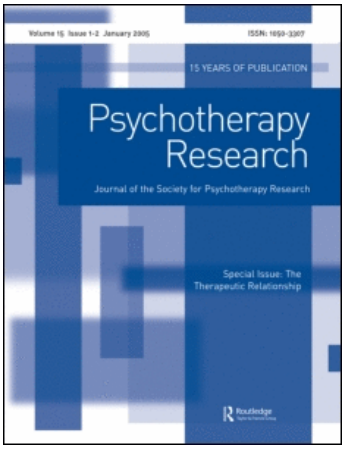

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Predictors of sustained therapeutic change

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RELATEDNESS & SELF-DEFINITION

Predictors of sustained therapeutic change

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Abstract
The authors integrate explorations by Blatt and colleagues of contributions of patient personality, therapeutic relationship, and change in mental representation to sustained therapeutic change. A pretreatment personality characteristic, self-critical perfectionism, a negative self-schema, significantly interfered with therapeutic progress in manual-directed, brief outpatient treatment for depression. The therapeutic relationship, however, facilitated changes in this negative self-representation, leading to sustained therapeutic change. The authors also explored change in the content and structural organization of representations of self and significant others in long-term, intensive inpatient treatment. A detailed clinical example elaborates the processes through which the therapeutic relationship facilitates changes in the thematic content and cognitive structural organization of patients' interpersonal schemas that appear to be the basis for sustained therapeutic gain.

Keywords: process research; therapeutic process; patient characteristics; therapeutic relationship; cognitive-affective schema

A major obstacle to the investigation of the processes of therapeutic change has been the assumption of a uniformity or homogeneity among patients, that is, that patients at the start of treatment are more alike than different and that all patients experience the therapeutic process and change in similar ways. Many psychotherapy investigators and research methodologists (e.g., Beutler, 1976, 1979; Colby, 1964; Cronbach, 1953) have stressed the need to abandon this homogeneity myth and instead to incorporate relevant differences among patients into research designs in order to address complex questions about whether different types of patients are responsive to different aspects of the therapeutic process and change in different ways (Blatt & Felsen, 1993; Paul, 1967). Harkness and Lilienfeld (1997, p. 349), for example, noted that findings from research on individual differences "require the inclusion of personality trait assessment for the construction and implementation of any treatment plan that would lay claim to scientific status." Thus, significant differences in sustained therapeutic change might occur, in a variety of treatment interventions, as a function of interactions between differences in patients' pretreatment personality organization and aspects of the treatment process. The inclusion of a differentiation among patients in research designs and data analytic strategies could provide fuller understanding of the processes that lead to sustained therapeutic change.

Early in the history of psychotherapy research, Cronbach (1953; Edwards & Cronbach, 1952) emphasized the need to examine complex patient–treatment and patient–outcome interactions that lead to therapeutic change. He also stressed that these explorations need to be based on a comprehensive theoretical framework of personality development and psychopathology that identifies patient personality

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characteristics relevant to the therapy process. As Edwards and Cronbach therefore noted in 1952, and as many other commentators have amplified since then (e.g., Beutler, 1991; Cronbach, 1975; Smith & Sechrest, 1991; Snow, 1991), the identification of relevant personality dimensions in psychotherapy research requires a theoretically comprehensive and empirically supported theory of personality development and organization if such efforts are to avoid entering a hall of mirrors (Beutler, 1991; Cronbach, 1953, 1975). One such theoretical model, consistent with other object relations approaches to the treatment process (e.g., Høglend et al., 2008; Piper, Joyce, McCallum, Azim, & Ogrodniczuk, 2002; Shahar & Blatt, 2005), is the two-configurations model of personality development and psychopathology articulated by Blatt (1974, 2004, 2006, 2008) and colleagues (Blatt & Blass, 1990, 1996; Blatt & Shichman, 1983). This theoretical model posits interpersonal relatedness and self-definition as basic dimensions underlying personality development, personality organization, concepts of psychopathology, and mechanisms of therapeutic change and thereby identifies a fundamental conceptual continuity across all these areas of inquiry.

This article integrates multiple findings from several studies that used this conceptual model to examine (a) the impact of patients' pretreatment personality dimensions on the treatment process, (b) the role of the therapeutic relationship in dealing with the disruptive effects of these dimensions in the treatment process, and (c) the mechanisms, especially revisions of mental representations or interpersonal schemas, through which aspects of the treatment process contribute to sustained therapeutic change.

The Two-Configurations Model of Personality Development and Psychopathology

A wide range of personality theorists, from Freud (1930/1961) to Bakan (1966), Wiggins (1991), and Benjamin (1995, 2003), have argued that two dimensions, interpersonal relatedness and self-definition (or communion and agency), are fundamental components of personality development and personality organization. Consistent with these views, Blatt (1974, 2004, 2008) and colleagues (Blatt & Blass, 1990, 1996; Blatt & Shichman, 1983) proposed that normal personality development evolves through a synergistic dialectical interaction between these two primary developmental dimensions across various phases of the life cycle. Throughout life, interpersonal relationships contribute to the development of a sense of self, and refinements in the sense of self contribute to the development of more mature interpersonal relationships. Although most individuals maintain a balanced commitment to both of these dimensions of psychological existence and experience, individuals generally tend to place somewhat greater emphasis or value on one or the other of these two basic psychological dimensions. Extensive research (see summaries in Blatt, 2004, 2008; Blatt & Zuroff, 1992) supports this basic distinction between two broad types of personality organization, one focused primarily on relatedness and one focused primarily on self-definition, with concomitant differences in the ways such individuals engage and experience life.

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

In contrast, self-definitional disorders, in which individuals are excessively preoccupied with the formation and protection of the self at the expense of the development of interpersonal relatedness, include paranoid schizophrenia, the self-critical borderline personality disorder (Blatt & Auerbach, 1988), paranoid personality disorder, obsessive–compulsive personality disorder, narcissistic personality disorder, and self-critical (introjective) depression (Blatt, 1974). These conditions are also termed *introjective* because they involve harsh self-criticism, perfectionism, and a need for control that

had been *internalized* from similar such attitudes from parents or other caregiving figures (Blatt, 1974; Blatt & Shichman, 1983). In introjective individuals, struggles around self-definition can be expressed at a primitive level, in feeling persecuted (e.g., attacked or criticized) by others, in paranoid forms of pathology; at an intermediate level, in excessive behavioral and ideational control, in obsessive–compulsive conditions; and at developmentally more advanced levels, in exaggerated concerns about self-worth, whether negative, as in self-critical (introjective) depression, or positive and sometimes grandiose, as in narcissistic states. In general, we use the terms *relational* and *self-definitional* to refer to normal functioning and the terms *anaclitic* and *introjective* to refer their respective decompensations from normal relational and self-definitional needs in psychopathology.

Blatt (2002, 2004) also speculated that sustained progress in effective psychotherapy results in a reactivation of the previously disrupted normal dialectic developmental interaction between relatedness and self-definition, such that anaclitic patients eventually become more agentic and assertive and introjective patients eventually become increasingly invested in interpersonal relationships. Thus, as anaclitic and introjective patients make therapeutic progress, they return to a more balanced synergistic developmental process.

Extensive research (see summaries in Blatt, 1974, 2004; Blatt & Zuroff, 1992) indicates that each of these two personality dimensions is the source of a primary vulnerability to depression: (a) disruptions of interpersonal relatedness (e.g., loss, abandonment, or need for closeness) in anaclitic conditions and (b) disruptions of self-esteem (e.g., feelings of failure, guilt, or unworthiness) in introjective states. Research (see summaries in Blatt, 2004; Blatt & Zuroff, 1992; Corveleyn, Luyten, & Blatt, 2004) also indicates that these two personality dimensions, especially the introjective personality characteristic of self-critical perfectionism, are central to the etiology, clinical course, and treatment of depression. Four major scales have been developed that systematically assess these two underlying depressive vulnerabilities: the Dysfunctional Attitudes Scale (DAS; A. N. Weissman & Beck, 1978), the Depressive Experiences Questionnaire (Blatt, D'Afflitti, & Quinlan, 1976, 1979), the Sociotropy-Autonomy Scale (Beck, 1983), and the Personal Styles Inventory (Robins et al., 1994). All four of these scales measure an interpersonal dimension that is variously labeled as dependency, sociotropy, or need for approval and a self-definitional dimension that is variously labeled as self-criticism, autonomy, or perfectionism (Blaney & Kutcher, 1991).

The differentiation between individuals preoccupied with issues of relatedness and those concerned with issues of self-definition has also enabled investigators to identify an empirically derived, theoretically coherent, replicated taxonomy for the diversity of personality disorders described in Axis II of the *Diagnostic and Statistical Manual of Mental Disorders*. Systematic empirical investigation with both inpatients and outpatients found that various Axis II personality disorders are meaningfully organized, in theoretically expected ways, in two primary configurations: one organized around issues of relatedness and the other around issues of self-definition. In accordance with theoretical assumptions (e.g., Blatt & Shichman, 1983), these studies have generally found that individuals with a dependent, histrionic, or borderline personality disorder have significantly greater concern with interpersonal relatedness than with issues of self-definition, whereas individuals with a paranoid, schizoid, schizotypic, antisocial, narcissistic, avoidant, obsessive–compulsive, or self-defeating personality disorder usually have significantly greater preoccupation with self-definition than with issues of interpersonal relatedness (Clark, Steer, Haslam, Beck, & Brown, 1997; Cogswell & Alloy, 2006; Goldberg, Segal, Vella, & Shaw, 1989; Levy et al., 1995; Morse, Robins, & Gittes-Fox, 2002; Nordahl & Stiles, 2000; Ouimette & Klein, 1993; Ouimette, Klein, Anderson, Riso, & Lizardi, 1994; Overholser & Freiheit, 1994; Pilkonis, 1988; Ryder, McBride, & Bagby, 2008). These findings are supported further by attachment research showing that personality disorders can be similarly organized in two-dimensional space defined by *attachment anxiety*, reflecting anaclitic concerns, and by *attachment avoidance*, reflecting introjective issues (Blatt & Luyten, in press; Meyer & Pilkonis, 2005).

Impact of Patients' Pretreatment Personality Organization on the Therapeutic Process

Prior research (e.g., Blatt, 1992; Blatt, Besser, & Ford, 2007; Blatt & Ford, 1994; Blatt & Shahar, 2004; Fertuck, Bucci, Blatt, & Ford, 2004; Vermote, 2005) indicates that these two groups of patients, anaclitic and introjective, can be reliably differentiated from each other through descriptions in clinical case records and have differential responses to treatment, responses that are consistent with their diverging personality organization. On the basis of these earlier findings, Blatt and colleagues (Donald Quinlan and David Zuroff) decided to introduce patients' pretreatment personality characteristics into further analyses of data from the extensive and remarkably comprehensive data set established by

the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP).

The TDCRP was planned and executed by several senior members of the NIMH extramural staff (Irene Elkin, Tracie Shea, John P. Docherty, and Morris P. Parloff), who designed an extensive, elegant, and well-conducted randomized clinical trial that compared several forms of brief treatment for depression: 16 weeks of medication (imipramine, the antidepressant medication of choice at the time [IMI-CM]) and a double-blind placebo, PLA-CM, both with clinical management (CM; minimal support but no specific therapeutic intervention), with 16 sessions of manual-directed cognitive–behavioral therapy (CBT) or interpersonal psychotherapy (IPT). Eighteen experienced psychiatrists and 10 experienced PhD clinical psychologists (with a mean clinical experience of 11 years) saw patients at one of three treatment sites (medical schools at George Washington University, University of Oklahoma, and University of Pittsburgh). Two hundred fifty patients were initially screened and randomized to the four treatment groups. Two hundred thirty-nine patients had at least one treatment session. Patients were evaluated extensively at intake, at 4-week intervals throughout treatment to termination at 16 weeks, and in three follow-up assessments at 6, 12, and 18 months after the termination of treatment.

Four primary outcome measures were used in the TDCRP: the interview-based Hamilton Depression Rating Scale (HAM; Hamilton, 1960), the self-report Beck Depression Inventory (BDI; Beck & Steer, 1993), the clinician-rated Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976), which is a forerunner of the Global Assessment of Functioning (GAF; American Psychiatric Association, 1987, 1994), and the self-report Symptom Checklist-90 (SCL-90; Derogatis, 1983). Blatt, Quinlan and colleagues (1995) also included as another outcome measure the interview evaluation of social adjustment (Social Adjustment Scale [SAS]; M. M. Weissman & Paykel, 1974) that had been included as part of the TDCRP. They found that the residualized gain scores of these five measures at termination formed a common factor, which they labeled "maladjustment" (Blatt, Quinlan et al., 1996).

The basic findings of the TDCRP (e.g., Elkin, 1994) indicated that medication (IMI-CM) led to a significantly more rapid decline in symptoms at midtreatment (at Session 8), but no significant differences were found in symptom reduction among the three active treatments at termination—the classic dodo bird effect. Shea et al. (1992), in an analysis of follow-up evaluations, considered approximately 35% of the patients to be recovered because they had minimal or no symptoms for at least 8 consecutive weeks following treatment (39% in CBT, 34% in IPT, 32% in IMI-CM, and 25.8% in PLA-CM). However, approximately 40% of these recovered patients had relapsed by the 18-month evaluation (39% in CBT, 33% in IPT, 50% in IMI-CM, and 37.5% in PLA-CM). Thus, only approximately 20% of the 239 patients who participated in the TDCRP were considered "fully recovered" (23.7% in CBT, 23.3% in IPT, 15.8% in IMI-CM, and 16.1% in PLA-CM). In sum, the results of the TDCRP found that there were no significant differences among the three active treatment conditions at termination and that all three active treatment conditions were relatively ineffective in producing therapeutic gain that was sustained through the follow-up period.

In 1994, after the TDCRP investigators had completed most of their analyses, the data from this extensive study became available to the scientific community. It should be noted that the TDCRP investigators, in addition to conducting a well-designed randomized controlled trial, had included many creative, state-of-the-art measures not only of the patients studied but also of the therapists and the therapeutic process. Our research group obtained the extensive TDCRP data files and began analyses of many of the collateral measures in this remarkable data set with the goal of understanding some of the processes of therapeutic change. We assumed that the essential equivalence of the three active therapeutic interventions in the TDCRP (the dodo bird effect), and possibly in many other studies, may be the consequence of the focus on symptom reduction as the measure of therapeutic change because symptom reduction can occur with minimal intervention, as noted, for example, in the Pennebaker (1997) effect, in which patients show symptomatic improvement simply through writing about their condition. Thus, we focused on developing broad evaluations in the TDCRP data beyond symptom reduction in our exploration of mechanisms that contributed to sustained therapeutic gain (see also Bateman & Fonagy, 2008; Blatt, Shahar, & Zuroff, 2002; Skodol et al., 2005; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005).

In the sections to follow, we evaluate the relationship of a personality vulnerability factor central to depression—the introjective personality factor of self-critical perfectionism (SC-PFT)—on treatment outcome at termination and at the 18-month follow-up evaluations in the TDCRP. We also explore the processes through which this personality dimension, a highly negative view of oneself, affected the treatment process and interfered with sustained therapeutic change, change that extends well beyond

termination and includes, in addition to symptom reduction, the development of adaptive capacities and a reduction in vulnerability to stress. Finally, we consider how the therapeutic relationship contributes to the revision of negative self-schemas that lead to sustained therapeutic change. Thus, we examine, as recently called for by Barber (2009), the impact of both patient and therapist on the therapeutic process.

Impact of Self-Critical Perfectionism on Treatment Outcome in the TDCRP

Fortunately, the TDCRP investigators included the DAS in their basic assessment battery. Several studies (e.g., Cane, Olinger, Gotlib, & Kuiper, 1986; Imber et al., 1990; Oliver & Baumgart, 1985; Rude & Burnham, 1995; Segal, Shaw, & Vella, 1987) indicate that the DAS assesses two fundamental personality dimensions—need for approval (NFA; e.g., "What other people think of me is important") and perfectionism (PFT; e.g., "If I do not do as well as other people, it means that I am an inferior human being")—that research (e.g., Blaney & Kutcher, 1991) indicates are analogous to relatedness and self-definition, the two personality dimensions central to Blatt's (e.g., 2006, 2008) formulations of personality development, psychopathology, and the therapeutic process. These two personality dimensions, which were assessed in the TDCRP throughout treatment and in the follow-up evaluations, provided the basis for introducing personality dimensions into the investigation of patient–treatment and patient–outcome interactions in the treatment process.

Because the PFT scale of the DAS is closely associated with self-criticism, we refer to it as self-critical perfectionism (SC-PFT), as suggested by the findings of Dunkley and colleagues (Dunkley & Kyparissis, 2008; Dunkley, Sanislow, Grilo, & McGlashan, 2004), to distinguish it from other forms of perfectionism (Powers, Zuroff, & Topciu, 2002). As noted earlier, extensive research (e.g., Blatt, 1974, 1995a, 2004; Blatt & Zuroff, 1992) indicates that the introjective personality trait of SC-PFT is a particularly insidious vulnerability factor in depression. We focus on this variable also because, as Ingram and Price have noted (2000, p. ix), "the future of clinical research and treatment lies in the study of vulnerability processes."

Pretreatment levels of SC-PFT, as measured by the DAS, significantly interfered with treatment outcome at termination, across all four treatment conditions, as measured on all five primary outcome measures in the TDCRP (i.e., Hamilton, BDI, GAS, SCL-90, and SAS), as well as by the composite maladjustment factor derived from factor analysis of these five measures (Blatt et al., 1995; Blatt, Auerbach, & Aryan, 1998). As Figure I illustrates, an analysis of therapeutic gain over the five assessments conducted during the treatment process (at intake and after 4, 8, 12, and 16 weeks of treatment) indicates that pretreatment level of SC-PFT interfered dramatically with therapeutic gain primarily in the later half of the treatment process, beginning in the ninth treatment session. Patients with high or moderate levels of SC-PFT failed to make additional therapeutic progress after the eighth treatment session. Only patients with lower levels of SC-PFT had significant therapeutic gain as they approached termination. It seems that therapeutic progress in patients with higher levels of SC-PFT was disrupted in the latter half of the treatment process by their anticipation of the forced termination after the 16th treatment session It is noteworthy that, in contrast, the NFA scale of the DAS tended ($p < .11$) to be associated with better therapeutic outcome, a result consistent with findings that preoccupation with interpersonal concerns has both adaptive and maladaptive features (e.g., Blatt, Zohar, Quinlan, Zuroff, & Mongrain, 1995; Rude & Burnham, 1995).

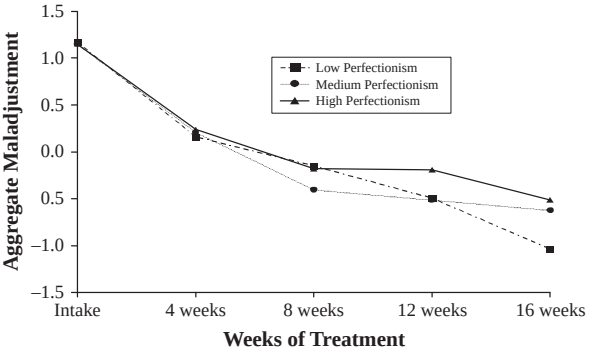

Figure I. Outcome in the Treatment of Depression Collaborative Research Program (TDCRP) as a function of perfectionism.

Pretreatment levels of SC-PFT were also associated with poor therapeutic outcome at the final, 18-month, follow-up assessment. Independent clinical evaluators (CEs; PhD-level clinical psychologists) rated patients on their current clinical condition and degree of therapeutic change at this point. The level of pretreatment SC-PFT correlated significantly ($p < .01$) with ratings of a poorer clinical condition at the 18-month follow-up after the completion of treatment. Patients also rated their current clinical condition, their satisfaction with their treatment, and their degree of therapeutic change. All three of these ratings at the 18-month follow-up were significantly (ps $< .05$ to $< .001$) correlated with pretreatment levels of SC-PFT (Blatt, Zuroff, Bondi, & Sanislow, 2000).

Patients in the follow-up assessments also rated eight items that measured the degree to which they thought their treatment had improved their interpersonal relationships and their ability to cope with their symptoms, feelings, and attitudes associated with depression using what Zuroff and Blatt (2006) labeled enhanced adaptive capacities (EACs). Prior analyses (Zuroff, Blatt, Krupnick, & Sotsky, 2003) of EACs during the follow-up period indicated that these ratings were associated with a capacity to manage life stress. Thus, it is noteworthy that pretreatment level of SC-PFT was significantly associated with reduced levels of EAC at all three follow-up assessments, especially at the final follow-up evaluation 18 months after treatment termination (Blatt et al., 2000; Zuroff et al., 2003).

To gauge the clinical significance of these effects for SC-PFT and variables related to therapeutic outcome, we computed effect size correlations for some of the major results reviewed previously. The effect size correlation was calculated using the formula: $r = [F/(F+df)]^{1/2}$ (Rosnow & Rosenthal, 1996); Cohen (1988) characterized $r = .10$ as a small effect, $r = .30$ as a medium effect, and $r = .50$ as a large effect. The majority of the reported effects fell in the small, .10–.30 range. For example, the effect size correlations for SC-PFT were .16 in predicting change in the maladjustment index (Blatt et al., 1998) and .21 in predicting EAC at the 18-month follow-up (Blatt et al., 2000), effect sizes not much lower than those found in meta-analyses of the therapeutic alliance and therapeutic outcome (e.g., Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Because psychotherapy is a very complex process with a multiply determined outcome, a single variable may account for a limited amount of the variance in outcome and still have great practical significance for the multitude of individuals receiving or needing psychotherapy.

Although it is clear that self-critical perfectionism is a primary vulnerability factor in the etiology of depression (e.g., Blatt, 1995a, 2004) and is very disruptive in the brief treatment of depression, it is noteworthy that issues of vulnerability are not usually the focus of most treatment manuals and clinical investigations of depression. Instead, such endeavors usually focus on current life difficulties and clinical symptoms.

To evaluate further the role of SC-PFT on the treatment process, Hawley, Ho, Zuroff, and Blatt, 2006), using latent difference score (LDS) analysis, a structural equation modeling technique that combines features of latent growth and cross-lagged regression models, evaluated temporal effects in coupled change processes across reduction in both symptoms and personality vulnerability (SC-PFT). Univariate LDS results indicate that depressive symptoms diminish rapidly early in the treatment process with relatively little therapeutic intervention (such as occurs in the Pennebaker effect). SC-PFT, in contrast, diminished very gradually throughout treatment. Despite the remarkably rapid decrease in depressive symptoms, significant unidirectional longitudinal coupling was found, in which a patient's level of SC-PFT predicted the rate of decline in symptoms of depression throughout the treatment. In other words, the lack of sustained therapeutic gain in the TDCRP may have been a consequence of the failure in treatment to address the personality factors involved in vulnerability to depression. We therefore thought it important to examine closely aspects of the treatment process, particularly the mechanisms through which pretreatment SC-PFT affects the treatment process.

Processes through Which SC-PFT Disrupts the Treatment Process

Treatment sessions in the TDCRP were videotaped, and Krupnick et al. (1996) used the recordings of Sessions 3, 9, and 15 to rate the contributions of patients and therapists to the therapeutic alliance on the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983). They found that the contributions of patients, but not therapists, to the therapeutic alliance significantly predicted therapeutic outcome at termination. Zuroff et al. (2000) found, as Figure II illustrates, that pretreatment SC-PFT significantly interfered with patients' participation in the therapeutic alliance in the last half of the treatment process.

Structural equation modeling (Shahar et al., 2004) of the relationships between pretreatment SC-PFT, patients' contribution to the therapeutic alliance, and outcome at termination indicated, however, that, despite the significant mediating effect of patients' contribution to the therapeutic alliance on the impact of pretreatment SC-PFT on treatment outcome

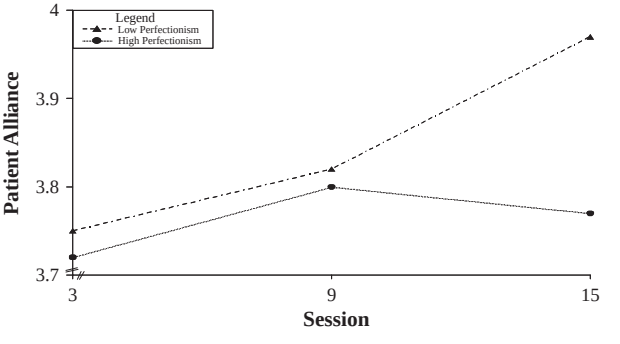

Figure II. Patient alliance as a function of perfectionism.

(Zuroff et al., 2000), a substantial portion of the variance remained unexplained. Thus, Shahar et al. (2004) examined the mediation of patients' perceived level of social support on the relationship of pretreatment SC-PFT to therapeutic outcome. Shahar et al. found striking similarity between the mediational effects of the social relationships and the mediational effects of the therapeutic alliance on therapeutic outcome. As Figure III illustrates, increases in both perceived social support and in the therapeutic alliance, as a consequence of lower pretreatment SC-PFT, significantly mediated therapeutic outcome at termination, accounting for almost all of the variance between pretreatment SC-PFT and treatment outcome at termination. Thus, pretreatment SC-PFT significantly interfered with therapeutic outcome in the TDCRP by disrupting not only the therapeutic alliance but also patients' general social relationships, factors that leave them vulnerable to stressful life events. These findings indicate the importance of the interpersonal aspects of the therapeutic process and call for further exploration of the role of the therapeutic relationship in the treatment process.

The Therapeutic Relationship in the Treatment Process

Despite consistent findings across many studies, among them our further analysis of the TDCRP data, that show the importance of the therapist (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Kim, Wampold, & Bolt, 2006) and the therapeutic alliance in determining therapeutic outcome (e.g., Wampold, 2002), considerable debate still persists about the role of the therapeutic alliance in the treatment process. Zuroff and Blatt (2006) note that skeptics raise a number of important questions about the role of the therapeutic alliance in treatment outcome, including (a) whether the positive relationship of the therapeutic alliance to treatment outcome is the by-product of symptom relief and clinical improvement because patients who improve tend to have more positive views of the therapist and the treatment process, (b) whether the therapeutic alliance is a consequence of particular patient characteristics, (c) whether the relationship of the therapeutic alliance to treatment outcome occurs across multiple outcome measures, and (d) whether the relationship of the therapeutic alliance to outcome occurs in different treatments (e.g., CBT, IPT, medication, placebo). Findings from several recent carefully conducted studies (Baldwin, Wampold, & Imel, 2007; Barber et al., 2001; Klein, Durbin, Shankman, & Santiago, 2002; Wampold, 2001, 2002; Zuroff & Blatt, 2006) clearly demonstrate the centrality of the therapeutic alliance, independent of the extent of symptom relief and clinical improvement, to treatment outcome on a range of outcome measures, across different forms of treatment, independent of a wide range of patient demographic and clinical characteristics.

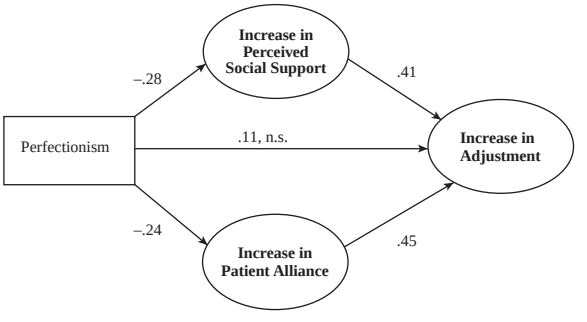

Figure III. Complete mediation of outcome by patient alliance and perceived social support.

Ackerman and Hilsenroth (2003) noted that a positive therapeutic relationship usually emerges when the therapist is flexible, respectful, warm, open, and accepting and makes interventions that are reflective, supportive, affirming, accurate, and affectively facilitating. Zuroff and Blatt (2006) described a constructive therapeutic relationship as one that is sensitively attuned to central aspects of the patient's personality organization, flexibly and appropriately responsive to the patient's concerns and the expressions of his or her personality organization in the treatment process. Efforts were made in the TDCRP to assess the quality of the therapeutic relationship with the Barrett-Lennard Relationship Inventory (B-L RI). Barrett-Lennard (1962, 1985), using Carl Rogers's (e.g., 1957, 1959) specification of the necessary and sufficient conditions of effective therapy, developed a scale to assess patients' experience of the therapeutic relationship with regard to therapist empathy (e.g., "Therapist wanted to understand how I saw things"), positive regard (e.g., "He respected me as a person") and congruence (e.g., "I felt he was real and genuine with me"). Substantial research (e.g., Gurman, 1977a, 1977b) demonstrated the relationship of the B-L RI to treatment outcome.

The B-L RI had been administered in the TDCRP at the end of the Sessions 2 and 16. Analysis indicates that the quality of the therapeutic relationship, assessed with the B-L RI at the end of Session 2, was significantly related to therapeutic gain, as measured by all five outcome measures (Hamilton, BDI, GAS, SCL-90, and SAS), as well as by the composite maladjustment factor at termination and at the 18-month follow-up. The B-L RI at the end of Session 2 was also significantly related both to a

decline in SC-PFT over the course of treatment and to patients' reporting in the follow-up assessment the extent to which they believed that treatment had helped them to deal with their symptoms of depression and to establish more effective and satisfying interpersonal relationships (EAC). These results across all four treatment conditions are consistent with findings by Kim et al. (2006) that therapist characteristics were more important in determining outcome in the brief treatment of depression than was type of treatment (see also Blatt et al., 1996). Furthermore, the two psychotherapy conditions in the TDCRP (CBT and IPT), compared with the medication conditions, led to significantly greater EAC (Blatt et al., 2000; Zuroff et al., 2003) and a significantly greater reduction of stress reactivity (Hawley, Ho, Zuroff, & Blatt, 2007; Zuroff et al., 2003) in the follow-up assessments.

The effect size correlations for the B-L RI were .15 for predicting subsequent change in the maladjustment index (Zuroff & Blatt, 2006) and .26 for predicting EAC during the follow-up. These smaller effect sizes are consistent with meta-analyses of the relationship between therapeutic alliance and therapeutic change and, as noted earlier, do not mean that they are of modest importance. It is impressive that the quality of the therapeutic relationship assessed so very early in the treatment process had a significant impact on treatment outcome both at termination and subsequently, as assessed on a wide range of measures.

These findings of the importance of the contributions of patient and therapist characteristics, and their interaction, on treatment outcome in the TDCRP are consistent with results from several other studies of different treatment interventions, including investigations of long-term, intensive, psychodynamically oriented treatment, with both outpatients and inpatients (e.g., Blatt, 1992; Blatt & Ford, 1994; Blatt & Shahar, 2004; Fertuck et al., 2004; Vermote, 2005). Although these findings in both brief and longer term treatment clearly indicate the importance of the interpersonal aspects of the therapeutic relationship, they do not provide understanding of the processes of therapeutic change. Questions still remain about how the therapeutic relationship leads to reduction in the negative self-schema as measured by SC-PFT.

To assess further these mediating factors in the treatment process, Hawley et al. (2006), using an LDS analysis of the ratings by Krupnick et al. (1996) of patients' contributions on the VTAS to the therapeutic alliance in the third treatment session in the TDCRP, found that the strength of patients' participation in the therapeutic alliance significantly influenced change in SC-PFT vulnerability, a development that, as noted earlier, in turn, significantly influenced the reduction of depressive symptoms. These findings indicating the importance of a reduction in the negative self-schema expressed in self-critical perfectionism are consistent with theoretical formulations both in certain varieties of cognitive–behavioral theory (e.g., Beck, 1996; Beck, Freeman, & Davis, 2003; Young, 1999; Young, Klosko, & Weisharr, 2003) and in psychodynamic theories (e.g., Benjamin, 1995, 2003; Blatt, 1974, 1991, 1995b, 2008; Bowlby, 1973, 1980, 1982, 1988; Horowitz, 1988, 1991, 1998; Jacobson, 1964; Kernberg, 1976, 1984) about the role of relatively stable, complex, cognitive–affective interpersonal schemas in psychological disturbance. These psychodynamic and cognitive–behavioral formulations suggest that distorted representations of self and significant others underlie most forms of psychopathology, depression among them. For example, patients with anaclitic or dependent depression often represent themselves as helpless or needy and significant others as absent, neglectful, or abandoning (Blatt, 1974; Blatt, Wein, Chevron, & Quinlan, 1979). On the other hand, patients with introjective or self-critical depression usually represent themselves as unworthy or bad and significant others as intrusive, controlling, or punitive (Blatt, 1974; Blatt et al., 1979).

Using these formulations and findings about the centrality of representations of self and significant others in psychopathology and in the therapeutic process, we turned to the exploration of changes in aspects of representations of self and significant others in long-term, intensive treatment. We attempted to examine the hypothesis that constructive experiences in the therapeutic relationship enable patients to revise and transform impaired and distorted representations (cognitive–affective schemas) of themselves and their significant others and to establish more realistic and adaptive interpersonal schemas (Blatt & Behrends, 1987; Blatt et al., 1996; Zuroff & Blatt, 2006) that are then expressed in symptomatic improvement.

Therapeutic Change in the Content and Cognitive Structural Organization of Representations of Self and Significant Others

To assess systematically the thematic content and cognitive structural organization of representations of self and of significant figures, Blatt and colleagues (e.g., Blatt et al., 1979; Diamond, Kaslow, Coonerty, & Blatt, 1990) used the Object Relations Inventory (ORI), an open-ended interview in which individuals are asked to describe self and significant others (e.g., mother, father, therapist). Blatt et al. developed several procedures for systematically assessing the

explicit or episodic thematic content and the cognitive structural or implicit or procedural organization of the spontaneous descriptions of self and of others on the ORI. Of particular note is the Differentiation-Relatedness (D-R) scale (Diamond, Blatt, Stayner, & Kaslow, 1991), which rates, on a 10-point scale, the degree of differentiation and the quality of interpersonal relatedness in descriptions of self and others—the extent to which a person represents significant figures (i.e., self and others) as both having a differentiated, autonomous identity and being involved in mutual, empathically attuned interpersonal relatedness. Figure IV presents schematically the 10 points of the D-R scale.

Empirical research with the ORI (Levy, Blatt, & Shaver, 1998) indicates that the D-R scale is significantly related to attachment style in a nonclinical sample of young adults. Securely attached women and men had significantly higher D-R scores in their descriptions of their mother and father than did insecurely attached individuals. In addition, two studies found that change in the D-R score in long-term, intensive, psychodynamically oriented, inpatient treatment of seriously disturbed young adults (the Yale Psychiatric Hospital [YPI] study; Blatt, Stayner, Auerbach, & Behrends, 1996) and of personality disordered patients (the Kortenberg-Leuven [K-L] study; Vermote, 2005) is significantly associated with change in clinical functioning.

In the YPI study (Blatt et al., 1996), partial correlations of change on the GAS, as independently rated in clinical case records at intake and discharge (after at least 1 year of treatment), correlated significantly with changes in D-R scores in the description of mother ($p < .0001$), father ($p < .05$), therapist ($p < .001$), and the self ($p < .0001$), as well with changes in the description of a self-designated significant other ($p < .0001$; Harpaz-Rotem & Blatt, 2005). Relatively large effect sizes were found for change in the D-R index's prediction of change in GAS, $r = .50$ in Blatt et al. (1996) and $r = .59$ in Harpaz-Rotem and Blatt (2005). It is understandable that large effects would be obtained with the D-R index because change in mental representations is believed, in psychodynamic theory, to be more directly linked to therapeutic changes (Blatt, 1995b).

The D-R scores in the K-L study, at admission and at discharge (after 9 months of inpatient psychodynamically oriented treatment), were rated at an acceptable level of reliability (intraclass correlation of .83, the same level found in the YPI study). No significant relations were found in the K-L study between the D-R score and age, sex, or educational level, but a significant increase ($p < .0001$) occurred in the D-R score from admission to termination and

A. Impairment in basic differentiation between self and other

1. Self–other boundary compromise'

2. Self–other boundary confusion

B. Efforts to establish and maintain object and self constancy

3. Self–other mirroring

4. Self–other idealization or denigration

5. Oscillation of dramatically opposite properties (polarization)

C. Differentiated and integrated concepts of self and other (object constancy)

6. Emergent constancy

7. Consolidated constancy

D. Capacity for empathic reciprocal relationships

8. Empathic relationships

9. Reciprocal relationships

10. Reflective appreciation of reciprocal relationships

Figure IV. Ten-point scale assessing differentiation relatedness in descriptions of self and others.

the follow-up assessment 1 year later, with an effect size of .61 (Vermote et al., in press). Furthermore, Vermote (2005), in the K-L study, constructed both a composite symptom score and a composite personality scale and found with growth curve models that change in the D-R scores significantly paralleled changes in both of these indexes ($p < .001$ for symptoms, $p < .05$ for personality), with effect sizes of .57 and .58, respectively (Vermote et al., in press).

Thus, findings from both the YPI and K-L studies indicate that change in the implicit structural organization of representations of self and significant others (the D-R score) is an important aspect of therapeutic change in long-term, intensive, psychodynamically oriented treatment of seriously disturbed patients, specifically that, as predicted, patients who developed more mature schemas of self and others also show improvement in psychological symptoms, personality organization, and psychosocial functioning (see also Harpaz-Rotem & Blatt, 2009). Similarly, with an outpatient sample, Philips, Wennberg, Werbart, and Schubert (2006) found significant increases in D-R scores from admission to termination in psychodynamic outpatient treatment of young adults, particularly for father and self, with a trend toward significance in the description of mother. These findings of significant increases in the implicit structural organization of mental representations (D-R scores) of self and significant others in the YPI and K-L studies with inpatients and in the Philips et al. study with outpatients are consistent with the conclusions of Sandell (2005) that successful psychodynamic treatment involves the establishment of more positively toned representations of significant figures or, alternatively, of inner soothing objects that can be helpful in times of distress.

Dynamics of Therapeutic Change in Representations of Self and Significant Others: Case Example

A clinical example provides further understanding of some of the processes or mechanisms through which aspects of the treatment process contribute to change in the implicit structural organization and explicit thematic content of representations of self and of significant others.

Thirteen-year-old Allison was admitted for long-term intensive inpatient treatment at YPI after much outpatient treatment and two unsuccessful brief psychiatric hospitalizations. She was considered to have a severe psychotic depression, serious substance abuse (intravenous heroin use), suicidal impulses, and marked paranoid trends in a borderline personality disorder. As part of her intensive treatment program, Allison was seen three times weekly in psychodynamically oriented psychotherapy. Her GAS rating at admission was 22 (needs some supervision to prevent hurting self or others) and 43 at discharge, after 19 months in inpatient treatment (serious symptoms or impairments that obviously require treatment or attention).

Figure V presents Allison's descriptions of her mother at admission and after 6, 12, and 19 months of treatment.

Allison's initial description of her mother, although quite negative, is concise and organized. Her description of her mother at 6 months is also negative and organized, but embedded in the midst of negative adjectives is the word "caring." Allison's description of her mother at 1 year is notably less organized, marked by intrusive, disruptive thoughts, especially the word "insomniac," which she wishes to retract. Her description of mother at discharge, although somewhat negative, is more reality based, complex, and organized, and she symbolically notes her mother's lack of a capacity for nurturance (i.e., "not much on top, sort of flat chested"). Noteworthy, despite Allison's serious level of disturbance, are the concise and well-organized descriptions of her mother at admission and after 6 months of treatment.

Allison's descriptions of her therapist are presented in Figure VI. Inspection of these descriptions suggests that an essentially positive, well-organized depiction of her therapist at admission deteriorates at 1 year. Independent case reports revealed that an intense negative transference emerged at this point in treatment. Allison became enraged with her therapist and attempted to assault her for failing to gratify her intense dependency longings. Specifically, the therapist refused to accede to Allison's request to allow her to sit on the therapist's lap, suggesting instead that they talk about that desire. This disruption in the therapeutic relationship occurred simultaneously with the deterioration in Allison's description of her mother, a development consistent with the thesis that Allison, in her transference, wished her therapist to be the mother she felt she never had. When her therapist disappointed this wish, Allison came for a time to regard her therapist as too much like, and perhaps identical to, her mother, whom she regarded, as her descriptions suggest, as intrusive and emotionally depriving. Working through of Allison's intense negative transference led to an integrated, differentiated, essentially positive description of the therapist at discharge. At this point, Allison now identified a quality she admired in her therapist, her therapist's verbal facility, that she also enacted with her statement, "I'm trying to think of a word ... that wasn't the word I was thinking of," paralleling her description of her therapist as "tactful ... not blunt ... put[ting]

Description at admission (D-R= 4)

Patient: Worried, aggressive, unhappy, and lonely.

Inquiry: (Anything else?) No.

Description at 6 Months (D-R = 5)

P: Neurotic, irregular, stubborn, caring, overwhelming, cold. That's it.

Inquiry: (Neurotic?) She's crazy. She's very edgy. The slightest thing may set her off. (Irregular?) Not consistent. Too moody. (Stubborn?) Won't budge on something she believes is right. Won't listen to reason. (Caring?) She means well. (Overwhelming?) Overbearing. (Cold?) She can turn herself off and becold.

Description at 1 Year (D-R = 5)

P: I don't want to do this… she means well. Tries hard to be understanding. Overprotective. Suspicious. Alone. Insomniac. No, don't write that please. Cross it out. That's it. Oh yeah, curly hair, bleached. Tweezed eyebrows. Bad skin.

Inquiry: (Means well?) Good intentions. (Understanding?) Self-explanatory. But has little concept of what my problems really are. (Overprotective?) Restricting of freedom. (Suspicious?) Untrusting. (Alone?) Doesn't really confide in anybody, I don't think.

Description at Discharge (D-R = 6)

P: She's sweet, caring, opinionated. She tries hard, works hard. She's about 5′5″, say 120 pounds, curly hair, not much on top, sort of flat chested. Stubborn.

Inquiry: (Overbearing?) Sometimes she's just too much for me—all these qualities are too much for me. She doesn't like to give in.

Figure V. Patient's descriptions of mother.

things in a better way that doesn't sound so intimidating or so cruel."

Figure VII presents Allison's descriptions of herself. Inspection of these descriptions indicates that differentiated but highly critical self-representations at admission and during the first year of treatment are transformed at discharge into a thoughtful, reflective, differentiated, although still depressed, self-schema that includes concern with fundamental philosophical issues like the ethics of suicide, a development that suggests the emergence of formal operational thinking.

Thus, Allison provides a particularly vivid example of how distorted (possibly pathological) representations of self and of others are expressed and experienced in the therapeutic relationship and how constructive therapeutic response to expressions of these impaired and distorted representations of self and others contributes to symptomatic improvement and to a reduction in depressogenic vulnerability, specifically both in the need for approval (the quality of interpersonal relationships) and in self-critical perfectionism (the quality of self-concept). Noteworthy is Allison's identification at termination with the qualities she admired about her therapist: the therapist's capacity for sensitive verbal articulation and her "high morals." This identification is reflected in Allison's efforts in her discharge self-description to find the precise phrases to describe her therapist and in Allison's concerns about the moral issue of suicide.

It is important to note, however, that this process of therapeutic change is more complex than role modeling or imitation or even the psychological process of internalization (identification). Of particular significance are the indications that Allison was already trying, early in treatment, to make her own those very same qualities that she later came to admire in her therapist. This more complex process was manifested, in the 6-month self-description,

Description at Admission (D-R = 6)

P: Sweet, supportive, trusting, and caring.

Description at 6 Months (D-R = 5)

P: I can't describe her because I don't know her. Seems to care about me. That's it.

Description at 1 Year (D-R = 5)

P: I don't know her. I won't do it. I don't like her. Unaware, without knowing it. Has too much faith in me. (Refused inquiry)

Description at Discharge (D-R= 8)

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

Figure VI. Patient's descriptions of therapist.

through Allison's attempt at verbal precision by requesting the examiner to change a phrase in her self-description from "getting more confident" to a more sophisticated phrasing, "gaining confidence." Thus, Allison can be regarded as not only identifying with her therapist but as constructing in her therapist and the treatment process qualities that she (Allison) was already seeking to acquire but which she could not actualize because of disruptive (pathological) representations of self and of others. Through her construction of these sought-after qualities in her therapist within the therapeutic relationship and the treatment process, Allison was able more effectively to integrate these qualities into her functional identity. Aspects of the self that Allison initially had difficulty in claiming as her own were attributed to the therapist and then reappropriated, through identification, in a more adaptive and functionally constructive form.

These findings of changes in the representation of self and of significant others in the course of treatment indicate that changes in the implicit structural organization of representations, as measured by the D-R scale, reflect the degree of therapeutic change. Additionally, qualitative analysis of changes in the explicit thematic content of the descriptions of self and of others provided understanding of the processes that contribute to therapeutic change. These findings are consistent with those of Lyons-Ruth and colleagues in the Boston Process of Change Study Group (e.g., 1998), who also discuss therapeutic change in procedural knowledge (e.g., Kihlstrom & Cantor, 1984) about interpersonal relatedness—"an implicit relational knowing" of the rules that influence organizational processes of action sequences (Crigsby & Hartlaub, 1990; Squire & Cohen, 1984)—as essential in the treatment process.

Activation and enactment of distorted representations of self and of significant other in the treatment process provides the patient and the therapist the opportunity to observe, understand, and revise distorted representations so that the patient might establish more adaptive schemas with the reduction of self-critical perfectionism and of desperate dependent longings. Reduction in these vulnerabilities and the development of more adaptive schemas contribute to substantial and sustained symptom reduction, the development of EACs, and reduced vulnerability to stressful life events (see also Harpaz-Rotem & Blatt, 2009).

Consolidation of Therapeutic Change After the Termination of Treatment

Psychotherapy, if effective, should produce change not only during and as a result of treatment but also after its completion. In this regard, many findings now indicate that psychotherapy results in decreases in depressive relapse after the discontinuation of treatment but that medication, if discontinued, does not have the same posttreatment effect (e.g., Blatt et al., 2000; Hollon et al., 2003; Ma & Teasdale, 2004; Reynolds et al., 1999; Teasdale et al., 2000; Zuroff et al., 2003). Thus, it is important not only to understand the mechanisms of therapeutic change during the treatment process but also to consider the possible mechanisms that can occur in the treatment

Description at Admission (D-R = 5)

P: Depends on how I'm feeling. Sometimes I'm outgoing but other times I'm withdrawn. I don't know.

Inquiry: (What else?) I don't want to describe myself (Why?) 'Cause I get upset when I do. (Can you tell me what upsets you?) I'm either too conceited or too modest to answer something like this.

Description at 6 Months (D-R = 5)

P: I can't describe myself. Yo u describe me. It's hard. No, it's easy. Vulnerable. Hurt. Lonely. Sort of happy. Getting more confident—no—please write "gaining confidence." Considerate.

Inquiry: (Vulnerable?) I can easily be hurt. (Hurt?) Can't say more. (Lonely?) I'm suffering from lack of caring. I'm not cared about in the way I'd like to be. (Considerate?) Care about others' feelings.

Description at 1 Year (D-R = 6)

P: Depressed, suspicious, alone, manipulative, musical, artistic, sensitive, hopeless. Drug abuser, sympathetic. Can be friendly. Opinionated, withdrawn, angry, chain smoker. Can be humorous. That's it.

Inquiry: (Depressed?) I don't enjoy life. (Suspicious?) Don't trust people easily. (Sensitive?) I take things personally. (Hopeless?) I'm a failure. I'll never make it. Doomed to be depressed. (Sympathetic?) Self-explanatory. (Opinionated?) I form my own opinions. (Withdrawn?) Keep to myself. (Angry?) Lots of hidden rage. Someday it will come out.

Description at Discharge (D-R = 7)

P: Lonely, insecure. Hiding behind a façade. Have sense. Abnormal opinions. One of my abnormal opinions is that people who want to kill themselves should be allowed to kill themselves—and I wasn't referring to myself either. Mature—can be mature—haven't really acted it during the psych testing. I sort of fooled around. Should have more confidence.

Figure VII. Patient's descriptions of self.

that lead to sustained and consolidated therapeutic change after termination.

Blatt's (2004, 2008) theoretical formulations of personality development, personality organization, and psychopathology view normal psychological development as a synergistic developmental interaction, throughout life, of experiences of interpersonal relatedness and self-definition, such that growth in interpersonal relatedness contributes to the development of the self and vice versa. Disruptions of the normal synergistic developmental process lead to various forms of psychopathology in which individuals become defensively preoccupied, at different developmental levels, with one or the other of these two developmental lines, interpersonal relatedness or self-definition, at the expense of the other. Sustained and consolidated progress in psychotherapy, according to these formulations (e.g., Blatt, 2002, 2004), is the consequence of the reactivation of the normal synergistic developmental process in which interpersonal experiences in the therapeutic relationship contribute to revisions in the sense of self that lead to more mature expressions of interpersonal relatedness that, in turn, contribute to further refinements in the sense of self. Behrends and Blatt (1985; Blatt & Behrends, 1987) described

this process, in both psychotherapy and personality development more broadly, as an alternation between experiences of gratifying involvement (e.g., attachment) and experienced incompatibility (e.g., separation), such that an integration of interpersonal relatedness and self-definition results. A similar view has been articulated by Safran and Muran (2000) as a result of their research on the resolution of two types of ruptures of the therapeutic alliance. They found that withdrawal ruptures, which usually involve relational issues like need for nurturance, are resolved through the patient's assertion and agency. Confrontation ruptures, in contrast, which usually involve self-definitional issues like assertion and aggression, are resolved through the patient's acknowledgment of vulnerability and need for nurturance. These findings and formulations suggest that successful treatment involves the emergence of the other voice—of self-assertion in interpersonally oriented anaclitic patients and of interpersonal concerns and interests in self-oriented introjective patients. This dialogue between relational and the self-definitional voices, we propose, is at the heart of both personality development and sustained psychotherapeutic change.

Conclusions

Further analyses of data from the TDCRP indicate that the frequent dodo bird finding of a lack of differences between different forms of treatment appears to be a function of a focus symptom reduction as the primary measure of therapeutic change rather than on broader dimensions like the quality of the therapeutic relationship and its impact on the patient's personality structure and the development of adaptive capacities. These further analyses of data from the TDCRP also indicate that the vulnerability to depression, specifically SC-PFT, is a major factor not only in the etiology of depression but also in the treatment process. Self-critical perfectionism significantly disrupted therapeutic progress, and reduction in SC-PFT over the treatment process was a significant mediator of the reduction of symptoms at termination and of the development of EACs and reduced vulnerability to stressful life events following the termination of treatment. The quality of the therapeutic relationship early in the treatment process and the patient's constructive participation in the therapeutic alliance significantly reduced the level of SC-PFT in the treatment process, which led, in turn, to sustained symptom reduction.

Data from several other studies indicate that the quality of the therapeutic relationship and the therapeutic alliance contributes to significant revisions of the representation of self and significant others, specifically a reduction of self-critical perfectionism, which, in turn, contributes to sustained symptom reduction and the development of EACs. Patients transform negative self-schemas into more positive ones by finding in others, especially in the therapist, the positive qualities that they wish to acquire for themselves. Psychotherapy is thus regarded as the reactivation of normal developmental processes, in which experiences of interpersonal relatedness and self-definition synergistically interact in mutually facilitating ways, such that patients come to represent themselves in new ways: Anaclitic patients learn to assert themselves and introjective patients become emotionally engaged with others. The reduction of distorted representations of self and significant others and the development of more adaptive interpersonal schemas are part of the reactivation of the normal dialectic developmental process that contributes to consolidated and sustained therapeutic change.

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