tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

Journal of Psychotherapy Integration

1053-0479/16/$12.00 http://dx.doi.org/10.1037/int0000042

A Clinical Science Approach to Training First Year Clinicians to Navigate Therapeutic Relationships

AQ: au

Alytia A. Levendosky and Christopher J. Hopwood
Michigan State University

In the rise of the clinical science movement within clinical psychology, the importance of the therapeutic relationship in training graduate students to do psychotherapy has been neglected compared with the emphasis on therapeutic techniques that target specific client symptoms. We argue that the reliable evidence for the importance of the therapeutic relationship for maintaining a therapeutic alliance and as a mechanism of change earns it a central place in training and supervision. We describe how we have used the principles of the clinical science perspective to develop a training model for graduate students emphasizing therapeutic relationships within the context of collaborative assessment and relational/interpersonal psychodynamic therapy. We use a case example to illustrate how our training model engages students in understanding and using the therapeutic relationship as a mechanism for change within treatments. We demonstrate how we have implemented this training model within the context of a clinical science program.

Keywords: therapeutic relationships, psychodynamic psychotherapy, clinical supervision, training, clinical science

"I feel rebellious" tittered a first year graduate student on the first day of our required course, titled Psychodynamic Theory, Research and Intervention Across the Life Span. The student further elaborated, echoed by her classmates, that none of their friends in other graduate programs would even be able to take such a course, much less have it required. The implicit question in the minds of our first year students is why do we, as a clinical science program, require this class and offer clinical supervision from this perspective, which in the minds of many in the clinical science movement is outdated and lacking scientific evidence (e.g., Zinbarg, Mashal, Black, & Flückiger, 2010).

AQ: 1

The answer is that we think it is important to train clinicians to navigate the therapeutic relationship. There is a great deal of scientific evidence that the therapeutic relationship matters for treatment outcomes (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Barber et al., 2014; Bennett, Parry, & Ryle, 2006; Connolly et al., 1999a; Constantino, Arnow, Blasey, & Agras, 2005; Hersoug, Høglend, Gabbard, & Lorentzen, 2013; Høglend et al., 2006, 2011; Kuutmann & Hilsenroth, 2012; Levy, Hilsenroth, & Owen, 2015; Muran et al., 2009; Stiles, Honos-Webb, & Surko, 1998). This includes not only the therapeutic alliance (Baldwin, Wampold, & Imel, 2007; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012), now generally accepted across therapeutic orientations, but also the use of the therapeutic relationship as a mechanism for change (Fonagy & Allison, 2014; Gassman & Grawe, 2006; Hill & Knox, 2009; Peluso, Liebovitch, Gottman, Norman, & Su, 2012; Watson, Steckley, & McMullen, 2014). Strong evidence also exists that elements of the therapeutic relationship related to positive therapeutic outcomes are trainable, including transference interpretations (e.g., Høglend et al., 2006, 2011), empathy (e.g., Watson et al., 2014), repair of ruptures

AQ: 3

AQ: 4

Alytia A. Levendosky and Christopher J. Hopwood, Department of Psychology, Michigan State University.

Both authors contributed equally to this article. The authors thank Nicola Bernard, Antonia Garcia, Jeff Lin, Sharon Lo, Xiaochen Luo, and Shannon O'Connor for their assistance in developing the ideas represented in this article.

Correspondence concerning this article should be addressed to Alytia A. Levendosky, Department of Psychology, 107 C Psychology Building, Michigan State University, 220 Trowbridge Road, East Lansing, MI 48824. E-mail: levendo1@msu.edu

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

(e,g, Safran & Kraus, 2014; Safran et al., 2014), and mentalizing (e.g., Bateman & Fonagy, 2013; Fonagy, Luyten, & Bateman, 2015).

Among the contemporary categories and brands of psychotherapy, the relational/interpersonal psychodynamic approach most clearly emphasizes therapeutic relationships. Our challenge, as supervisors in a clinical science training program, is that the prevailing view in clinical science is that cognitive-behavioral therapy (CBT) is the most evidence-based approach (e.g., Baker & McFall, 2014; Baker, McFall, & Shoham, 2008; Zinbarg et al., 2010), coupled with the general focus of this approach on techniques that could be delivered by any competent clinician to any client with a particular diagnosis, rather than the unique and dynamic relationship between therapist and client. Some third-wave CBT approaches, including dialectical behavior therapy (Linehan, 1993) and Acceptance and Commitment Therapy (Hayes, 2004), focus relatively more than traditional CBT on the relational aspects of treatment. However, the primary approach of the clinical science training model is to de-emphasize the role of therapist behavior or the therapist−client relationship. This is clearly stated in the clinical science manifesto (Baker et al., 2008), in which the authors claim that the evidence on therapeutic alliance is so "ineffable that no set of procedures can be distilled into any specific therapeutic techniques and thereby earn EST status" and the therapeutic relationship as a mechanism of change goes unmentioned (p. 82). Finally, despite the claims made by many in the clinical science movement (e.g., Baker et al., 2008; Zinbarg et al., 2010) that CBT interventions are the only ones with evidence to support their broad dissemination and use, psychodynamic therapies have amassed considerable evidence as to their effectiveness (Dreissen et al., 2010; Fonagy, 2015; Leichsenring et al., 2015; Leichsenring & Rabung, 2008; Leichsenring, Rabunh, & Leibing, 2004).

Our students' surprise at being trained in psychodynamic psychotherapy is understandable in this context. They are correct that our program, situated in a Research 1 University in a research-oriented department of psychology, is unusual in requiring psychodynamic training (Sayette, Norcross, & Dimoff, 2011; Heatherington et al., 2012; Levy & Anderson, 2013) and explicitly training students about the importance of the therapeutic relationship. In fact, Levy and Anderson (2013) found that over the past 22 years, the percentage of faculty in clinical psychology programs who adhere to any theoretical perspective other than CBT is falling (with the exception of family which has held constant) whereas the proportion of CBT-identified faculty has increased to 67%. At clinical science programs (those programs that are members of the Academy of Psychological Clinical Science; APCS), 80% of faculty identify with a CBT orientation and only 7% as psychodynamic (Heatherington et al., 2012). Our own survey found that ours is the only one of 61 programs with a course titled psychodynamic psychotherapy (we also have a course titled CBT), whereas about one third of the APCS programs have courses titled CBT or Empirically Supported Treatments. Only three, in addition to ours, included a reference to psychodynamic therapy in course descriptions.

The motivation for our emphasis on training relational principles comes from the established association between relational factors and therapeutic outcomes in the psychotherapy literature, coupled with the relative emphasis on symptom-focused techniques in the clinical science movement. We emphasize that we see this approach as relatively free from any particular treatment package or orientation, despite our use of certain manuals and models to guide students. Our view is broader than the application of a specific therapy: We expect that training students about the role of the therapeutic relationship as a mechanism of change will be useful regardless of their ultimate therapeutic theoretical orientation (cf. Safran's alliance rupture training for CBT therapists: Safran et al., 2014). We are not particularly concerned about training students in treatments for particular disorders, in part because we are fortunate to have colleagues in our program who complement our training via our required CBT class and through clinical supervision that emphasizes disorder-specific approaches.[1] Instead, our therapy model, as specified below, considers all "problems in living" to be inherently interpersonal in

[1] Note that there is evidence supporting relational/psychodynamic approaches to symptom reduction even in disorders that are not typically considered "interpersonal" (e.g., Milrod et al., 2007).

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

that they involve how the person relates to self and others, both in representations and in behavior. We view our perspective as fitting comfortably within a clinical science perspective. For instance, our approach aligns with the principles of the APA Division 12 (Society for Clinical Psychology) working group that included faculty at several APCS programs (Beck et al., 2014), which emphasize the following principles: (a) teaching students to base clinical practice on research, (b) teaching critical thinking, (c) teaching lifelong learning, and (d) integrating experiential with didactic learning in all aspects of training. The authors explicitly state that their training model is "atheoretical" in advocating evidence-base for clinical work independent of ideology and emphasize teaching students the evidence for therapist characteristics, and process variables, among others. Indeed, we view the relatively broad and ecumenical approach in our program as relatively more in line with a principled approach to clinical science than one which focuses narrowly on a single theoretical perspective or which assumes that one set of mechanisms (e.g., symptom focused techniques) are superior to others (e.g., relational processes) despite evidence to the contrary.

The goal of this article is to describe our approach to training relational process to novice trainees in a clinical science program. We begin by outlining our general theoretical model. We then describe the specifics of our training approach in greater detail. We conclude with a case that demonstrates the value of explicitly teaching trainees how to navigate therapeutic relationships.

Our Theoretical Model

Our approach is informed by Sullivan (1953) who viewed client's problems as involving maladaptive interpersonal patterns that recur because they worked well in important interpersonal situations during personality development and have thus become difficult to change (see Benjamin, 1993; Pincus, Lukowitsky, & Wright, 2010). We are also influenced by object relations theorists such as Winnicott (1965) and Kernberg (1967, 1987) who emphasized the importance of internal representational models of self, other, and affect. Together these conceptual approaches inform our treatment goal to help clients develop more adaptive interpersonal patterns. We try to achieve this goal primarily through trying to understand and modify recurring maladaptive patterns (Connolly et al., 1999b), particularly as they develop in the therapeutic relationship (Binder & Betan, 2013; Clarkin, Yeomans, & Kernberg, 2006; Messer, 2013; Strupp & Binder, 1984; Teyber & Teyber, 2014).

To modify these recurring maladaptive patterns, we apply Sullivan's (1953) view of the therapist stance as alternating between participation in and observation of the therapeutic relationship. Balancing participation and observation is facilitated by three core therapeutic qualities that we emphasize in our training (see Rogers, 1957 for a similar model): *authenticity* (i.e., genuine participation in the relationship with the client), *empathy* (i.e., understanding the client's perspectives across behavior and representations), and *curiosity* (i.e., wondering what is happening in the here-and-now in the therapeutic relationship across the levels of behavior and representations). Following Sullivan (1953) and contemporary relational psychodynamic therapists (Binder & Betan, 2013; Messer, 2013; Safran & Kraus, 2014; Teyber & Teyber, 2014), the therapist is expected to empathically engage with the client in an authentic relationship that activates the client's unconscious representations of self and other.

Given that interpersonal functioning is a core feature of personality disorders, and all evidence-based treatments for personality disorders emphasize the careful navigation of the therapeutic relationship (Hopwood et al., 2013), clients with personality problems who present at our training clinic tend to be triaged to our team. Because we focus on training our students to treat clients with personality pathology, frequently the clients have relatively severe maladaptive patterns characterized by distortion (i.e., perceptions of self and other that differ from most others with whom the client interacts) and dysregulation in the self and affect systems and interpersonal field, which can lead to rather rigid projective identifications and transference/countertransference patterns (e.g., Clarkin et al., 2006; Pincus & Hopwood, 2012). Careful attention to relational dynamics are particularly important in such cases.

Once the therapist has participated in the relationship, she can move into observation of

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

the therapeutic dyad and through mentalizing (i.e., reflecting on the conscious and unconscious motives of self and other; cf. Bateman & Fonagy, 2006; Fonagy & Allison, 2014) of these rigid patterns to begin working with the client toward change. As part of authentic participation in the relationship, we view rupture between the client and therapist as inevitable (Safran & Kraus, 2014). Ruptures in the therapeutic situation, as in any other intimate relationship, involve the participation of both members of the dyad (Safran, Muran, & Eubanks-Carter, 2011; Safran, Muran, Samstag, & Stevens, 2001). Typically, the client contribution reflects the client's maladaptive interpersonal patterns, including some degree of distortion and dysregulation, whereas the therapist contribution may be an empathic lapse, perhaps related to distortion or dysregulation within the therapist. Similar to Safran, we view the process of repair to be mutual, but typically initiated by the therapist, who is able to step back and observe the rupture, mentalize it, and then collaboratively and empathically invite the client to explore what happened between them and its meaning for the client and for the therapeutic dyad (Safran & Kraus, 2014). As the client and therapist explore this together, the distortion and dysregulation in the client's internal representations of self and other can be understood. As the client feels understood, repair occurs and shifts to healthier, less distorted representations of self and other begin to happen as reflected in more adaptive functioning in the relationship with the therapist and other important figures in the client's life.

As described in preceding text, while our approach emphasizing the therapeutic relationship as a mechanism of change through the therapist stance of authenticity, empathy, and curiosity developed out of contemporary psychodynamic approach to treatment, our goal is to prepare students for navigating therapeutic relationships regardless of their ultimate theoretical orientation of choice. Indeed, training in rupture-repair sequences for CBT therapists improves therapeutic outcomes (Safran et al., 2014), and we expect our training to transfer to our students' work under CBT supervisors. Our view is that training about the therapeutic relationship is critical for future clinical psychologists, regardless of theoretical orientation and treatment approach.

Our Training Model

We have developed a training model that emphasizes the importance of the therapeutic relationship, using interpersonally oriented relational psychodynamic theory to guide assessment and intervention for clinical psychology graduate students within a clinical science program. We supervise together a team of graduate students in practicum, called the *Interpersonal Problems Clinic* (IPC), and our in-house psychological clinic assigns clinical cases to our team that are deemed appropriate for our approach. Note that the intake process at our training clinic attempts to exclude clients who are actively suicidal or actively abusing alcohol or other drugs or who have psychotic or bipolar disorder. The clinic director refers cases to our team that do not have a clear behavioral treatment target and are thus less suited for a short-term CBT treatment. Thus, the cases referred to our IPC team are those whom the intake process suggests some likely personality pathology, frequently co-occurring with depression or anxiety symptoms. Our training model involves the use of multimethod assessment of clients, the therapeutic dyad, and therapist behavior, consistent with a clinical science approach to intervention, and focuses on mentalizing rupture−repair sequences in the relationship between the client and the therapist as the mechanism of change (Fonagy & Allison, 2014). As described subsequently, we explicitly frame the therapeutic dyad as participating in an ongoing interpersonal situation that reflects conscious and unconscious contributions of the client and the therapist. We train student therapists to conceptualize the client's problems, and to intervene, through the lens of the here-and-now interpersonal situation. Finally, we use individual and group supervision to help student therapists understand their own and the client's contribution to the present interpersonal situation in the therapy room.

The Interpersonal Situation

We use a contemporary interpersonal model of personality to organize data and hypotheses about maladaptive relational patterns (Hopwood, Pincus, & Wright, in press; Pincus, 2005; Pincus & Hopwood, 2012). The key organizing construct from an interpersonal perspective is

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

the interpersonal situation. Following Sullivan (1953) and as shown in Figure 1, every interpersonal situation involves two people. In general, our treatment targets unconscious representations of self and other which are reflected in interpersonal behavior. The *self* is consciously experienced as "I/me", but also reflects unconscious motives and identifications. The *other* may be real (e.g., the therapist relative to the client) or represented, consciously or unconsciously (e.g., the client's representation of the therapist).

Two systems exist within each person: the self system and the affect system (Sullivan, 1953). The *self system* depicts variability in self-concept. We conceptualize the self system as organized around two orthogonal dimensions of agency and communion (Pincus, 2005). These dimensions reflect two fundamental motives (see also concepts such as self-definition and relatedness [Luyten & Blatt, 2013] or sociotropy and autonomy [Beck, 1991]) underlying interpersonal dynamics. The *affect system* depicts variability in affects. The discrete emotional experiences that emerge from the affect system can be arranged within a circle defined by arousal, or the amount of overall emotional intensity, and valence, or the degree to which emotions are pleasant or unpleasant (Posner, Russell, & Peterson, 2005). The self and affect systems are assumed to mutually influence each other, as shown by the double-headed arrow. The third system, the *interpersonal field*, connects people (Wiggins & Trapnell, 1996). The self and other interact in an ongoing sequence of behaviors, each of which can be organized around the dimensions of dominance (vs. submission) and warmth (vs. coldness). In addition,

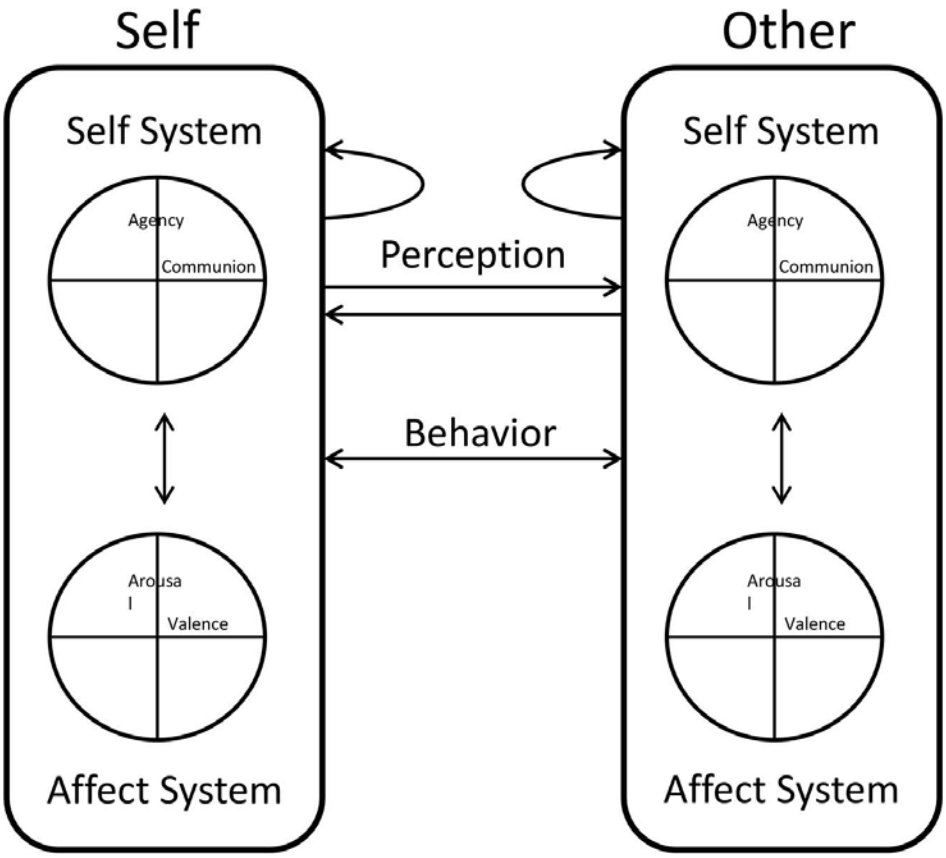

Figure 1. The interpersonal situation. From "The Interpersonal Situation: Integrating Clinical Assessment, Formulation and Psychotherapy," by C. J. Hopwood, A. L. Pincus, and A. G. C. Wright, in D. B. Samuel & D. Lynam (Eds.), *Using basic personality research to inform personality disorders*, in press, New York, NY: Oxford University Press. Copyright 2016 by the Oxford University Press. Adapted with permission.

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

the self must also perceive the other, the other must perceive the self, and both parties must perceive their own affect (arousal and valence) and behavior (dominance and warmth). The accuracy of these perceptions will have a major impact on likelihood for adaptive behavior. These perceptions are indicated by the four single-headed arrows at the top part of the figure.

We use this figure for a number of purposes on our team. First, all assessment data are understood as indicating some level of dysregulation in the self, affect, or interpersonal systems or some level of distortion of self or other. Thus AQ: 7 interpersonal diagnosis (Leary, 1957) amounts to understanding assessment data in terms of the impacts of various factors on dysregulation and distortion in interpersonal situations (Hopwood et al., 2013). Conceptualizing assessment data this way hones our students' focus on relational aspects of personality and environmental context. Second, the figure offers an internal model of the interactions between student and client, so that students can remain grounded in the assessment data and treatment principles that guide their work, and integrate real time interactions with the client into their developing formulation. This use of the figure provides a framework within which the student can be flexible, authentic, empathic, and curious as their relationship with the client unfolds. Third, the figure offers a model for efficiently communicating information with supervisors. We often reference the figure, for instance in trying to understand assessment data or a particular interaction during therapy, in our supervision meetings. Fourth, the model provides a baseline against which dynamic complexity can be understood. For instance, it is understood that different "surfaces" or levels of the interpersonal situation exist, as represented for instance by more and less conscious aspects of self, affect, or interpersonal behavior. In this manner, the figure flexibly covers multiple levels of personality that range in depth and observability. It is also understood that behavior is systematically patterned (e.g., Luborsky & Crits-Cristoph, 1998; Strupp & Binder, 1984), and thus the model can be extended to capture such dynamic patterns, as represented by shifting placements of self, other, and affect on the interpersonal and affective planes over time (Pincus & Hopwood, 2012; see case example in the following text).

Collaborative Assessment

We train our students to use a collaborative approach (Finn, 2007) for developing and discussing formulations with their clients. This approach integrates the data-gathering function of assessment with authenticity, empathy, and curiosity on the part of the clinician (Finn & Tonsager, 1997; see Hilsenroth, 2007, for an AQ: 8-9 example that heavily influenced our approach). The collaborative case formulation is then used to inform our students' relational approach to psychotherapy. The critical value in evaluating the utility of specific interventions is local science (Stricker & Trierweiler, 1995) or the idea that every intervention should be based on a specific formulation, the effects of which are tested via ongoing assessment throughout treatment. Intervention strategies are regularly modified according to the dynamic formulation that is accrued across assessments/treatment, and within the context of the principles and constraints of the selected treatment. It is important to note that the use of this model provides a common language on the treatment team which can accommodate the strategies of evidence-based psychodynamic treatment (and, at times, techniques from other theoretical models) and tether clinical behavior to the assessments being gathered by the team.

In sum, we use the interpersonal situation model of integrating collaborative assessment with contemporary relationally oriented, interpersonal psychodynamic psychotherapy to train the students in navigating therapeutic relationships. This therapeutic model is based on evidence from basic and applied research suggesting the efficacy and effectiveness of this approach. In addition, our emphasis on focusing on the relational aspects of therapist-client dyad, and rupture and repair sequences specifically, have been shown to be helpful to treatments from other approaches (e.g., Safran et al., 2014).

Specifics of Our Training Model

Structure of training. Our training model begins with the students' first year coursework, particularly in the required courses in psychodynamic psychotherapy and personality assessment. Students also have courses in psychopathology, cognitive assessment, cognitive-

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

behavioral therapy, statistics, and diversity and social justice during their first year of our program. Although the psychodynamic psychotherapy and personality assessment courses are tasked with training students in these domains in general, we allocate some parts of these courses on the underlying philosophy and interventions that are specifically used on the team.

The class on psychodynamic psychotherapy gives students a broad background in evidence-based psychoanalytic concepts, for example, unconscious, mental representations, defenses, attachment, mentalizing, as well as teaching evidence-based psychodynamic treatments, both short (time-limited dynamic psychotherapy [TLDP]; Strupp & Binder, 1984) and long-term (transference-focused psychotherapy [TFP]; Clarkin et al., 2006). We chose TLDP and TFP because although they differ on the length of treatment and the client population (TLDP is for the neurotic client and TFP is for the client with personality pathology), they both focus on the importance of the therapeutic relationship. Discussion in this course focuses on the therapist−client relationship and how it both facilitates understanding of the client's representational world and can modify it. TLDP and TFP both emphasize the role of the therapist in the inevitable enactments or projective identifications that develop over the course of treatment. Rupture−repair sequences in therapeutic relationships and the role of the therapist in working toward repair, through mentalization and collaboration (e.g., Safran & Kraus, 2014), are taught and role-played in class with each student having the opportunity to play the therapist.

The personality assessment course focuses primarily on training students to use a variety of assessment tools, including instruments such as the Personality Assessment Inventory (Morey, 1991), self- and informant-report Interpersonal Circumplex measures, and Thematic Apperception Test (Murray, 1943) that are used on our treatment team. The class teaches a collaborative approach to assessment (Finn, 2007), which parts ways with traditional information gathering approaches in its focus on collaboration with the client. Assessment tools are considered, in this approach, as empathy magnifiers whose scores could be interpreted in multiple ways, rather than as truth generators. Assessment is understood as encompassing a great deal more than psychiatric diagnosis (Meyer et al., 2001) but is regarded instead as a way for the client and therapist to collaborate in understanding the functional and developmental factors that support an individual's problems in living and contextual and personality factors that color or mediate those problems. In line with this approach, significant emphasis is placed on the process of relating to clients using one's own inner reactions as a way of understanding client difficulties (Sullivan, 1953).

After completing their first year in the program, students may elect to be part of our IPC supervision team either during their first year of practicum (second year of the clinical program) or in a later year of the program.[2] We each serve as individual supervisors for students on the team, in addition to working closely together as we supervise in the group format. As part of individual supervision, we focus significant attention to watching videos of students' interactions with clients throughout the supervision year. We each spend about 8 to 10 hr/week in supervisory activities with typically two students assigned to each of us.

We are in the position of training novice therapists, many of whom are in their first year of psychotherapy training, but all of whom are in doctoral training. Thus, we view our training as important for building basic psychotherapy skills through a psychodynamic lens. On our supervision team, we are not training students to conduct TLDP or TFP or any other manualized psychotherapy. Instead, we use the principles taught in those treatments to train foundational skills, especially emphasizing the therapeutic relationship that not only will carry forward to psychodynamic psychotherapy but also will generalize to good foundational skills for all psychotherapeutic practice.

Content of training. We are sensitive to the issues of declarative and procedural knowledge for learning how to do psychotherapy as articulated by Binder (1993). The courses described earlier primarily provide declarative knowledge which may be inert by the time the students begin seeing clients. Thus supervision is intended to both reawaken declarative knowledge and emphasize procedural knowledge. The

[2] Training manual is available from the corresponding author on request.

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

former is done through the didactic component of our team, including the rereading of and discussion of some of the articles from the courses, and watching videos of supervisors conducting therapy. Procedural knowledge is emphasized through role plays, detailed examination of client-therapist interactions, and in vivo process of student-therapist and team member relationships.

Prior to the student therapists beginning to see clients, we have several group meetings in which we orient students to the team, both reawakening and presenting new declarative knowledge and potentiating procedural knowledge. We read and discuss the theoretical background for interpersonal assessment through a collaborative frame (Finn, 2007) and teach the students how to administer and interpret the particular assessments (Hopwood, 2010). We read about and discuss articles relevant to psychotherapy, focusing on transference dynamics and mentalizing rupture and repair cycles (e.g., Binder & Betan, 2013; Messer, 2013; Safran & Kraus, 2014; Teyber & Teyber, 2014). We also present several annotated videos of ourselves conducting psychotherapy. Finally, we attend a private workshop for our team run by a faculty member in the Theater Department who teaches the importance of understanding your own inner monologue (Roznowski, 2013) to understand the inner monologue of others, whether it is a character you are playing or the client in the room. The faculty member and his graduate students conduct exercises with the team to help them become more aware of their own inner monologues and then to practice awareness of that while also gaining awareness of another person's inner monologue. This workshop begins the process of experiential training which is continued in group supervision and facilitates the development of procedural knowledge for supervision.

During individual supervision for the initial phase of treatment, we focus on helping students use collaborative assessment (Finn, 2007) to understand the client's concerns and questions and to develop a case formulation in response to these questions. As treatment continues, individual supervision helps students use the case formulation as a guide for their interventions. Video clips that either the student or supervisor have noted contain important client−therapist interactions are viewed regularly. Particular attention is paid in supervision to the therapist behavior and how countertransference may be influencing student therapist responses to the clients, consistent with current psychodynamic supervision practice (e.g., Diener & Mesrie, 2015). In addition, attention is paid to how countertransference may influence supervisor responses to student therapists, consistent with understanding supervision as a parallel process to psychotherapy (Tracey, Bludworth, & Glidden-Tracey, 2012).

In addition, we attend a biweekly 2-hr group supervision meeting that involves didactics, supervision, and in vivo group process. The didactic component includes assigned readings relevant to our training goals (e.g., listening, alliance rupture and repair) and discussion of those readings focused on the competencies that we hope that the students will gain (i.e., how to do active listening, how to identify ruptures and work toward repair) and, in the beginning of the year, watching videos of supervisors and expert psychodynamic clinicians do therapy. This component solidifies and activates declarative knowledge of psychodynamic concepts and therapeutic skills.

The therapy supervision component of the group meeting involves discussion of cases, reviewing session tapes and assessment data, and preparation for program-wide case conference presentations. Students select video clips that illustrate one of the primary training topics (e.g., alliance rupture and/or repair; Eubanks-Carter, Muran, & Safran, 2015). We watch the video clip as a team, and address therapist and/or supervisor questions about the video clip or the case more generally. We also use the video clips to train students to understand how their behavior affects the interpersonal situation, and to inform our role plays of clients we have observed to help students with imagined scenarios that may occur with their clients. The students role play both their own clients to see their supervisors respond therapeutically and themselves with a supervisor playing the client, to try out particular techniques. Students on the team are expected to do some peer supervision, especially in the second semester as they become oriented to doing therapy and to how supervision works. These role plays and detailed examinations of the client-therapist interactions from the video facilitate procedural knowledge of therapy transactions.

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

Finally, individual and group supervision allow for an in vivo experience of the interpersonal situation. Our students experience this as one of the more unique aspects of our training model. During supervision, the supervisor(s) is expected to be authentic, empathic, and curious and to mentalize the student(s), thus scaffolding the learning process. The supervisors and students discuss interpersonal ruptures as they occur and work to repair them, consistent with relationally oriented psychodynamic supervision practice (see Eubanks-Carter et al., 2015; Friedlander, 2015). This can be an uncomfortable experience for students but it facilitates their procedural knowledge of how to handle ruptures and how to work toward repair in meaningful relationships. The supervisor(s) help to repair the ruptures by empathically encouraging the student(s) to stay with the ruptures until the content and affect associated with the rupture is understood by all involved so that repair can occur. Resistance by group members to staying in the rupture/repair cycle is acknowledged and discussed. This cycle of acknowledging ruptures and working actively to repair them through discussing content and feelings related to them, along with the resistance to talking about this process, gives students the opportunity to experience holding all of this for themselves and the other group members as they are encouraged to do with their clients in psychotherapy. As the supervisors and students experience these rupture/repair cycles together over the course of the year, students begin to mentalize their supervisors, allowing them to be more active in the repair process, again similar to what we expect will happen with clients in psychotherapy.

Near the end of the supervision year, the termination process of the group and individual supervision is discussed; supervisors share their feelings and encourage students to do the same, including feelings about the group process. It can be uncomfortable for students to talk with the supervisors ~~talk~~ about the experience of working together during the year and saying goodbye. However, this experience offers the opportunity for students to hold those feelings of loss both for themselves and the others on the supervision team, much as they will do in therapy with their clients. The importance of authenticity, empathy, and curiosity are experienced in vivo in the group during these discussions, and modeled to highlight the importance of these qualities in therapy, itself. Thus, the supervision experience is intentionally designed as a parallel process to psychotherapy in our approach to supervision (Friedlander, 2015; Tracey et al., 2012).

Developmentally across the year of supervision and summatively at the end of the supervision year, we assess our students' progress in learning to navigate therapeutic relationships and effect positive change via multimethod assessments (see Table 1). These assessments include the Comparative Psychotherapy Process Scale (CPPS; Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005), completed by the supervisor and the Working Alliance Inventory (WAI; Hatcher & Gillaspy, 2006; completed by client and therapist) and indices of client change including the *Outcome Questionnaire—45* (OQ-45; Lambert & Finch, 1999), several Interpersonal Circumplex measures including Inventory of Interpersonal Problems—Short Circumplex (IIP-SC; Horowitz, Alden, Wiggins, & Pincus, 2000; Soldz, Budman, Demby, & Merry, 1995), Interpersonal Sensitivities Circumplex (ISC; Hopwood et al., 2011) and Circumplex Scales of Interpersonal Values (CSIV; Locke, 2000). In addition, we ask clients during the assessment phase to collect two weeks of ecological momentary assessment (EMA) of daily interactions in which the client rates himself and the other interactant on self-warmth, self-dominance, other warmth, other dominance, and positive versus negative affective valence for self on a 1 to 7 scale. Finally, we also use the Continuous Assessment of Interpersonal Dynamics (CAID; Sadler, Ethier, Gunn, Duong, & Woody, 2009), a video-coding procedure to collect information about dynamics that occur within assessment and therapy sessions.

T1

AQ: 10

Throughout the supervision year, these assessments are used to guide the supervisor and student in terms of relative progress in applying the approach we are teaching. We expect that CPPS scores will tend to reflect an increasing use of psychodynamic interventions, that WAI scores will show good alliances that improve over the course of the training year, and that IIP-SC and OQ-45 scores will show client improvement. Students also complete measures of their own emotional and interpersonal functioning at the beginning of the year, which we use to understand any areas of growth that emerge during the training. At the end of the year of

Table 1
Interpersonal Problems Clinic Assessment Measures

Session	Self	Performance	Informant	Supervisor	Clinician
1	Personality Assessment Inventory	Ecological Momentary Assessment (2 weeks)	Inventory of Interpersonal Problems-Short Circumplex		
	Inventory of Interpersonal Problems-Short Circumplex				
	Outcome Questionnaire-45				
2 to 3	Working Alliance Inventory	Thematic Apperception Test		Comparative Psychotherapy Process Scales	Working Alliance Inventory
	Interpersonal Sensitivities Circumplex				DSM Diagnosis
	Circumplex Scales of Interpersonal Values				
Every 8th	Inventory of Interpersonal Problems-Short Circumplex			Comparative Psychotherapy Process Scales	Working Alliance Inventory
	Outcome Questionnaire-45				
	Working Alliance Inventory				
Termination/End of semester	Personality Assessment Inventory	Thematic Apperception Test	Inventory of Interpersonal Problems-Short Circumplex	Comparative Psychotherapy Process Scales	Working Alliance Inventory
	Inventory of Interpersonal Problems-Short Circumplex				DSM Diagnosis
	Outcome Questionnaire-45				
	Working Alliance Inventory				
	Interpersonal Sensitivities Circumplex				
	Circumplex Scales of Interpersonal Values				

supervision, the supervisor and student together use these assessments as well as or clinic-wide rating forms and their ongoing relationship to discuss the experience of the student on our team, including the progress and limitations in the student's application of our approach, as well as the student's view of the effectiveness of this approach for their work as a therapist. We are currently exploring the possibility of using a number of other assessments, including measures of countertransference, rupture/repair sequences, reflective function, and authenticity, as a way of further assessing the impacts of our training and the development of our students' ability to navigate therapeutic relationships and affect positive change. Finally, our next steps will also include in assessing the roles of the various elements of our supervision team in the growth of our student therapists.

Case example. We conclude with a case example (identifying information is disguised) that highlights how our approach to training and supervision was helpful in navigating a complicated rupture-repair sequence for a first-year trainee. The trainee in this case was a 23-year-old European American woman with a warm and submissive interpersonal style. Although smart and accomplished, she could come across as soft and even naïve. The client was a 35-year-old European American male with a dominant and somewhat abrasive interpersonal style. He had some history of suicidal ideation but was not judged to be a current risk for self-harm, other harm, or thought disorder. Although boisterous and self-promoting in dress and demeanor, he was unemployed, had dropped out of college, and was in a mutually unsatisfying romantic relationship. The client had a long history of sexual and emotional abuse, and focused in his presentation on how others in his current environment were holding him back from success.

Initial self-report data suggested moderate distress, with particular problems related to grandiosity, feelings of persecution, and a lack of social support. TAT data and ratings of reflective function by the therapist and supervisor suggested a relatively low-level of mentalizing. The client saw himself as highly socially capable, although he acknowledged that he could be "too generous" at times. For instance, he reported that he stayed with, and slept with, his

girlfriend out of pity, and that although he regularly tried to encourage her to lose weight, she did not comply due to her "laziness." Perhaps, unsurprisingly, his girlfriend rated him as having significant interpersonal problems involving being too cold and dominant. He developed the following questions to guide the assessment: "Why do I care about people who are beneath me?" and "Why do I seek others' approval?" and was ultimately diagnosed with narcissistic personality disorder.

The disconnection between the content and process of his presentation was remarkable to the student, who had a difficult time cutting in and generally felt tentative and meek during the first session. In the first supervision meeting, the supervisor emphasized the goal of "getting in there" in a way that would make the interaction more mutual. In retrospect, the supervisor's feedback applied more pressure to the student without fully mentalizing the interpersonal situation. The student later reported feeling confused during this stage of the supervision, and feeling unable to articulate her confusion because of her respect for the authority of the supervisor. The client rated the working alliance as relatively low and commented in the third session on the therapist's apparent lack of competence and professionalism, citing the fact that she did not seem to contribute much.

This pattern was understood as a projective identification and mentalized more thoroughly during the third supervision meeting. The therapist and supervisor mentalized this pattern in terms of temporal dynamics among self, other, and affect that unfold within interpersonal situations. The pattern is depicted in Figure 2, which is an extension of Figure 1 that represents a cyclical maladaptive pattern involving self (*S* in the interpersonal circle), other (*O* in the interpersonal circle), and affect (in quotes below the interpersonal circle) that was learned in development and enacted in the consulting room. The client's baseline (top left of the figure) is to see himself as an admirable authority, and for others to love and comply. He feels calm in this situation, and internally seems to stay there most of the time, even when it is at odds with the actual contours of interpersonal situations. When challenged by another person's assertions of dominance, he becomes threatened, which quickly leads to anger, typically expressed as a verbal outburst.

The course of this pattern depends, in part, on his perception and the behavior of the other. If the other is powerful and meets his anger with a challenge, the client can decompensate somewhat, feel weak and afraid, and become highly vulnerable and dysregulated. This was the course of this pattern early in life as a victim of abuse, when authority figures with more power than him lashed out or took advantage, and he was powerless to respond with any sense of dignity. In this (lower) track, the best he could do was endure humiliation and withdraw from the situation. For instance, he related a story about being a high school wrestler, when as a freshman he was "hazed" by his teammates. He recalled crying in the locker room following a practice in which his teammates had locked all

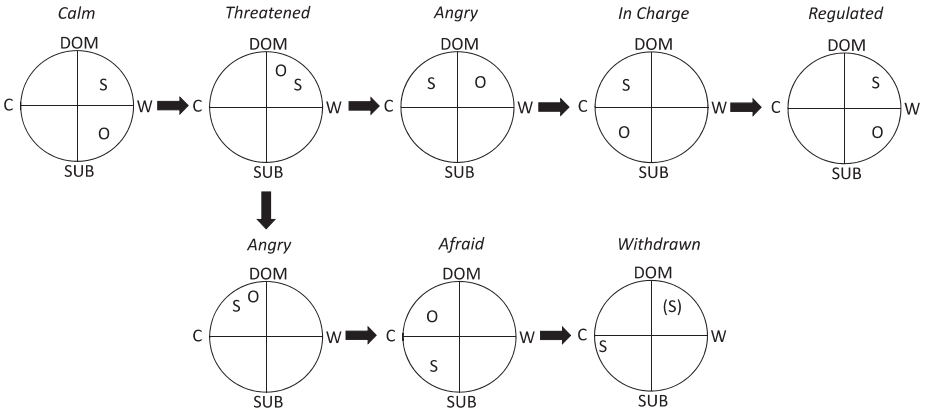

Figure 2. Formulation of the client's cyclical maladaptive pattern. S = Self; O = Other; DOM = Dominance; SUB = Submission; W = Warm; C = Cold.

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

of his clothes in a locker while he was naked and hit him with their towels, and he was particularly shamed by his coach's disinterested reaction to the scene. He quit the team, but focused in telling this story to the therapist on how he did his team a favor, because they ended up being quite successful, perhaps in part because he would have been a distraction. In this way, he was able to take some credit for his team's success. He also related how sorry he felt for his teammates, as anyone who could treat a person that way must not be OK on the inside. He described interactions with his former teammates as adults, ~~in which they~~ had not achieved their full potential, as evidence. This proved to be a useful comment for the therapist to return to as insight developed later in the treatment.

The more common experience is shown in the top track—the other does not want to fight so submits in the moment to his dominance. Feeling "in charge," the client reregulates and the interaction becomes warm again, although the rupture is rarely mentalized and repaired. This is what was happening in the third session, as indicated by Figure 3, which presents data on the unfolding interpersonal interaction between therapist and client during that session. These data were derived from a continuous interpersonal coding procedure (CAID) in which four trained research assistants manipulate a computer joystick device which plots momentary dominance (the vertical dimension, with higher values indicating more dominant behavior) and warmth (the horizontal dimension, with higher values indicating warmer behavior) for both the therapist and client every half second (Sadler et al., 2009; Thomas, Hopwood, Woody, Ethier, & Sadler, 2014). The resulting data were averaged over the four sets of codes (one from each research assistant) and was plotted as graphs of density distributions across each quartile (about 12 min) of the session.

In the first quartile of the session, the interaction is calm, somewhat warm, but mostly business like, and the client is clearly dominating the conversation. During the second quartile, the client really takes over, leading the therapist to become more passive. She acknowledged in supervision that she was internally frustrated and self-critical during this time, because her goal was to "get in there." The light cloud in the warm-dominant quadrant of Quartile 2 reflected her effort to interpret his dominance as a way of putting her in a passive position, and wondered whether this had something to do with his feeling that others are often "beneath him." This proved to be dysregulating

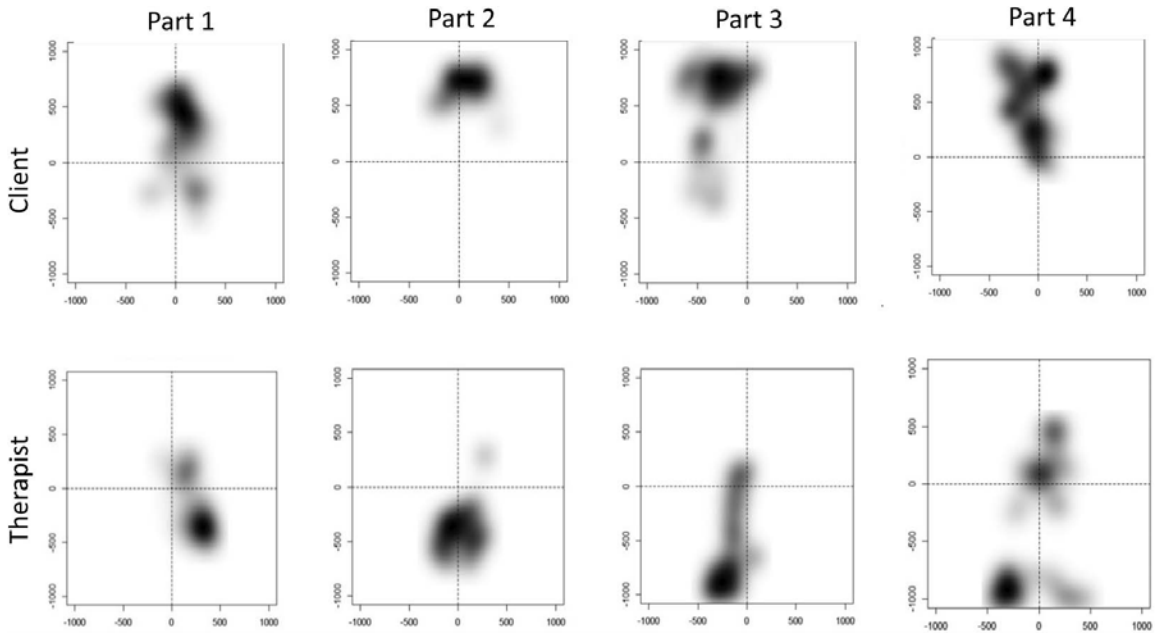

Figure 3. Interpersonal process data from Session 3.

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

for the client, who became angry and took over the dyad in Stage 3. The therapist responded with passive withdrawal, in part because she was self-critically preoccupied with thinking about the fact that she should be helping him mentalize, rather than actually mentalizing with him.

There were, however, noticeable efforts in the direction of dominance coupled with warmth, which paid off to some extend toward the end of the session, when the interaction warmed up somewhat and the pair were able to repair at least some aspects of the rupture. Whereas in the third quartile he directly questioned her competence and even coached her about how to do therapy, in the fourth they were able to discuss, in some limited fashion, how the pattern of their session was similar to some other patterns during the client's development. In particular, the therapist was able to offer the interpretation that one way he protects himself from others who are powerful and intimidating is to take a dominant role, and she was able to acknowledge that when this occurred in the therapeutic relationship, it left her feeling incompetent and unsure. She imagined with him that others may have felt that way too when interacting with him and that perhaps he had also felt that way in the past, at times. He agreed that this kind of dynamic does tend to occur in his relationships, and that it is "better to be the one on top than the one on bottom." The session ended more warmly than before, and the dyad had experienced a relatively effective rupture–repair sequence. Although the case would continue to be challenging, this was an important early experience for the student and the client to build upon moving forward.

Several aspects of our approach were helpful to the student in understanding this client and navigating this complex interaction. The combination of rich assessment data and training in relational processes and collaborative assessment contributed to the development of a useful conceptualization of the client relatively early in the treatment. However, this understanding was not enough, because in the first few sessions she participated in, but was unable to effectively observe, the client's cyclical maladaptive pattern as it emerged in the room. Initially, the supervision focused on how to balance participation and observation, but this approach put too much weight on observation, without recognizing how difficult this was for the student. The supervisor realized how the supervision had not been helpful in that the supervisor advised the student to "get in there" without sufficiently validating the challenge that would entail. This failure on the part of the supervisor was mentalized and repaired during supervision. This process provided the student with an interactive example of how to repair the rupture with her client, which she was then able to translate, to some degree, into the therapy. She later recognized the degree to which she had participated in an enactment both in the treatment and the supervision. Finally, the group meeting provided support and validation of how difficult this case was for a first year student, while also offering useful feedback to the student about how to mentalize the client, observe her own inner reactions, and repair rupture. The student went from an experience of incompetence and failure to one of being supported for trying and at least partially succeeding at something that is very difficult. Discussing this case also provided a powerful training example for other students on the team.

Overall, we have observed that many clients in our clinic present with this level of functioning, and that there tend to be two types of responses from the therapist that roughly mirror the two trajectories in the client's pattern (see also Tracey, 1993). One type of response is that the student therapist essentially reinforces the client's problems by allowing their own well-intentioned motives to be kind and listen interfere with their capacity for effective mentalizing. The student in this case acknowledged that this type of response is probably what she would have done without careful supervision and training—the client would have talked, she would have listened, and this would have reinforced his maladaptive defenses rather than challenging him to develop new, more adaptive patterns. This kind of pattern might be particularly likely to emerge in treatment approaches that focus on maintaining a positive, as opposed to authentic, therapy relationship. In the other type of response, the therapist meets the pathology with a focus on change and growth, and the client does not feel listened to, often dropping out of treatment. We are concerned that this kind of pattern is particularly likely in treatment approaches that focus on intervention techniques, with limited attention to the relation-

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

ship. The challenge for our students, and for trainees in general, is learning to integrate participation and observation in the therapeutic relationship so that these kinds of interpersonal ruptures can be effectively mentalized and repaired, and it is this challenge that our approach to training and supervision is designed to meet.

Conclusion

In this article we have described a clinical science approach to teaching students how to navigate therapeutic relationships by balancing participation and observation to mentalize rupture repair sequences that occur during psychotherapy. Our approach aligns with clinical science by integrating evidence-based principles of assessment, therapy, and supervision in the training, and insofar as we collect data to evaluate treatment, supervision, and student development (cf. McFall, 2006). Although we use a psychodynamic framework, our approach is intended to provide students with relational skills that will translate to various therapeutic approaches. In fact, we are concerned that the field is too organized around theoretical orientation and in particular the promulgation of acronmyed therapies, rather than basic principles of intervention that clinicians can use to understand and treat the individual needs of clients.

Ultimately, we view psychotherapy as "a process of interaction, a function of two variables, the personalities of two people working together towards free spontaneous growth" (Guntrip, 1975). We hope to encourage in our students the development of the three qualities (i.e., authenticity, empathy, and curiosity) that we think are critical for clinical psychologists, regardless of orientation. We believe that these qualities underlie the capacity of the therapist to engage in participant-observation with the client, to mentalize, and to successfully repair ruptures. If we have succeeded with our students, they will bring these three qualities to their therapeutic stance, and the relationships they develop with their clients will guide them toward mutual growth. In addition, and more central to the principles of a clinical science model, there is increasing evidence that understanding and using the therapeutic relationship will lead to better treatment outcomes. Thus, we encourage other programs to follow the approach advocated by Beck and colleagues (2014) that would take into account the evidence base for therapist characteristics and process variables and expand their training to include relational processes. Ultimately, we hope that approaches like this can find their way in the clinical science movement so that the mainstream clinical science perspective can overcome its relatively narrow focus on techniques from a particular intervention, toward a broader, less ideological, and more truly scientific approach to clinical practice.

References

Baker, T. B., & McFall, R. M. (2014). The promise of science-based training and application in psychological clinical science. *Psychotherapy: Theory, Research, & Practice, 51,* 482–486. http://dx.doi.org/10.1037/a0036563

Baker, T. B., McFall, R. M., & Shoham, V. (2008). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. *Psychological Science in the Public Interest, 9,* 67–103.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75,* 842–852. http://dx.doi.org/10.1037/0022-006X.75.6.842

Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, L., & Siqueland, L. (2009). Alliance predicts clients' outcome beyond in-treatment change in symptoms. *Personality Disorders: Theory, Research, and Treatment, 1,* 80–89.

Barber, J. P., Zilcha-Mano, S., Gallop, R., Barrett, M., McCarthy, K. S., & Dinger, U. (2014). The associations among improvement and alliance expectations, alliance during treatment, and treatment outcome for major depressive disorder. *Psychotherapy Research, 24,* 257–268. http://dx.doi.org/10.1080/10503307.2013.871080

Bateman, A. W., & Fonagy, P. (2006). *Mentalization-based treatment for borderline personality disorder: A practical guide*. New York, NY: Oxford University Press. http://dx.doi.org/10.1093/med/9780198570905.001.0001

Bateman, A., & Fonagy, P. (2013). Mentalization-based treatment. *Psychoanalytic Inquiry, 33,* 595–613. http://dx.doi.org/10.1080/07351690.2013.835170

Beck, A. T. (1991). Cognitive therapy. A 30-year retrospective. *American Psychologist, 46,* 368–375. http://dx.doi.org/10.1037/0003-066X.46.4.368

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

Beck, J. G., Castonguay, L. G., Chronis-Tuscano, A., Klonsky, E. D., McGinn, L. K., & Youngstrom, E. A. (2014). Principles for training in evidence-based psychology: Recommendations for the graduate curricula in clinical psychology. *Clinical Psychology: Science and Practice, 21,* 410–424. http://dx.doi.org/10.1111/cpsp.12079

Benjamin, L. S. (1993). Every psychopathology is a gift of love. *Psychotherapy Research, 3,* 1–24. http://dx.doi.org/10.1080/10503309312331333629

Bennett, D., Parry, G., & Ryle, A. (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: A task analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 79,* 395–418. http://dx.doi.org/10.1348/147608305X58355

Binder, J. L. (1993). Is it time to improve psychotherapy training? *Clinical Psychology Review, 13,* 301–318. http://dx.doi.org/10.1016/0272-7358(93)90015-E

Binder, J. L., & Betan, E. J. (2013). Essential activities in a session of brief dynamic/interpersonal psychotherapy. *Psychotherapy: Theory, Research, & Practice, 50,* 428–432. http://dx.doi.org/10.1037/a0032521

Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2006). *Psychotherapy for borderline personality: Focusing on object relations*. Washington, DC: American Psychiatric Publishing.

Connolly, M. B., Crits-Christoph, P., Shappell, S., Barber, J. P., Luborsky, L., & Shaffer, C. (1999a). The relation of transference interpretations to outcome in the early sessions of brief supportive-expressive psychotherapy. *Psychotherapy Research, 9,* 485–495.

Connolly, M. B., Crits-Christoph, P., Kurtz, J., Butler, S. F., Shelton, R. C., Hollon, S., . . . Thase, M. E. (1999b). The reliability and validity of a measure of self-understanding of interpersonal patterns. *Journal of Counseling Psychology, 46,* 472–482. http://dx.doi.org/10.1037/0022-0167.46.4.472

Constantino, M. J., Arnow, B. A., Blasey, C., & Agras, W. S. (2005). The association between patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa. *Journal of Consulting and Clinical Psychology, 73,* 203–211. http://dx.doi.org/10.1037/0022-006X.73.2.203

Del Re, A. C., Flückiger, C., Horvath, A. O., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review, 32,* 642–649. http://dx.doi.org/10.1016/j.cpr.2012.07.002

Diener, M. J., & Mesrie, V. (2015). Supervisory process from a supportive-expressive relational psychodynamic approach. *Psychotherapy: Theory, Research, & Practice, 52,* 153–157. http://dx.doi.org/10.1037/a0038085

Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2015). Alliance-focused training. *Psychotherapy: Theory, Research, & Practice, 52,* 169–173. http://dx.doi.org/10.1037/a0037596

Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of therapeutic assessment*. Mahwah, NJ: Lawrence Erlbaum.

Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment, 9,* 374–385. http://dx.doi.org/10.1037/1040-3590.9.4.374

Fonagy, P. (2015). The effectiveness of psychodynamic psychotherapies: An update. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 14,* 137–150. http://dx.doi.org/10.1002/wps.20235

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy: Theory, Research, & Practice, 51,* 372–380. http://dx.doi.org/10.1037/a0036505

Fonagy, P., Luyten, P., & Bateman, A. (2015). Translation: Mentalizing as treatment target in borderline personality disorder. *Personality Disorders, 6,* 380–392. http://dx.doi.org/10.1037/per0000113

Friedlander, M. L. (2015). Use of relational strategies to repair alliance ruptures: How responsive supervisors train responsive psychotherapists. *Psychotherapy: Theory, Research, & Practice, 52,* 174–179. http://dx.doi.org/10.1037/a0037044

Gassman, D., & Grawe, K. (2006). General change mechanisms: The relation between problem activation and resource activation in successful and unsuccessful therapeutic interactions. *Clinical Psychology & Psychotherapy, 13,* 1–11. http://dx.doi.org/10.1002/cpp.442

Guntrip, H. (1975). My experience of analysis with Fairbairn and Winnicott: How complete a result does psychoanalytic therapy achieve? *The International Review of Psycho-Analysis, 2,* 145–156.

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16,* 12–25. http://dx.doi.org/10.1080/10503300500352500

Hayes, S. C. (2004). Acceptance and Commitment Therapy and the new behavior therapies: Mindfulness, acceptance and relationship. In S. C. Hayes, V. M. Follette, & M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive behavioral tradition* (pp. 1–29). New York, NY: Guilford Press.

Heatherington, L., Messer, S. B., Angus, L., Strauman, T. J., Friedlander, M. L., & Kolden, G. G. (2012). The narrowing of theoretical orientations

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

in clinical psychology doctoral training. *Clinical Psychology: Science and Practice, 19,* 364–374. http://dx.doi.org/10.1111/cpsp.12012

Hersoug, A. G., Høglend, P., Gabbard, G. O., & Lorentzen, S. (2013). The combined predictive effect of patient characteristics and alliance on long-term dynamic and interpersonal functioning after dynamic psychotherapy. *Clinical Psychology & Psychotherapy, 20,* 297–307. http://dx.doi.org/10.1002/cpp.1770

Hill, C. E., & Knox, S. (2009). Processing the therapeutic relationship. *Psychotherapy Research, 19,* 13–29. http://dx.doi.org/10.1080/10503300802621206

Hilsenroth, M., Blagys, M. D., Ackerman, S. J., Bonge, D. R., & Blais, M. A. (2005). Measuring psychodynamic-interpersonal and cognitive-behavioral techniques: Development of the Comparative Psychotherapy Process Scale. *Psychotherapy: Theory, Research, & Practice, 42,* 340–356. http://dx.doi.org/10.1037/0033-3204.42.3.340

Hilsenroth, M. J. (2007). A programmatic study of short-term psychodynamic psychotherapy: Assessment, process, outcome, and training. *Psychotherapy Research, 17,* 31–45. http://dx.doi.org/10.1080/10503300600953504

Høglend, P., Amlo, S., Marble, A., Bøgwald, K.-P., Sørbye, O., Sjaastad, M. C., & Heyerdahl, O. (2006). Analysis of the patient-therapist relationship in dynamic psychotherapy: An experimental study of transference interpretations. *The American Journal of Psychiatry, 163,* 1739–1746. http://dx.doi.org/10.1176/ajp.2006.163.10.1739

Høglend, P., Hersoug, A. G., Bøgwald, K. P., Amlo, S., Marble, A., Sørbye, Ø., . . . Crits-Christoph, P. (2011). Effects of transference work in the context of therapeutic alliance and quality of object relations. *Journal of Consulting and Clinical Psychology, 79,* 697–706. http://dx.doi.org/10.1037/a0024863

Hopwood, C. J. (2010). An interpersonal perspective on the personality assessment process. *Journal of Personality Assessment, 92,* 471–479. http://dx.doi.org/10.1080/00223891.2010.513284

Hopwood, C. J., Ansell, E. B., Pincus, A. L., Wright, A. G. C., Lukowitsky, M. R., & Roche, M. J. (2011). The circumplex structure of interpersonal sensitivities. *Journal of Personality, 79,* 707–740. http://dx.doi.org/10.1111/j.1467-6494.2011.00696.x

Hopwood, C. J., Pincus, A. L., & Wright, A. G. C. (in press). The interpersonal situation: Integrating clinical assessment, formulation and psychotherapy. In D. B. Samuel & D. Lynam (Eds.), *Using basic personality research to inform personality disorders*. New York, NY: Oxford University Press.

Hopwood, C. J., Wright, A. G. C., Ansell, E. B., & Pincus, A. L. (2013). The interpersonal core of personality pathology. *Journal of Personality Disorders, 27,* 270–295. http://dx.doi.org/10.1521/pedi.2013.27.3.270

Horowitz, L. M., Alden, L. E., Wiggins, J. S., & Pincus, A. L. (2000). *Inventory of interpersonal problems manual*. Odessa, FL: The Psychological Corporation.

Kernberg, O. F. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association, 15,* 641–685. http://dx.doi.org/10.1177/000306516701500309

Kernberg, O. F. (1987). Projection and projective identification: Developmental and clinical aspects. *Journal of the American Psychoanalytic Association, 35,* 795–819. http://dx.doi.org/10.1177/000306518703500401

Kuutmann, K., & Hilsenroth, M. J. (2012). Exploring in-session focus on the patient-therapist relationship: Patient characteristics, process and outcome. *Clinical Psychology & Psychotherapy, 19,* 187–202. http://dx.doi.org/10.1002/cpp.743

Lambert, M. J., & Finch, A. E. (1999). The Outcome Questionaire. In M. Maruish (Ed.), *The use of psychological testing for treatment planning and outcomes assessment* (2nd ed., pp. 831–869). Mahwah, NJ: Lawrence Erlbaum.

Leary, T. (1957). *Interpersonal diagnosis of personality*. New York, NY: Ronald Press.

Leichsenring, F., Luyten, P., Hilsenroth, M. J., Abbass, A., Barber, J. P., Keefe, J. R., . . . Steinert, C. (2015). Psychodynamic therapy meets evidence-based medicine: A systematic review using updated criteria. *Lancet Psychiatry, 2,* 648–660.

Leichsenring, F., & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *Journal of the American Medical Association, 300,* 1551–1565. http://dx.doi.org/10.1001/jama.300.13.1551

Leichsenring, F., Rabunh, S., & Leibing, E. (2004). Effectiveness of short-term psychodynamic psychotherapy in specific disorders: A meta-analysis. *Archives of General Psychiatry, 61,* 1208–1216. http://dx.doi.org/10.1001/archpsyc.61.12.1208

Levy, K. N., & Anderson, T. (2013). Is clinical psychology doctoral training becoming less intellectually diverse? And if so, what can be done? *Clinical Psychology: Science and Practice, 20,* 211–220. http://dx.doi.org/10.1111/cpsp.12035

Levy, S. R., Hilsenroth, M. J., & Owen, J. J. (2015). Relationship between interpretation, alliance, and outcome in psychodynamic psychotherapy: Control of therapist effects and assessment of moderator variable impact. *Journal of Nervous and Mental Disease, 203,* 418–424. http://dx.doi.org/10.1097/NMD.0000000000000302

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

Locke, K. D. (2000). Circumplex scales of interpersonal values: Reliability, validity, and applicability to interpersonal problems and personality disorders. *Journal of Personality Assessment, 75,* 249–267. http://dx.doi.org/10.1207/S15327752JPA7502_6

Luborsky, L., & Crits-Cristoph, P. (1998). *Understanding transference: The core conflictual relationship theme method*. Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/10250-000

Luyten, P., & Blatt, S. J. (2013). Interpersonal relatedness and self-definition in normal and disrupted personality development: Retrospect and prospect. *American Psychologist, 68,* 172–183. http://dx.doi.org/10.1037/a0032243

McFall, R. M. (2006). Doctoral training in clinical psychology. *Annual Review of Clinical Psychology, 2,* 21–49. http://dx.doi.org/10.1146/annurev.clinpsy.2.022305.095245

Messer, S. B. (2013). Three mechanisms of change in psychodynamic therapy: Insight, affect, and alliance. *Psychotherapy: Theory, Research, & Practice, 50,* 408–412. http://dx.doi.org/10.1037/a0032414

Meyer, G. J., Finn, S. E., Eyde, L. D., Kay, G. G., Moreland, K. L., Dies, R. R., . . . Reed, G. M. (2001). Psychological testing and psychological assessment. A review of evidence and issues. *American Psychologist, 56,* 128–165. http://dx.doi.org/10.1037/0003-066x.56.2.128

Milrod, B., Leon, A. C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., . . . Shear, M. K. (2007). A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *The American Journal of Psychiatry, 164,* 265–272. http://dx.doi.org/10.1176/ajp.2007.164.2.265

Morey, L. C. (1991). *The Personality Assessment Inventory: Professional manual*. Odessa, FL: Psychological Assessment Resources.

Muran, J. C., Safran, J. D., Gorman, B. S., Samstag, L. W., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, & Practice, 46,* 233–248. http://dx.doi.org/10.1037/a0016085

Murray, H. A. (1943). *Thematic Apperception Test manual*. Cambridge, MA: Harvard University Press.

Peluso, P. R., Liebovitch, L. S., Gottman, J. M., Norman, M. D., & Su, J. (2012). A mathematical model of psychotherapy: An investigation using dynamic non-linear equations to model the therapeutic relationship. *Psychotherapy Research, 22,* 40–55. http://dx.doi.org/10.1080/10503307.2011.622314

Pincus, A. L. (2005). A contemporary integrative interpersonal theory of personality disorders. In M. Lenzenweger & J. Clarkin (Eds.), *Major theories of personality disorder* (2nd ed., pp. 282–331). New York, NY: Guilford Press.

Pincus, A. L., & Hopwood, C. J. (2012). A contemporary interpersonal model of personality pathology and personality disorder. In T. A. Widiger (Ed.), *Oxford handbook of personality disorders* (pp. 372–398). New York, NY: Oxford University Press.

Pincus, A. L., Lukowitsky, M. R., & Wright, A. G. C. (2010). The interpersonal nexus of personality and psychopathology. In T. Millon, R. Kreuger, & E. Simonsen (Eds.), *Contemporary directions in psychopathology: Scientific foundations for DSM-V and ICD-11* (pp. 523–552). New York, NY: Guilford Press.

Posner, J., Russell, J. A., & Peterson, B. S. (2005). The circumplex model of affect: An integrative approach to affective neuroscience, cognitive development, and psychopathology. *Development and Psychopathology, 17,* 715–734. http://dx.doi.org/10.1017/S0954579405050340

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95–103. http://dx.doi.org/10.1037/h0045357

Roznowski, R. (2013). *Inner Monologue in Acting*. New York, NY: Palgrave Macmillon. http://dx.doi.org/10.1057/9781137354297

Sadler, P., Ethier, N., Gunn, G. R., Duong, D., & Woody, E. (2009). Are we on the same wavelength? Interpersonal complementarity as shared cyclical patterns during interactions. *Journal of Personality and Social Psychology, 97,* 1005–1020. http://dx.doi.org/10.1037/a0016232

Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy: Theory, Research, & Practice, 51,* 381–387. http://dx.doi.org/10.1037/a0036815

Safran, J., Muran, J. C., Demaria, A., Boutwell, C., Eubanks-Carter, C., & Winston, A. (2014). Investigating the impact of alliance-focused training on interpersonal process and therapists' capacity for experiential reflection. *Psychotherapy Research, 24,* 269–285. http://dx.doi.org/10.1080/10503307.2013.874054

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy: Theory, Research, & Practice, 48,* 80–87. http://dx.doi.org/10.1037/a0022140

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2001). Repairing alliance ruptures. *Psychotherapy: Theory, Research, & Practice, 38,* 406–412.

Sayette, M. A., Norcross, J. C., & Dimoff, J. D. (2011). The heterogeneity of clinical psychology

tapraid5/int-int/int-int/int00316/int2307d16z | xppws | S=1 | 6/8/16 | 1:47 | Art: 2015-0047

Ph. D. programs and the distinctiveness of APCS programs. *Clinical Psychology: Science and Practice, 18,* 4–11. http://dx.doi.org/10.1111/j.1468-2850.2010.01227.x

Soldz, S., Budman, S., Demby, A., & Merry, J. (1995). A short form of the Inventory of Interpersonal Problems Circumplex scales. *Assessment, 2,* 53–63. http://dx.doi.org/10.1177/1073191195002001006

Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice, 5,* 439–458. http://dx.doi.org/10.1111/j.1468-2850.1998.tb00166.x

Stricker, G., & Trierweiler, S. J. (1995). The local clinical scientist. A bridge between science and practice. *American Psychologist, 50,* 995–1002. http://dx.doi.org/10.1037/0003-066X.50.12.995

Strupp, H. H., & Binder, J. L. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy*. New York, NY: Basic Books.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York, NY: Norton.

Teyber, E., & Teyber, F. M. (2014). Working with the process dimension in relational therapies: Guidelines for clinical training. *Journal of Counseling Psychology, 51,* 334–341. http://dx.doi.org/10.1037/a0036579

Thomas, K. M., Hopwood, C. J., Woody, E., Ethier, N., & Sadler, P. (2014). Interpersonal processes in psychotherapy: A reanalysis of the Gloria Films. *Journal of Counseling Psychology, 61,* 1–14. http://dx.doi.org/10.1037/a0034277

Tracey, T. J. (1993). An interpersonal stage model of the therapeutic process. *Journal of Counseling Psychology, 40,* 396–409. http://dx.doi.org/10.1037/0022-0167.40.4.396

Tracey, T. J., Bludworth, J., & Glidden-Tracey, C. E. (2012). Are there parallel processes in psychotherapy supervision? An empirical examination. *Psychotherapy: Theory, Research, & Practice, 49,* 330–343. http://dx.doi.org/10.1037/a0026246

Watson, J. C., Steckley, P. L., & McMullen, E. J. (2014). The role of empathy in promoting change. *Psychotherapy Research, 24,* 286–298. http://dx.doi.org/10.1080/10503307.2013.802823

Wiggins, J. S., & Trapnell, P. D. (1996). A dyadic-interactional perspective on the five-factor model. In J. S. Wiggins (Ed.), *The five-factor model of personality*. New York, NY: Guilford Press.

Winnicott, D. W. (1965). *The maturational process and the facilitating environment: Studies in the theory of emotional development*. New York, NY: International UP Inc.

Zinbarg, R. E., Mashal, N. M., Black, D. A., & Flückiger, C. (2010). The future and promise of cognitive behavioral therapy: A commentary. *The Psychiatric Clinics of North America, 33,* 711–727. http://dx.doi.org/10.1016/j.psc.2010.04.003

AQ: 11

Received October 5, 2015
Revision received March 18, 2016
Accepted May 7, 2016 ■

AUTHOR QUERIES

AUTHOR PLEASE ANSWER ALL QUERIES 1

AQau—Please confirm the given-names and surnames are identified properly by the colors.
■= Given-Name, ■= Surname
The colors are for proofing purposes only. The colors will not appear online or in print.

AQ1—Author: There is no Zinbarg, 2010 on the reference list. Please resolve.

AQ2—Author: There is no Hoglend et al., 2006 or Hoglend et al., 2011 on the reference list. Please resolve.

AQ3—Author: There is no Kurtmann & Hilsenroth, 2012 on the reference list. Please resolve.

AQ4—Author: There is no Hoglend et al., 2006 or Hoglend et al., 2011 on the reference list. Please resolve.

AQ5—Author: There is no Zinbarg, 2010 on the reference list. Please resolve.

AQ6—Author: There is no Zinbarg, 2010 on the reference list. Please resolve.

AQ7—Author: There is no Leary, 1957 on the reference list. Please resolve.

AQ8—Author: There is no Finn & Tonsager, 1997 on the reference list. Please resolve.

AQ9—Author: There is no Hilsenroth, 2007 on the reference list. Please resolve.

AQ10—Author: There is no Horowitz et al., 1979 on the reference list. Please resolve.

AQ11—Author: The following reference does not appear to be cited in text. Please resolve.
Zinbarg, R. E., Mashal, N. M., Black, D. A., & Flückiger, C. (2010).

AQ12—Author: Figures 2 and 3 are poor quality, please provide better quality figures.