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Adelphi University

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Sigal Zilcha-Mano, Kevin S. McCarthy, Ulrike Dinger, and Jacques P. Barber

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Sigal Zilcha-Mano
Adelphi University

Kevin S. McCarthy
Chestnut Hill College

Ulrike Dinger
University of Heidelberg

Jacques P. Barber
Adelphi University

Will patients project their representations of significant others onto the therapist in a way that influences the formation of the therapeutic alliance? To address this issue, the current study explored the following questions: (1) To what extent are pretreatment representations of others projected onto the therapist and thereby predict the development of alliance throughout the course of treatment? (2) To what extent are these projections affected by the real relationship? (3) Are there specific representations of others that are more prone to be projected onto the alliance? To this end, data on 134 patients from a randomized controlled trial for depression comparing dynamic supportive–expressive therapy with supportive clinical management combined with pharmacotherapy or placebo were used. Findings demonstrated that the patients' pretreatment representations of significant others predicted a substantial part of the alliance with the therapist throughout the course of treatment. However, the representations of others were not automatically projected onto the alliance but rather the projections were also influenced by the real relationship with the therapist. Throughout this process, the alliance evolves into a collage of significant others. A process of assimilation seemed to emerge during treatment, in which the most relevant representations of significant others were projected onto the alliance with the therapist.

Keywords: alliance, transference, internal representations, significant others, CCRT

Shelley is a woman in her late twenties. She maintains emotional distance from others, holds a negative view of them as hurtful and not loving, and is reluctant to rely on them for support. Owing to a recent depressive episode, she sought treatment. The question of what type of alliance a patient such as Shelley, who holds negative, malevolent representations of others, will form with her therapist has been debated topic in clinical research (e.g., Greenson, 1965). Will Shelley project her maladaptive representations of significant others onto the therapist, diminishing her chances of forming a strong positive alliance early in treatment? Or will the ways in which Shelley interacts with significant others play a minimal role in how she will view her therapist and not interfere with the formation of a positive alliance?

The above scenario highlights an important issue in the field of psychotherapy research: the extent to which transference (i.e.,

Shelley's projections of her representations of significant others onto her relationship with her therapist[1]) can affect the therapeutic alliance. In other words, to what extent do patients' representations of others overlap with their alliances with their therapists? One view of Shelley's story may assume that there will be a large overlap between the ways Shelley perceives significant others in her life and the way she will view her therapist. According to this view, Shelley may project her maladaptive representations of significant others onto the therapist, thereby impeding the likelihood of forming a positive strong alliance early in treatment (Andersen & Przybylinski, 2012; Bowlby, 1988; Freud, 1912/ 1958; Luborsky, 1998; Mallinckrodt, 2010).

An alternative view to Shelley's story assumes that the overlap between the ways Shelley perceives significant others in her life and the way she views her therapist may in fact be rather minimal. According to this view, the alliance may not be too contaminated by transference. Thus, Shelley may form a strong positive alliance early in treatment that will enable teamwork collaboration with her therapist, despite her maladaptive representations of others. Accordingly, she may agree with her therapist about the tasks and goals of treatment and may perceive a qualified, professional therapist as helpful and trustworthy (Beck, Rush, Shaw & Emery,

Sigal Zilcha-Mano, The Derner Institute of Advanced Psychological Studies, Adelphi University; Kevin S. McCarthy, Department of Psychology, Chestnut Hill College; Ulrike Dinger, Clinic for General Internal Medicine and Psychosomatics, University of Heidelberg; Jacques P. Barber, The Derner Institute of Advanced Psychological Studies, Adelphi University.

Correspondence concerning this article should be addressed to Sigal Zilcha-Mano, The Derner Institute of Advanced Psychological Studies, Adelphi University, Hy Weinberg Center, Room 111, 1 South Avenue, P.O. Box 701, Garden City, NY 11530-0701. E-mail: sigalzil@gmail.com

[1] Following Connolly et al. (1996) as well as other researchers using the CCRT method, the concepts of transference and the projections of representations of others are used interchangeably in this article.

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1979; Bordin, 1994; Raue & Goldfried, 1994; for review see Castonguay, Constantino, McAleavey, & Goldfried, 2010).

Approaching this debate empirically is important for understanding the origins of the therapeutic alliance, which is one of the most researched constructs in the field of psychotherapy research. The most widely used definition of alliance in psychotherapy research is Bordin's (1979) tripartite pantheoretical definition of the alliance as including the emotional bond established in the therapeutic dyad, agreement pertaining to the goals of therapy, and the degree of concordance regarding the tasks pertinent to accomplishing these goals (see also Hatcher & Barends, 2006). Decades of research have focused on the alliance as a predictor of treatment outcomes. Specifically, the association between alliance and psychotherapy outcome across 14,000 treatments was found to be small to moderate ($r = .27$) but reliable (Horvath, Del Re, Flückiger & Symonds, 2011), even while controlling for temporal precedence between alliance and symptoms throughout the course of treatment (Zilcha-Mano, Dinger, McCarthy, & Barber, in press). However, much less is known empirically about the origins of the alliance, and specifically the extent to which alliance is affected by transference. In the current study we use a research-based contemporary definition of transference, which involves both distorted and accurate construals of relationships with others in the patient's life that influence the relationship with the therapist (Crits-Christoph et al., 1990). This definition is in line with other research-based contemporary approaches, which conceptualize transference as the influences of personality styles that are rooted in developmental history on a novel relational experience with the therapist (DeFife, Hilsenroth, & Kuutmann, 2014).

While approaching the question to which extent alliance is influenced by transference empirically, the following frameworks can be helpful: attachment theory and the Core Conflictual Relationship Theme (CCRT) method. The two frameworks have been most often (but definitely not exclusively) studied in different disciplines of psychology: attachment theory within personality development and social psychology, and the CCRT within clinical psychology, and especially within psychotherapy research. Each one offer different conceptualizations of individual differences (i.e., while attachment orientations are most frequently delineated based on the two dimensions of attachment avoidance and attachment anxiety, the CCRT focuses on the three core components of Wish, Response of Others, and Response of Self). However, both frameworks attempt to capture an individual's internal relationship representations, and both focus on pervasive and persistent patterns of relating to oneself and others that guide the formation of future relationships. Therefore, both may be valuable sources of information for the present study (Mikulincer, Shaver, & Berant, 2013; Luborsky & Crits-Christoph, 1998).

From an attachment perspective (Bowlby, 1988; Mikulincer, Shaver, & Berant, 2013), studies have examined the extent to which insecure representations of others could predict the alliance. A review of these studies indicates a wide range of possible overlap between representations of others and alliance, ranging from $r = .04$ to $r = .31$ (Diener, Hilsenroth, & Weinberger, 2009; Smith, Msetfi, & Golding, 2010). However, the above-mentioned studies have two main shortcomings. First, they mainly focused on alliance as assessed at one single time point during therapy for each patient and that time point was not consistent across studies. Yet, the extent of overlap between alliance and representations of

others may differ as a function of time and may not be the same throughout the whole course of treatment (e.g., Horowitz, 1986; Mann, 1973). Therefore, it is possible that differences between phases of treatment may have contributed to the wide range of reported overlap. A second shortcoming is that these studies mostly used one generic ("average") representation of significant others (e.g., the Adult Attachment Interview; Main & Goldwyn, 1994). Although some scholars posit that one major pattern of interacting with others exists across relevant relationships (e.g., Luborsky et al., 1985), others have suggested that more than one pattern of relating may be apparent (e.g., Collins & Read, 1994; Freud, 1912/1958; Horowitz et al., 1984; Strupp & Binder, 1984). However, the present attachment literature leaves this debate unresolved.

The second framework that may assist in learning about the extent to which patients' representations of others may overlap with therapeutic alliance is the CCRT method (Luborsky & Crits-Christoph, 1998), which focuses on identifying an individual's major relationship themes. Although these studies did not focus directly on alliance (for an exception see Beretta et al., 2005), they examined a related concept of the patients' representations of the therapists. Again, results showed a wide range of possible overlap (34%–60%) between the therapist's representation and core relationships themes (e.g., Barber, Foltz, DeRubeis, & Landis, 2002; Connolly et al., 1996; Crits-Christoph, Demorest, & Connolly, 1990; Fried, Crits-Christoph, Luborsky, 1992). Similar to the studies using the attachment paradigm, a shortcoming of these studies is that they gauge a single time point (inconsistent across patients and studies) in the course of treatment (for an exception see Connolly, Crits-Christoph, Barber, & Luborsky, 2000, though note that in their study only a few patients ($n = 5$) were assessed at *both* time points). Therefore, the question of whether changes occur in the extent of overlap between the alliance and representations of others *throughout* treatment remains unanswered.

In addition, studies from both paradigms disregarded aspects of the real patient–therapist relationship, which may influence the therapeutic alliance from the moment the patient and therapist first meet (Gelso, 2011). The real relationship is most widely defined as the interpersonal relationship that exists from the moment the patient and therapist meet for the first time (Gelso, 2002; Gelso & Hayes, 1998), and is marked by the extent to which each is genuine with the other and perceives the other individual in ways that suit the other individual (Gelso, in press). Although previous studies have examined the overlap between the alliance and representations of others after the patient has already met the real therapist, they were not able to untangle the influences of the real relationship on this overlap from the part that is not influenced by the real relationship (using different terminology, the influences of the real relationship were not untangled from the automatic projections).

Based on previous conceptualizations asserting that all therapeutic relationships consist of three main interrelated components—a real relationship, a working alliance, and a transference configuration (the tripartite model; Gelso, in press; Gelso & Hayes, 1998; see also Greenson, 1967), in the current article we are interested in investigating the extent of the overlap between these three components. Figure 1 illustrates two of the many possible configurations for the extent of overlap among the real relationship, alliance, and transference. Moreover, as illustrated in Figure 1, the overlap between alliance and transference may in-
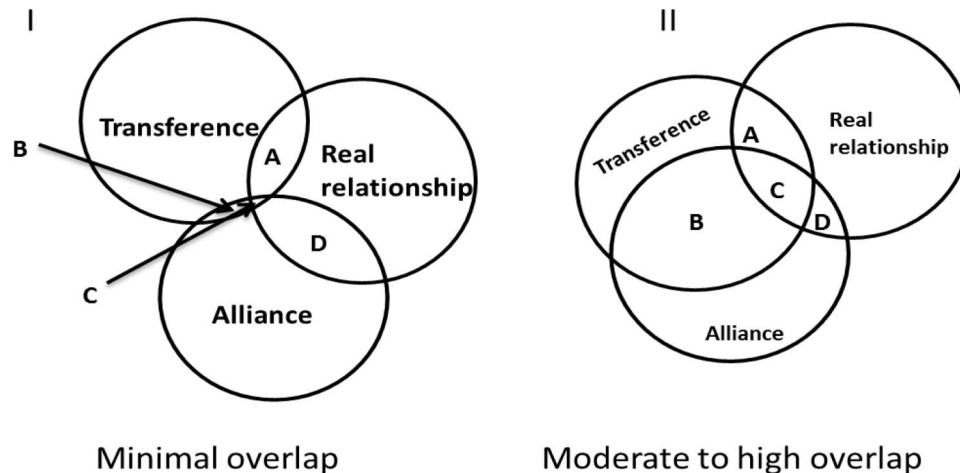
Figure 1. Illustration of two possible models of the extent of overlap between alliance and transference.

clude two different components (B + C). B is unaffected by the real relationship, and was created even before the patient met the real therapist (using different terminology, B may also be defined as the overlap between representations of others and pretreatment representation of the alliance). This a priori construct may contribute to a patient's tendency to see different therapists in relatively similar ways (e.g., a possible tendency of Shelley to automatically project onto the therapist her tendency to see others as untrustworthy, irrespective of the therapist's real characteristics). In contrast, part C emerges only after the patient encounters the real therapist. While part C includes the characteristics of the real therapist that also characterizes some of the patient's representations of others (e.g., after the therapist has tried to show Shelley a different perspective on her difficulties, Shelley might come to view her therapist in the same way that she views her mother–as being critical toward her), part D cannot be explained by representations of others (e.g., Shelley may see her therapist, but none of her significant others, as loving). Research has yet to determine the ratio of C versus B (in other words, how large is the influence of the real relationship on the overlap between alliance and representations of others).

The present study is an exploratory investigation of our proposed model and is focused on the following questions: first, to what extent do patients' representations of significant others predict the alliance with the therapist (i.e., the size of the overlap between the transference, namely projections of representations of others, and alliance; within Figure 1 parts C + B) at different time points throughout treatment? Second, to what extent does the impact of the patients' representations of significant others on the alliance change on meeting the real therapist (untangling part C from B + C)? Third, are there representations of significant others that are more prone to be projected onto the alliance? To explore these questions we examined the patients' representations of significant others, their pretreatment representation of the alliance, and their alliance throughout treatment. Representations of significant others were assessed pretreatment (to avoid a potential confounding effect of the therapist's influence on the reports on significant others, Connolly et al., 2000) using a self-report CCRT questionnaire with the aim of differentiating between significant

others (father, mother, best friend, romantic partner) as well as between different characteristics of others (hurtful, independent, loving, submissive).

The construct of the real relationship was operationalized in the current study based on Gelso's definition and referred to any questionnaire about the relationship with the actual therapist (e.g., alliance questionnaire) that was filled out after the first moment of contact between therapist and patient as potentially affected by the real relationship (e.g., Gelso & Hayes, 1998). Based on this definition, we refer to the overlap between alliance and representations of others that existed before meeting the real therapist as not affected by the real relationship and to the part that was developed only after meeting the real therapist as potentially affected by the real relationship. This is an indirect method of assessing the effect of the real relationship and is in line with relational conceptualizations stating that there is no therapist–patient interaction that does not involve the subjectivity of the therapist (Mitchell & Aron, 1999).

In the current randomized controlled trial, patients in all three treatment conditions—dynamic supportive–expressive therapy and supportive clinical management combined with pharmacotherapy or placebo—showed significant reductions in symptoms of depression (Barber, Barret, Gallop, Rynn, & Rickels, 2012), anxiety symptoms, and interpersonal distress, as well as improvements in quality of life and physical and mental health (Zilcha-Mano, Dinger, McCarthy, Barrett, & Barber, 2014). No significant differences were found between the three treatment conditions in any of the outcome measures. Finally, there were no significant differences between the conditions or between different time points in the extent to which alliance predicted symptoms throughout the course of treatment (Barber et al., in press; Zilcha-Mano et al., in press).

Method

Participants

Individuals meeting Major Depressive Disorder diagnostic criteria (American Psychiatric Association, 1994) using the Structural Clinical Interviews for *DSM–IV* (First, Spitzer, Gibbon & William, 1995) and scoring more than 14 on the 17-item Hamilton Rating

Scale for Depression at two evaluations one week apart ($n = 156$) were randomly assigned to one of three treatment conditions: supportive–expressive therapy (SET), clinical management combined with pharmacotherapy (CM + MED) or clinical management combined with placebo (CM + PBO; for more details see Barber et al., 2012). Only those who completed the revised Central Relationship Questionnaire (CRQ-R) at intake and rated the alliance at least once over the course of treatment ($n = 134$) were included in the current study. Exclusion criteria were bipolar disorder, current or past psychosis, other *DSM–IV* axis I disorders judged to be more severe than the depression, high suicide risk, a medical condition contraindicating study medication, functional illiteracy, and current *DSM–IV* substance dependence. The inclusion of individuals with substance abuse was allowed. Participant mean age was 37.45 ($SD = 12.12$), and 83 participants (61%) of the sample were female. The majority of the sample identified as Caucasians (50%), African Americans (43%), Latino Americans (5%) and Asian Americans (2%). At intake 84.5% of the patients had at least one comorbid disorder. Axis-I comorbidities included anxiety disorders (44.9%) as well as current substance abuse or a past dependence disorder (35%). In addition, 59% had a comorbid Axis-II personality disorder. Most of the patients (67%) did not have previous psychotherapy/counseling experience.

Treatments

All treatments were administered for 16 weeks. In the SET condition ($n = 42$), patients received 20 sessions of a time-limited manualized dynamic therapy for depression (Luborsky, 1995), twice weekly for the first month and then weekly for the remaining three months. Psychotherapists delivering SET were four experienced clinicians (three women, one man; all Caucasian) with at least 15 years of clinical experience and at least 10 years of experience in SET. All therapists had served as therapists and/or supervisors in prior SET studies. In the other two conditions, patients received supportive clinical management (CM) combined with either Sertraline (CM + MED, $n = 46$) or a placebo pill (CM + PBO, $n = 46$). Patients in both of these conditions met weekly with their psychopharmacotherapists for the first six weeks and could switch to every other week for the remaining study period if patients' condition warranted it. In both CM conditions, techniques specific to a psychotherapeutic orientation were prohibited, but supportive interventions (such as helping patients express their emotions and experiences, acknowledging gains, reinforcing accomplishments, and offering empathy and warmth) were allowed (Fawcett, Epstein, Fiester, Elkin, & Autry, 1987). The CM was delivered by 10 experienced psychopharmacologists (four women, six men; eight Caucasian, one South Asian, one East Asian) with at least 7 years of experience each. For all therapists (SET and psychopharmacotherapists) median caseload was 11. The study was approved by the university institutional review board.

Measures

Alliance. The 12-item Working Alliance Inventory (WAI; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989) was used. Items describing the agreement between patients and therapists about the goals and tasks of treatment, as well as the affective bond between the patient and therapist, were rated on a 7-point Likert scale. The reliability and validity of the WAI have been demonstrated in previous studies (e.g., Tracey & Kokotovic, 1989). The WAI was administered at pretreatment intake (before meeting the real therapist) and throughout treatment at Weeks 2, 4, and 8. The following instruction was added when administered at intake to assess patients' representations of the alliance before meeting the real therapist: "Because you have not yet experienced treatment through this study, answer the following questions thinking about how you expect treatment to be." In addition, at the intake assessment, patients were explicitly instructed (verbally as well as in the instructions on the form) to complete the questionnaire in terms of their upcoming therapist and not their intake evaluator. In the current study, the internal reliability range of the WAI for the four time points was .92 to .95. The correlations of pre-treatment alliance and alliance throughout treatment were .47, .57, and .55, for Weeks 2, 4, and 8, respectively (see Barber et al., in press).

Representations of significant others. The 23-item Response of Others (ROs) scale of the CRQ-R (McCarthy, Connolly Gibbons, & Barber, 2008) was used to assess different ROs (i.e., characteristics of others as hurtful, loving, submissive, and independent), separately for each significant other (i.e., father, mother, best friend, romantic partner). Participants were instructed to rate their relationship with their father, mother, same-sex best friend, and romantic partner using four separate CRQ-R forms. Participants that did not have a current romantic partner were asked to rate a past partner or leave the section blank. Items describing the extent to which the other (e.g., mother) could be characterized as hurtful, loving, submissive, and independent were rated on a 7-point Likert scale. The reliability and validity of the CRQ-R have been examined in previous studies (Barber, Foltz, & Weinryb, 1998; McCarthy et al., 2008). Cronbach's alphas for the CRQ-R subscales in the current study are presented in Table 1. The intercorrelations between subscales were low to moderate (most correlations between the CRQ-R subscales were not significant, with the significant correlations being mainly around .2–.3).

Procedure

At intake, patients filled out the alliance pretreatment measure as well as separate CRQ-R forms for each of their core relationships (father, mother, best friend, romantic partner). Alliance throughout treatment was assessed at Weeks 2, 4, and 8. For each measurement time point, the sample size was restricted only to those patients who filled out both the CRQ-R at intake and the alliance at the specific time point (with the most minimal number of participants per analyses being 70 patients at Week 8).

Data Analysis Overview

Given the hierarchical nature of the data (patients nested within therapists), the therapist was added as a random effect into the models predicting alliance from representation of others at each time point (i.e., for Week 2, 4, and 8; Baldwin & Imel, 2013). Multilevel analyses were performed using SAS PROC MIXED procedure for multilevel modeling (Littell, Milliken, Stroup, Wolfinger, & Schabenberger, 2006). Intraclass Correlation (ICC) was used to measure the amount of variance in the alliance that is due to differences between therapists in the models predicting the

Table 1

Descriptive Statistics for the CRQ-R RO Subscales for Each Relationship

Variable (N_{items})	Relationship	*M*	Median	*SD*	Cronbach's alpha
The other is hurtful (11)	Best friend	2.02	1.79	.86	.89
	Father	2.99	2.71	1.29	.97
	Mother	2.76	2.46	1.29	.87
	Romantic partner	2.98	2.75	1.3	.95
The other is independent (3)	Best friend	6.07	6.33	1.02	.88
	Father	5.97	6.33	1.21	.97
	Mother	5.47	6	1.59	.86
	Romantic partner	5.68	6	1.33	.94
The other is loving (3)	Best friend	5.1	5	1.45	.83
	Father	3.96	4	1.82	.89
	Mother	5.14	5.33	1.61	.39
	Romantic partner	4.76	5	1.66	.82
The other is submissive (3)	Best friend	2.52	2.67	1.09	.50
	Father	2.32	2	1.10	.87
	Mother	2.83	2.76	1.16	.43
	Romantic partner	2.92	3	1.19	.82

alliance by representations of others. ICC is the percent of variance of the random effect of the therapist out of the total unexplained variance. It is calculated as follows: $\sigma^2_{therapist} / (\sigma^2_{therapist} + \sigma^2_{error})$, with $\sigma^2_{therapist}$ as the variance of therapist random effect and σ^2_{error} as the variance of the error. Irrespective of the ICC value, the use of multilevel modeling was retained in all subsequent analyses. Specifically, all analyses were conducted as hierarchal multilevel models with therapist as a random effect (therapists in level 2 of the analyses). Because we attempted to estimate the overlap between the components of interest in Figure 1 at each time point separately, we used separate multilevel analyses for each time point in all analyses. It is important to note that missing data were not predicted by early alliance (Barber et al., in press).

To answer our first question, we use a multilevel linear regression model to determine the percentage of the alliance variance that can be explained by the representations of significant others at each time point. With the aim of estimating the conceptual framework as a whole (rather than reaching the most parsimonious model), all predictors were introduced to the model together (Greene, 2008). Specifically, each of the four ROs (hurtful, independent, loving, and submissive) of the four significant others (father, mother, best friend, and romantic partner) were entered as predictors, resulting in a total of 16 predicting variables. Following Vonesh, Chinchilli and Pu (1996), R^2 in multilevel models was obtained by the squared correlation between the predicted values of the alliance (by the 16 Response of Others predictors) and the observed values. This procedure resulted in an estimate of the overall extent to which representations of others predicted the alliance at each time point.

Next, we addressed our second question regarding the amount of overlap between alliance and representations of others that is formed only after meeting the real therapist (i.e., part C in Figure 1). Put another way, we aimed to distinguish between the part of the alliance throughout treatment that was unaffected by encountering the real therapist (i.e., the part of the alliance that existed even before the patient met the therapist, namely, pretreatment alliance) and the part of the alliance that was created only after the patient met the real therapist. To do so, we examined the contri-

bution of representations of others in explaining the alliance beyond pretreatment alliance. Specifically, we compared two models predicting alliance. The first model included only pretreatment alliance as an explanatory variable, and the second model included both pretreatment alliance and the 16 representations of others. Then, we subtracted the percentage of alliance explained in the second model from that obtained in the first model. This was conducted for each time point separately including therapist random effect as a second level. The results of such analyses are the percentages of alliance explained by the 16 representations of others beyond what can be explained by pretreatment alliance (i.e., beyond what existed before meeting the real therapist).

Finally, to examine the third question, whether there were specific representations of others that were most prone to being transferred onto the relationship with the therapist, we conducted a series of multilevel analyses for each of the four characteristics (hurtful, independent, loving, submissive) while accounting for therapist's effect. The entire process was repeated four times, for each of the four assessment points (intake and Weeks 2, 4, and 8). Since the third question was aimed at examining which relationship made significant unique contributions to each RO, above and beyond the contributions of other relationships, only the specific ROs for each relationship (i.e., mother, father, same-sex best friend, and romantic partner) were introduced to each multilevel model, with a total of four predictors in each model. This procedure resulted in the identification of the specific relationships that made significant contributions to the alliance for each of the ROs, and therefore, conceptually, are most prone to being transferred onto the alliance.

Results

Means, standard deviations, and Cronbach's alphas for the CRQ-R subscales are presented in Table 1. Internal consistencies were equal to or above .82 for 13 of the 16 CRQ-R subscales for each of the four relationships (see Table 1). A hierarchical multilevel analysis in which patients were nested within therapists, suggested that the estimated variances of the therapist's random

effect were null or nonsignificant for all time points. Specifically, the proportion of therapist effect variance for Week 2 was approximately 0 ($\sigma^2_{therapist} = 0.001$, $p = .99$), the proportion of therapist effect variance for Week 4 was 14.7% ($\sigma^2_{therapist} = 31.44$, $SE = 35.56$, $Z = 0.88$, $p = .18$), and the proportion of therapist effect variance for Week 8 was 12.54% ($\sigma^2_{therapist} = 13.71$, $SE = 19.60$, $Z = 0.70$, $p = .24$).

To What Extent Is the Alliance Explained by Pretreatment Representations of Significant Others?

A multilevel analysis predicting alliance by the four ROs of all significant others (introduced in one step) was conducted. This analysis was repeated for each of the four time points (intake, Week 2, 4, and 8). As can be seen in the "total variance explained" column in Table 2, at intake and during the second week, around one third of the alliance was explained by the representations of the four significant others. As treatment progressed into Week 4, a quarter of the alliance was explained by representations of significant others. Halfway through the treatment (Week 8), pretreatment ROs explained more than half of the alliance variance.[2]

To What Extent Is the Alliance With the Therapist Explained by the Representations of Significant Others Was Formed Solely After Meeting the Therapist?

The contribution of representations of others in explaining the alliance beyond the ability of pretreatment alliance to explain the alliance is given in the right column of Table 2 (the "variance not explained by pretreatment alliance" column). As can be seen in Table 2, throughout the course of treatment at least half of the overlap between alliance and representations of significant others was formed only after meeting the real therapist.

Are There Specific Representations of Significant Others That Are More Prone to Being Transferred Onto the Alliance?

For each of the four ROs, we performed a multilevel analysis to determine whether there were specific representations of others that made a *unique* contribution in predicting the alliance. This procedure was repeated for each of the four time points (intake and Weeks 2, 4, and 8). As can be seen in Table 3, at intake and during

Table 2
The Alliance Variance Explained by Representation of Others

Time	Total variance explained (%)	Variance not explained by pretreatment alliance (%)
Intake	32	—
W2	35	20
W4	25	17
W8	54	35

Note. Total variance explained = the percentage of the alliance variance explained by the representations of significant others at each time point. Variance not explained by pretreatment alliance = the percentage of the alliance variance explained by the representations of significant others at each time point, while controlling for the effects of pretreatment alliance. W = week.

Table 3
Representation of Significant Others That Were Found to Have a Significant Unique Contribution in Predicting Alliance for Each of the ROs

Time	Hurtful		Independent		Loving	
	RO	B	RO	B	RO	B
Intake	Fa	−0.22**	Fa	0.26**		
			RP	0.22*		
W2			Fa	5.11**		
W4	Mo	−4.04**				
W8	Fa	−5.36***			Mo	2.34*
	Mo	−2.97*			RP	2.17*

Note. No significant B's were found for the submissive characteristic. RO = Response of Other; Fa = father; Mo = mother; BF = best friend; RP = romantic partner; W = week; B = estimate coefficient.
* $p < .05$.   ** $p < .01$.   *** $p < .001$.

the second week of treatment, the representation of the father—specifically, his independent and hurtful characteristics—was the best predictor of alliance. The representation of the romantic partner as independent also made a significant unique contribution. As treatment progressed through Week 4, only the representation of the mother as hurtful made a significant unique contribution. By the middle of treatment (Week 8), the alliance became more multifaceted as both the father's and mother's representations as hurtful, and the mother's and the romantic partner's representations as loving, made significant unique contributions.

As can be seen in Table 3, viewing others as hurtful was negatively related to the alliance, while seeing others as independent and loving was positively related to the alliance. Additional post hoc analyses showed that a patient's gender did not influence the current findings.[3]

Discussion

The alliance is considered an essential aspect of psychotherapy by many theorists and researchers (e.g., Muran & Barber, 2010). In the current study we delved into one of the possible origins of the alliance by examining the extent to which it could be explained by the

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[2] To explore descriptive differences between treatment conditions in the model fit, we calculated the percentage of alliance (from Week 2 to Week 8) explained by representations of others in our model in both SET and the two CM conditions. First, a multilevel analysis was conducted in which the representations of others (16 variables) and treatment conditions were introduced as the predictors of the alliance throughout treatment, and the residuals were saved. Second, we estimated the variances of these residuals within the SET condition and within the two CM conditions. Third, we divided these variances by the variances of the alliance (within the SET and CM conditions) and subtracted it from 1, resulting in an estimation of the percentage of variance explained in each condition. Findings showed that while in the CM conditions, 42% of the alliance variance was explained by representations of others, in SET 20% of the variance was explained. Although the difference seems meaningful, it is unknown whether it is significant, as no relevant statistical test was found that would be applicable and some differences between conditions were apparent even at intake.

[3] We also examined whether patients with previous psychotherapy or counseling had different pretreatment alliance scores from those who did not have previous psychotherapy or counseling. Findings show that the two groups did not significantly differ in their pretreatment alliance score, $t(125) = 0.009$, $p = .99$.

patient's representations of significant others. Our findings showed that representations of significant others, as examined before treatment begins, predicted a substantial part of the alliance with the real therapist: benevolent representations of others at intake were positively related to the alliance subsequently developed with the therapist, while malevolent representations of others were negatively related to the alliance subsequently developed with the therapist.

Importantly, the current findings delineate a process of the development of the alliance from the representations of others. Before treatment began, patients form expectations of the therapeutic alliance that are, to a large extent, the projection of representations of significant others onto the therapist (32% of the alliance expectations are explained by representations of others), with one figure (the father) dominating the influence on the alliance. The same remains true at Week 2, when the patient has had only few meetings with the therapist (at this point approximately 35% of the alliance is explained by representations of others). By Week 4, however, when the patient has had approximately eight sessions with the therapist and is presumably starting to build up a relationship with the therapist, only 25% of the alliance is explained by representations of others.[4] In a post hoc interpretation of our findings we suggest that a process of "incubation" is taking place, in which the patient "puts aside" his or her projections while learning how he or she can fit the therapist into his or her existing patterns of relating to others. In what one may see as the results of the "incubation" process, by Week 8, after approximately 12 sessions with the therapist, there was an increase in the influence of representations of others on the alliance. Although the alliance at this point is substantially influenced by the patient's representations of others (approximately 54% of the alliance), those parts of the alliance were mainly formed through the encounters with the real therapist (and therefore are potentially not automatically projected). The projections at this point include a collage of representations of significant others (father, mother, and romantic partner). This collage seems to evolve to include different parts of the patient's inner representations that originated in different relationships, with the real relationship influencing the specific collage of others that is projected. The contribution of the real therapist to this process can also be evident by the changes in therapist's effect, which is null in the second week of treatment but becomes more than 10th at the fourth and the eighth week of treatment (although still not significant).

Getting back to Shelley's story, the findings may "predict" that before starting treatment, and perhaps also at the very beginning of treatment, the alliance she will form with her therapist is likely to be highly influenced by her automatic projections of representations of others. After a few sessions, a decrease in the influence of the projections can be expected, before a more complex view on the alliance can be created, which is likely to be influenced by both the projections of representations of others and the encounters with her real therapist. Throughout this process, her view of the alliance may evolve to include different parts of her inner representations that originate in different relationships, with the real therapist's characteristics potentially influencing the specific collage of others that is projected. For example, Shelley may see her therapist as abandoning her–exactly as she sees her father—after her therapist ended a session exactly on time, although she felt she was in the middle of her line of thinking. Therefore, although a substantial part of the alliance is formed only through encounters with the real therapist, the therapist is

still perceived by Shelley in ways that are familiar to her from her relationships with significant others. These findings may suggest that a process analogous to Piagetian assimilation (Piaget, 1970) takes place in which the patients use their familiar existing patterns of perceiving others to perceive the interactions with the real therapist. Throughout this assimilation process, the most relevant representations might be projected, such that the alliance becomes a collage of significant others' representations.

The findings from our current empirical investigation are consistent with descriptions from case studies demonstrating a process of change in the overlap between alliance and transference, from a relatively small overlap in the early stages of alliance formation to a great amount of overlap in the middle of treatment (e.g., Crits-Christoph et al., 1990). Additionally, although the current findings may to some extent not be in line with previous conceptualizations of the alliance, the transference, and the real relationship as distinct, orthogonal entities (Gelso & Hayes, 1998), they are consistent with findings showing high correlations among these components (e.g., $r = .79$ between alliance and the real relationship in Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010, as well as $r = -.50$ between the therapist's rating of the real relationship and negative transference in Marmarosh et al., 2009).

Furthermore, our current findings support the view that there are multiple transference themes rather than one, especially at the middle of treatment. Freud himself showed some ambivalence regarding this issue (Freud, 1912/1966). Luborsky et al. (1985) argued that one major dominant theme exists, while Horowitz et al. (1984), and Strupp and Binder (1984), argued that a variety of themes are most often apparent, especially as treatment progresses (Strupp & Binder, 1984). Our findings are consistent with Horowitz et al. (1984) claim that a variety of conflicts and issues can be transferred to the therapist, and therefore, not only one major theme of transference predominates. The current findings are also closely related to Strupp and Binder's (1984) description of a process in which at the beginning of therapy, one dominant theme exists, but as treatment progresses, several themes become apparent. Consistent with these theoretical assumptions, the current findings provide support for theoretical conceptualizations of transference that includes an initial uniform theme that evolves into a multiplicity of patterns as therapy progresses.

Although the results of the current study are grounded in clinical observations and support existing theories, our findings should be interpreted as preliminary and exploratory. Specifically, owing to the moderate sample size (which is still larger than many other studies in the field) and the inevitable missing data, the relatively large number of analyses and predictors conducted are a weakness. Additionally, the samples at the different time points are also not entirely overlapping (e.g., a specific patient may have missed one of the assessments or dropped out before the last assessment point). Therefore, although missing data were not associated with alliance or outcomes in the current study, the use of data only from patients who remained in therapy at each time point may still introduce a bias, as the analyses are based only on the available data (see Smith et al., 2010). The moderate sample size also prevented us from examining whether significant differences exist between treatment types. In a sense, not

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[4] It is unknown whether the changes in the percentage of alliance explained by representation of significant others are significant.

being able to distinguish SET from supportive CM is a major short-coming of the present study. In fact, discussing alliance and transference across both supportive CM and SET might appear surprising if one expects the interpretative psychodynamic work on interpersonal relationships to play a causal role in the formation of transference. However, our findings are in line with a view of transference as a phenomenon that is not restricted only to psychoanalysis or psychodynamic treatment (Gelso & Bhatia, 2012). Our findings are also in line with studies demonstrating the role of the alliance as a common factor across different treatment orientations, including supportive treatment (Horvath et al., 2011), and are empirically supported by a separate analysis on the current data set showing that type of treatment did not moderate the alliance–outcome association (Zilcha-Mano et al., in press). Furthermore, keeping in mind that there were no significant differences in efficacy among the three treatments, the fact that the effect of representations of others on alliance was revealed in such a heterogeneous sample cannot be ignored. It may support the argument that relatively similar interpersonal processes take place in distinct, but equally effective, treatments. Saying that, it is important to acknowledge that our findings do not rule out the possibility that different tasks may be related to different amounts of transference, and different overlaps between alliance and transference (Wampold & Budge, 2012), as different treatments may still result in the same outcomes even when different processes occur (DeRubeis, Brotman, & Gibbons, 2005; Ulvenes et al., 2012). Future research should further examine this issue.

A further limitation of the current study is its reliance on self-report measures, which restrict our understanding of unconscious processes and may also have contributed to inflated associations due to shared method variance. Another limitation is the low reliability of three of the CRQ-R subscales and the fact that although we explicitly asked patients to answer the pretreatment alliance questionnaire for their upcoming therapy and not their intake evaluator, we cannot know exactly how participants interpreted the questions or what they were thinking when they answered them (see Hill, Chui, & Baumann, 2013). Additionally, although our study is based on one of the most widely used definitions of the real relationship as the conceptual framework, and the findings are in line with other studies that used direct methods to examine the real relationship and the real therapist, the analyses conducted in this study were based on indirect methods of examining the real relationship, and we cannot rule out the possibility of alternative explanations. Therefore, the current findings ought to be integrated with findings using other methods of examining the real relationship (such as patient and therapist self-report measures or observer coding that more directly addresses the genuineness and realistic perceptions of the therapist and the relationship, for review see Gelso, in press) in order to enable a comprehensive understanding of this concept. Finally, although a temporal relation exists between representations of others (examined at intake) and alliance (examined through treatment), causality cannot be implied, as third-variable explanations cannot be ruled out.

As discussed in the introduction, the current study addresses the controversial theoretical issue of whether the alliance mainly includes nontransferential parts or rather that no aspect of the therapeutic relationship is devoid of transferential loading (e.g., Greenson, 1967). The findings of the current study support both perspectives. Specifically, on the one hand, results showed that substantial parts of the alliance originated in intrapsychic processes (i.e., projections of representations of significant others).

However, on the other hand, the parts that are projected are eventually assimilated to fit the encounters with the real therapist and were not only automatically projected onto the alliance. Therefore, even the intrapsychic origins of the alliance seem not to be a "pure" intrapsychic process but rather arise from within the interpersonal relationship with the real therapist. Additionally, there were other parts of the alliance that could not be explained by the representations of significant others (at least as operationalized in the current study).

The current findings constitute fertile ground for further examination of a variety of clinically important questions. While the current study focused on describing general phenomena, future research could examine the effect of individual differences between patients (such as patient's interpersonal problems, Dinger, Zilcha-Mano, McCarthy, Barrett, & Barber, 2013, or attachment orientation) as well as the effects of specific characteristics of the real therapist (such as the therapist's attachment orientation, or the therapist's personal therapy experience, Gold & Hilsenroth, 2009), and the characteristics of the specific interactions between the patient and the therapist on the phenomena described in this study. Additionally, as the current study is not ideal for evaluating therapist effects, future large-scale studies with appropriate designs for investigating therapist's effect (e.g., appropriate patients–therapist ratio and number of therapists, see Baldwin & Imel, 2013 for comprehensive description), should further examine the influence of the therapist's effect on the findings. Moreover, our interpretations of the findings (e.g., our "incubation process" suggestion) should be examined in clinical practice and research to learn about their potential utility. Additionally, future studies could use other theoretical (e.g., attachment theory, cognitive scheme) and methodological (e.g., The Quantitative Assessment of Interpersonal Themes, Crits-Christoph et al., 1990; Adult Attachment Interview, Main & Goldwyn, 1994; Real Relationship Inventory, Kelley et al., 2010) perspectives to observe the impact of transference on alliance in a variety of treatments (e.g., cognitive behavioral therapy, long-term dynamic therapy), such that broader understanding of the patient–therapist relationship can be obtained. Using those methods and others may help in answering questions such as why certain themes get enacted in the alliance while others do not, and how the characteristics of the real therapist contributes to the interpersonal patterns exhibited in the alliance. These questions are of great importance, especially as contemporary evidence-based approaches to transference have started to emerge (DeFife, Hilsenroth, & Kuutmann, 2014).

In sum, our findings delineate a process of alliance formation that is highly influenced by both representations of others and the patient's encounter with the real therapist. If replicated in future studies with diverse treatments and large sample sizes, these findings will have important implications for the practice of psychotherapy. For example, by paying greater attention early in treatment to patients' relational patterns, clinicians could learn more about potential risks and benefits to the alliance formation relevant to a specific patient, and accordingly, better manage the alliance using interventions relevant to create and repair the alliance. Specific evidence-based strategies can be used to resolve ruptures in the alliance that may originate from issues of conflictual needs for relatedness and agency as emerged in the patients' relational patterns (Safran, Muran, & Eubanks-Carter, 2011) and to offer corrective emotional experiences (Friedlander et al., 2012). Ther-

apists may also choose to use empathically attuned, open, and curious interpretations of the transference to facilitate patients' awareness and understandings of the maladaptive parts of their transference patterns (Crits-Christoph, Barber, & Kurcias, 1993; Levy & Scala, 2012) and to explore with the patient the in-session interactions between themselves and the patient (i.e., the therapeutic immediacy, DeFife, Hilsenroth, & Kuutmann, 2014; Kuutmann & Hilsenroth, 2012). Finally, some hope for collaborations with the patients' nontransferential parts of relating might be suggested based on the current findings.

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