

Interpersonal Problems, Attachment Styles, and Outcome in Brief Dynamic Psychotherapy

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The Inventory of Interpersonal Problems (IIP) has been used to identify dysfunctional patterns in interpersonal interactions. Interpersonal problems can be organized in two dimensions, and the two-dimensional space can be divided into eight equal sectors (octants). Subscales of the IIP describe each of these octants. The instrument has been used to identify (a) interpersonal problems that are discussed most often in a brief dynamic psychotherapy and (b) problems that are treated most easily. The results show that problems in the “exploitable” octant improve most frequently, whereas problems in the “dominating,” “vindictive,” and “cold” octants do not improve as readily. Attachment styles in adulthood were examined (following a model proposed by Bowlby), and different attachment styles were found to correspond to different types of interpersonal problems. Finally, these variables were related to the ability to describe other people clearly. The article also discusses implications for brief dynamic psychotherapy.

Interpersonal problems are among the most common complaints that patients report during clinical interviews (Horowitz, 1979). Although good instruments exist for describing interpersonal behaviors and traits (e.g., Benjamin, 1974; 1986; Kiesler, 1983; Wiggins, 1979), researchers have also needed an easily administered self-report inventory for describing different types of interpersonal problems. Therefore, we developed the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) to systematize the different types of interpersonal complaints. The IIP has enabled us to ask which interpersonal problems are discussed most often in brief dynamic psychotherapy and which show the greatest improvement. Some types of interpersonal problems seem to be more difficult to treat than others, and people who complain primarily of the more difficult types of problems would seem to be poor candidates for brief dynamic psychotherapy.

In this article, we first show how the IIP has been used to answer some of these questions. Then we relate interpersonal problems to other aspects of interpersonal functioning. We assume that interpersonal problems arise in part from the patient's attachment history, so different attachment styles should

correspond to different types of interpersonal problems. Furthermore, an attachment style has other implications. A patient with a dismissing attachment style, for example, should have had fewer intimate relationships over the years, so this person's internal representations and descriptions of other people should be less well articulated. We therefore examined the clarity of patients' descriptions of significant others as well.

The Interpersonal Model

Our research has been guided by an interpersonal perspective derived from psychodynamic theorists such as Sullivan (1953) and Horney (1945), interpersonal theorists such as Leary (1957), and theorists of the object relations school (Greenberg & Mitchell, 1983). Interpersonal theorists have explored the interpersonal dynamics that lead people to re-enact maladaptive interpersonal patterns in an effort to maintain a psychological tie to an earlier attachment figure. Although maladaptive relationship patterns are often experienced as painful, the defensive efforts to avoid anxiety and to protect the self-image lead an individual to repeat those patterns. A psychodynamic treatment offers ways to identify interpersonal problems, clarify the conflict, and help the person experiment with alternative behaviors. Since interpersonal behaviors are often the most observable, describable, and verifiable component of the process, psychodynamic treatments frequently begin with an exploration of interpersonal problems.

One current version of the interpersonal theory (Horowitz & Vitkus, 1986; Kiesler, 1983; Orford, 1986; Wiggins, 1982) contains two basic postulates. The first postulate is that every interpersonal behavior can be described along two axes—a dimension of affiliation or nurturance that ranges from hostile behavior to friendly behavior and a dimension of power, control, or dominance that ranges from submissive behavior to dominating behavior. For example, scolding lies in the quadrant of the two-dimensional space that reflects hostile dominance, and advising lies in the quadrant that reflects friendly

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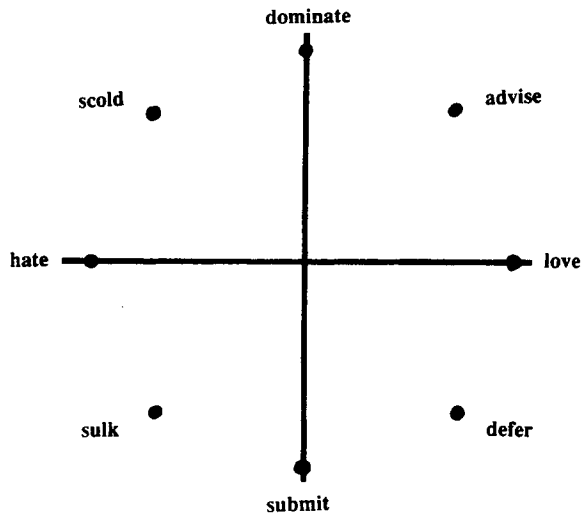


Figure 1. The two-dimensional space used to systematize interpersonal behaviors.

dominance (see Figure 1). Several factor analytic studies have confirmed this semantic structure by showing that these two dimensions account for a large proportion of the variance in ratings of personality traits (e.g., Becker & Krug, 1964; Conte & Plutchik, 1981; Foa, 1961; Wiggins, 1979).

The second postulate is that two interacting people reciprocally influence each other's behavior as they interact (e.g., Darley & Fazio, 1980; Horowitz & Vitkus, 1986; Kiesler, 1983; Leary, 1957; Orford, 1986; Sullivan, 1953). This principle asserts that one person's actions elicit, evoke, or invite particular classes of reactions from another person (Carson, 1969). The behavior and its most probable reaction are said to be *complementary*. Complementary behaviors are assumed to be similar with respect to the hostile–friendly dimension and reciprocal with respect to the submissive–dominant dimension; in other words, dominant hostile behavior invites submissive hostile behavior, and dominant friendly behavior invites submissive friendly behavior. Thus, as Person A scolds Person B, Person B is invited to sulk or self-justify. If a noncomplementary reaction occurs (e.g., both partners dominate), a tension arises. To reduce this tension, one or both partners must either adapt and change their behavior or leave the field. Thus, complementarity satisfies the participants' social motives, given their cognitions about each other.

For this reason, people who exhibit friendly submissive behaviors tend to elicit advice and support from others; that reaction in turn invites continued submissiveness, sustaining the unflattering self-views that had prompted submissiveness in the first place. As a result, people become trapped (or “stuck”) in vicious circles and experience interpersonal problems in their interactions with others. The task of a psychodynamic therapist, in part, is to modify these interactional patterns within the patient–therapist relationship and help the patient produce similar changes outside of treatment (Strupp & Binder, 1984).

The principle of complementarity has been used particularly to conceptualize the dilemma of a depressed person (Horowitz & Vitkus, 1986). Research has shown that depressed people think self-derogating thoughts, expect future failure, and experi-

ence a lack of efficacy (e.g., Altman & Wittenborn, 1980; Beck, 1967; Blumberg & Hokanson, 1983; Cofer & Wittenborn, 1980; Coyne, 1976a; Gotlib & Robinson, 1982; Hokanson, Sacco, Blumberg, & Landrum, 1980). As depressed people express their distress to others, they often seem to exhibit submissiveness and helplessness (Horowitz, Locke, Morse, Waikar, Dryer, Tarnow, & Ghannam, 1991; Kiesler, Anchin, Perkins, Chirico, Kyle, & Federman, 1976; Stephens, Hokanson, & Welker, 1987), and the listener in many cases reacts with dominating actions designed to reduce the depressed person's distress (Burgess, 1969; Coates & Wortman, 1980; Coyne, 1976b; Hammen & Peters, 1978; Hinchcliffe, Hooper, & Roberts, 1978; Horowitz et al., 1991; Horowitz & Vitkus, 1986; Howes & Hokanson, 1979; Notarius & Herrick, 1988; Watzlawick, Weakland & Fisch, 1974). These dominating reactions then invite further submissiveness and helplessness, thereby sustaining the depressed person's depression.

Such interactional patterns can reflect negatively on the self. People who find themselves expressing passive, submissive, and helpless behavior understandably feel dissatisfied with their self-image, and their dissatisfaction contributes to depression. The person naturally wants to change these dysfunctional interpersonal patterns, but the conflicts are very severe and the potential consequences are too threatening. Therefore, the person complains of wanting to be more dominating, assertive, or hostile but finding it hard to do so. As a result, interpersonal problems are often reported in comments such as “It is hard for me to (do something desired)” or “I (do something undesired) too much.”

Identification of Interpersonal Problems

Our first step in developing an inventory was to identify problems mentioned in intake interviews by patients about to begin psychotherapy that had the general form “it is hard for me to (do something).” In the first study (Horowitz, 1979), outpatients at a psychiatric clinic between the ages of 21 and 55 years were interviewed on videotape. Two observers identified every problem, and problems that they agreed about were tabulated. There were 2 to 12 problems per patient ($M = 6.9$, $SD = 2.3$), such as “I find it hard to say ‘no’ to my husband,” “I can't disclose personal things to my wife,” and “I can't make demands of my secretary.”

Because some problems were not stated in interpersonal terms (e.g., “I find it hard to fall asleep at night”), the items were submitted to 14 judges who judged whether each problem was interpersonal. On the average, 5.2 problems per patient (76% of the original set) were considered interpersonal by 13 or more judges. From these problems judged to be interpersonal, we then developed the IIP (Horowitz et al. 1988), which we believe can help patients and therapists delineate specific sources of interpersonal distress that are the focus of treatment. A fragment of the IIP is shown in Figure 2.

We have used the IIP to solve several methodological problems. First, it has allowed us to compare the amount of distress that a patient reports from interpersonal problems (e.g., problems of assertiveness) with the amount that the same patient reports from noninterpersonal problems (e.g., somatic complaints, inability to work, unwanted thoughts). We have found, for example, that patients who complain of relatively more noninterpersonal problems have a higher dropout rate from brief

Inventory of Interpersonal Problems

EXAMPLE					
How much have you been distressed by this problem?					
It is hard for me to:	Not at all	A little bit	Moder- ately	Quite a bit	Ex- tremely
get along with my relatives.	0	1	2	3	4

Part I. The following are things you find hard to do with other people.

It is hard for me to:	Not at all	A little bit	Moder- ately	Quite a bit	Ex- tremely
1. trust other people.	0	1	2	3	4
2. say "no" to other people.	0	1	2	3	4
3. join in on groups.	0	1	2	3	4
4. keep things private from other people.	0	1	2	3	4
5. let other people know what I want.	0	1	2	3	4
6. tell a person to stop bothering me.	0	1	2	3	4

Figure 2. A fragment of the Inventory of Interpersonal Problems (IIP).

dynamic psychotherapy and achieve poorer outcomes than patients who complain of relatively more interpersonal problems (Horowitz et al., 1988). Second, the inventory has allowed us to identify and track specific interpersonal problems and compare progress on different problems in the course of treatment. Third, the inventory has allowed us to compare change in specific interpersonal problems with change in specific symptoms and syndromes. The most common psychiatric syndrome in the population that we have studied is depression, but we do not yet know whether a syndrome like depression should be conceptualized independently of the patient's interpersonal problems. According to the interpersonal perspective, the two are not independent: A change in depression requires a concomitant change in the patient's interpersonal problems. Now that we can assess specific types of interpersonal problems using our inventory, we can identify groups of equally depressed patients who differ with respect to particular types of interpersonal problems. If these groups differ in their rates of overcoming corresponding interpersonal problems, they should also differ in their rates of recovering from depression.

Circumplex Analysis of Interpersonal Problems

We administered the IIP to a sample of patients just before they began outpatient psychotherapy, and we demonstrated the salience of the two interpersonal dimensions in the matrix of

interitem correlations (Horowitz et al., 1988), as hypothesized by interpersonal theorists such as Benjamin (1974), Kiesler (1983), Leary (1957), Lorr and McNair (1963), and Wiggins (1979). Alden, Wiggins, and Pincus (1990) developed circumplex scales from the items of the IIP, which can be described in this two-dimensional space. In their procedure, ipsatized item scores were intercorrelated, and the matrix of item correlation coefficients was subjected to a principal-components analysis in which the first two components were extracted. The loadings of individual items on the two components were determined, and these loadings were converted to angular locations in the two-dimensional space (Wiggins, Phillips, & Trapnell, 1989). Then the two-dimensional space was divided into eight equal sectors (octants), and eight items were identified that best characterized each octant. The eight octants were labeled, respectively, PA, BC, DE, FG, HI, JK, LM, and NO. When the resulting eight subscale scores were intercorrelated and factored, they showed a clear two-dimensional structure that accounted for 64% of the variance (Alden et al., 1990). Each of the eight resulting eight-item scales describes a different interpersonal theme: domineering (PA), vindictive (BC), cold (DE), socially avoidant (FG), nonassertive (HI), exploitable (JK), overly nurturant (LM), and intrusive (NO). The procedure was then cross-validated on a larger sample of respondents. An illustrative item from each subscale is shown graphically in Figure 3.

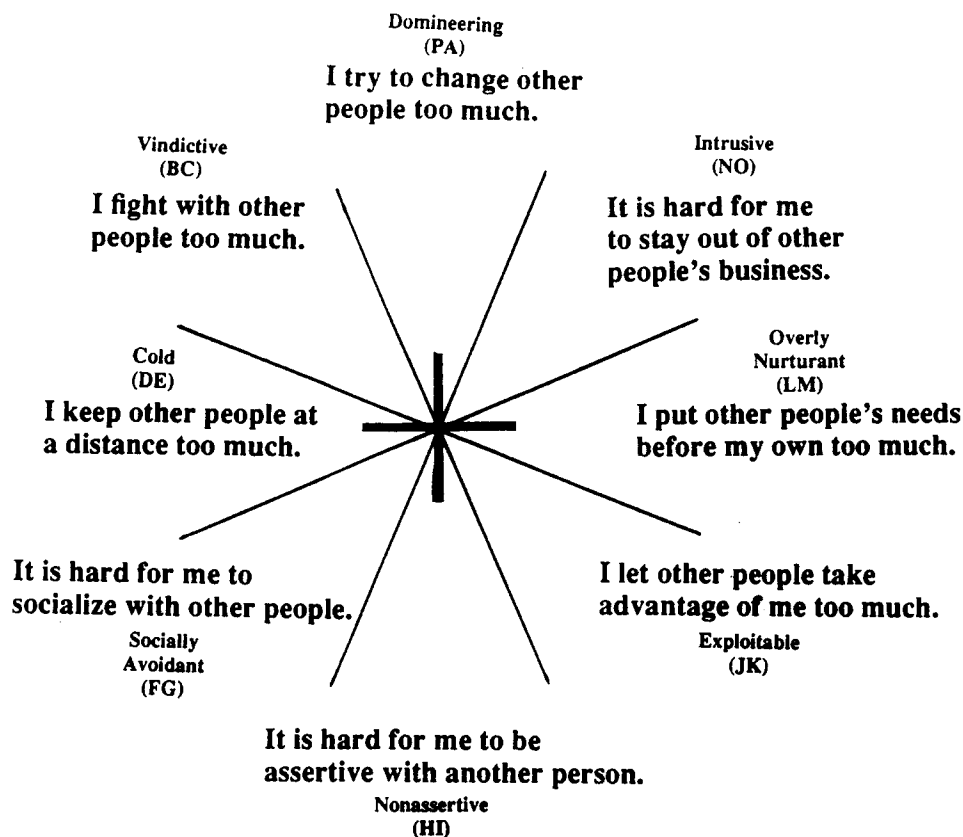


Figure 3. Illustrative items (and their abbreviations in parentheses) of each circumplex subscale of the Inventory of Interpersonal Problems (IIP).

A Case Example

Ms. A was a patient in our study who sought brief dynamic psychotherapy because of an inability to establish and maintain a long-term relationship with a man. Her reason for seeking treatment is described succinctly in the following formulation. This formulation was generated by the consensual response method (Horowitz, Rosenberg, Ureño, Kalehzan, & O'Halloran, 1989), a method used to produce a clinical formulation from the propositions that occur most frequently in the independent formulations of experienced clinicians. The advantage of consensual propositions for describing a patient has been discussed by Horowitz and Malle (in press).

This patient is a single 38-year-old woman with a number of positive attributes (she is bright, articulate, and attractive). She seeks therapy primarily because she has been unable to establish and maintain a long-term relationship with a man. Two relationships recently failed, and her current involvement with a new boyfriend may further explain her wish for treatment at this time. Her family included one sibling, a sister who was 2 years younger. Her father was in the military and absent for the first 3 years of her life. She described her mother as domineering, the parent "who wore the pants in the family"; her mother also came across as unnurturant and lacking in maternal qualities. She described her father as weak and passive. Thus, she herself appears to have been a person whose dependency needs were not met. As an adult, she has had many brief sexual encounters with men. She described herself in these relationships as taking a masculine and aggressive role and spoke of herself as the "conqueror" in sexual relationships. She

wants to have an unconflicted intimate relationship, but she fears intimacy because a relationship with a strong man makes her feel inferior. Instead, she acts tough and cool. As a result of the conflict, she feels depressed, discouraged, and troubled by a feeling of emptiness. She is also concerned that she is approaching 40 and has not yet had children. To defend against her uncomfortable feelings, she drinks alcohol excessively, possibly another tacit reason for seeking therapy. Also, when she drinks, she sometimes loses control over her aggression, and she fears both this lack of control over her aggression and her use of alcohol.

Ms. A's mean amount of distress on each circumplex subscale is shown in Figure 4. The length of a line on the graph from the center outward represents the patient's self-reported distress expressed as a standardized score for problems in that octant of the space. The graph shows that Ms. A's major distress was located in the octants reflecting dominance and hostility: being too bossy, too vindictive and critical, too cold. She expressed very few complaints about being socially avoidant, nonassertive, or exploitable. Thus, one can infer that the primary interpersonal problems in her life concerned her inability to relax control over other people and enter a relationship of intimacy.

A Study of Interpersonal Problems in Treatment

After we were able to describe each patient's interpersonal problems, we wondered which types of problems are discussed most often in a brief dynamic psychotherapy and which types

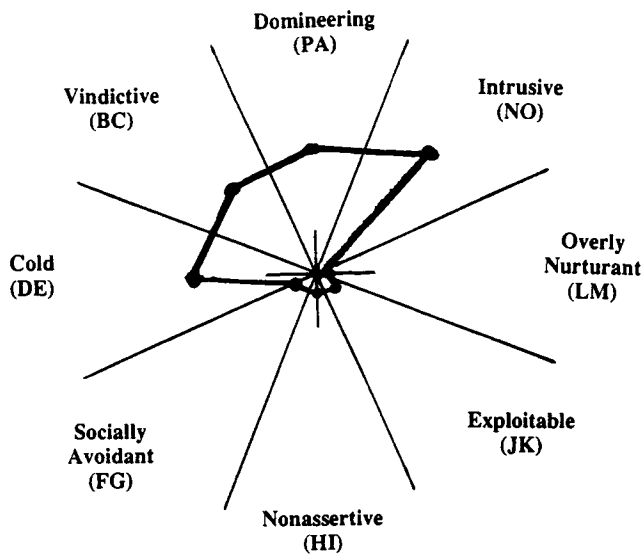


Figure 4. Mean amount of distress reported by Ms. A. caused by items of each circumplex subscale of the Inventory of Interpersonal Problems (IIP). (The length of a line on the graph from the center outward represents Ms. A's self-reported distress expressed as a standardized score for problems in that octant of the space.)

show the most improvement. The 36 patients in our study included 8 men and 28 women with a mean age of 33 years and a mean educational level of 1 year of college. They were treated by clinicians practicing brief dynamic psychotherapy in an outpatient health maintenance organization setting (Kaiser Medical Center, South San Francisco). Every patient in the sample was entitled to receive up to 20 sessions of individual psychotherapy as part of his or her health insurance. First, the patients were interviewed by an independent evaluator, and then three judges independently judged whether the patient was a suitable candidate for brief dynamic psychotherapy. (See Horowitz et al. [1988] for specific criteria.) Once accepted, the patient was assigned to a regular staff therapist and met once weekly with the therapist for 20 sessions. The therapists were 16 regular staff members who practiced various forms of brief dynamic psychotherapy.

The patient and therapist completed various inventories before, during, and after treatment. One variant of the IIP, Progress in Interpersonal Problems, is an adaptation that contains a list of the interpersonal problems on the IIP and requires the patient and therapist to indicate which problems were discussed during the treatment and whether each problem showed improvement. After the 10th session and again after the 20th session, the patient and therapist independently considered each problem and indicated (a) whether that problem had been discussed during the treatment and (b) whether that problem had shown improvement. A measure of their consensus on a given problem could range from 0 (*neither patient nor therapist ever said that they had discussed the problem*) to 4 (*both said they had discussed the problem both times*). We identified those problems on the inventory that had a consensus of 3 or 4 (problems that the patient and therapist generally agreed had been discussed). The same procedure was used to identify problems

that the patient and therapist generally agreed had shown improvement.

Table 1 shows the results for some particular problems. For example, the problem "it is hard for me to say 'no' to other people" was discussed in the treatment of 15 patients in the sample. This problem showed improvement in all 15 cases. Thus, this particular problem was apparently amenable to change, showing improvement every time it had been a clear focus of discussion. In contrast, the problem "it is hard for me to make a long-term commitment to another person" was discussed in 10 cases but only showed improvement in 1 case. Similarly, the problem "I keep other people at a distance too much" was discussed in 11 cases but only showed improvement in 4 of those cases.

These examples suggest that certain types of problems improved more readily than others, and we wondered whether the treatability of a problem was related to its location in the interpersonal space. First, we examined the problems in the circumplex subscales to determine how often problems of each subscale were discussed throughout the 36 treatments. Figure 5 shows the frequency with which interpersonal problems were discussed for each octant of the interpersonal space. If each frequency is divided by the number of patients ($N = 36$), the result tells the mean number of problems from each region discussed by the average patient. The results showed that problems from the "nonassertive" and "exploitable" octants were discussed most often, whereas very few problems were discussed from the "cold," "vindictive," and "dominating" octants.

Then we determined what proportion of the problems that were discussed showed improvement, and that result is shown in Figure 6. The results showed that problems in the "exploitable" octant improved most frequently (nearly 90% of them showed improvement). The octants that showed the poorest rate of improvement were those in the octants labeled "dominating," "vindictive," and "cold." Less than one third of the problems in these octants actually showed improvement. Apparently, problems of hostile dominance are not as amenable to change through a brief dynamic psychotherapy as problems of friendly submissiveness.

This result suggests that a patient whose interpersonal problems are primarily in the region of hostile dominance is less apt to succeed in a brief dynamic psychotherapy. For example, Ms. A, whose problems were shown in Figure 4, primarily exhibited problems of hostile dominance. One might therefore hypothesize that she would not have been a good candidate for brief dynamic psychotherapy. Indeed, the z score describing Ms. A's outcome, a composite of multiple measures, was $-.70$; Ms. A, her therapist, and the independent evaluator all agreed at the end of treatment that her major problems remained unchanged. Her difficulties in achieving a stable, committed relationship seemed to be as severe at the end of the treatment as they had been at the beginning.

Attachment Style and Interpersonal Problems

Interpersonal problems often reflect a conflict between the person's desire to express a particular behavior and the person's feared consequence of expressing that behavior. Such conflicts arise out of the person's interpersonal learning history, which manifests itself in part in the person's attachment history and

Table 1
 Number of Cases in Which Patient and Therapist Independently Agreed
 That a Problem Was Discussed, Improved, or Both

Problem	Problem was discussed	Problem was improved
It is hard for me to say "no" to other people.	15	15
It is hard for me to let other people know when I am angry.	23	23
It is hard for me to confront people with problems that come up.	19	17
It is hard for me to make a long-term commitment to another person.	10	1
I keep other people at a distance.	11	4
It is hard for me to trust other people.	13	5

attachment style. For example, people whose early experiences with other people have been disappointing might come to distrust other people, avoid intimate contact with other people, and refuse to relinquish control to other people. As a result, they might report problems of hostile dominance. On the other hand, people whose early experiences have underscored their own incompetence and dependence on others might report problems of interpersonal submissiveness. Thus, different attachment styles would seem to correspond to different types of interpersonal problems. We were therefore curious to examine the relationship between the two.

Recent research has examined people's attachment styles in adulthood. Bartholomew and Horowitz (1991) proposed a model that was based on Bowlby's (1977) suggestion that children, over time, internalize early attachment experiences and use these internal representations to judge "(a) whether or not the attachment figure is . . . the sort of person who . . . responds to calls for support and protection; [and] (b) whether or not the self is . . . the sort of person towards whom anyone, and the attachment figure in particular, is likely to respond in a helpful way" (p. 204). The first judgment concerns the child's image of other people, and the second concerns the child's

image of the self. By dichotomizing each of Bowlby's two variables, one can form a 2×2 matrix with four prototypic forms of adult attachment (Bartholomew, 1990; Bartholomew & Horowitz, 1991). As shown in Figure 7, the person's image of the self is dichotomized as positive or negative (the self is or is not worthy of love and support), and the person's image of other people is also dichotomized as positive or negative (other people are seen as either trustworthy and available or unreliable and rejecting).

Figure 7 shows the four resulting attachment patterns. Each cell represents a theoretical ideal of an attachment style. Cell I indicates a sense of worthiness (lovability) plus an expectation that other people are generally accepting and responsive. This cell corresponds to a category that other investigators have called securely attached (Hazan & Shaver, 1987; Main, Kaplan, & Cassidy, 1985); we call it *secure*. Cell II indicates a sense of unworthiness (unlovability) combined with a positive evaluation of others, leading the person to strive for self-acceptance by gaining the acceptance of valued others. It corresponds to Hazan and Shaver's (1987) ambivalent group and to Main's enmeshed or preoccupied-with-attachment pattern (Main et al., 1985); we call it *preoccupied*. Cell III indicates a sense of unworthiness (unlovability) combined with an expectation that others will be negatively disposed (untrustworthy, rejecting). By avoiding close involvement with others, people using this style are able to protect themselves against anticipated rejection. Although not explicitly discussed in previous work in adult attachment, it corresponds in part to the avoidant style described by Hazan and Shaver (1987). We therefore call it *fearful-avoidant*. Finally, Cell IV indicates a sense of love-worthiness combined with a negative disposition toward other people. Such people protect themselves against disappointment by avoiding close relationships and maintaining a sense of independence and invulnerability. This style corresponds conceptually to the detached or dismissing-of-attachment attitude described by Main et al. (1985); we call it *dismissive-avoidant*.

The different attachment styles of Figure 7 imply different types of interpersonal problems. Cells I and II, for example, imply a friendly orientation toward other people, whereas Cells III and IV imply a hostile or cold orientation toward other people, and the corresponding interpersonal problems should reflect differences in affiliation (being too friendly or being too cold). A given person is assumed to approximate each style to various degrees. To make the assessment, a semistructure interview is first administered in which people are asked about the

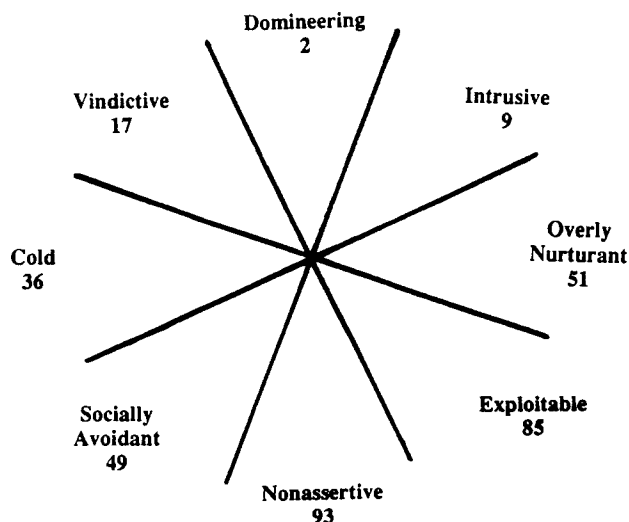


Figure 5. Total number of times that problems in each subscale were considered discussed by both patient and therapist ($N = 36$).

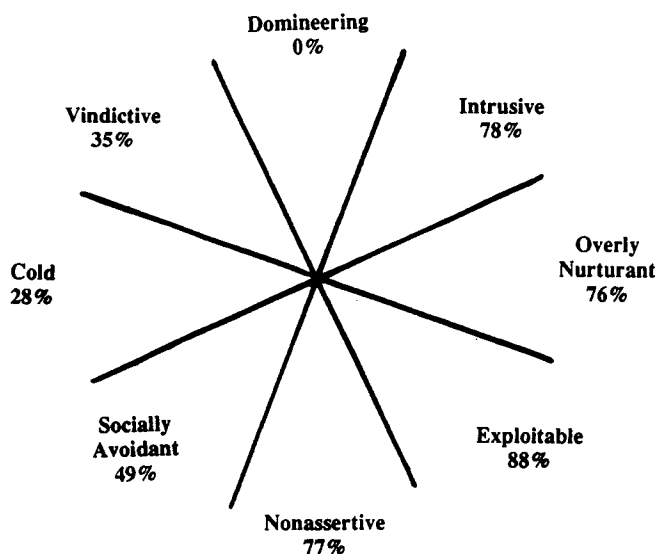


Figure 6. Percentage of problems in each category in Figure 5 that were considered improved by both patient and therapist (N = 36).

importance of close relationships, their experiences with loneliness and shyness, their trust of other people, their impressions of other people's evaluations of themselves, and their hopes for change in their social lives. Each interview is tape-recorded, and three raters listen to each interview and independently rate the person along various dimensions relevant to attachment. Then they independently rate the person with respect to each attachment style to determine the degree to which the person's interpersonal style approximates that category. For further details about the scoring procedure, see Bartholomew and Horowitz (1991).

In the following study, we examined the relationship between attachment style and interpersonal problems in a sample of students. Forty female and 37 male students were invited to participate in a study of friendship. Each subject was asked to bring a close, nonromantic friend of the same sex whom the subject had known for at least 6 months. Each subject and each friend completed questionnaires about themselves and about their partner. Then in a second session, the subject was interviewed. The raters rated each subject on four 9-point scales describing the degree to which the patient seemed to approximate each of the four attachment styles. The ratings were averaged across raters, and the highest of the four average ratings was considered to be the best fitting category for that subject. From this procedure, 47% of the sample was classified as secure, 18% as dismissing, 14% as preoccupied, and 21% as fearful.

The subjects and their friends also completed the IIP. In the friend's version, each item was worded to describe the subject. For example, the item "I try to please other people too much" became "(your friend) tries to please other people too much."

First, we determined whether ratings of the four attachment styles were consistent with our two-dimensional model. A correlation matrix was prepared for the set of attachment ratings. Using correlation coefficients as measures of proximity, each matrix was subjected to a nonmetric, multidimensional scaling using the program KYST (Kruskal, Young, & Seery, 1973). The results showed that the dimensional structure underlying the intercorrelations of the attachment ratings was highly consistent with the model proposed in Figure 7.

Then we examined the subjects' responses to the IIP. Each subject's score on each of the eight subscales (for both self-report and friend report) was converted to an ipsative score; that is, each subscale score was expressed as a deviation from that subject's overall mean, thereby reflecting the extent to which

Model of Self

		Positive	Negative
Model of Other	Positive	<p>CELL I</p> <p>SECURE Comfortable with intimacy and autonomy</p>	<p>CELL II</p> <p>PREOCCUPIED Preoccupied with relationships</p>
	Negative	<p>CELL IV</p> <p>DISMISSING Dismissing of intimacy Counter-dependent</p>	<p>CELL III</p> <p>FEARFUL Fearful of intimacy Socially avoidant</p>

Figure 7. Four theoretical attachment styles.

that group of problems was problematic for that particular person. Each subscale score was then expressed as a *z* score, using the mean and standard deviation for the entire sample on that subscale. Then the mean of each subscale was computed for each attachment group. Group means on the circumplex subscales, for self- and friend reports, are shown graphically in Figure 8.

As shown in Figure 8, the secure group's profile of means was elevated on the warm side of the interpersonal space (in both self-reports and friend reports), but no subscale score was extreme. In contrast, the dismissing group showed a self-reported profile that centered on the hostile side of the interpersonal space. The problems of coldness shown in the profile of Ms. A (Figure 4) thus seem to be associated more with the dismissing attachment style than with any other attachment style. The preoccupied group showed an elevation on the overly expressive subscale in the self-reports. The friends' reports also described these subjects as highest on the overly expressive subscale, but the friends' means were also elevated in octants reflecting dominance (i.e., the autocratic and competitive scales). The friends' descriptions of the subjects' problems revealed less overall warmth and more overall dominance than the subjects' own self-reports. Although one thinks of preoccupied individuals as needy and dependent, they and their friends seem to have emphasized the role of dominance in their interpersonal style. Finally, the fearful group reported relatively more problems reflecting unassertiveness and social inhibition (introversion), and the corresponding friends' reports confirmed this general pattern of results. These results thus indicate that different types of interpersonal problems are associated with different attachment styles. In particular, the interpersonal problems of Ms. A (Figure 4) seem to correspond to the dismissing attachment style, a style that is consistent with her poor response to treatment.

The Capacity to Describe Other People

People with a dismissing attachment style seem to report the kind of interpersonal problems that are particularly difficult to treat, particularly problems involving hostility or coldness. Because these kinds of problems keep the person relatively disengaged from other people, the person would have less opportunity to come to know other people and, therefore, would have vaguer internal representations of other people and would be relatively unable to describe other people clearly. Furthermore, patients do vary in the clarity with which they describe other people: Some patients manage to evoke such vivid images in the listener that the listener can easily visualize the person being described, whereas other patients provide such vague, sketchy descriptions that the listener is left only with indistinct impressions. Because the work of brief dynamic psychotherapy focuses to a large extent on interpersonal relationships between the patient and significant others (Luborsky, 1984; Strupp & Binder, 1984), brief dynamic psychotherapy would be at a disadvantage if the patient could not describe other people clearly. Therefore, we were curious to determine whether a patient's capacity to describe his or her parents might be related to therapeutic outcome and, if so, whether the person's principal types of interpersonal problems are related to this capacity.

Thirty-six patients who seemed suitable for brief dynamic

psychotherapy were selected from the 200 patients who had applied for treatment. A 55-min evaluation interview was conducted by an independent evaluator, a psychodynamically oriented clinical psychologist with more than 10 years of postlicensure clinical experience; all interviews were conducted by the same person. This interview, which was videotaped, followed a semistructured format that explored the patient's presenting problems, symptoms, precipitating stresses, family history, and current functioning. As part of the questioning about family history, all patients were asked to describe their mother and father. After the interview, each patient was assigned to the next available therapist; the therapists, who were unaware of the specific purposes of the project, practiced various forms of brief dynamic psychotherapy using principles described by Budman (1981), Luborsky (1984), and Strupp and Binder (1984). After the 20th session, the independent evaluator contacted the patient to schedule an exit interview.

The sample consisted of 8 men and 28 women between the ages of 23 and 41 years. Fifteen were single, 16 were married, and 5 were divorced or separated. The patient's improvement at the end of treatment was derived from three principal sources: five patient self-report measures, four therapist evaluations, and four evaluations from independent evaluators. The measures from each source were individually converted to *z* scores, and the *z* scores were averaged to produce a single overall measure of improvement. (Details about this procedure and the final measure are described by Horowitz et al., 1988.) Because the measure of improvement is a mean *z* score, its value could be negative (implying below average improvement), 0, or positive (implying above average improvement).

The patients were divided into two groups—those who had done relatively well in treatment and those who had not done so well—and the descriptions of the parents from the initial interview were transcribed. Five patients were identified from each subset so that the descriptions were approximately equal in length. The improvement scores of the group that improved the most ranged from .64 to 1.27, and those of the group that did not do well ranged from -2.20 to 0.17. Each mother and father description was then rerecorded and presented to a group of naive undergraduate student listeners. The students listened to each description and wrote from memory what they recalled of that description. Then they rated the clarity and specificity of each description on a scale from 1 to 7.

First, we examined the ratings of clarity. For each set, the descriptions produced by patients who had done well in treatment were judged to be clearer. The corresponding means for the descriptions of mothers of the successful and unsuccessful patients were, 4.70 and 4.16, respectively, and those for descriptions of fathers were 5.06 and 4.42, respectively. A repeated-measures *t* test gave $t(9) = 2.83$, $p = .02$, for the mother descriptions and $t(9) = 2.50$, $p = .03$, for the father descriptions. The ratings of specificity were comparable. The mean ratings of specificity for the descriptions of mothers were 4.90 and 4.10, respectively, and those for the descriptions of fathers were 5.10 and 4.18, respectively. For the mother descriptions, $t(9) = 10.95$, $p < .001$; for father descriptions, $t(9) = 3.57$, $p < .01$.

Each recalled description was then divided into "thought-units" (see Horowitz et al., 1989, p. 601); a thought-unit is defined as "a basic subject-predicate proposition that is conveyed by a given sentence" and is always organized around a verb or an

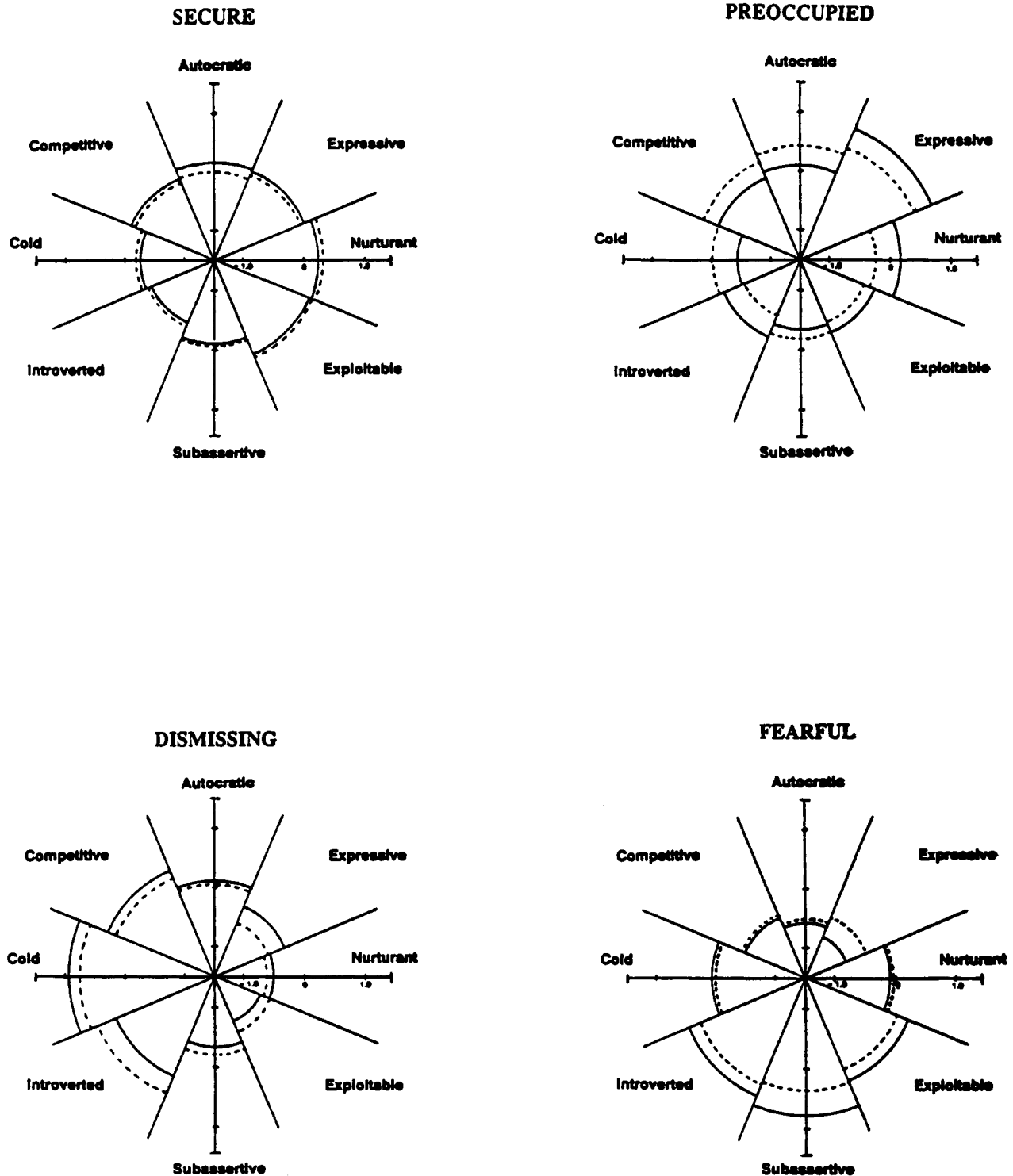


Figure 8. Mean rating of distress (by self and by friend) on each subscale of the Inventory of Interpersonal Problems (IIP) for subjects in each attachment style category.

implied verb. The mean number of thought-units across the recalls of the successful patients' mother descriptions was 6.02 ($SD = 1.88$); for the father descriptions, it was 5.38 ($SD = 2.73$). The corresponding means for the mother and father descriptions of unsuccessful patients were 4.66 ($SD = 1.50$) and 4.38

($SD = 2.48$), respectively. The corresponding means differed significantly: For the mother descriptions, $t(9) = 4.71$, $p = .001$; for the father descriptions, $t(9) = 3.44$, $p < .01$. Thus, on the average, raters recalled more content from descriptions provided by patients who subsequently did well in the treatment. If

correlated variables such as the word count had not been controlled, the difference in clarity would probably have been even greater.

Then we identified thought-units that were consensually recalled by the raters. First, we counted the number of thought-units that occurred repeatedly among the raters in their recall of a given description. A consensual thought-unit was defined as a unit that was mentioned in the recall of 3 or more of the 10 raters. In recalling the mother descriptions of the successful patients, the raters produced a mean of 7.0 consensual units ($SEM = 0.32$), but in recalling descriptions by the unsuccessful patients, they produced a mean of only 5.2 consensual units ($SEM = 0.49$). The difference between the means was significant: $t(8) = 3.09, p = .01$. This result suggests that the descriptions of successful patients contained more details that were consensually recalled than the descriptions of unsuccessful patients.

The following is an example of the consensual recall of a mother description that had been judged to be clear. "This mother was described as strong and authoritative. She was also controlling, protective, and a strict disciplinarian. Initially she did not trust her daughter, but as the daughter grew up, she became more accepting, and later the relationship between mother and daughter became more like equals." Here is a contrasting example of the consensual recall of a mother description that had been judged to be less clear. "This mother was described as a person who liked to dance and liked to talk. She was very upset after her own mother's death, and over the years she has been very emotional and very stressed." In general, clear mother and father descriptions yielded a larger number of consensually recalled thought-units, although the original descriptions were equal in length.

What makes a description clear? Apparently, certain descriptions contain content that better matches concepts that are consensually available to a listener. Because consensually recalled content is the content that an average listener is likely to remember in the future, one could predict that a therapist would more easily remember the content that naive raters rate to be clear. Furthermore, brief dynamic psychotherapy requires a dialogue over time about significant persons and relationships, and the process is enhanced if the therapist can better recall the patient's descriptions of significant persons. Therefore, unclear descriptions would handicap the treatment and lower the probability of a successful outcome.

We believe that the person's attachment style, interpersonal problems, and ability to describe other people are related variables. If a person avoids other people out of distrust, the person would have less intimate contact with other people and would know other people less well, so the person would be relatively unaccustomed to describing other people, and the limited capacity to describe other people could impede a brief psychodynamic treatment. Future research is needed to relate these variables directly. We need to determine, for example, whether problems of hostile dominance are directly associated with an inability to describe other people clearly and whether unclear descriptions of other people directly impede the course of treatment.

Summary and Discussion

The results reported here can be organized around a circumplex description of interpersonal problems. Problems of

friendly submissiveness seem to be more easily treated in brief dynamic psychotherapy than problems of hostile dominance. Therefore, people who express primarily problems of friendly submissiveness would seem to be better candidates for brief dynamic psychotherapy than people who express primarily problems of hostile dominance. The findings also suggest a connection between a person's principal type of interpersonal problems and the person's attachment style. People with a dismissing attachment style seem to exhibit a number of problems of hostile dominance, so they probably should not be good candidates for brief dynamic psychotherapy. Finally, the results help us identify one kind of dysfunction that may also impede progress in brief dynamic psychotherapy—namely, a difficulty in describing other people clearly. Apparently, the interpersonal problems associated with a dismissing attachment style prevent the person from knowing other people very well, so the person's internal representations and descriptions of other people are relatively unclear.

It is therefore possible that brief dynamic psychotherapy is not the treatment of choice for people with problems of hostile dominance. Long-term dynamic therapy, cognitive therapy, or pharmacotherapy may be more appropriate at least initially in the treatment. It is also possible that group treatment is more helpful to these patients because patients in a group hear other people describing significant others and can learn the vocabulary of person description. Thus, our studies raise some issues that are related to interpersonal problems and to internal representations of other people. Some of these issues are addressed in the sections that follow.

Issues Related to Interpersonal Problems

When people begin psychotherapy, they express many kinds of complaints. Some complaints consist of uncomfortable feelings, which may be interpersonal (feeling guilty) or noninterpersonal (feeling bored). Others consist of disturbing thoughts, which may also be interpersonal ("people don't like me") or noninterpersonal ("I am not a well person"). Still others consist of dysfunctional behaviors, and they too may be interpersonal ("it is hard for me to make friends") or noninterpersonal ("it is hard for me to stop overeating"). These and other kinds of complaints frequently occur in intake interviews, but we do not yet understand the relationship among the various categories. For example, the most common target complaint for patients in our study was depression, and recent literature has distinguished between different subtypes of depression. In this literature, one subtype has been organized around interpersonal problems, and another has been organized around noninterpersonal problems. Beck (1983), for example, has differentiated between socially dependent and autonomous subtypes of depression. Socially dependent people are motivated to seek friendly interpersonal interaction and become depressed over interpersonal loss, whereas autonomous people are motivated to seek evidence of their own competence and individuality and become depressed over performance failures. Similarly, Blatt and his associates (Blatt, 1974; Blatt & Schichman, 1983) have distinguished between anaclitic people (characterized by a strong need for interpersonal involvement that leaves the person vulnerable to depression over interpersonal loss) and introjective people (characterized by a self-critical attitude that leaves the

person vulnerable to feelings of worthlessness). The former type is excessively dependent, whereas the latter type is harshly self-critical. Arieti and Bemporad (1980) made a similar distinction. The interpersonal subtype proposed by each theorist thus includes people whose depression stems from interpersonal difficulties, and that type of patient may be a good candidate for brief dynamic psychotherapy.

Items of the IIP generally describe dysfunctional behaviors presented in one of two forms—statements that begin with the phrase “it is hard for me to” and statements that begin with the phrase “these are things I do too much” (Horowitz, 1979). However, the phrase “it is hard for me to” is ambiguous. At times, this phrase refers to a lack of competence and has the meaning, “I don’t know how to.” A person who “finds it hard to make friends,” for example, may lack relevant social skills. At other times, the phrase refers to an inhibition against executing the behavior and has the meaning “I can’t bring myself to,” implying some form of conflict. At still other times, the phrase implies that performance anxiety is disrupting the person’s performance, masking a competence that would otherwise be evident. Therefore, we need to understand the intended meaning of the problem statement if we are to formulate appropriate treatment strategies. If the person’s problem implies a lack of competence, then the treatment should help the person acquire relevant skills. If the problem reflects conflicting motives and maladaptive defenses, then the treatment should clarify whatever wishes are producing the conflict. If the problem reflects the disruptive effect of anxiety, then the treatment should investigate the dangerous consequences that the patient anticipates and help reduce the level of the patient’s anxiety. Therefore, assessment procedures still need to be devised to clarify the nature of the person’s dysfunction. Possibly, problems in one region of the circumplex (e.g., being overly exploitable) reflect a conceptually different type of problem from those in other regions of the space (e.g., social avoidance).

Issues Related to Internal Representations and the Clarity of Person Descriptions

Further research is also needed to explain why the clarity of a patient’s descriptions of other people is related to the patient’s outcome in brief dynamic psychotherapy. When raters recall the content of a patient’s mother and father descriptions, the recalled content can be classified into (a) external characteristics (e.g., physical attributes) and (b) internal characteristics (e.g., inferred feelings). Internal characteristics occurred in our studies much more often than external characteristics and can be further divided into interpersonal characteristics (e.g., affectionate, a strict disciplinarian) and noninterpersonal characteristics (e.g., unhappy, likes to dance). Possibly, patients vary in the relative frequency of these two types of descriptions, and the relative frequency may itself be related to the clarity of the description. In other words, people who themselves are not interpersonally engaged with other people may not use interpersonal descriptors in characterizing significant others. Future studies with larger samples are needed to explore this difference.

One can also differentiate conceptually between the clarity and the accuracy of person descriptions. A patient’s description of a significant other may depart in two ways from an objective

account. The patient’s description may differ from other people’s descriptions of that same person. For example, a patient’s description of a parent may differ systematically from the patient’s sibling’s description of that same parent. However, differences of this kind do not necessarily reflect a distortion in the patient’s perception, because each person’s experiences with a target person may be unique. On the other hand, a person’s description of a target person may change in the course of treatment, and those changes could reflect an earlier use of defense mechanisms (cf. Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975), implying inaccuracy in the earlier account.

Finally, a person’s clarity in describing other people may be one component of the important but poorly defined concept of psychological-mindedness. The ability to describe other people may be just one manifestation of a more general interpersonal orientation. An investigator could assess the person’s ability to describe the self clearly, to describe interactions clearly, to speculate about motives, and so on. Because component skills would only be imperfectly correlated with one another, certain people might be identified who are skillful in describing the self but poor in describing other people. Future research is therefore needed to examine the full range of abilities that together constitute the characteristic that we call psychological-mindedness.

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