutic relationship springs from the development of thinking on the beneficial effects "created" by the therapist, from the re-examination of the concept of alliance and the formulation of the concept of "collaborative interaction". The basic idea is that both the therapist and the patient contribute to the formation of an efficacious therapeutic collaboration, and that to study it, there needs to decompose it into its components and identify other "variables of the relationship" such as *transference*, *empathy*, *real relation*, state of mind towards *attachment*, *individual traits*, etc. (see Lingiardi, 2002; Safran & Muran, 2000).

The conclusion was therefore reached that the alliance cannot be seen as a suit that fits all comers. Depending on the patients and the therapists it in fact shows particular features: hence the success of expressions *matching patients to therapies* (Roth & Fonagy, 2004), *tailoring psychotherapies and therapists to patients* (Horwitz, Gabbard, & Allen, 1996; Lambert, 2004).

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[2] The development of the concept of alliance in the psychoanalytic model has a complex history that cannot be summed up in a few lines. We will simply recall that, starting from Freud's original rupture of transference into a "positive" or "irreprehensible" form and a "negative" form (Freud, 1912, pp. 528-529), the concept of therapeutic alliance has been minimized or openly challenged by some (above all by those authors who link all relational dynamics to transference), while others have valorized it and placed it among the structural dimensions of the therapeutic relationship. Among the founders of the concept there are Sterba ("alliance of the Ego", 1934), Zeztel ("the analyst enters the analytic process as a real person and not only as an object of transference", 1958, p. 357) and Greenson (1965, who distinguishes between the working alliance, transference and real relationship). Right down to its recent "dissolving" into the North American relational movement (see Ponsi, 2002). For a more detailed description of the history of the construct, see Lingiardi (2002), Lingiardi and Colli (2003), Safran and Muran (2000).

The vision of the alliance as a static characteristic (something that either exists or does not) has been replaced by the idea of something that is constructed in the course of the treatment, through processes of rupture and repair (Lingiardi & De Bei, 2005; Safran & Muran, 2000); consequently, also the idea that the alliance is a factor that on its own is capable of explaining change has faded away. Today the construct of alliance is general and aspecific (and not a panacea), studied in its interaction with other factors (both specific and aspecific; Beutler, Moliero, Malik, & Harwood, 2000), but above all it is no longer considered simply a (pre)condition, but also a goal of change: achieving cooperation can itself be an objective of the therapy (in particular in the treatment of severe personality disorders and psychosis) (Bateman & Fonagy, 2004; Dimaggio & Semerari, 2003; Liotti, 2005).

It is useful to stop and think about the direction that has been taken by the study of the therapeutic relationship in recent years. As we have already mentioned, the growing interest in the concept of alliance (Horvath & Symonds, 1991; Horvath & Bedi, 2002; Lambert, 2004; Martin, Garske, & Davis, 2000) is partly a result of the poor results produced by research aimed at evaluating the comparative efficacy of the psychotherapies (Dazzi, 2006; Luborsky, 1976; Wampold, 2001) and of the contradictory results of studies on the significance of specific factors for the outcome (Colli, 2006; Dazzi, 2006). There are now numerous studies, on the other hand, that point to the alliance as a factor which (if compared to other factors held to be responsible for change, such as the specific factors) can be strongly predictive of the outcome (Horvath & Bedi, 2002). It remains difficult however to understand the success of this construct purely on the basis of empirical evidence. To be honest, in fact, a correlation of around .25 (about 6% of the variance of the result) does not seem to indicate a great effect. Other factors, such as the *allegiance* of the therapist (Norcross, Beutler, & Levant, 2005) seem to account for a higher percentage of variance of over 10% (Robinson, Berman, & Neimeyer, 1990), just as the therapist's characteristics seem to explain 9% of the total variance (Wampold, 2001). "Why then is the therapeutic alliance so popular amongst psychotherapy researchers?" (Safran & Muran, 2006, p. 286).

This popularity can probably be attributed, at least in part, to the paradigm shift that has taken place in many (if not all) the psychotherapy approaches: the "relational shift"[3] which in the research field has promoted the development of instruments to identify and study the characteristics of the therapist, his/her personality, the quality of his/her interventions, the influence of the gender, etc.[4].

On the strictly empirical plane, paradigmatic of this change of direction seems the response of Division 29 of the American Psychological Association to the EST movement (*Empirically Supported Treatment*; Chambless & Ollendick, 2001; see also Westen, Morrison, & Thompson-Brenner, 2004), with the creation of a task-force

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[3] It should however be noticed that, paradoxically, while on the one hand in the emergence of the relational paradigm (Greenberg & Mitchell, 1983; Mitchell, 1988, 2000) more and more importance is given to the relationship, on the other, the authors who support this model seem to have "neglected" any explicit mention of the construct of the therapeutic alliance. This is because "once the whole analytic situation is conceived in a bi-personal perspective, and that the quality and the regulation of the analytic relation become central issues in theory and technique – writes Ponsi (2002, p.79) –, there is no longer any need to have a construct which had appeared necessary in a phase in which relational aspects were underestimated".

[4] It must be specified that mainstream research into the therapeutic alliance today actually embraces the study of many aspects of the therapeutic relationship aimed at the main objective of understanding how psychotherapy works (Horvath, 2005). These include, for example, the study of how the patient interprets the therapist's behaviour (Beneke, Peham, & Banninger-Huber, 2005), the cognitive processes that play a role in forming and maintaining a positive relationship with the therapist (Casey, Oei, & Newcombe, 2005; Sexton, Littauer, Sexton, & Tommeras, 2005), and the identification of diagnostic and personality characteristics linked to the quality of the relationship established with the clinician (Lingiardi, Filippucci, & Baiocco, 2005).

(Norcross, 2002) devoted to the study of the role played by the relationship in psychotherapy, first of all the therapeutic alliance (Safran, Muran, Samstag & Stevens, 2002). In short, Division 29 promoted, at the empirical level, what therapists have always been convinced of at the clinical and individual level: the curative side of the relationship.

Even more important is the central idea conveyed by the ESR movement (*Empirically Supported Relationships*): the alliance is a fundamental component of the therapeutic relationship *together with* a series of other interpersonal constructs (like the therapist's characteristics, the type of therapist-patient attachment, the empathic dimension, the characterisitcis of the patient, the type of patient-therapist attachment, etc). As Roth and Fonagy (2004) say, rather than *treating the therapeutic alliance as a single concept, it should be seen as a means by which different aspects of the therapeutic process operate at different times during the therapy.*

The renewed interest in the relationship between patient and therapist has not only brought clinicians closer to research, providing both fertile grounds for exchange and a meeting point for the needs of clinicians and researchers, but also raised awareness among researchers that the alliance in itself is a generic concept that can, and must, be studied jointly with the other variables of the process, in which technical and relational elements should be seen as aspects of the process operating in synergy.

"Deconstructing the therapeutic relationship in order to reconstruct it" therefore means indicating not only the need to monitor the general quality of the patient-therapist alliance, but also the nature of a series of related micro-processes that contribute to the progress and outcome of the therapy.

Before proceeding with this deconstruction, however, it would be useful to clarify what we know today about the alliance construct.

What we know about the alliance

Castonguay and collaborators (2006) recently indicated a series of crucial data for a clinical reflection on the alliance:

1. The main fact, confirmed in numerous studies, is that the alliance has a positive correlation with therapeutic change (Horvath & Symonds, 1991; Horvath & Bedi, 2002; Lingiardi, 2002; Martin, Garske, & Davis, 2000). Various meta-analyses have shown an *effect size* ranging between .22 and .26 (see Horvath & Bedi, 2002): a level that, though not great, seems strong. Moreover, the size of the effect is supposedly constant: this is no minor feature if one considers that it concerns a variable measured in such a complex context as psychotherapy.
2. In general terms, the alliance, as it is measured, is a construct correlated but not entirely overlapping the related therapeutic profit (Horvat, 2005). The literature also indicates that the quality of the alliance correlates positively with some patient characteristics (such as capacity for mentalization, expectations of change, quality of object relations, etc.) and negatively with others (such as avoidance, interpersonal difficulties, depressive thoughts etc; see Costantino, Castonguay, & Schut, 2002).
3. Some of the therapist's characteristics and attitudes are associated negatively with the quality of the alliance (such as rigidity, being critical, inappropriate self-disclosure etc.; see Ackerman & Hilsenroth, 2001). Also in this case there are studies (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Piper, Ogrodniczuck, Joyce, & McCullum, 1999) that emphasise the clinician's capacity to manage and guide the relationship. It is probable in fact that these characteristics of the clinician in themselves do not have a negative effect on the relationship, but are aspects that can indirectly affect the quality of the alliance: faced with a rupture or an impasse in the alliance, the therapist may apply his/her technique or reference model more strictly or inflexibly, and in this way not manage to repair the rupture, or may even worsen the impasse.
4. There is evidence suggesting that the quality of the alliance is particularly predictive of outcome when it is measured in the early stages of treatment, while conversely a weak alliance can be predictive of a drop-out (see Costantino, Castonguay, & Schut, 2002). Clinically, this fact points to the need for the clinician to monitor the relationship from the

very beginning. "Rather than assuming that initial problems of cooperation or early signs of detachment will be automatically reduced in time", say Castonguay et al. (2006, p. 273), "the therapist should start to support the alliance from the very first moment of therapy and be prepared to deal with rupture as soon as they occur"[5].

5. Lastly, as a result of the numerous research works on the alliance, we now have a series of tools available to measure this costruct from a variety of perspectives (patient, therapist, external observer) (for a detailed description of the tools see Costantino, Castonguay, & Schut, 2002; De Bei, 2006; Lingiardi, 2002). These include some that are anchored to the psychoanalystic tradition, like the WAI (*Working Alliance Inventory*) of Horvath and Greenberg (1989), and were developed from a trans-theoretical viewpoint. The alliance can therefore be measured in every form of therapy. The possibility of evaluating the relationship from multiple viewpoints has led to a fact with important clinical effects. Although many therapists feel that they are generally capable of accurately assessing the quality of their relationship with the patient, there is data to suggest that the visions of the alliance that patient and therapist have diverge from each other, particularly during the early phase of the therapy; and that it is the evaluation made by the patient that is more predictive of the outcome (in the initial phase of treatment) (Horvath & Bedi, 2002).

Even from this short and certainly not exhaustive overview, it emerges clearly that the relational variables have reached a new, more balanced status in the field of research into psychotherapy. The latest research into the alliance shows that the therapeutic relationship cannot simply be understood as a non-specific variable, an auxiliary to the other active components of treatment (Hatcher & Barends, 2006): it should rather be seen as an active element of the therapeutic exchange, whose quality is due to the interaction among different variables involving both the patient and the therapist.

Instead of considering the alliance an overarching concept holding within it the variables of the two participants in the relationship, we are inclined to see *the therapeutic process as an attempt to construct* (therapeutic alliance) *a secure relationship* (attachment) *through a relatively identifiable series of vicissitudes* (rupture, reparair), *characterized by dynamics involving the subjectivity of the participants* (transference, countertransference) (Lingiardi & De Bei, 2007).

While in conceptual terms, therefore, the alliance takes the form of a bridging construct that can bind together different elements of the clinical exchange that find a centre in the therapeutic relationship (and in its quality). In evaluative terms one must look at the quality of the patient-therapist relationship from a multi-instrumental viewpoint to capture the various aspects underlying the relationship and how these interact with the characteristics of the two participants.

In this article we will indicate a list of instruments that we have found particularly useful for the study of the process and outcome of psychotherapy. These are tools which, though constructed to assess a specific aspect of the therapeutic relationship, represent successful attempts at compromise between empirical requirements and clinical complexity.

In short, it is an attempt to deconstruct the concept of alliance in order to operationalize the main relational components:

- Transference/Countertransference;
- Attachment;
- Quality interventions⇔contributions (reciprocal regulation of the therapeutic relationship);
- Rupture ⇔ repair;

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[5]This does not mean however that the therapist should confine the evaluation of the quality of the alliance only to the early phase of therapy. In fact it is a task that the therapist should take on for the whole course of the therapeutic relationship (Safran, Muran, Samstag, & Stevens, 2002).

Transference and countertransference: the Psychotherapy Relationship Questionnaire and the Countertransference Questionnaire

The Westen group has recently administered clinical questionnaires to patients in psychotherapy to explore the dimensions of transference (Bradley, Heim, & Westen, 2005) and those of countertransference (Betan, Heim, Conklin, & Westen, 2005) in the therapeutic relationship using two tools: the *Countertransference Questionnaire* (CT-Q; Zittel & Westen, 2003) and the *Psychotherapy Relationship Questionnaire* (PRQ; Westen, 2000).

The CT-Q is a clinical report of 79 items drawn from an examination of the theoretical, clinical and research literature on countertransference. The items evaluate a wide range of thoughts, feelings and attitudes expressed by the therapist towards his/her patients, and considers statements ranging from relatively specific feelings ("In the session with him/her I'm bored") to complex constructs like that of projective identification ("With him/her, more than with other patients, I feel driven to think and feel things that I only fully realise when the session is over").

PR-Q is a 90-item questionnaire which assesses a wide range of thoughts, feelings, motives and conflicts of the patient towards the therapist, including what is traditionally described as transference and/or therapeutic alliance. In this case, too, the items were taken from an overview of the literature on the subject (transference, therapeutic alliance and related constructs). The items were formulated in a clear, comprehensible way, avoiding technical terms, so as to make them accessible to clinicians of all theoretical orientations[6]. For instance, to capture the Kohutian concept (Kohut, 1968) of "mirror" and "twinship" transference in patients with narcissistic personality disorders, items were formulated of the type "The patient imagines that the therapist shares his point of view, his beliefs, values etc. even when this is unlikely" or "The patient imagines that s/he and the therapist are much more alike than they actually are; s/he seems to want to "become twins" with the therapist".

Table 2 and 3 describe the five transference factors and the eight countertransference factors that emerged from the factorial analysis.

Table 2. Transference factors **(Bradley, Heim, & Westen, 2005)**.

Factor 1 Angry/Entitled	Factor composed of items indicating the tendency to make excessive demands on the therapist and at the same time to be angry and distant. These are items that fit the description of the process of transference that tends to develop in patients with Axis II, cluster B disorders, in particular narcissistic and borderline disorders.
Factor 2 Anxious/Preoccupied	Factor composed of items describing the fear of disapproval or rejection by the therapist, and a particularly complaining, dependent attitude towards the therapist. The relationship style closely recalls the "preoccupied" attachment style, related to a classification of the anxious/ambivalent type of childhood attachment (Main, Kaplan, & Cassidy, 1985).
Factor 3 Secure/Engaged	Factor composed of items describing the patient's capacity to contribute to a positive therapeutic alliance and to a playful, comfortable and secure experience of the therapeutic relationship.
Factor 4 Avoidant/	Factor composed of items describing the presence of an effort to avoid a meaningful relationship with the therapist or

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[6]The use of descriptions that are clear and correspond to clinical reality, to ensure that they are comprehensible for clinicians of different theoretical orientations and also to minimize the possibility of idiosyncratic leaps of interpretation, is one of the features distinguishing the Shedler-Westen Assessment Procedure-200 (SWAP-200; Westen, Shedler, & Lingiardi, 2003).

Counterdependent	a dependence on him/her. Conceptually, this factor appears to be related both to the distancing style of adult attachment and to a common dynamic in obsessive, avoidant patients.
Factor 5 Sexualized	Factor composed of items describing the presence of sexual feelings towards the therapist, including the tendency to act in a seductive manner.

Table 3. Factors of countertransference (Betan, Heim, Conklin, & Westen, 2005).

Factor 1 Overwhelmed/Disorganized	Factor composed of items indicating the desire to avoid or escape from the patient, and the presence of strong negative feelings like fear, resentment, and repulsion. The items fit the description of cluster B personality disorders (borderline and narcissistic) and of disorganized attachment patterns (cfr. Solomon & George, 1999).
Factor 2 Helpless/Inadequate	Factor composed of items describing feelings of inadequacy, incompetence, desperation and anxiety.
Factor 3 Positive	Factor composed of items indicative of the presence of a positive experience of working alliance and of intimacy with the patient.
Factor 4 Special/Overinvolved	Factor composed of items describing the sense that the patient is special compared to other patients and "slight signs" of a problem in maintaining a bond; for example in managing self-disclosure, in finishing the session on time, in feeling guilty, responsible or excessively worried about the patient.
Factor 5 Sexualized	Factor composed of items describing the presence of feelings of a sexual nature or the experience of sexual tension towards the patient.
Factor 6 Disengaged	Factor composed of items describing the presence in a session of a sense of distraction, withdrawal, irritation or boredom.
Factor 7 Parental/Protective	Factor composed of items expressing the presence of a desire to protect and care for the patient in a parental way, in a manner that goes beyond the normal positive feelings towards the patient.
Factor 8 Criticised/Mistreated	Factor composed of items that describe the patient's feeling of being not appreciated, kept at a distance, or belittled.

The Westen group used these tools to test a possible correlation between the cluster of the Axis II of the DSM-IV and specific factors associated with transference and countertransference. The analysis of the five transference factors and the eight countertransference factors tends to indicate an actual correlation with specific personality disorders.

The *cluster A* disorders (paranoid, schizoid, schizotypical) were positively correlated, though to a slight degree, to the avoidant/counter-dependent transference factor, and negatively, to a significant degree, to the secure/engaged factor; as far as the therapist is concerned, on the other hand, these transference factors are associated with a countertransference dynamic of a critical type (factor 8).

The *cluster B* disorders (antisocial, borderline, histrionic, narcissistic) were associated to the transference factors angry/demanding-recriminative and sexualized; countertransference feelings associated with them are overwhelmed/disorganized, helpless/inadequate, sexualized, disengaged; cluster B also presents a significant negative association with the positive countertransference factor.

The *cluster C* disorders (dependent, avoidant, obsessive-compulsive), lastly, are associated significantly with the transference factor anxious/preoccupied and with countertransference feelings of the parental/protective type (factor 7)[7].

Overall, these correlations provide us with a photograph of the relational dynamics associated with patients of a certain psychopathological area, but above all they also give us valuable pointers on how the constructs of alliance, attachment, transference and countertransference can be connected to each other, clinically and conceptually:

1. In general, as far as the therapist is concerned, the results that emerge seem to indicate that, despite the singularity of each therapeutic dyad, the correlations found between countertransference factors and personality disorders suggest a certain coherence and predictability of the countertransference responses. In this sense one could talk about an "average expected countertransference response" developed by the clinician, which in many cases resembles the typical responses coming from other significant others in the patient's life (Betan, Heim, Conklin, & Westen, 2005).

2. As far as transference is concerned, an important and unexpected result is the overlapping of transference factors with the styles of adult attachment identified with the AAI. It is obvious that not all therapeutic relationships can be described as attachment relations (i.e.characterized by seeking closeness or by distress due to physical or psychological distance from an attachment figure), but these results support the vision of the therapeutic relationship as an intimate, asymmetrical relationship, emotionally loaded and aimed at care-giving, with the power to activate patterns of thought, feeling, affects, affective regulation etc, linked to attachment (Bradley, Heim, & Westen, 2005).

3. One of the dimensions that emerge (Secure/Engaged) seems to describe not only a style of attachment in which the patient feels at ease, secure, able to speak freely of his/her own significant experiences, but also a dimension often described as working alliance (Bradley, Heim, & Westen, 2005). The fact that the items that make up the Secure/Engaged factor describe both a positive alliance and a safe style of attachment, seems to reflect the fact that alliance and transference involve similar cognitive and affective processes which entail the activation of representation, affects, and stategies of affective regulation based on the concordance between the present relationship and prototypes of the past (Westen, Gabbard, 2002). Therefore, "although the distinction between working alliance and transference may be heuristically useful, in both cases the patient is responding on the basis of a combination between *a priori* expectations and the current situation" (Bradley, Heim, & Westen, 2005).

Attachment: the Patient-Therapist Adult Attachment Interview

The PT-AAI (Diamond, Clarkin, Stovall, & Levy, 2001; George, Kaplan, & Main,1996) is a semistructured interview, created as an adaptation of the AAI, aimed at classifying the mental states concerning patients' attachment towards their respective therapists (and vice versa). Like the AAI, the PT-AAI is addressed to the evaluation of the state of mind towards attachment and towards the rules, conscious and unconscious,

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[7]Confirmation of the factors that emerged and their correlation with the alliance also comes from other studies on the alliance with patients suffering from personality disorders. Lingiardi, Filippucci, Baiocco (2005) for example found that schizoid, schizotypical and paranoid (Cluster A) patients, if compared with cluster B and C patients, consider it more difficult to jointly construct working strategies with the therapist. Compared to cluster A and C patients, those in cluster B receive from the therapist a more negative assessment of the alliance. In contrast, with dependent, avoidant, obsessive-compulsive patients, therapists assess the quality of the alliance established in a more positive way.

developed by individuals to organize the experiences, thoughts and feelings connected to attachment. Unlike the AAI, the PT-AAI assesses these processes just as they appear in the therapeutic relationship, rather than in relation to the figures of attachment. The tool, modified in this way, makes it possible to understand and assess how the status of attachment can influence both transference/countertransference dynamics (Dozier, Tyrrell, 1998; Fonagy, Steele, M., Moran Steele, H., & Higgitt 1991a; Fonagy, Steele, & Steele, 1991b, Holmes, 1995; Szajnberg, Crittenden, 1997) and the quality and nature of the therapeutic alliance (Harris, 2003; Mackie, 1981; Slade, 1999).

The protocol consists of 28 questions that follow the same order and format as the questions in the AAI (Diamond, Clarkin, Stovall, & Levy, 2001). However, some necessary modifications have been made in formulating the questions so as to take into account the different context of application, i.e. the therapeutic setting. The administration of the interview envisages different phases and questions, from general to specific. 12 questions were added to the original protocol, in order to further explore the therapeutic relationship as well as the capacity to reflect on it[8].

As for the AAI, based on the scores given on the two groups of 9-point scales (scale of experience and scale of the mind), the transcript is assigned to a category. In the PT-AAI, the scales assess (Diamond, Clarkin, Stovall, & Levy, 2001):

- *Experience scales*: in the AAI scoring system these scales assess the interviewee's probable experiences with the primary attachment figures; what is now evaluated by these scales is the experience in the therapeutic setting as it is reported by the patient/therapist.
- *State of mind scales:* in the AAI this second group of scales, on which most of the classification assigned is based, evaluates the interviewee's mental state towards attachment; in the PT-AAI these scales are used to classify the patient's state of mind towards the therapist and vice versa.

The PT-AAI also envisages scores for the reflexive function (assigned using the Reflective Function Scale; Fonagy, Steele, Steele, & Target,1997)[9]. The importance of this scale, in particular in the therapeutic context, is shown by the studies on mentalization in the development of a secure attachment, both in the parent-child relationship and in that between therapist and patient (Fonagy, Steele, M., Moran Steele, H., & Higgitt 1991a; Fonagy, Steele, & Steele, 1991b; Fonagy *et al.*,1996; Fonagy & Target, 2001; Slade, 2002).

As for the AAI, also the PT-AAI interviews are transcribed completely. The classification of the subjects uses an adaptation of the scoring and classification system used in the AAI, *Adult Attachment Scoring and Classification System* (Diamond, Clarkin, Stovall, & Levy, 2001). According to the scores obtained in the different scales, the interviews are assigned to one of the four primary classifications, and they refer to the quality of the attachment relationship between patient and therapist: Secure/Autonomous, Preoccupied, Distancing, Can't classify[10] (see table 1).

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[8] "In your opinion, how does your patient/therapist feel towards you?" and "Do you ever think of your patient/therapist outside the therapeutic setting?" are examples of these additional questions.

9 The AAI envisages a scale for "metacognitive capacity" (Main, Goldwyn, 1998). It should be remembered that the constructs of "reflexive function" (Fonagy, Target, 2001) and "metacognitive capacity" (Main, Goldwyn, 1998), often used as synonyms, actually share only some important aspects. As underlined by Caviglia (2003, pp. 138-146), who talks about "a question to clarify", Main uses the term metacognition above all in its self-evaluative sense, with the function of self-regulation of one's thoughts and statements, of understanding the other's point of view etc. Fonagy, on the other hand, uses the term in relation to his hypotheses on the child's psychological development and to the maternal self-reflexive capacity (therefore in a more interpersonal and on-going sense than Main).

[10] The category *Unresolved*/(U/D) is not contemplated in the PT-AAI classification system. This category, unlike the others, is not important in the therapeutic context in that it refers directly to the possible non-resolution of traumatic events or loss of attachment figures.

Table 1. Classifications of mental state used by the PT-AAI (Diamond et al., 2003).

State of mind Secure/Autonomous (F)	Patients: provide a credible description of the therapist as a secure base during treatment, or if the latter does not represent a secure base, they describe the relationship coherently. Therapists: provide a credible coherent description of the relationship with the patient and show the capacity to reflect on any difficult aspects of the relationship, including countertransference reactions. Therapists assessed as secure/autonomous also have great faith in their capacity to function as a secure base for their patients.
State of mind Dismissing (D)	Patients and therapists are classified as distancing when their interviews reveal a denial of the feelings related to attachment in the therapeutic relationship, which can on the other hand be idealized or denigrated. In the exposition, the imperfections of the therapist/patient are often denied, in spite of clearly contradictory evidence. On the other hand, this can prove to be an active denigration of the therapeutic relationship or of psychotherapy in general. In these interviews there often appear statements of independence from or non-invovlement with the patient or therapist. Patients: describe the relationship in a mildly or strongly idealized manner, without supporting their statements with specific examples or memories of positive past experiences. Therapists: describe the relationship with the patient as globally positive without providing specific episodes or describing concrete experiences. In the interviews of both there is also an acknowledgement of the difficulties encountered in the relationship with the other, but these are admitted in a cold detached way, or as a "matter of fact" denoting the presence of a minimum emotional involvement.
State of mind Preoccupied (E)	Patients and therapists are excessively involved in the relationship with the other and show a preoccupation concerning the therapeutic relationship that goes beyond what can be considered "normal" in psychotherapy. Narrations about experiences during treatment are confused and incoherent. They may show a confused sense of personal identity and tend to organize their affective life around the therapeutic interaction. In extreme cases the patient may express hsi/her preoccupation through destructive and self-destructive actions, aimed at attracting the therapist's attention and at punishing the latter for imagined affronts. Therapists classified as preoccupied appear hyper-involved in the patient and his/her progress and they immerse themselves in the emotional life of the patient, infringing the fundamental rules for maintaining the setting; at times they express the belief that their professional reputation depends on the outcome of the treatment.
Can't classify (CC)	As in AAI (Hesse, 1996). Interviews are assessed as CC when the patient or the therapist use during the interview two or more discorsive strategies indicating mental states that are mutually incompatible (distancing and preoccupied).

The PT-AAI can therefore be considered a "measurement" of the kind of mental state towards the therapeutic relationship developed in the analytic dyad. Starting from the equation *good alliance =secure base*, the PT-AAI can be considered at the same time an empirical application capable of embodying Bowlby's idea of "secure base" and also a tool to identify the type of alliance created. It goes without saying that the main aspect is that the PT-AAI takes into account and provides information on both the participants, showing that the state of mind towards the therapeutic relationship is the

result of the encounter between the relational styles of patient and therapist (see also De Bei, 2006; Lingiardi & De Bei, 2007; Speranza, 2006).

Quality of the patient's contributions and of the therapist's interventions: Analytic Process Scales *and* Adjustment Ratio

These are two tools created for process evaluation. The *Analytic Process Scales* (APS; Scharf, Waldron, Firestein, Goldberger, & Burton, 1999-2003) are a tool designed to assess the contributions of the patient and the therapist at the outset and in the course of an *analytic process* in the different kinds of psychotherapy. The APS consist of 36 scales, 14 for the patient, 4 for the rater and 18 for the therapist. Each scale is subdivided into 5 points, from 0 to 4, and assesses a different and independent dimension of the patient and the therapist's verbal and non verbal communication. The prerequisite for assessment with the APS is the presence of audio and videorecorders from which to obtain the transcripts of the sessions.

While they are a methodologically innovative tool, the APS are in line with tools that try to evaluate the therapeutic process in the belief that it is not enough to establish whether the therapy has been successful or not, nor whether or not it is analytic. The premises of the APS concern the need to identify the characteristics of the contributions by the patient and by the therapist *which prove to correlate with the outcome* and to consider the *analytic character of a therapy in terms of dimensions rather than categories* (Kernberg, 2004; Thomä & Kächele, 1987; Wallerstein, 1986). In other words, the APS basically try to respond to two questions:

1. What are the factors of patient and therapist that underlie the success or failure of a therapeutic process?
2. To what degree in a given therapy does one observe the establishment of an analytic process?

From the empirical point of view, the APS are inspired by some tools constructed previously to assess the analytic process or analytic aspects of psychotherapy work. These tools include the *Vanderbilt Psychotherapy Process Scales* (VPPS; O'Malley, Suh, & Strupp, 1983), the *Core Conflict Relational Theme* (CCRT; Luborsky & Crits-Christoph, 1998), the *Therapist Verbal Intervention Inventory* (TVII; Koenigsberg et al., 1985), the *Psychotherapy Process Q-Set* (PQS; Jones & Windolz, 1990), the *Adult Attachment Interview* (AAI; George, Kaplan, & Main, 1996), the *Computerized Referential Activity* (CRA; Mergenthaler & Bucci, 1997) and the *Psychodynamic Intervention Rating Scale* (PIRS; Cooper & Bond, 1992; Milbrath et al., 1999). The APS come with a long coding handbook that gives detailed instructions for the segmentation of sessions, a precise definition and a detailed explanation of each scale and the way it is applied, along with examples of contributions assessed at 0, 2 and 4 on each scale. The *interrater reliability* for the segmentation is around 80% even with no training. With additional training, the level of agreement related to the segmentation reached 95% with a kappa of .86 (Waldron et al., 2004a; Waldron, Scharf, Hurst, Firestein, & Burton 2004b). The kappa related to the coding of the scales is generally quite good, being on average .82 for the patient scales and .71 for those of the therapist (Waldron & Helm, 2004). It is important to consult the handbook every time a segment is coded; once one is familiar with the handbook, the coding of an average session takes less than a couple of hours. Let us see in greater detail the variables measured by the different scales.

As far as the patient's contribution is concerned, the APS makes it possible to assess, through 14 scales:

1-2) how clearly the patient communicates experiences that enable the assessor to identify his/her *conflicts* both inside and outside the therapeutic situation;

3-4) to what degree the patient manages to *reflect on him/herself* in such a way as to improve self-understanding both in relation to the therapist and in contexts outside therapy;
5-6) to what degree the *feelings* of the patient contribute to the perception that the assessor has of his/her experience in the segment, both in relation to the therapist and the therapeutic situation and in relation to other situations;
7) to what degree the patient talks about *romantic or sexual topics*;
8) to what degree s/he talks or manifests *assertiveness, aggressivity and hostility*;
9) to what degree s/he sees his/her own *emotional experiences /expressions* as a problem;
10) to what degree s/he refers to his/her own *development*;
11) how often issues arise related to *self-esteem*;
12) to what degree s/he responds in a *therapeutically useful way* to the therapist's comments;
13) to what degree there is psychological continuity between his/her communications and those earlier in the session or in previous sessions;
14) what is the *overall therapeutic productivity* of his/her contribution.

There are then 4 scales that the rater has to use with the therapist's interventions to assess to what degree, in his opinion, it would have been wise to intervene:

1. with an encouragement to elaborate,
2. with a clarification,
3. with an interpretation,
4. with support.

Lastly, the APS present 18 scales to apply to the therapist's contributions in order to assess to what degree the therapist:

1. encourages elaboration in the segment,
2. clarifies,
3. interprets,
4. offers support,
5. makes a contribution centred on defences,
6. is focused on the therapeutic relationship,
7. is focused on conflicts,
8. deals with romantic or sexual topics,
9. deals with the issues of the patient's assertiveness, aggressivity and hostility,
10. is focused on the patient's development,
11. is focused on the patient's problems of self-esteem,
12. makes a confronting contribution,
13. makes a contribution influenced or formed by his/her feelings,
14. makes a friendly contribution,
15. makes a hostile contribution,
16. makes a contribution that follows the patient's immediate psychological focus,
17. makes a contribution in continuity with the earlier interventions in the same session or in previous sessions,
18. makes a contribution that can be considered a good contribution.

The first results of the application of the APS to the study of the process study of three analytic psychotherapies (Waldron et al., 2004a; Waldron, Scharf, Hurst, Firestein, & Burton 2004b) show that the overall therapeutic productivity of the patient's communications presents a partial correlation (i.e. independent of the value assumed by all the other variables) that is positive and significant ($r =.44$ with $p < .05$) with the quality of the therapist's contributions in the segment immediately before. In other words, it is possible to formulate the hypothesis that good quality interventions by the therapist favour a better participation by the patient in the therapy. The implicit hypothesis in these studies, which has yet to be tested empirically, is that the overall therapeutic productivity of the patient's segments correlates positively and significantly to a successful outcome of the therapy.
Preliminary results obtained by using the APS show that (Gazzillo & Lingiardi, 2006):

1. The *quality of the therapist's contributions* correlates positively and significantly with the productivity of the patient's communications coming immediately afterwards (r = .35, p<.001).
2. The *quality of the therapist's contributions* correlates positively and significantly with the *quality of the patient's communications, coming immediately afterwards* (r = .74, p < .001).
3. This ratio remains positive and significant even if the influence of the therapist and patient's other factors is excluded 28, p < .001).
4. The *quality of the therapist's interventions* can be seen as a predictor of the quality of the patient's later contributions (F = 928,23, p < .001; r2 = .54).
5. The *quality of the patient's communications* correlates in a positive, significant way both with the High Functioning of the SWAP and with the patient's *level of global defensiveness*, measured with the DMRS (r = .64, p = .03).

The *Adjustment Ratio* (from now on AR) of the therapist's interventions concerning the the patient's defensive functioning (Despland, De Roten, Despars, Stigler, & Perry, 2001) can be considered an investigative methodology (more than an actual tool) designed to investigate the quality of the therapist's interventions, in the sense of adequacy of the therapist's interventions in view of the patient's level of defensive functioning. In such a methodology, the expressivity of the therapist's interventions is placed in relation to the level of defensive functioning. The strength of this methodology can, in our view, be summed up in two points:

1) the authors have created yet another new tool to assess the therapist's interventions[11] although they have managed to creatively combine the evaluations made with instruments already available such as the *Defense Mechanism Rating Scale* for the assessment of the patient's defensive functioning (Perry, 1990) and the *Pychodynamic Interventions Rating Scale* (Cooper & Bond, 1992) for the assessment of the therapist's interventions;

2) the AR represents the attempt to advance past an exclusively "quantitative" logic for the study of the therapist's specific factors moving towards a qualitative[12] type of logic through the joint study of the therapist (interventions) and of one of the patient's variables (level of defensive functioning) in relation to one variable of the patient/therapist couple (therapeutic alliance).

To calculate the AR of the interventions according to the methodology proposed by Despland, it is firstly necessary to assess the patient's defensive functioning through the DMRS and the therapist's interventions using the PIRS.
The DMRS divides the patient's defences into 7 categories ordered in a hierarchy from level 1 (highly immature defences) to level 7 (high-level defences). Similarly, Despland ordered the therapeutic interventions described in the PIRS scale according to the level of expressiveness of the interventions themselves.
This hierarchical scale called ESIL (Espressive Supportive Intervention Level) orders the therapist's interventions on 7 levels from the most supportive – level 1 – to the most expressive – level 7.

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[11] For a discussion of the proliferation of instruments in the field of psychotherapy research, see Dazzi (2006).
[12] For a more detailed critical examination of the methodology of investigating specific factors and in particular the therapist's interventions, see Colli (2006).

Interventions	ESIL (PIRS)	ODF (DMRS)
Interpretation of transference	7	7 Mature
Interpretation defences (levels 3-5)	6	6 Obsessive
Interpretation defences (levels 1-2)	5	5 Other neurotic
Questions, Clarifications, work-enhancing strategies	4	4 Narcissistic
Reflection	3	3 Denial
Supportive strategies Arrangement of contract	2	2 Borderline
Associations, Acknowledgement	1	1 Acting

The AR of the therapist's interventions is obtained by dividing the average expressive-supportive intervention level (ESIL) by the patient's overall defensive functioning (ODF):

$$AR = \frac{\text{Espressive-Supportive Intervention Level}}{\text{Overall Defensive Functioning}}$$

The AR level seems to be obtained in relation to the level of the therapeutic alliance (Despland, De Roten, Despars, Stigler, & Perry, 2001) but also in relation to the processes of rupture and repair of the therapeutic alliance (Colli & Lingiardi, 2006). In particular it seems important to point out that the AR level seems to correlate significantly not only with the therapeutic alliance as a whole but also with the level of the therapist's alliance (Colli, Di Meo, Di Pumpo, & Lingiardi, 2006). In these terms the AR could also be considered an indicator of the therapist's capacity to get himself onto the same wavelength as the patient and his resources.

Rupture and repair in the alliance: the Therapeutic Alliance Assessment Index - R

The Therapeutic Alliance Assessment Index *(Indice di Valutazione dell'Alleanza Terapeutica* IVAT (Colli & Lingiardi, 2002; Colli & Lingiardi, 2005) in its present version IVAT-R consists of two main scales, one devoted to the assessment of the patient's communications, the IVAT –P, and one devoted to the assessment of the therapist's communications, IVAT – T. The IVAT – P makes it possible to assess the patient's contribution to the therapeutic relationship both in quantitative and qualitative terms. On the qualitative plane the scale envisages the classification and identification of three types of communication by the patient: markers of direct Rupture (MD), markers of indirect Rupture (MI) and collaborative processes (PC). With the expression "Rupture marker" we refer to those aspects (behaviour, words etc) that can be indicative/predictive of a rupture, be it manifest or not, or at any rate of distress on the part of the patient concerning the therapy and/or the relationship with the therapist. Direct markers (MD) are explicit, direct, confronting communications, while indirect markers (MI) are non-explicit manifestations of withdrawal from the therapeutic relationship.
Examples of MD are when the patient expresses his lack of confidence in the therapeutic process and in his chances of changing, when s/he verbally attacks the therapist concerning his/her competence, human qualities, etc. Examples of MI are

when the patient visibly changes the subject to avoid getting onto stressful issues, when s/he dwells on subjects that are irrelevant to the therapy.

PC are communications by the patient that do not hinder the therapeutic process and that can in various ways make a positive contribution to it, in particular to the construction and/or maintenance of an adequate level of collaboration with the therapist.

In quantitative terms, the patient's communications are assessed according to a continuum from collaboration to non-collaboration , using a 7-point Likert scale (called LCP scale – or patient collaboration level scale) with a positive pole and a negative pole. By means of the IVAT – T scale, the therapist's interventions are assessed, being divided into two broad categories: interventions of problem solving – coded MR – which help the alliance with the patient to be set up or maintained, and negative interventions – coded IN – that make a negative contribution to the process and to the therapeutic relationship. MR may be attempts by the therapist to bring the patient's indirect rupture markers into the open, or empathic responses aimed at facilitating the patient in expressing negative feelings towards the therapist; they may be interventions designed to shift the patient's attention to the here-and-now of the relationship, interventions of clarification or confrontation, or simply aimed at maintaining a good alliance.

IN are interventions by the therapist that seem to make a negative contribution to the process. For instance, we consider it IN when the therapist seems to be competing with the patient, or appears confused about what stategies to adopt, or expresses him/herself in an obscure, incomprehensible way, etc.

The therapist's interventions are also assessed in quantitative terms based on their collaboration according to the Therapist Collaboration Level Scale –LCT Scale –, also with a 7-point scale with a negative and positive pole. Compared to the first version of the scale, the IVAT now also enables us to assess the patient's positive contributions to the therapeutic process and the therapist's negative ones[13].
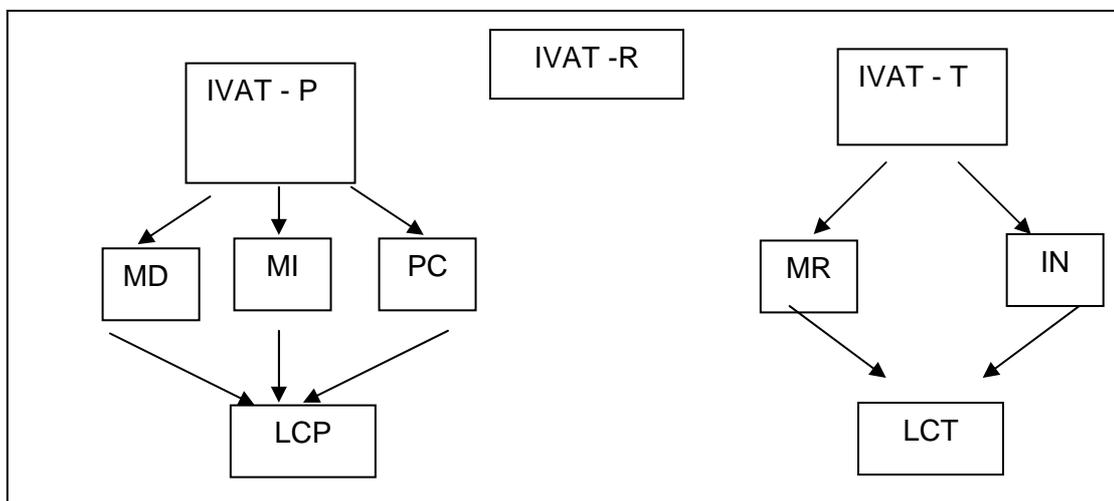
The creation of a new instrument to assess the therapeutic alliance on the basis of the transcripts of sessions or interviews arose both from the need to approach the construct through a less static vision (IVAT-R does not assess only the alliance as a whole, but also the process leading to its formation and rupture), and from the need to

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[13]The first data on the reliability and convergent validity of the scale show quite good levels of agreement among judges (ICC average .72 LCP scale; .73 LCT scale) (Colli & Lingiardi, 2005) and a strong correlation with the Bond scale of *Working Alliance Inventory* (Colli & Lingiardi, 2005).

study, at a microanalytic level, the "rhythm" of the therapeutic relationship in line with the theoretical models of a relational, intersubjective and cognitive-interpersonal type (Aron, 1996; Beebe & Lachmann, 2002; Mitchell, 2000; Safran & Segal, 1990; Stern, 2004). The emphasis on the text and microanalytic investigation through the study of the text in fact reflects the interest today in dialogue and reciprocal influence (Beebe & Lachmann, 2002; Siegel, 2002).

In conclusion

In this article, with the presentation of some instruments, we have tried to pull apart the elements making up the therapeutic relationship.

One comment is however necessary. Since researchers started to study psychotherapy in order to validate it empirically, their efforts have mainly been aimed at creating tools for research rather than at research itself (Kiesler, 1973). Hence the worrying proliferation of instruments of all kinds and for every construct often used for a single research project and exclusively at a local level (Dazzi, 2006).

In a contribution like the one you have just read, where research instruments are the focus of the discussion, one runs the risk of giving the idea that the object of study (psychotherapy) is identical to the tools used to study it. Ours, however, is not intended as a "shopping list" (Instruments to Use), but more as a grounded methodological proposal (which instruments? How to combine/integrate them?) addressed to a conceptual redefinition of the construct "therapeutic alliance" (Horvath, 2005).

Our multi-instruments approach – combining instrument to study related constructs (transference, countertransference, attachment, etc), on different materials (questionnaires, transcripts) and with different observational standpoints (observer, therapist, patient) – is intended to be a way of acknowledging the multidimensional nature of the therapeutic relationship.

With this approach, moreover, we can jointly study the technical elements (cfr. APS, Adjustment Ratio) and those more "specifically" relational (processes of rupture and repair, countertransference, etc.). Furthermore, the relational and personal variables of the participants in the relationship are indispensable factors for understanding how the "management" of technical factors comes about. In other words, if the literature indicates an "interdependence of technical and relational factors", then it is easier to think that "the meaning of each technical factor can be understood only in the relational context in which it is applied" (Safran & Muran, 2001, p. 166). Slightly more cautiously, but substantially in agreement, is also Horvath (2005, p. 6): "perhaps, with the progress of the dialogue between the conceptual and empirical levels, we will be able to get beyond the present dichotomy between relational Vs. technical elements, to reach an understanding of the relationship and the intervention as mutually co-determined".

In a relational context, technical factors can be seen as emerging from the therapeutic relationship – bringing the subjective and technical dimensions of the relationship even closer. In short, qualitatively "good" interventions will be the result of a qualitatively "good" relationship and vice versa.

Finally, empirically contextualizing the factors in the therapeutic relationship means no longer studying just the patient, but also the therapist, his/her personality, his/her way of participating in the relationship, of behaving etc. (Colli, 2006). At the empirical level, too, the therapist is no longer considered a "constant" , but a proper variable, largely responsible for the differences (or similarities) in therapy results.

The therapist is again the "protagonist" not only because s/he is at the centre of the empirical investigation in the study of the therapeutic relationship, but also as a tool, through his/her clinical opinion, of the research (see the questionnaire on countertransference presented in this article, or the systems of personality assessment like SWAP 200 which use the clinician as the source of information).

A certain "paucity of results" that has long characterized psychotherapy research is not due to problems purely of methodology, but also of dialogue, meaning the need for

greater cooperation between the three areas, conceptual, clinical and empirical, through which one can study not only the therapeutic relationship, but psychotherapy as a whole. The way intermediate variables, such as the type of attachment between patient and therapist, the management of technical interventions, the relation between these and the use made of them by the patient etc., interact with each other to determine the observed quality of the relationship, is a central element not only to understand how the alliance is formed, but also to provide a coherent conceptual framework in which to read and interpret the empirical data available today.

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