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The relationship between patient object relations and the therapeutic alliance in a naturalistic psychotherapy sample^{*}

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Abstract

Objectives. This study examined the relationship between patients' object relations and interpersonal process in psychotherapy. Namely, we tested the hypothesis that the quality of patients' object relations is positively associated with both patient- and therapist-rated alliance quality. **Design.** Psychotherapy was administered naturalistically, with quantitative data collection before and during treatment. **Methods.** Participants included 73 adult outpatients and 23 therapists at two mental health clinics. Using the Bell Object Relations and Reality Testing Inventory, we measured 4 dimensions of patients' object relations at baseline—alienation, insecure attachment, egocentricity, and social incompetence. Using the Working Alliance Inventory, we measure alliance from patient and therapist perspectives. Control variables included time, patient demographics, symptom severity, and clinic. We employed hierarchical linear modeling to analyze data with a nested structure, with 138 sessions at level 1, 73 patients at level 2, and 23 therapists at level 3. **Results.** Patient alienation and insecure attachment were associated with lower patient-rated alliance, while egocentricity was associated with higher patient-rated alliance. Patients' object relations were not significantly associated with therapist-rated alliance. On average, patients perceived the alliance more positively than their therapists, with a weak positive correlation between the alliance perspectives. **Conclusions.** The results suggest that object relation dimensions may be important patient characteristics for forecasting therapeutic relationship quality. They also call for more attention to differences between alliance rating perspectives.

Keywords: alliance, patient object relations, alienation, insecure attachment, egocentrism, social incompetence, hierarchical linear modeling.

Practitioner points

- Treatment may benefit from more attention to the quality of patients' object relations.
- If patients present with high levels of alienation and insecure attachment, therapists may need to pay especially close attention to the therapeutic alliance, and prudently address any ruptures in its quality.
- When monitoring the alliance quality, it is important to consider that patients and therapists may have different perspectives. Therapists relying solely on their own perceptions are at risk of missing alliance difficulties, and patients' object relations may be uniquely predictive of their own sense of the alliance. Therefore, it may be helpful to ask patients in session and through standardized measures for feedback on how they perceive the goals and tasks of treatment and the emotional bond with their therapist. Again, any alliance tensions could then be addressed directly as a means to maintaining engagement in the service of better outcome.

The quality of the patient-therapist relationship has long been considered an important psychotherapeutic ingredient across most theoretical orientations (Constantino, Castonguay, & Schut, 2002; Hill & Knox, 2009). Amidst the various theory-specific alliance definitions that developed since Freud's (1912) early conceptions of the psychotherapy relationship, Bordin (1979, 1994) proposed a landmark pantheoretical conceptualization centered on the patient and therapist's agreement on treatment goals, their agreement on treatment tasks, and the quality of their emotional bond. Bordin viewed the alliance as a central treatment factor that allows the patient to engage genuinely in the psychotherapeutic process and to reap its benefits.

Empirically, the alliance has become the most widely studied aspect of the treatment process across different psychotherapies and psychological conditions (Castonguay, Constantino, & Holtforth, 2006; Crits-Christoph & Connolly Gibbons, 2003). Such work has demonstrated that the alliance is positively related to a broad range of treatment outcomes, including symptom reduction, improvement in interpersonal functioning, global ratings of success, and improvement in target complaints (Castonguay et al., 2006; Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000). Furthermore, multiple studies have demonstrated that alliance quality relates to *subsequently* rated outcome even after controlling for *prior* change on the outcome measure (Arnou et al., 2013; Klein et al., 2003); this is the most stringent test of the alliance-outcome correlation in that it suggests that the alliance precedes, versus solely results from, symptom improvement.

Although both patient and therapist ratings have been linked with outcome, their ratings of the same relationship context often diverge (Castonguay et al., 2006). This is perhaps not surprising considering the inherent asymmetry in the psychotherapy relationship (Markin et al., 2014). Supporting this notion empirically, therapist and patient alliance ratings tend to be only

moderately correlated with one another at best (Horvath et al., 2011; Tryon, Blackwell, & Hammel, 2007). Thus, it makes sense to assess the alliance from multiple perspectives and, given that both perspectives relate to outcome, to examine correlates of both perspectives (which could conceivably differ).

In this vein, the extant literature shows that both therapists and patients contribute to alliance quality and negotiation. For example, therapist characteristics, such as being warm, honest, respectful, flexible, supportive, empathic, interested, congruent, and open are associated with a positive alliance (Ackerman & Hilsenroth, 2003; Constantino, Castonguay, Zack, & DeGeorge, 2010). On the other hand, therapist's rigidity, criticalness, inappropriate self-disclosure, and self-directed hostility have been associated with alliance difficulties (Ackerman & Hilsenroth, 2001; Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010).

Patient characteristics, both intrapsychic and interpersonal, are also associated with the alliance. At the intrapsychic level, patients' positive expectations for improvement, motivation for treatment, emotional involvement in treatment, and psychological mindedness have been found to relate positively to alliance quality, while their avoidance, perfectionism, and depressogenic beliefs have been found to relate negatively to alliance quality (Constantino et al., 2010). Interpersonally, patients with more global interpersonal problems have more difficulty developing a positive alliance in treatment. More specifically, patients who are overly resistant, cold, hostile, defensive, or negativistic have worse psychotherapy relationships than patients who are warmer, more affiliative, and more engaged (Constantino et al., 2010).

Inasmuch as psychotherapy involves an interpersonal process, it also is reasonable to expect that patients' object relations would have a bearing on the therapeutic relationship (Le Bloc'h, de Roten, Drapeau, & Despland, 2006). Object relations are mental representations of

self and others, which appear to originate early in life and influence how one thinks, feels, and acts toward self and others (Blatt, 1974; Bowlby, 1969; Huprich & Greenberg, 2003; Jacobson, 1964; Kernberg, 1976). According to object relations theory, these mental representations are created in interpersonal transactions that begin with the infant-caregiver relationship, are constructed and revised over the life cycle, and have conscious and unconscious cognitive, affective, and experiential components (Blatt & Auerbach, 2003; Blatt, Auerbach, & Aryan, 1998). Object relations are postulated to derive from and, in turn, to determine the experience of the self in an interpersonal environment (Jacobson, 1964). Key aspects in the development of healthy object relations include the capacity to establish and maintain a sense of separateness between self and other, the capacity to establish and maintain consistent emotional relationships with significant others, and a consolidated, cohesive, and stable representation of oneself (Blatt, 1974, 1995).

According to Bell (1995), object relations deficits can be grouped into four dimensions: alienation, insecure attachment, egocentricity, and social incompetence. High alienation reflects difficulty trusting others, establishing intimacy in relationships, and connecting emotionally. Persons with insecure attachment are hypersensitive to rejection, easily hurt by others and desperately seek close relationships. Nevertheless, they may perceive security threats and distance themselves from others. Individuals with high egocentricism tend to perceive others' existence only in relation to themselves, and are demanding, manipulative, and controlling. Finally, persons with high social incompetence tend to be shy, socially anxious, and have difficulties making friends. Bell theorized that difficulties in any of these dimensions would pose challenges for the psychotherapeutic relationship.

There is some preliminary evidence to support Bell's (1995) assertion. For example, in a sample of 40 adult psychotherapy patients, higher patient alliance ratings were significantly related to higher quality of object relations, as assessed through patients' narratives during an initial psychoanalytic interview (Ryan & Cicchetti, 1985). In a second study of 64 adults receiving short-term dynamic psychotherapy, patients who were assessed through an interview as having high quality of object relations had better patient and therapist-rated alliance than those with low quality objects relations (Piper et al., 1991). In addition, a third study of 42 adult psychotherapy patients found that those with higher quality of object relations, assessed through an open-ended description of the patient's mother during an interview, engaged with their therapist in the task of self-improvement, while patients with a lower quality of object relations related to their therapist in a way that helped manage their intrapsychic needs and expressions of anger, but not in a way that helped them work meaningfully toward self-improvement (Honig, Farber, & Geller, 1997). Even though these studies did not use standardized measures of object relations, they support the idea that as quality of object relations increases, the capacity to have a more mature representation of the therapist, as manifested in alliance quality, also increases.

Studies of early memory narratives also suggest that a person's representations of self and others play a significant role in alliance development. For example, in a sample of 57 patients in psychodynamic psychotherapy, those who reported a stronger alliance exhibited greater complexity, differentiation, and interrelatedness of self and other in their early memory narratives (Pinsker-Aspen, Stein, & Hilsenroth, 2007).

In addition to research focused on object relations, studies focused on the attachment construct provide indirect but converging support for the association between object relations and the alliance. In a systematic review, Smith, Msetfi, and Golding (2010) concluded that even

though there are inconsistencies in the measurement and conceptualization of attachment and the alliance, the evidence suggests that patients who report having a more secure attachment pattern are more likely to report stronger alliances than those with attachment insecurities. Further supporting this perspective, a recent meta-analysis of the relation between adult patients' attachment style and the working alliance revealed an inverse correlation between the alliance and both attachment avoidance and attachment anxiety (Bernecker, Levy, & Ellison, 2014). Thus, even though there may be some inconsistencies between individual studies on the attachment-alliance link, the aggregated empirical effect is clinically significant for aspects of attachment.

Despite the converging evidence for a positive association between object relations (and, indirectly, attachment) and the alliance, the evidence is not conclusive. Two studies that used the Bell Object Relations and Reality Testing Inventory (BORRTI; Bell, 1995) and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) did not find a significant association between quality of object relations and patient-rated alliance (Goldman & Anderson, 2007; Mallinckrodt et al., 2005). It is possible that the small sample size precluded the ability to find significant results in these studies: the first study had a sub-sample of 30 patients, and the second study had a sample of 44 patients. Furthermore, several other shortcomings characterize the empirical literature: the studies that provide evidence for a significant relation use measures of the alliance and/or object relations that are not well known or are study-specific, making their findings difficult to compare across studies; none of the aforementioned studies controlled for therapist variability; and most of the studies have either the therapist or patient as the alliance rater, but not both.

The current study examined the relation between object relations and alliance quality using well-known measures of both constructs and addressed prior studies' shortcomings by taking into account therapist differences and patient characteristics and assessing the alliance from both patient and therapist's perspective. We hypothesized that the quality of patients' object relations would be positively associated with both patient- and therapist-rated alliance.

Method

Participants

Participants were 73 adult outpatients receiving naturalistically delivered psychotherapy (i.e., no researcher control over the type or length of the treatment administered or the supervisory oversight) from 23 therapists at one of two university-based mental health clinics in Massachusetts, USA. Twenty-three patients were treated at clinic 1 and 50 at clinic 2. All patients were new referrals at clinic 1, while at clinic 2, 25 were new referrals and 25 were newly transferred to a new therapist within the same clinic. The institutional review boards of both universities approved the study, and all participants were treated in a manner that complied with the ethical standards of the American Psychological Association (2002).

Measures

Object relations. Patients self-reported on their own object relations according to Form O of the BORRTI, which consists of 45 "true" or "false" statements (Bell, 1995). The BORRTI yields T-scores of four object relations' subscales: alienation, insecure attachment, egocentricity, and social incompetence, for which higher scores reflect greater object relations' deficits, ranging from 30 to 80. Factor analysis has revealed that each subscale reflects a distinct object relations' dimension (Bell, 1995). Furthermore, the BORRTI has been shown to possess adequate psychometric properties, with Cronbach's alpha in the good to excellent range for all

subscales (Bell, 1995; Kline, 1999). In our sample, alphas for the subscales were all in the acceptable to excellent range as follows: alienation (.83), insecure attachment (.79), egocentricity (.92), and social incompetence (.71).

Therapeutic alliance. The short form of the WAI was used to assess alliance quality from patients' and therapists' perspectives (Hatcher & Gillaspay, 2006; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989). This pantheoretical instrument, which is comprised of 12 items rated on a 7-point scale from 1 ("never") to 7 ("always"), assesses Bordin's (1979, 1994) three proposed alliance dimensions: agreement on treatment goals, agreement on treatment tasks, and the quality of the emotional bond. Given that several studies have demonstrated high correlations among the WAI subscales (Klein et al., 2003) and that the subscales do not necessarily predict improvement beyond the global alliance factor (Hatcher & Barends, 1996), we only calculated the total WAI score. Total alliance scores range from 12 to 84, with higher scores indicating better alliances. The patient and therapist versions of the WAI have yielded high internal consistency (Horvath & Greenberg, 1989). In the current study, Cronbach's alpha for the patient version was good (.87), and for the therapist version it was excellent (.93).

Control Variables. Patients' global impairment at baseline was assessed using the DSM-IV-TR GAF score (American Psychiatric Association, 2000), which was rated by the patient's treating clinician. The GAF has demonstrated adequate reliability, with an intraclass correlation coefficient of .81 (Söderberg, Tungström, & Armelius, 2005). GAF scores can range from 0 to 100, with higher scores reflecting less severe symptomatology and higher levels of functioning. Patients' demographic information was collected using the Treatment Outcome Package Consumer Registration Form (Behavioral Health Laboratories, Inc., 2007). Because the sample was small, ethnicity was recoded into a categorical variable (0 = non-ethnic minority, 1 = ethnic

minority). We also controlled for time (session number), transfer status (0 = new patient, 1 = transferred patient), and clinic (0 = clinic 1, 1 = clinic 2). Patient demographic information was collected with a short self-report questionnaire that included gender, ethnicity, age, and income. Finally, therapists completed a questionnaire that included demographic information (gender, ethnicity, and age) and theoretical orientation (identification with cognitive, psychodynamic, behavioral, humanistic/existential, and systems theories, all measured on a continuous scale).

Procedure

Patients and therapists in the two clinics were invited to participate in the study by research assistants and the first author, respectively. All participants reviewed a consent form, received information about confidentiality, and were told that the other person in the therapeutic dyad would not have access to any of the information provided by them during the study. Approximately 79% of the individuals invited to participate in the study agreed to do so.

Once participants provided written consent, they completed the BORRTI at baseline. WAI data were collected from therapists and patients after sessions 1, 3, 7, 15, and 30. Patients who entered the study close to the end of the data collection period only completed the WAI at earlier sessions. During the study period, the number of attended sessions ranged from 1 to 31, with an average of 6.40 ($SD = 7.99$). On average, data were reported for each patient on 1.89 sessions, which yielded a total of 138 sessions for all patients. Only one patient finished treatment before the study ended. All patients were offered a small gift as compensation after completing the BORRTI. Therapists did not receive any compensation for participating in the study.

Analytic strategy

Outliers, with z-scores larger than ± 3.29 , were transformed by replacing their raw score value with the next highest or lowest value as recommended by Tabachnick and Fidell (2001). Missing data were imputed through a single deterministic imputation in STATA (StataCorp, 2007).

We used hierarchical linear modeling (HLM) to analyze the relation between object relations and the alliance, controlling for patient global impairment, transfer status, demographic variables, therapist differences, and clinic (Raudenbush & Bryk, 1992). An advantage of HLM is that it extends multiple regression analyses for different levels of data, making it suitable for nested data structure. In this study, sessions at level 1 were nested within patients at level 2, who were nested within therapists at level 3 (see Figure 1). Having therapists at level 3 allowed us to control for unobserved differences between therapists (e.g., different personalities and therapeutic styles), which would not be possible with a one level multiple regression. Another advantage of HLM is that it allows analysis of data when not all individuals have the same number of observations and when the time between data collection varies between individuals (Tasca & Gallop, 2009). Because the WAI was not always collected during the exact session for which it was planned, the actual session during which it was collected was included in the model as a predictor (time) in order to control for the effect of time. In the HLM models, all continuous variables were grand mean centered and all categorical variables remained uncentered.

Singer and Willett (2003) have suggested building sequences of models from simpler to more complex. Following these suggestions, we developed two sequences of models, one for patient-rated alliance and another for therapist-rated alliance. We began by building base models including the alliance as outcome, with no predictors at any level. Estimating these base or null

models with only random components allowed us to decompose variance in therapeutic alliance across levels. In the unconditional model for patient-rated alliance, 32.79% of the variance was between sessions or over time (level 1), 64.79% between patients (level 2), and was not statistically significant between therapists (level 3). In the unconditional model for therapist-rated alliance, 37.01% of the variance was between sessions, 10.05% between patients, and 52.94% between therapists.

Next we built conditional intercept models, including alliance as outcome and object relations as level 2 predictors. Then we built unconditional linear, quadratic, and cubic models, including alliance as outcome and time as a level 1 predictor. Because the quadratic and cubic effects of time were not significant in either model, they were dropped. Subsequently, we built conditional linear models, including controls at the 3 levels: time at level 1, patients' object relations and patient control variables (gender, age, ethnic minority status, family income, GAF score, and transfer status) at level 2, and clinic where therapists provided treatment at level 3. Even though we measured some therapist characteristics (level 3), such as age, gender, quality of object relations, and years of clinical experience, we did not control for these variables due to our small therapist sample size. Finally, we trimmed the models by dropping control variables that were non-significant in either model. The equation for these final models was:

$$\text{Alliance}_{tij} = g000 + g010 * \text{GAF}_{ij} + g020 * \text{Alienation}_{ij} + g030 * \text{Insecure Attachment}_{ij} + g040 * \text{Egocentrism}_{ij} + g050 * \text{Social Incompetence}_{ij} + g100 * \text{Time}_{tij} + r0ij + u00j + etij, \text{ with alliance rated by both patients and therapists.}$$

Results

Of the 73 patients, 64.38% were female and 78.08% were White. The average age was 27.53 years ($SD = 7.78$ years) and the median family income was \$25,000.00, ranging from

\$5,000.00 to \$187,000.00. Regarding patient object relations, on average, they presented with moderate levels of alienation ($M = 56.74$, $SD = 9.65$), insecure attachment ($M = 55.52$, $SD = 9.00$), egocentricity ($M = 52.07$, $SD = 7.31$), and social incompetence ($M = 52.32$, $SD = 8.34$). The average GAF score was 62.10 ($SD = 6.36$), which is considered mild to moderate impairment. With regard to *DSM-IV-TR* diagnoses, 59.09% of patients met criteria for a mood disorder, 42.42% for an anxiety disorder, 10.61% for an adjustment disorder, 10.61% for a substance abuse disorder, 9.09% for an eating disorder, 4.55% for a disorder usually diagnosed in childhood or adolescence, 6.06% for a V-code diagnosis, 3.03% for a somatoform disorder, 4.55% for a personality disorder, and 3.03% for a sexual and gender identity disorder. Five percent of patients did not meet criteria for any *DSM-IV-TR* disorder and 59.09% met criteria for two or more diagnoses. *T*-tests revealed no significant differences between clinics on any patient characteristics.

Of the 23 therapists, 55.80% were female and 53.57% were White. The average age was 30.83 years ($SD = 4.33$ years). Twenty of the 23 therapists were enrolled in a clinical psychology doctoral program and the remaining three were studying social work; all were supervised by licensed therapists. At the beginning of the study, therapists had been in clinical training for an average of 2.74 years ($SD = 2.04$ years). *T*-tests revealed no significant differences in therapists' demographic characteristics and training experience between the two clinics. However, a significant and large effect size (Cohen, 1992) was found for the difference of theoretical orientation influences between the clinics. Compared with clinic 2, therapists at clinic 1 reported that their practice was guided more by cognitive theory (diff = 1.12, $t(18) 2.46$, $p = .02$; $d = 1.03$) and less by psychodynamic theory (diff = -2.96, $t(18) -4.52$, $p < .001$; $d = 2.46$). Descriptive statistics for all study variables at each level are presented in Table 1.

The correlation between patient and therapist alliance ratings at each session was small, but statistically significant ($r = .24, p = .05$; see Figure 2). Examination of the average alliance across time for each dyad revealed that patients' ratings were significantly higher than therapists' ratings by an average of 4.54 points ($\text{diff} = 4.54, t(72) 4.23, p < .001, d = .61$), which is considered a medium effect size (Cohen, 1992).

Table 2 presents the results of the final HLM models. Results in the left column suggest that patient alienation, insecure attachment, and egocentricity are significantly associated with patient-rated alliance. As hypothesized, higher alienation ($g020 -.33, t(45) -2.15, p = .04$) and higher insecure attachment ($g030 -.21, t(45) -2.57, p = .01$) were associated with more negative patient-rated alliance. Contrary to our hypothesis, higher egocentricity was associated with more positive patient-rated alliance ($g040 .44, t(45) 2.40, p = .02$) and patient-rated alliance was not significantly associated with social incompetence ($g050 .14, t(45) 1.34, p = .19$), time ($g100 .01, t(41) .21, p = .83$), or GAF ($g010 .22, t(45) 1.93, p = .06$).

Results in the right column of Table 2 suggest that, contrary to our hypotheses, patient alienation ($g020 .07, t(67) .74, p = .46$), insecure attachment ($g030 .05, t(67) .74, p = .46$), egocentricity ($g040 -.09, t(67) -.74, p = .46$), and social incompetence ($g050 -.001, t(67) -.01, p = .99$) were not significantly associated with therapist-rated alliance. Control variables suggest a significant linear increase in therapist-rated alliance over time ($g100 .21, t(131) 2.93, p < .01$) and a positive significant association between patient global impairment and therapist-rated alliance (GAF; $g010 .27, t(67) 3.96, p < .001$).

The bottom of Table 2 reports random unexplained variance in therapeutic alliance and the percentage of variance explained by our models. Compared to a null model with random components and no independent variables, the final model for patient-rated alliance explained

15.57% of the variance between patients, while our final model for therapist-rated alliance explained 33.51% of the variance between patients and 9.50% of the variance between therapists.

Discussion

This study examined the association between patients' object relations and both patient- and therapist-rated alliance. The main findings were as follows: (1) There was low agreement within the therapeutic dyad on how each member perceived the alliance, with patients perceiving it more positively than their therapists; (2) patient alienation and insecure attachment were negatively associated with patient-rated alliance, but patient egocentricity was positively associated with patient-rated alliance; and (3) no patient object relation dimension was significantly related to therapist-rated alliance.

Differences between alliance rating perspectives, and a more positive outlook on the alliance by patients as compared to therapists, have been previously reported in research focusing on early treatment (Horvath et al., 2011). It seems important to keep in mind that the therapeutic relationship involves at least two people who may have different subjective experiences of their relationship and their work together. This might be partly due to their differing social roles, expectations, needs, and the asymmetry of the therapeutic relationship (Horvath & Bedi, 2002; Markin et al., 2014). It may also be explained by our finding that for both patients and therapists, alliance perception is mostly dependent on variability at the level of the perceiver rather than the other person in the dyad. This makes theoretical sense considering that object relations determine the experience of the self in an interpersonal environment (Blatt & Lerner, 1983; Bowlby, 1988; Jacobson, 1964). Due to the likely discrepancies in patients and therapists' experience of their relationship, it may be helpful that they metacommunicate about their experiences as the treatment process unfolds (Safran & Muran, 2000).

Even though we did not test directly whether rating perspective moderated the relation between object relations and the alliance, we did find different results depending on rating perspective. Object relations appear to be associated with patient-rated alliance, but not to therapist-rated alliance. Furthermore, object relations are associated with patient-rated alliance in complex ways. As hypothesized, patients' greater alienation and insecure attachment are associated with lower patient alliance. Because healthy object relations involve the capacity to establish and maintain a sense of separateness between self and other, consistent emotional relationships, and cohesive and stable representations of oneself, it is not surprising that certain patients' object relations predicted how patients perceived their relationship with their therapist. These findings are consistent with Bell's (1995) description of patients with high alienation experiencing lack of trust in relationships and having difficulties with intimacy, and patients with high insecure attachment being sensitive to rejection, concerned about being liked and accepted by others, and fearing abandonment. They are also consistent with the empirical evidence demonstrating that secure attachment predicts a stronger alliance perception (Smith et al., 2010).

Contrary to our hypothesis, greater egocentricity was associated with a more positive patient alliance perception. This finding is surprising considering Bell's (1995) description of patients with high egocentricity as mistrusting others' motivations and having a tendency to feel humiliated and defeated by others. However, it is possible that because of their egocentricity these patients tend to have a more positive perception of their own ability to establish positive relationships, and of how others perceive them.

The fourth dimension of object relations, social incompetence, was not significantly associated with patient- or therapist-rated alliance. Although less socially competent patients tend to have more difficulty establishing satisfactory relationships, this may be counterbalanced

by their greater appreciation of the relationship that they do establish with the therapist. These patients may also be more protective of the relationship with their therapist and, thus, avoid reporting negative feelings about it. In the case of patients with severe mental illness and a history of trauma, it has been reported that PTSD symptoms significantly predict alienation, insecure, attachment, and egocentricity, but not social incompetence (Chapleau, Bell, & Lysaker, 2014). It is possible that traumatic experiences could be an underlying mechanism that disrupts the therapeutic alliance, impacting certain aspects of object relations more than others. Finally, it is important to note that, on average, patients' egocentricity and social incompetence scores were lower than their alienation and insecure attachment scores. Thus, it is possible that restricted range in egocentricity and social incompetence scores may partly explain their unexpected positive association and lack of association, respectively.

The finding that patients' greater alienation and insecure attachment were associated to worse patient alliance perception supports previous findings of a significant relation between patient object relations and patients' alliance perception (Pinsker-Aspen et al., 2007; Piper et al., 1991), and are inconsistent with studies that failed to find a significant link (Goldman & Anderson, 2007; Mallinckrodt et al., 2005). In the case of Goldman and Anderson's study, most of their effects, although not statistically significant, were in the same direction as our study. It should also be noted that the current findings are consistent with studies reporting that patients' global interpersonal problems, resistance, coldness, hostility, defensiveness, negativistic thinking, and attachment pattern relate negatively to alliance quality (Constantino et al., 2002; Constantino et al., 2010; Parish & Eagle, 2003).

Counter to our hypothesis, and Piper et al. (1991) findings, patients' object relations were not significantly associated to therapists' alliance perceptions. Since Piper et al. assessed object

relations through an interview, it is difficult to compare their findings directly to ours.

Nevertheless, from a clinical perspective, we can speculate reasons we did not find a significant association. It is likely that therapists adapted their expectations of the alliance according to their patients' relational difficulties, and that they focused on working through their patients' interpersonal problems. In this scenario, a therapist's assessment of their collaborative working relationship with their patients might be less affected by object relation-related deficits.

A non-hypothesized finding was that less severe patient impairment was associated with more positive therapist-rated alliance; however, impairment was not associated with patient-rated alliance. This finding may be partly explained by a self-fulfilling prophecy, where therapists are biased to perceive patients with more severe impairment as more challenging and less gratifying to work with. Previous research also has arrived at mixed results about the relation between symptom severity and the alliance (Horvath & Bedi, 2002), so our results, while not hypothesized a priori, are not necessarily surprising.

A greater number of sessions was associated with a more positive psychotherapist-rated alliance, while patient-rated alliance remained stable across session number. These results suggest that, as members of the dyad get to know each other better, therapists tend to have a more positive impression on the level of agreement on the goals and tasks of treatment, and feel a greater emotional bond with their patients. Why isn't the same true for patients? One possibility is that there may be a ceiling effect because patients' perception of the alliance starts higher. It is also possible that at the same time that patients' become more comfortable in therapy and get to know the therapist better, they start getting into more difficult psychotherapy material, which could negatively affect their alliance perception. Another possibility is that psychotherapists expect the alliance to improve as the therapeutic process develops and this

tendency biases their increasingly positive perceptions of the relationship. Patients, on the other hand, are likely to be less biased by theory and expectations, thus possibly rendering their perceptions as more stable. It is important to note that for this study most of the alliance data were collected early in treatment; thus, the results may not be representative of what happens later in treatment.

Limitations of this study suggest caution in interpreting the results, but they also point to directions for future research. Because measures of the alliance and object relations consisted of self-report, this created a problem of shared method variance. Having two raters of the alliance helped to partly address this problem, but future research could also include therapists' assessment of patients' object relations (as noted, we collected therapist object relations data, but had too little power at the therapist level to include these data in our analytic models). In addition, the fact that both patient object relations and alliance were self-reported may account for the finding that patients' object relations predicted patient-rated alliance, but not therapist-rated alliance. Also, **As hypothesized, patients' greater alienation.** Future research could include observer ratings of the alliance, add a measure of object relations that is not self-report, and measure patient symptomatology. Even though larger than in many similar studies, our relatively small sample may have prevented us from finding significant results for small effects. Finally, our therapists had little clinical experience and most patients in our sample had mild to moderate impairment. We recommend that future studies have a larger sample, assign research-oriented ratings of impairment, and include experienced therapists and patients with more severe symptomatology. In addition, future work could focus on the relation between object relations and the alliance across the full trajectory of treatment and assess whether therapist object relations influence the alliance.

Our study followed a naturalistic design, with data collection at two training clinics, a setting that has been recognized as ideal for integrating science and practice and the production of clinically meaningful research (Borkovec, 2004). Several clinical implications can be drawn from the results of our study in conjunction with previous literature. Given that object relations is associated with patients' alliance perception, and a positive alliance appears important for positive therapy outcome (Castonguay et al., 2006; Horvath et al., 2011), it may be important to consider the quality of object relations for treatment planning and during ongoing treatment. For patients who present higher levels of alienation and insecure attachment, it may be especially important to monitor the alliance and to repair alliance ruptures promptly. It may be helpful to openly discuss possible alliance difficulties even before they emerge with patients, as a way to maintain engagement and to prevent drop out. Asking patients in session how they feel about their relationship with the therapist and the therapy process, as well as collecting alliance data through standardized measures, can help detect possible alliance difficulties in a timely fashion. It is important to note that repairing alliance ruptures not only prevents dropouts, but can also help restructure the patient's relational schemas (Safran & Muran, 2000). As Horvath and Bedi (2002) noted, an essential challenge for therapists is progressively negotiating the quality of the relationship. This is especially relevant considering the low agreement within the therapeutic dyad about therapy goals and tasks, and the quality of the emotional bond. If therapists rely solely on their own alliance perceptions, it is likely that they will miss opportunities to recognize when a patient is struggling with the therapeutic relationship.

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Table 1

Descriptive Statistics for Study Variables

| Variable Name | <i>M</i> / % | <i>SD</i> | Minimum | Maximum |
|---------------------------|--------------|-----------|---------|-----------|
| Level 1 (<i>N</i> = 138) | | | | |
| Time | 5.04 | 6.55 | 1.00 | 31.00 |
| Alliance Patient | 61.06 | 7.33 | 37.00 | 82.00 |
| Alliance Therapist | 57.17 | 7.73 | 37.00 | 72.00 |
| Level 2 (<i>N</i> = 73) | | | | |
| Alienation | 56.74 | 9.65 | 37.00 | 76.00 |
| Insecure Attachment | 55.52 | 9.00 | 36.00 | 74.00 |
| Egocentricity | 52.07 | 7.31 | 40.00 | 65.00 |
| Social Incompetence | 52.32 | 8.34 | 41.00 | 71.00 |
| Male | 35.62% | 0.48 | 0.00 | 1.00 |
| Age | 27.53 | 7.78 | 19.00 | 54.00 |
| Ethnic minority | 21.92% | 0.42 | 0.00 | 1.00 |
| Income | \$38,066 | \$42,090 | \$5,000 | \$187,000 |
| GAF | 62.10 | 6.36 | 50.00 | 80.00 |
| Transfer | 34.25% | 0.48 | 0.00 | 1.00 |
| Level 3 (<i>N</i> = 23) | | | | |
| Clinic 2 | 30.43% | 0.47 | 0.00 | 1.00 |

Table 2

*HLM Models of Object Relations Predicting Patient- and Therapist-rated Alliance:**Unstandardized Coefficients and Standard Errors*

| Alliance | Patient-rated | | Therapist-rated | |
|---------------------|-----------------------------|-------------------------|-----------------------------|-------------------------|
| Intercept | | | 57.24*** (1.21) | |
| Objects relations | | | | |
| Alienation | 60.98*** | (0.78) | 0.07 (0.09) | |
| Insecure Attachment | -0.33* | (0.15) | 0.05 (0.07) | |
| Egocentricity | -0.21* | (0.08) | -0.09 (0.11) | |
| Social Incompetence | 0.44* | (0.18) | 0.00 (0.10) | |
| Control variables | | | | |
| Time | 0.01 | (0.06) | 0.21** (0.07) | |
| GAF score | 0.22 | (0.12) | 0.27*** (0.07) | |
| Variance components | Patient-rated | | Therapist-rated | |
| | Random Unexplained Variance | % of Variance Explained | Random Unexplained Variance | % of Variance Explained |
| Level 1: sessions | 19.01 (4.36) | 5.00% | 17.85 (4.22) | 12.71% |
| Level 2: patients | 31.72*** (4.36) | 15.57% | 3.69*** (1.92) | 33.51% |
| Level 3: therapists | 0.14 (0.02) | 90.14% | 26.47*** (5.14) | 9.50% |
| Deviance | 895.46 | | 852.90 | |
| Parameters | 10 | | 10 | |

Note. Estimation of fixed effects using robust standard errors.

*** $p < .001$, ** $p < .01$ * $p < .05$.

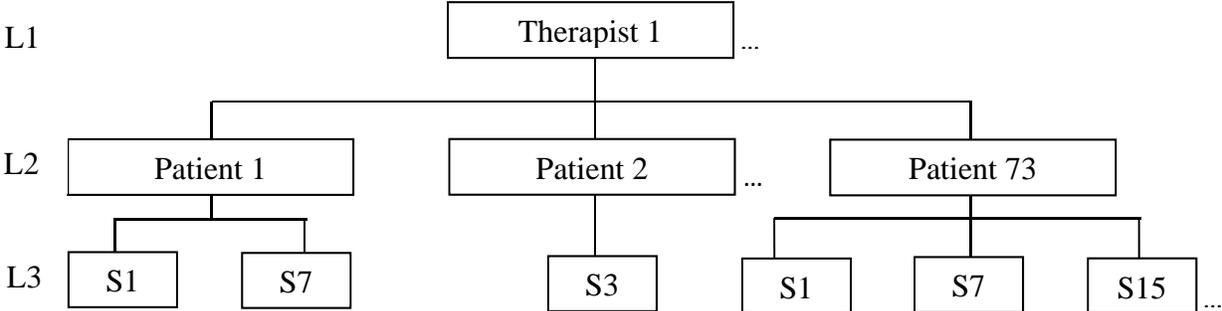


Figure 1. Three-level nested data.

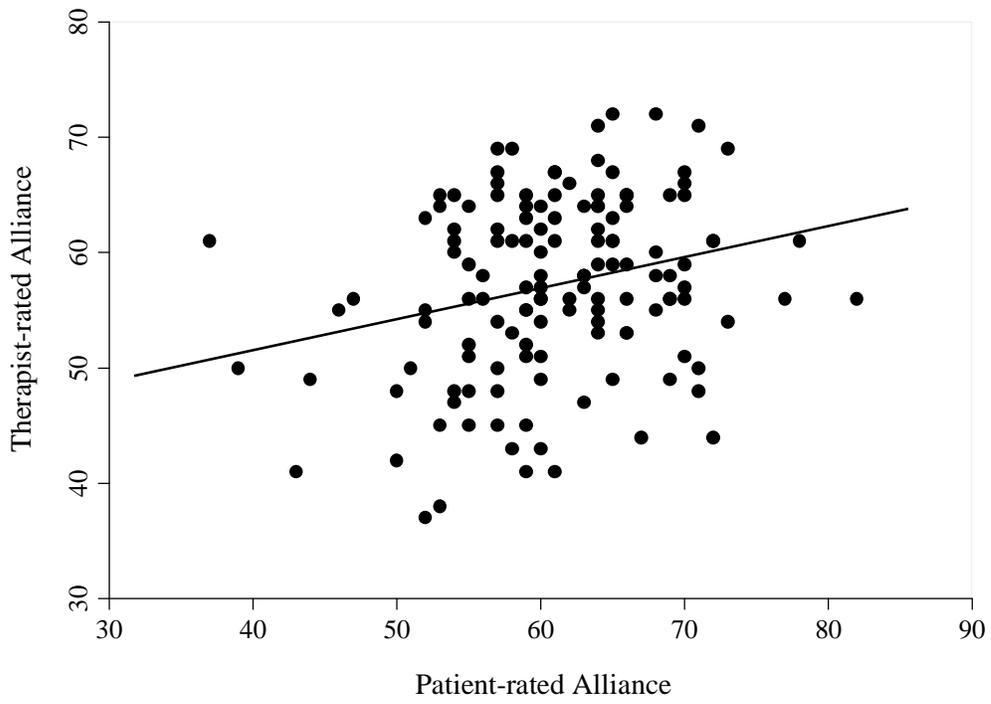


Figure 2. Weak Positive Correlation in Alliance Perception between Patients and their Therapists.