



## A quantitative and qualitative exploration of client-therapist interaction and engagement in treatment in an alcohol service

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Studies have suggested that differences in the effectiveness of therapists may be related to the therapist's ability to maintain a facilitative stance in the face of client resistance or hostility. The current study, examined a sample of audiotaped sessions from Hyams, Cartwright, and Spratley's (1996) study of engagement in an alcohol treatment service in an attempt to see whether the therapists' effectiveness at engaging clients in treatment was related to client-therapist interaction in assessment interviews. It was hypothesized that there would be (1) more overall negative interpersonal behaviour (2) more negative interpersonal behaviour by the therapist and (3) more negative interpersonal complementarity in interviews where the client failed to engage. Structural Analysis of Social Behaviour was used to assess the interpersonal behaviour of clients and therapists in three case comparisons, each of which focused on an engage and a non-engage case provided by one of three participating therapists. An additional series of follow-up qualitative case studies was carried out on the interviews where the client failed to engage. The results were mixed, with the qualitative analyses providing more support for the hypotheses than the quantitative analysis. It was concluded that problematic interpersonal processes might be harder to gauge in assessment sessions than later on in therapy and methodological recommendations were made for enhancing the likelihood of detecting problematic processes in future studies.

Evidence of the equivalent effectiveness of different models of therapy, the differential effectiveness of different therapists and the central role of the therapeutic alliance has highlighted the role of generic interpersonal processes in the outcome of psychotherapy (Hubble, Duncan, & Miller, 1999; Lambert & Okiiski, 1997; Luborsky, McLellan, Diguier, Woody, & Seligman, 1997; Ogles, Anderson, & Lunnen, 1999; Orlinsky, Grawe, & Parks, 1994; Strupp & Anderson, 1997; Wampold *et al.*, 1997). One facet of the interpersonal process in cases of poor therapeutic alliance and poor outcome may be the communication of subtle forms of hostility by the therapist (Strupp, 1998; Strupp, Hadley, & Gomes-Schwartz, 1977). While the source of such

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communications may derive from the therapist's own introjects or theoretical ideas (Meares & Hobson, 1977; Wachtel, 1993; Wile, 1984), a number of researchers and theorists have suggested that problematic communications from therapist to client also result from the difficulty of responding in an affiliative manner to hostile client communications (e.g. Benjamin, 1996; Kiesler, 1996; Strupp, 1998; Strupp *et al.*, 1977; Tracey, 1993). According to interpersonal theories such as Benjamin (1996) and Kiesler, the interpersonal principle of 'complementarity' suggests that hostile client communications may exert a 'pull' on the therapist to reciprocate with a similar level of hostility but a complementary level of control. Typically, this might involve a client who is hostile and submissive 'pulling' a therapist response that is hostile and dominant, and a therapist who is hostile and dominant 'pulling' a hostile and submissive response in their client. Tracey (1993) and Kiesler suggest that, as a result of social norms, hostility is likely to be latent and non-obvious, particularly at the beginning of therapy.

The impact of hostile complementarity on therapeutic outcome has been examined empirically by Strupp and his colleagues in a number of pioneering studies. Following a series of qualitative case studies illustrating the role of hostile complementarity in poor outcome cases (Strupp, 1980a, 1980b, 1980c, 1980d), Henry, Schacht, and Strupp (1986) used Structural Analysis of Social Behaviour (SASB) (SASB Benjamin, 1974) as a way of operationalizing the moment-by-moment transactions between client and therapist. They coded 15 to 20 minutes of the beginning of the third session using data from eight psychotherapies, a good- and a poor-outcome case for each of four therapists who took part in the Vanderbilt I outcome study (Moras & Strupp, 1982; Strupp & Hadley, 1979). They found more negative interpersonal process in low change cases. There was also significantly higher negative complementarity in low change cases. In keeping with the notion that hostility in psychotherapy is often subtle and indirect, Henry *et al.* found a higher proportion of 'complex' communications in the low change cases (defined as communications 'in which a single thought unit communicates more than one interpersonal message', p. 30). Henry, Schacht, and Strupp (1990) replicated this study on a larger sample of 14 therapeutic dyads from the first cohort of the Vanderbilt II study, coding the first 30 minutes of the third session of therapy. Again, high change dyads were characterized by more positive and less negative interpersonal process. They concluded that, while 'the *absence* of a negative interpersonal process may not be sufficient for therapeutic change, the *presence* of even relatively low levels of negative therapist behaviour may be sufficient to prevent change' (p. 773). Further analysis of the Vanderbilt I data by Tasca and McMullen (1992), found that the hostility that differentiated good from poor outcome therapies in session three pervaded the whole therapy suggesting that 'once the hostile exchanges were in place there seemed no reparation in the relationship' (p. 520). Von der Lippe, Monsen, Eilertsen, and Rønnestad (2000) have replicated the findings of Henry *et al.* (1986) and Henry *et al.* (1990) in another study comparing a high and low change case for eight therapists. They found that high change cases had higher scores on affiliative codes and lower scores on disaffiliative codes for both clients and therapists. They also found more negative complex codes and higher levels of negative complementarity in low change cases. In addition to these studies of completed short-term therapies, both qualitative (Piper *et al.*, 1999; Strupp, Schacht, Henry, & Binder, 1992) and quantitative (Najavits & Strupp, 1994) studies have suggested that negative interpersonal process between clients and therapists may also play a significant role in premature termination of therapy.

Consistent with the findings reviewed above, research on the treatment of substance misuse has suggested therapist effects both with regard to outcome (Luborsky, McLellan,

Woody, O'Brien, & Auerbach, 1985; McLellan, Woody, Luborsky, & Goehl, 1988; Najavits & Weiss, 1994; Project MATCH Research Group, 1998) and drop-out (Najavits & Weiss, 1994). In one study, which forms the background to the current project, Cartwright and his colleagues examined the role of relationship factors in the engagement of clients in psychological treatment for alcohol problems. In a sample of 131 clients, Hyams *et al.* (1996) found that only 51% of clients engaged in treatment. They found large and significant differences in the rates of engagement between six different therapists, ranging from 18.2 to 76.2% of clients engaged. Engagement was associated with aspects of the therapeutic relationship assessed using two questionnaires, one filled in by the client (the Client Experiences and Satisfaction Questionnaire - CESQ, Hyams *et al.*, 1996) and one filled in by the therapist (The Alcohol and Alcohol Problems Questionnaire - AAPPQ, Cartwright, Hyams, & Spratley, 1996) after the client's first session. Clients were more likely to engage if they felt liked by the therapist, if they felt understood, if they felt at ease and if they felt the therapist was warm and friendly towards them. They were less likely to engage if they felt criticized by the therapist, if they felt that the therapist had treated them as if they were stupid, if they felt that the therapist was not always genuine but was acting a part and if they felt the therapist had withheld information from them (Hyams *et al.*, 1996). Cartwright *et al.* examining the AAPPQ data found that all questions related to the therapists' motivation to work with the client (e.g. 'I would like to work with this client') and their satisfaction in working with the client (e.g. 'I feel pessimistic about this client') were associated with client engagement. When therapists showed lower levels of such 'therapeutic commitment', clients felt that the interviewer was critical, not interested in them and unwilling to provide information, as well as tending not to engage in treatment. This study suggests that interpersonal processes may play a prominent role in the engagement and successful treatment of clients with alcohol and drug problems.

Other research has suggested that interpersonal behaviours of the therapist such as 'accurate empathy' (Miller, Taylor, & West, 1980) and a less confrontational approach (Miller, Benefield, & Tonigan, 1993) are associated with good outcome in treatment of people with alcohol problems. However, in spite of the evidence suggesting strong therapist effects in the treatment of addictions, detailed interpersonal analyses such as those of Strupp and his colleagues do not appear to have been conducted for psychological therapy of addictions. As Najavits and Weiss (1994) put it 'the study of process variables - what therapists do during treatment that relates to their ultimate effectiveness - has received relatively little attention for substance misuse' (p. 685).

Cartwright *et al.* (1996) speculated that in cases in their study where the client failed to engage in treatment the therapists may have struggled to handle difficult interpersonal aspects of the interview. As they put it 'In most assessment interviews there are difficult times and the differences between workers reflects their capacities to deal with these problems. Some are able to maintain a sense of commitment when the client is resistant and others are less able to do so' (p. 227). The current study aims to explore this issue by analysing interpersonal process in a sample of audiotaped interviews, which were collected as part of Cartwright and his colleagues' study. Specifically, the current study aims to investigate (1) whether a higher level of overall hostility will be associated with clients' failure to engage in alcohol treatment; (2) whether therapists' hostile communications will be associated with clients' failure to engage and (3) whether hostile complementarity will be associated with clients' failure to engage.

## Method

### Participants

The participants were three nurse therapists and six clients who took part in the earlier study by Hyams *et al.* (1996) and Cartwright *et al.* (1996). The clients had been referred to a National Health Service therapeutic day unit for clients with alcohol problems, where the therapists were working. The data for the current study consists of six transcribed and audiotaped first assessment interviews.

The three therapists were male, had passed a diploma in alcohol counselling and consultation and each had over three years experience in counselling clients with alcohol problems. Two of them had completed further therapy training. They were selected from the six therapists who took part in the larger study because their whereabouts was still known at the day unit, which meant they could be contacted for permission for their data to be included in the current study. The therapists were the one with the highest engagement rate in the Hyams *et al.* study (76.2% of the clients he assessed engaged in treatment) and two with intermediate engagement rates (46.7 and 37.5%).

The client participants were selected according to a number of criteria. Firstly, only male clients were selected as the sample in the study as a whole were predominantly male (Hyams *et al.*, 1996) and it was thought that selecting only male participants would reduce the variance associated with factors beyond the scope of the study. Secondly, only tapes which were already transcribed were used due to restrictions of time and money. Nineteen transcriptions had been made at an earlier stage of the alcohol project, selected to reflect a mixture of outcomes for each therapist. Finally, two cases were selected for each of the participating therapists: one where the client engaged in treatment and one where they did not. In line with Hyams *et al.* (p. 109), the criterion used for engagement in treatment was either attendance at two further counselling sessions or attendance at five group therapy sessions within three months of the assessment interview. The average age of the six clients was 39.6. Clients completed the Severity of Alcohol Dependence Questionnaire (SADQ Stockwell, Murphy, & Hodgson, 1983), the average score for which was 23.8 indicating mild or moderate alcohol dependence, somewhat below the mean in the wider study of 27.4. In all cases the therapist believed that the patient 'should enter treatment'.

For clarity of presentation the six interviews will be denoted as 'One-E' for therapist one, engaged interview; 'One-N' for therapist one, non-engaged interview and so on. Comparisons 'One', 'Two' and 'Three' will therefore refer to the comparisons between each of the three therapists' engaged and non-engaged interviews.

### Design

Binder and Strupp (1997) have suggested that the intensive study of sequences of interpersonal transactions in cases where negative interpersonal process is effectively managed and where it is not 'may well be the most promising strategy for understanding the nature of negative process and the specific skills required to manage it' (p. 135). In a similar vein, Hilliard (1993) argues that single-case designs are an essential means of studying the reciprocal interpersonal dynamics of therapist and client communication over time as cross-sectional designs fail to describe contingent interaction within dyads (see also Chassan, 1981; Stiles, Honos-Webb, & Surko, 1998; Tracey, 1985). The current study consists of six case studies, forming three case comparisons, designed for the most part to be 'confirmatory' (i.e. designed to test *a priori* hypotheses) rather than 'exploratory' (designed to generate hypotheses).

A major issue with single-case research is 'how to establish the generality of one's findings' (Hilliard, 1993, p. 376) with most authors recommending a strategy of replication across multiple cases (Hilliard, 1993; Tracey, 1985; Yin, 1989). The current series of case analyses involves *systematic replication* ('the attempt to show that the findings differ in predictable ways when one selects subjects that differ along the critical individual-difference variables', Hilliard, 1993, p. 376) by comparing a case for each therapist where a client engaged in treatment with a case where a client failed to engage in treatment. *Direct replication* ('the attempt to replicate the findings in subjects that are similar in terms of the individual differences variables that are viewed as affecting the phenomenon of interest', Hilliard, 1993, p. 376) is addressed in the repetition of these comparisons across three therapists.

### Measures

The SASB observational coding system (SASB Benjamin, 1974; Benjamin & Cushing, 2000; Florsheim & Benjamin, 2001) was used as a measure of interpersonal process (cf. Henry, 1996). SASB is designed for the 'micro-analysis' of interpersonal communication and has been widely utilized in process-outcome research (e.g. Henry *et al.*, 1986, 1990; Hilliard, Henry, & Strupp, 2000; Safran & Muran, 1996; Wisner & Goldfried, 1998). Coding is applied to 'thought units' and requires decisions about 'interpersonal focus' ('self', 'other' or 'introject', constituting the three 'surfaces' of the SASB model), level of affiliation and level of interdependence before locating the code 'which captures the essence of the interpersonal message' (Benjamin & Cushing, 2000, p. 3). One feature of the SASB coding system is that more than one code can be applied to any thought unit. Such 'complex' codes are often used to describe communications 'in which the literal meaning of the words spoken seems at odds with the tone in which they are conveyed' (Florsheim & Benjamin, 2001, p. 138). This means that, as Benjamin and Cushing suggest, SASB coding 'often unveils subtleties of interpersonal messages that are not apparent to either the participants or even to experienced clinicians during a therapy hour' (p. 3). In this study the 'simplified cluster version' of SASB, which has 24 different codes, was used.

A third of the material to be coded was coded by a second rater. In order to ensure that a range of the material was covered by the inter-rater reliability check the full forty minutes of coding was checked on two interviews. These interviews featured two separate therapists and comprised one after which the client engaged (Three-E) and one where the client failed to engage (Two-N). The reliability of the coding in Three-E was high, with a Kappa of 0.86. Although the reliability for Two-N was low at 0.62, this is still considered as an acceptable level of reliability for SASB analysis (Florsheim & Benjamin, 2001). Much of the discrepancy between the two coders in Two-N was caused by the second coder's failure to recognize a recurring complexity in the client's communications in this interview, which became apparent to her and which she readily accepted when discussing the material with the first coder. Consensus codes for both Two-N and Three-E were agreed and these were used in the final analysis of data.

### Analysis

#### Quantitative

Weighted scores summarizing the underlying dimensions of affiliation and autonomy (Benjamin & Cushing, 2000) in each interview are reported. Chi-squared analyses were used to compare the overall levels of hostility and complexity and therapist levels of

hostility and complexity in each case comparison. Lagged cross-tabulations have been used to address the question of client-therapist complementarity. Lagged cross-tabulations are a means of plotting the relationship between codes given to one speaker and codes given to another speaker on the following segment (i.e. the contingency between therapist codes and following patient codes and vice versa). The calculations provide a value of Phi, which is the equivalent of the product moment correlation in a two by two table. Descriptive data in the form of 'SASB cluster scores' (Benjamin & Cushing, 2000), which are percentages for each of the sixteen SASB cluster codes on Surfaces One ('focus on other') and Two ('focus on self') for each participant are presented in the Appendix<sup>1</sup>.

#### *Qualitative*

Three qualitative case studies were carried out on the interviews where the client failed to engage. These interviews were selected because the interpersonal processes associated with failure to engage were the main focus of the study.

The purpose of these studies was (1) to check the validity of the quantitative findings in the context of the whole interviews (since in all but one instance the quantitative part of the study is based on coding of only part of the interview). In this sense the aim was to reduce the danger of making a type II error as a result of limitations in the quantitative method (e.g. limited sampling of the interviews), just as the quantitative method may militate against the dangers of making a Type I error as a result of confirmatory bias in the qualitative analysis (2) to develop a more contextual understanding of the underlying interpersonal processes at work in the interviews and therefore to refine the conclusions of the quantitative study and to clarify how these findings might be extended (3) to provide illustrations of the SASB codes which otherwise can be opaque to the reader who wishes to make clinical sense of the findings and (4) to enable the reader to put the quantitative findings of the main study back into clinical context and so exploit the potential of single-case studies to contribute to an 'increased integration of research and practice' (Tracey, 1985, p. 196).

The qualitative case studies were modelled on the series of qualitative studies conducted by Strupp (Strupp, 1980a, 1980b, 1980c, 1980d). However, they were focused by using a SASB-based analysis of the interactants' communication as a starting-point and their major aim was to develop a qualitative understanding of the key interpersonal patterns which occurred in the interviews. In this way the analysis started by developing categories of recurring interpersonal behaviours for each participant based on the SASB codes (e.g. code 1-8, 'Ignoring and Neglecting') and then using the full context of the interview to make sense of how the client and therapist interpersonal behaviours interacted. The back and forth qualitative-quantitative analysis in this study was facilitated by using Code-A-Text Integrated System for the Analysis of Interviews and Dialogues (C-I-SAID) software, which enables the researcher to move easily between a data grid and the source material (Cartwright, 2000), for example, it is possible to look at a spreadsheet of all the codes in an interview and then to click on the segment number to display the text and hear the audiofile of the particular segment. It was hoped that this approach would also enable the reader to put the quantitative findings of the main study back into clinical context so as to exploit the potential of single-case studies to contribute to 'an increased integration of research and practice' (Tracey, 1985, p. 196).

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<sup>1</sup> The 'introject' focus was not coded in this study of interpersonal process.

Due to space limitations, only one qualitative case study is included, selected because it was the shortest. The other two case studies are reported in full in Macdonald (2001).

### **Procedure**

The first author was provided with the interview transcripts and digitized audiofiles from the earlier study. These were then entered into a coding frame in a computer program, the C-I-SAID (Cartwright, 2000). The transcripts were then checked against the audiofiles and corrected where necessary. The sections of each interview that were to be coded were divided into 'elements' or segments representing complete thoughts<sup>2</sup>. Each element was then linked at the correct point to the digitized recording of the interview, enabling C-I-SAID to play the sound for each segment at the same time as displaying the text.

SASB coding was conducted on two twenty minutes portions of each interview. The first portion started five minutes into the interview and the second portion consisted of the final twenty minutes of the session. The decision to code only part of the interviews was based on the SASB 'pond water theory' which specifies that coding a small sample of a person's interpersonal behaviour typically results in a representative sample of interpersonal patterns (Benjamin & Cushing, 2000). In the most directly comparable study by Henry *et al.* (1986), only 15 to 20 minutes of one session were coded. The decision to code more of the interviews in the current study was made because it was thought that this might provide a clearer picture of any deterioration in interpersonal communication, hypothesized as being likely to occur in therapeutic dyads where the client did not engage in treatment. The decision to start coding five minutes into the interview was taken because typically the first five minutes involved very practically focused discussions of the client's referral route, etc. Codes were entered into the C-I-SAID coding frame. As the first coder was also responsible for managing the data it was not possible for him to be blind to the outcomes of the interviews while coding. However, the second coder was blind to the outcome status of the two interviews that she coded. Most of the data analysis was conducted using C-I-SAID which has a number of statistical analytic and graphing features.

### **Results**

For clarity and ease of interpretation, quantitative results will be organized around the three principle research questions (rather than being presented separately for each case or case comparison). SASB cluster scores for clients and therapists in all the interviews are presented in table form in the Appendix.

#### **Overall negative process, clients' negative process and failure to engage in alcohol treatment**

The percentages of thought units for each speaker in each interview coded with *any* of the hostile SASB codes (Belittling and Blaming 1-6; Attacking and Rejecting 1-7; Ignoring and Neglecting 1-8; Sulking and Scurrying 2-6; Protesting and Recoiling 2-7; and Walling off and Distancing 2-8) are presented in Table 1. This table shows that the proportion of thought units given a hostile code was less than 4% for all the clients, with the exception of the client

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<sup>2</sup> The segmenting process was not subjected to a reliability check. It is recognized that the definition of elements is to some extent 'arbitrary' (Benjamin & Cushing, 2000), however, this is not regarded as of paramount importance 'since all material is coded in one element or another' and the 'process of defining elements does not introduce any selective bias jeopardizing validity', p. 9.

**Table 1.** Percentages of hostile, complex and hostile and complex codes for each speaker in all interviews

	T One-E	T One-N	C One-E	C One-N	T Two-E	T Two-N	C Two-E	C Two-N	T Three-E	T Three-N	C Three-E	C Three-N
Total % hostile codes	0.4% (1/257)	1.7% (6/353)	1.6% (5/310)	3% (13/435)	0	2.5% (5/201)	0.8% (3/366)	16.5% (44/266)	2% (4/196)	0.3% (1/312)	2.4% (6/245)	2.5% (10/282)
Total % complex codes	5% (13/257)	10.5% (37/353)	2.9% (9/310)	5% (22/435)	9.3% (14/151)	10.4% (21/201)	7.9% (29/366)	15.4% (41/266)	9.7% (19/196)	5.4% (17/312)	10.2% (25/245)	6.7% (19/282)
Total % costile complex codes	0.4% (1/257)	1.7% (6/353)	1.3% (4/310)	2.3% (10/435)	0	2.5% (5/201)	0.8% (3/366)	9.8% (26/266)	2% (4/196)	0.3% (1/312)	2.4% (6/245)	2.5% (7/282)

T, therapist; C, Client; E, Engaged; N, Non-engaged.



in Two-N (16.5% of whose communications were given a hostile code). This contrast with contrasts with the studies by Henry and colleagues. Henry *et al.* (1986), for example, found that in session three of unsuccessful cases 19% of the clients' communications were judged to be hostile compared with 0% in the high change cases.

Where possible, overall levels of hostility of the engaging and the non-engaging interview in each case were compared using Chi-squared analyses (see Table 2). Hostile codes were too infrequent in Comparison One for the analysis to be carried out. Overall hostility in Comparison Two was significantly greater in the non-engage interview, as predicted. However, there was no significant difference in Comparison Three.

**Table 2.** Chi-Square values analyses (d.f., 1) comparing engage and non-engage interviews for each therapist on overall hostility, client hostility, therapist hostility, overall disaffiliation, client disaffiliation, therapist disaffiliation, overall complexity, client complexity and therapist complexity

	Comparison one	Comparison two	Comparison three
Overall hostility	Not analysed	49.37 ( $p > .005$ )	0.22 (ns)
Client hostility	Not analysed	56.88 ( $p > .005$ )	0.536 (ns)
Therapist hostility	Not analysed	Not analysed	Not analysed
Overall disaffiliation	2.592 (ns)	82.31 ( $p > .005$ )	0.19 (ns)
Client disaffiliation	4.417 ( $p > .05$ )	83.61 ( $p > .005$ )	0.43 (ns)
Therapist disaffiliation	0.051 (ns)	12.59 ( $p > .005$ )	1.457 (ns)
Overall complexity	7.634 ( $p > .05$ )	7.88 ( $p > .05$ )	5.44 (ns)
Client complexity	2.143 (ns)	11.198 ( $p > .001$ )	2.06 (ns)
Therapist complexity	5.718 ( $p > .05$ )	0.133 (ns)	3.29 (ns)

ns, non-significant.

Because of the low numbers of hostile codes in the interviews it was decided to conduct statistical comparisons comparing levels of 'disaffiliation' rather than hostility between the two interviews. The rationale for this was based on an earlier Maudsley Alcohol Pilot Project finding that alcohol workers who felt insecure in their role with particular clients tended to withdraw in a variety of ways from the therapeutic relationship (Shaw, Cartwright, Spratley, & Harwin, 1978). Disaffiliation was defined as the presence of any code which suggested a move away from friendly interaction on the part of one of the speakers. Codes for Freeing and Forgetting (1-1), Watching and Controlling (1-5), Asserting and Separating (2-1) and Deferring and Submitting (2-5), all of which are neutral codes with regard to affiliation, were included with the hostile codes listed above. Chi-squared analyses showed that, although there was a significant difference in overall disaffiliation in Comparison Two as predicted, there was no significant difference between engage and non-engage interviews in Comparisons One and Three.

Table 1 shows that most hostile codes in the interviews were also 'complex' in the SASB sense of occurring in multiply coded thought units. This is consistent with the notion that hostility in therapeutic interviews is generally subtle as suggested by Tracey (1993) and Kiesler (1996). Chi-squared comparisons indicated that overall there were significantly more complex communications in the non-engage interviews in Comparisons One and Two as expected, but not in Comparison Three. There were significantly more complex client communications in the non-engage interview in Comparison Two as expected but not in Comparison One or Three.

In summary, out of the three case comparisons, only Comparison Two shows clear evidence of the predicted differences in overall negative process between engage and

non-engage interviews, with significant differences on overall hostility, client hostility, overall disaffiliation, client disaffiliation, overall complexity and client complexity. It is notable that the client in the non-engage interview in this case comparison is considerably more hostile than the clients in all the other interviews, with 16.5% of his communications coded as hostile (the next most hostile client was hostile only 3% of the time). Comparison One shows some trends in the predicted direction, with more hostile codes in the non-engage interview, although hostile codes were too infrequent for Chi-squared analyses to be conducted and there was no significant difference in overall disaffiliation between the two interviews. However, there was significantly more client disaffiliation and significantly more overall complexity in the non-engage interview in Comparison One. Comparison Three showed no trends in the predicted direction and analyses comparing overall hostility, client hostility, overall disaffiliation, client disaffiliation, overall complexity and client complexity were all non-significant.

#### **Therapists' negative process and clients' failure to engage in treatment**

Table 1 shows the percentage of therapist communications coded as hostile in each interview. The highest percentage of hostile therapist communications is 2.5% and occurs in Two-N, which, as noted above, had the most hostile client in the study. This level of therapist hostility is much lower than the levels of hostility noted for therapists in unsuccessful outcome cases in the two studies by Henry and colleagues, which were 20% and 26%, respectively (Henry *et al.*, 1986, 1990). The low frequency of hostile therapist communications in all of the case comparisons in this study meant that Chi-squared analyses for therapist hostility could not be conducted, which in itself argues against the notion of therapist hostility impacting on client engagement. In Comparisons One and Two there seems to be a trend of the therapist being more hostile in the non-engaging interviews, however there is a trend in the opposite direction in Comparison Three. Using the expanded measure of 'disaffiliation', there was a significant difference in therapist disaffiliation in Comparison Two, but not in Comparisons One and Three (see Table 2).

Every hostile therapist communication coded in the study was a complex communication (see Table 1), suggesting that therapist hostility when it occurred was subtle and indirect. Although the therapist used significantly more complex communications in the non-engage interview in Comparison One as predicted, this was not the case for Comparisons Two and Three (see Table 2).

In order to compare the relative levels of affiliation and control in the interviews (reflecting the two underlying dimensions of the SASB model), weighted scores for affiliation and autonomy/control were calculated for the therapist and client, following the procedure outlined by Benjamin and Cushing (2000)<sup>3</sup>. These are presented in Table 3. Inspection of this table shows that while levels of both therapist and client affiliation only

<sup>3</sup> For the therapist this was calculated on Surface One (focus on other) of the SASB model and for the client this was calculated on Surface Two (focus on self). This is because almost all the therapists' codes were on Surface One and almost all the clients' codes were on Surface Two, as expected in therapy (see Benjamin & Cushing, 2000). In Interview One-E 94.8% (256/270) of the therapist's communications were coded on Surface One and 94.8% (302/319) of the client's communications were coded on Surface Two. In Interview One-N 93.1% (366/393) of the therapist's communications were coded on Surface One and 97.6% (444/455) of the client's communications were coded on Surface Two. 88.5% (146/165) of the therapist's communications were made on Surface One of the SASB model in Interview Two-E and 92.2% (202/219) in Interview Two-N. 96.7% (382/395) of the client's communications were made on Surface Two of the model in Interview Two-E and 93.5% (287/307) of the client's in Interview Two-N. 95.3% (207/215) of the therapist's communications were made on Surface One of the SASB model in Interview Three-E and 98.8% (326/330) in Interview Three-N. 94.8% (256/270) of the client communications were coded on Surface Two in Interview Three-E and 98% (295/301) of the client's communications in Interview Three-N.

**Table 3.** Weighted affiliation scores for affiliation and autonomy/control for therapist and for client

	Interview One-E	Interview One-N	Interview Two-E	Interview Two-N	Interview Three-E	Interview Three-N
Therapist affiliation (Surface one)	85.22	85.34	93.36	84.32	82.99	89.82
Therapist autonomy granting (Surface one)	24.27	8.13	27.18	8.38	48.45	– 9.77
Client affiliation (Surface two)	87.41	85.34	92.07	53.61	79.8	79.36
Client autonomy taking (Surface two)	80.34	59.55	69.23	45.02	55.5	35.2

E, Engaged; N, Non-engaged.

appear to differ in Comparison Two, there do appear to be differences in the degree of autonomy granting (on the part of the therapist) and autonomy taking (on the part of the client) between the engage and non-engage interviews in each of the case comparisons, with less in the non-engage interviews. This suggests that therapists may have been more controlling and clients more submissive in the failure to engage interviews.

#### **Negative complementarity and clients' failure to engage in treatment**

Due to the low rates of hostile communications in the interviews, the aim of examining the relationship between engagement and complementary hostile interactions has been expanded to the more general notion of complementary disaffiliative communications, with disaffiliation operationalized in the manner described above. Two lagged cross-tabulations, one with the clients' disaffiliative codes as the stimulus and the therapists' disaffiliative codes as the target, the other with the therapists' disaffiliative codes as the stimulus and the clients' disaffiliative codes as the target, are presented for each interview in Table 4. The findings are surprising in that in two of the comparisons (Comparisons One and Three) there appeared to be strong evidence of complementary disaffiliative communication in both directions in the engage interviews (the other engage interview was not analysed because there were very few therapist disaffiliative behaviours), while a significant association was only found for one speaker, the therapist, in one of the failure to engage interviews. The fact that disaffiliative complementarity is more apparent in the engage interviews runs counter to the notion that negative complementarity will be associated with failure to engage, suggesting that

**Table 4.** Phi values for lagged cross-tabulations examining the relationship between disaffiliative communication on the part of one member of the dyad and disaffiliative communication in the following thought unit of the recipient

	Interview One-E	Interview One-N	Interview Two-E	Interview Two-N	Interview Three-E	Interview Three-N
Client to therapist	0.34 ( $p < .001$ )	0.01 (ns)	Not analysed	0.13 (ns)	0.22 ( $p < .005$ )	0.11 (ns)
Therapist to client	0.34 ( $p < .001$ )	0.1 (ns)	Not analysed	0.13 (ns)	0.36 ( $p < .001$ )	0.38 ( $p < .001$ )

E, Engaged; N, Non-engaged.

overall this hypothesis has not been supported, although there was evidence of disaffiliative complementarity from therapist to client in Three-N.

### Qualitative findings

The qualitative approach will be illustrated by the analysis of Interview One-N. The qualitative analysis extends and contextualizes the SASB derived descriptions of the interpersonal behaviour of both client and therapist, looking at how this unfolded in the interview as a whole.

#### *The client's interpersonal style*

This client was a rapid and fluent speaker. Perhaps reflecting his experience of Alcoholics Anonymous (AA), he presented himself as someone who now knew that he was an alcoholic, using the word freely, and adopting a kind of *post hoc* therapeutic perspective on his difficulties, as in for example: 'I had one hell of a binge and I said I'm going to have a binge and that's it really, to end all binges, *and that was a mistake of course*' (2)<sup>4</sup>. However, in addition to this apparent deference to the therapist's perspective the client tended to gloss over the more emotional aspects of painful life experiences, often no sooner mentioning a source of emotional pain than seeming to minimize its significance or dismiss it with a light laugh, as in, for example, 'I've got a court case pending. *It's nothing really important*' (8). This quality resulted in a number of Walling off and Distancing (2-8) codes in the SASB coding, often occurring when the client laughed in the course of describing something that seemed as though it might be especially painful (for example when describing how nurses gave whisky to his father in the context of describing the degrading circumstances of his father's alcoholism and death). The rapidity of the client's speech contributed to a sense that, although he was apparently open in discussing his difficulties, he tended to gloss quickly over his feelings. The manner in which the client approached and then moved quickly over the emotional significance of painful events is illustrated in the following example when he speaks about an experience of being rejected, but does so in a way which makes this sound like something of passing curiosity: 'A very strange thing happened, on the first Thursday night I, I got a phone call, I'd been with this girl after my marriage, and she said she didn't want to see me any more, you know' (2-2) (60.01).

The slightly superficial quality in the manner of the client's speech had its counterpart in his accounts of shifting interpersonal allegiances in his love life (it was unclear whether a number of relationships he mentioned were ongoing or not) and his frequent job changes. An underlying anxiety regarding intimacy was suggested when he related an upsurge in drinking to himself and a girlfriend 'getting settled into each other'. It appeared to be easy for the client to take the initial step in forming relationships (he said at one point that he had always found it easy to pick up women) and this was perhaps evident in the interview where he appeared on the face of it open and motivated to engage in treatment, but became evasive (evidenced in a number of Sulking and Scuffling, 2-6; and Asserting and Separating, 2-1, comments) when the therapist started making active suggestions about how his treatment could proceed.

<sup>4</sup> Segment numbers are included in brackets after each quotation. In the first two analyses when quotations from coded segments are made the codes have been placed in brackets following the quotations.

*The therapist's interpersonal style in Interview One-N*

The therapist appeared less fluent and more hesitant in his manner than the client, and his speech was often full of hesitation, fillers and slight changes in tack, as in, for example 'I think you're probably right, you probably you know, sort of, because you've looked after yourself it (the alcohol) might not have taken such a toll on you.' (171). While this hesitant quality remained constant across the two interviews he contributed to the study, a pattern particular to this interview, captured variously by codes involving either Ignoring and Neglecting (1-8) or Asserting and Separating (2-1), involved the therapist trying to impose an agenda that interrupted the client's flow. These comments were often prefaced by the word 'but', an opening which we were able to find only once in the 64 minutes of Interview One but which occurs four times in the seven minutes between segments 75 and 159 in this interview. For example, in segment 98 the client has been speaking about how a girlfriend had rejected him as a result of his drinking - 'and er it got to such a point where we'd been together about four months I moved in (2-2)/and she'd just had enough of it' (2-2). After this there is a three second silence and the therapist continues: 'But what, how often were your binges happening recently' (1-2, 1-8) as if the client's disclosure of this recent interpersonal rejection was of no importance or relevance and the therapist is keen to return to a proper focus on the client's drinking patterns. Another example occurs after the client has been talking about his father and the client reveals that towards the end his father 'couldn't even get out of the bed to go to the toilet so (2-2)' (138). The therapist again ignores what the client is saying and returns to a focus on drinking patterns 'But when you say you've always been a binge drinker . . .' (1-2, 1-8). At this stage in the interview almost all these comments are attempts to steer the client back to a concrete description of his drinking patterns, an agenda that the therapist introduced in segment 51 approximately six minutes into the interview. However, later on a similar pattern also appears. For example, the client talks about how thirsty he is the morning after drinking and adds 'I suppose because all the alcohol has evaporated' (2-2). The therapist immediately corrects him with the comment 'Well, I think you get a bit dehydrated' (1-4, 2-1) (217). A similar exchange occurs in segment 197.01 when the client says he thinks that a seizure he had may have been like epilepsy and the therapist replies 'Yes, but it sounds like it would be what they call a withdrawal fit' (1-4, 2-1).

A second unique feature of the therapist's communication in this interview, which in this instance is not reflected in the SASB codes, is the therapist's introduction of colloquial terms, something that does not take place in Interview One. In segment 173 he introduces a euphemism for the client's drinking: 'plus you, you know, you're not *bashing it* all the time' (1-4) and in segment 285 when, in discussing the relationship between the client's drinking and his feelings of resentment, he says some people say there's a '*fuck it* factor (Client: yes) people just say *fuck it*'. The coexistence of the therapist's somewhat unconfident manner at times early in the interview, his struggle to maintain the client's focus on drinking patterns and the macho quality of these colloquialisms suggest that in this interview the therapist may have felt somewhat competitive with this client in a way that he did not with his client in Interview One.

An unfortunate consequence of the therapist's attempts to ground the early agenda of the interview in a discussion of the client's drinking patterns may have been that, by ignoring or moving away from painful interpersonal experiences touched on by the client, the therapist became enmeshed in a pattern which maintained the client's emotional avoidance. This is suggested powerfully in later parts of the interview when the therapist paints a highly flattering portrait of the client in terms which appear to miss the implied (but glossed over) emotional content of the client's narratives.

In segment 364.01 for example the therapist comments 'From what you're saying it seems to me that you're not the sort of person that is very badly damaged (1-4)/although its damaged you a lot with your drinking, your problem with drinking, you, your personality is good, your brain is very sharp, you, you look well, you think well of yourself, (1-4, 1-8)' a comment which appears to gloss over the client's many self-critical remarks as well as narratives about an attempt at suicide, feelings of being belittled at work, and his chronic interpersonal difficulties. Many other somewhat flattering comments the therapist makes to the client suggest that the client's self-confident interpersonal manner has blinded the therapist to the client's underlying emotional and interpersonal suffering.

The client's ultimate failure to engage in treatment is foreshadowed in a sequence towards the end of the interview when the therapist makes a series of recommendations about treatment options in the clinic which are followed by the client making excuses, many of which received Sulking and Scurrying (2-6) or Asserting and Separating (2-1) codes or a combination of the two, as in the following example, which occurs after the therapist has been explaining a group treatment approach:

Therapist: if, when that time comes, you say 'yes, I would like to go into this program. I mean, if you come to the groups, you will be able to talk to other people who have been through the education, they'll tell you, you know, what its about' (1-4).

Client: 'The only reason why (Unclear) I know this sounds terrible, the only reason I (Unclear) but like I say, I left my job' (2-1, 2-6) (464),

Six out of the client's seven Sulking and Scurrying (2-6) communications occur in the last eight minutes of the interview as the therapist makes various suggestions and recommendations for the client's treatment. Nevertheless, the therapist persists with this and the session is terminated hurriedly so that the client can join in with a group that is about to start elsewhere in the building to see if he likes it. The client not only expresses ambivalence about committing to treatment in the unit he also expresses ambivalence about continuing with AA - which supports the notion that the client's particular difficulties around commitment are being played out here. His ambivalence is suggested in a number of remarks about, on the one hand, how much he likes AA and on the other his reservations about getting more deeply involved with it. For example, in segment 495 he describes how the same people in his AA group talk 'over and over again' which becomes 'a bit monotonous' adding that this is the third week and I don't want to suddenly turn round and say, 'Shut up'. On the other hand he expresses ambivalence about attending the clinic saying that he finds the AA 'good' and that he doesn't want to 'saturate' himself with both treatments. In this respect, as noted above, the client seems to be suspended between the two different approaches without being able to commit fully to either, a process which mirrors the lack of depth and commitment that seems to characterize other relationships in his life. At one point the client says that he would prefer not to commit to any treatment because he wants to get to the point where he can help himself. In his reply the therapist seems enmeshed and complicit in what appears to be one of the client's maladaptive interpersonal patterns: 'I mean, you know, having said that, I mean I think that's nice for you because you don't want to get too, sort of, dependent and' (1-4, 2-5) (484).

### Conclusion

Qualitative analysis of Interview One-N suggests how the SASB model and codes can combine with a fine grain clinical reading of the interview to clarify problematic

processes, which remained opaque in the earlier quantitative analysis. Furthermore, this qualitative analysis suggests that the notion that a 'little bit of negative process can go a long way' may hold for this interview. It suggests that the therapist may have unwittingly become enmeshed in the client's maladaptive interpersonal dynamics in a way which may ultimately have recreated a familiar scenario in this client's life, one of initiating but being unable to deepen intimate contacts. Clinically, this reading of the interpersonal dynamics of the interview is congruent with theoretical models which stress the importance of the therapist's ability to identify and disembed themselves from inevitable interpersonal 'enactments' of the client's maladaptive interpersonal patterns (e.g. Kiesler, 1996; Safran & Muran, 2000; Strupp & Binder, 1984)<sup>5</sup> However, it should be stressed that, as noted below, there are likely to be many reasons why a client does not engage in treatment. The current analysis merely highlights aspects of the interpersonal process, which may have played a part.

#### **Qualitative findings in Interviews Two-N and Three-N**

Reported in full in Macdonald (2001), these analyses suggested that both therapists, like the therapist in One-N, engaged in problematic hostile responses which were complementary to problematic aspects of their clients' interpersonal communications in their non-engage interviews. An additional finding was that in both interviews key interpersonal sequences in which the therapists appeared to have responded in a complementarily hostile way to the client's hostility occurred in the middle section of the interview, which was not coded.

#### **Discussion**

There are a number of possible explanations for the inconclusive findings of the quantitative part of the study. The discussion that follows highlights the value of the qualitative follow-up analysis in guiding the interpretation of the quantitative findings.

#### ***The importance of factors other than interpersonal process on engagement***

In at least two of the comparisons (Comparisons Two and Three), factors other than the client-therapist interaction may have determined whether the clients engaged or failed to engage in treatment. There could be weak or strong versions of this interpretation. In a strong version client-therapist interaction may be considered a relatively unimportant factor in client engagement and in a weak version it may be considered one of the number of factors which contribute towards engagement, depending on circumstances. Clients present to assessment interviews at different stages in the change process and will evidently be more receptive to their therapists and the treatment if they are ready to change (Prochaska, DiClemente, & Norcross, 1992). In Interview Three-E there was evidence from a qualitative reading of the interview, which suggested that having failed in treatment previously, the client was now determined to engage more successfully in treatment. A qualitative reading of this interview (reported in Macdonald, 2001) suggested that this had much to do with having recently hit rock bottom with his

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<sup>5</sup> It should be noted that in Interview One-E this therapist provides a good example of how a therapist may sidestep a client's invitation to engage in an enactment of the client's maladaptive pattern. This occurs when the therapist politely declines the client's suggestion that he speak to his wife to get her perspective on their relationship.

wife and his determination to regain his family and comparatively little to do with what the therapist said or did in the assessment interview. Conversely, a qualitative reading of Interview Two-N (Macdonald, 2001) indicated that the client had not himself actively sought treatment for his drinking problems and remained unconvinced that drinking was currently one of his major difficulties, suggesting that he was already well primed to drop-out. In the former case, the client in Three-E is probably an illustration of a case where there is a strong argument that the client-therapist interaction in the assessment interview was not a critical factor in non-engagement. However, in the case of the client in Two-N, although the client's ambivalence is clearly a factor in his failure to engage, the higher levels of therapist negative process in this interview and the suggestions from the qualitative analysis of the interview suggest that interpersonal processes in the interview may have played a role in his failure to engage. Other client related factors which emerged in the interviews and may have played a role in non-engagement are, in the case of the client in Three-N, not having a car, and in the case of the client in One-N, prior engagement with AA. It is likely that in many cases extraneous factors (e.g. transport difficulties, AA meetings) interact with the interpersonal quality of the interview to determine outcome. After all, if these extraneous factors were wholly responsible for the client's decision then the client would scarcely have bothered to attend the assessment interview.

***The possibility that negative processes occurred which were too subtle to be detected by SASB coding***

The quantitative findings may, as suggested in the qualitative cases studies, reflect the fact that negative processes in an initial session may be subtler and less differentiated than they are later on in therapy. As noted previously, the third session was the focus of the comparable studies by Henry *et al.* (1986, 1990) and von der Lippe *et al.* (2000). If this is indeed the case, even the fine-grained and painstaking quantitative methodology used in the study may yet be too coarse a net to detect problematic interpersonal sequences. The qualitative follow-up analyses uncovered evidence in each non-engaging case of problematic interpersonal sequences in which the therapist appeared at some points in the interview to enact either blaming or neglecting interpersonal patterns which may have confirmed their client's negative interpersonal expectations about being helped. In each case the rupture in the alliance that resulted was quite subtle, and, even if occurring in the coded portions of the interview, could have occurred in the context of comparatively few coded hostile communications. If such low frequency events can indicate ruptures in the therapeutic relationship then a quantitative methodology may be ill suited in detecting them because low frequency is unlikely to yield statistical significance (cf. Stiles *et al.*, 1998). The importance of significant moments, that may be unique, to disengagement can be contrasted with the assumption of repeated patterns of negative interpersonal behaviour assumed in the 'pond water theory' of SASB coding, as we discuss below.

***The pond water theory of sampling***

In line with Benjamin's 'pond water theory' (Benjamin & Cushing, 2000) it is common practice to code incomplete sessions in studies of interpersonal process using SASB. Indeed, this could be considered a practical necessity in most studies considering the length of time required for coding and training (Benjamin & Cushing, 2000). Studies comparable to the current one have actually coded smaller selections of interpersonal



process than was the case in this study (e.g. Henry *et al.*, 1986; Henry *et al.*, 1990; von der Lippe *et al.*, 2000). Underlying the 'pond water theory' is the assumption that the same patterns are repeated over and over again (Benjamin & Cushing, 2000). Qualitative analysis of the whole of the non-engaging interviews in this study suggested that especially in Interviews Two-N and Three-N, selecting two 20 minutes passages, one at the beginning and one at the end of the interviews, for SASB coding appeared to have resulted in the omission of passages of problematic interpersonal process involving quite significant misattunement between therapist and client (e.g. the therapist being unresponsive to client statements of distress).

This conclusion that the coding sample omitted significant passages of problematic process was reinforced by conducting a preliminary content analysis using the C-I-SAID content analysis features looking at the distribution of words in the concept category 'negative evaluation'. This analysis suggested that there was a significant difference between the coded and uncoded segments of the interviews in that the segments selected for coding contained significantly less of these words. This supports the evidence from the qualitative analysis that if the interviews had been coded in their entirety higher levels of negative interpersonal process would have been identified. In addition to this, the qualitative analyses suggested that the therapist's role and associated interpersonal behaviour appear to vary markedly at different moments in the interview, for instance when gathering information and when educating the client.

#### ***The possibility of different coding cultures developing which undermine the ability to generalize from the findings***

It is possible that the coding conducted in this study adopted different criteria and a higher threshold for coding hostile communications relative to the coding in Henry *et al.*'s studies. In this respect it seems likely that teams of SASB coders could not only develop very high reliability but also develop quite distinctive local 'cultures' of SASB coding resulting in systematic differences between different coding communities, a factor invoked by von der Lippe *et al.* (2000) to account for some of the differences they found between their work and that of Henry and his colleagues. It is unfortunate that most of the published work, which uses SASB coding fails to include detailed examples of the coding, something which clearly limits the ability of readers to compare the coding of different research groups or make clinical sense of the findings. (It is hoped that the presentation of coded material in the qualitative part of this study goes some way to addressing this difficulty).

#### ***Quantitative identification of complementarity***

Another methodological issue relates to the failure in the quantitative analysis to find evidence of therapist negative complementarity in all of the non-engage interviews, although the qualitative case studies suggested that this did occur. The more subtle processes suggested in the qualitative case analyses suggest that the narrow definition of complementarity (i.e. that a disaffiliative code of one speaker would be followed by a disaffiliative code of another speaker in the following speech turn) is arbitrarily narrow. The qualitative analyses suggest that it is likely that complementarity occurs in a more covert and less obviously 'tit for tat' manner, consistent with the interpretation that early negative process may be harder to identify than negative processes in the third session

and beyond. In addition to this, therapist Watching and Controlling (1-5) behaviours and client Deferring and Submitting (2-5) behaviours, which were included in the disaffiliation scale used for the lagged cross-tabulations addressing the issue of complementarity, and which are likely to have contributed to the significant findings of complementarity in Interviews One-E, Three-E and Three-N, may sometimes have been part of an adaptive sequence in which the therapist made recommendations which the client accepted (see Macdonald, 2001).

### Conclusions

In drawing overall conclusions from the study it is necessary to pick a pathway between the dangers of making a Type II error as a result of the limitations in the quantitative method and making a Type I error as a result of confirmatory bias in the qualitative analysis. The main conclusions of the current study appear to be methodological, highlighting possible weaknesses in adopting the 'pond water' approach to SASB sampling and indicating the fruitfulness of engaging in qualitative analysis of the source material to guide the interpretation of quantitative findings and possibly the selection of specific sequences to be analysed quantitatively. Given the labour intense nature of both SASB coding and qualitative analysis, it may be that in future studies a systematic qualitative approach, guided by specific research questions, may yield a better understanding of problematic interpersonal processes than a purely quantitative approach.

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**Appendix:** SASB cluster scores for clients and therapists in all interviews (% refers to the % of the participants' speech segments receiving the code)

SASB clusters	T One-E	C One-E	T One-N	C One-N	T Two-E	C Two-E	T Two-N	C Two-N	T Three-E	C Three-E	T Three-N	C Three-N
Freeing and forgetting (1-1)	0 (1/257)	0 (1/310)	0.3% (1/353)	0	0	0	1% (2/201)	0	0.5% (1/196)	0	0	0
Affirming and understanding (1-2)	6.3% (162/257)	4.8% (153/310)	54.9% (194/353)	2.1% (4/435)	67.5% (102/151)	3.5% (13/366)	54.7% (110/201)	6.4% (17/266)	78.1% (153/196)	4.5% (11/245)	47.4% (148/312)	2.1% (6/282)
Loving and approaching (1-3)	0	0	0	0	0	0	0	0	0	0	0	0
Nurturing and protecting (1-4)	29.2% (75/257)	0.4% (1/310)	44.2% (156/353)	0	36.4% (55/151)	0	40.3% (81/201)	0.4% (1/266)	17.3% (34/196)	0.8% (2/245)	50.3% (157/312)	0
Watching and controlling (1-5)	7% (18/257)	0.6% (2/310)	2.5% (9/353)	0	0	0	4% (8/201)	0	7.6% (15/196)	0	6.4% (20/312)	0
Belittling and blaming (1-6)	0	0	0.3% (1/353)	0	0	0	0.5% (1/201)	0.4% (1/266)	0	0.4% (1/245)	0.3% (1/312)	0
Attacking and rejecting (1-7)	0	0	0	0	0	0	0	0	0	0	0	0
Ignoring and neglecting (1-8)	0.4% (1/257)	0	1.4% (5/353)	0	0	0	0	0.4% (1/266)	2% (4/196)	0	0	0
Asserting and separating (2-1)	0.4% (1/257)	0.3% (2/310)	2% (7/353)	2.1% (9/435)	0	0.8% (3/366)	0	6.4% (17/266)	0	2% (5/245)	0	0.3% (1/282)
Disclosing and expressing (2-2)	4.7% (12/257)	90.3% (280/310)	3.7% (13/353)	80.2% (349/435)	4% (6/151)	88.8% (325/366)	6% (12/201)	69.9% (186/266)	4.1% (8/196)	81.2% (199/245)	1.3% (4/312)	69.8% (197/282)
Joyfully connecting (2-3)	0	0	0	0	0	0	0	0	0	0	0	0
Trusting and relying (2-4)	0.4% (1/257)	3.5% (11/310)	0	14.7% (64/435)	0	13.9% (51/366)	0.5% (1/201)	10.9% (29/266)	0	11% (27/245)	0	20.6% (58/282)
Deferring and submitting (2-5)	0	1% (3/310)	1.1% (4/353)	2.7% (12/435)	0	0	0.5% (1/201)	4.1% (11/266)	0	8.2% (20/245)	0	10.3% (29/282)
Sulking and scurrying (2-6)	0	1.6% (5/310)	0	1.6% (7/435)	0	0	1.5% (3/201)	11.6% (31/266)	0	1.2% (3/245)	0	1.4% (4/282)
Protesting and recoiling (2-7)	0	0	0	0	0	0	0	0	0	0	0	0
Walling off and distancing (2-8)	0	0	0	1.4% (6/435)	0	0.8% (3/366)	0.5% (1/201)	4.9% (13/266)	0	0.8% (2/245)	0	2.1% (6/282)

T, therapist; C, Client; E, Engaged; N, Non-engaged.