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Transference patterns and working alliance during the early phase of psychodynamic psychotherapy

Transferni obrasci i radni savez tokom rane faze psihodinamičke psihoterapije

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Abstract

Background/Aim. Working alliance, as a collaborative part of the therapeutic relationship has been proven to be one of the most powerful therapeutic factors in psychotherapy in general, regardless many technical differences between numerous psychotherapeutic modalities. On the other hand, transference is the basic concept of psychodynamic psychotherapy, and, according to the psychoanalytic theory and practice, it forms a major part of the therapeutic relationship. The aim of our paper was to determine the differences between the groups of patients with low, middle, and high working alliance scores and the dropout group in transference patterns, sociodemographic and clinical parameters, during the early phase of psychodynamic psychotherapy. **Methods.** Our sample consisted of 61 non-psychotic patients, randomly selected by the method of consecutive admissions and treated with psychoanalytic psychotherapy in the outpatient clinical setting. The patients were prospectively followed during 5 initial sessions of the therapeutic process. The working alliance inventory and Core conflictual relationship theme method were used for the estimation of working alliance and transference patterns, respectively. According to the Working Alliance Inventory scores, four groups of patients were formed and than compared. **Results.** Our results show a significant difference between the groups of patients with low, middle, and high working alliance inventory scores and the dropout group on the variable – transference patterns in the therapeutic relationship. **Conclusion.** Disharmonious transference patterns are more frequent in patients who form poor quality working alliance in the early phase of psychotherapy, or early dropout psychotherapy. It is of great importance to recognize transference patterns of a patient at the beginning of the psychotherapeutic process, because of their potentially harmful influence on the quality of working alliance.

Key words:
psychotherapy; young adult; physician-patient relations; transference (psychology).

Apstrakt

Uvod/Cilj. Dokazano je da je radni savez, kao saradnički deo psihoterapijskog odnosa, jedan od najmoćnijih terapijskih faktora u psihoterapiji uopšte, bez obzira na mnoge razlike u tehnici koje postoje među brojnim psihoterapijskim pravcima. Sa druge strane, transfer je osnovni koncept psihodinamičke psihoterapije, i prema psihoanalitičkoj teoriji i praksi, čini veliki deo terapijskog odnosa. Cilj našeg rada bio je da utvrdimo razlike između grupa bolesnika sa niskim, srednjim i visokim skorom radnog saveza i grupe bolesnika koji su prekinuli terapiju, i to u odnosu na transferne obrasce u terapijskom odnosu, kao i sociodemografske i kliničke karakteristike. **Metode.** U ovu studiju bio je uključen 61 nepsihotični bolesnik, slučajno izabran metodom konsekutivnih prijema i tretiran psihoanalitičkom psihoterapijom u ambulantnim uslovima. Bolesnici su prospektivno praćeni tokom pet početnih seansi terapijskog procesa. Za procenu radnog saveza i transfernih obrazaca korišćeni su Upitnik radnog saveza i Metod jezgrovne konfliktne teme u odnosima. Na osnovu visine skora na Upitniku radnog saveza, formirane su i upoređivane četiri grupe bolesnika. **Rezultati.** Naši rezultati pokazuju da postoji značajna razlika između bolesnika sa niskim, srednjim i visokim skorom radnog saveza i grupe bolesnika koji su prekinuli terapiju, i to u odnosu na ponavljanje transfernih obrazaca u terapijskom odnosu. **Zaključak.** Disharmonični transferni obrasci češći su kod bolesnika koji u ranoj fazi psihoterapije, formiraju radni savez lošeg kvaliteta, ili rano prekidaju psihoterapiju. Veoma je značajno transferne obrasce bolesnika na početku psihoterapijskog procesa, zbog njihovog potencijalno štetnog uticaja na kvalitet radnog saveza.

Ključne reči:
psihoterapija; mlade osobe; lekar-bolesnik, odnosi; transfer (psihološki).

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Introduction

During past several decades, there has been growing interest in psychotherapy research. This is partly due to the fact that it has been established that research is one of the ways leading to the integration of more and more numerous psychotherapeutic modalities, because there has been success in research aimed at extracting common therapeutic factors as the ground basis for integration [1]. The therapeutic or working alliance (WA) has been proven to be one of the factors with the constant and the most potent predictive value for psychotherapy outcome, found out in many researches, on different types of psychotherapeutic treatments and patient's problems [2–4]. In psychotherapy research WA has been conceptualized as the collaborative relationship between a patient and a therapist, defined according to the Bordin's tripartite definition [5]. This definition points to the importance of the agreement between patient and therapist about the goals of the therapy, tasks leading to these goal's achievement, as well as emotional bond between the participants of psychotherapy process (a patient and a therapist). It refers mainly to the conscious dimension of the wholeness of a therapeutic relationship.

Transference is one of the cornerstones of the psychoanalytic theory. It is mainly unconscious part of a therapeutic relationship, covering all the unconscious feelings, whishes, attitudes and behaviors displaced (transferred) from the important persons in patient's past and present life, to the person of therapist in a therapeutic relationship [6]. In psychotherapy research, transference is operationalized through transference patterns, referring to the enduring relational patterns, repeated (enacted) in the therapeutic relationship [7].

Working alliance and transference patterns are intertwined in different proportions during a process of psychotherapy. Their interrelationship has not been investigated, until instruments for their assessment have been developed. There are still many unknowns about their mutual influences. It seems that the therapeutic relationship is "the servant of two cruel masters" – transference and working alliance, like in the famous Freud's metaphor about the Ego as a servant of two masters – Id and Superego. It is not clear – do patient's transference patterns manifest themselves in the early phase of psychotherapy.

The aim of our paper was to determine differences between groups of patients with low, middle, high working alliance scores and dropout group in transference patterns, socio-demographic and clinical parameters, during the early phase of psychodynamic psychotherapy.

Methods

Sample. For this study, 61 non-psychotic outpatients of the Clinic for Mental Health-Clinical Center Niš, referred from the Department for Psychiatric Diagnostics to the Department for Psychotherapy, with indication for psychodynamic psychotherapy, were selected by the method of consecutive admissions in the period from January 2009 to January 2012. Clinical diagnosis was established in accordance with the criteria of the International Classification of Mental Disorders – 10 (ICD 10) [7] and using Mini International Neuropsychiatric Interview (M.I.N.I. Version 5.0.0) [8]. For the assessment of global functioning, the Global Assessment of Functioning (GAF) [9] Scale was used. The patients were from the diagnostic groups – neurotic, stress related and somatoform disorders (F40-F48), depressive episode without psychotic features (F32.0-F32.2), and personality disorders (F60-F61). All the patients were 18 to 45 years old, they were informed about the research and signed informed consent form. Patients with mental retardation, dependency disease, organic mental disorders, imminent suicidality, serious somatic disease, or in need for hospitalization were excluded from the study. After the psychiatrist had done initial psychiatric assessment, the patients were assessed by the psychotherapist. For the establishment of psychodynamic diagnosis, semi-structured interview for the Operationalized Psychodynamic Diagnosis (OPD-2) [10] was used. The Relationship Anecdotes Paradigm Interview (RAP) [11] was a part of it directed toward collecting relationship episodes with important others. This is the semi structured interview, lasting about 20 minutes, describing relevant interactions with important persons from the patient's past and present. Six to 8 interactions are needed, describing 3 components of a transference pattern – dominant wish, attitude or need of the patient toward the other; answer of the other person to this wish; and reaction of the patient to this person's answer. These 3 elements constitute a relationship episode. The most dysfunctional repetitive relationship episode is used for extracting core conflictual relationship theme (CCRT) which is than scored using Category system CCRT-LU [12]. CCRT has been used in many researches as the measure of transference patterns. Scoring has been done by the practicing psychotherapist, immediately after the initial psychodynamic assessment. For every patient, the most dominant wish (W), reaction of other (RO) and reaction of self (RS) match with one category from CCRT-LU category system that best describes it. This category system consists of 119 descriptive categories and 13 clusters. Clusters A, B, C and D with belonging categories are harmonious, and clusters from E to M are disharmonious in relation to the feelings associated with them [13–16].

After the initial psychiatric and psychodynamic assessment, all of the patients started psychodynamic psychotherapy treatment with the same therapist. The therapy has been conducted according to the standard procedure for psychodynamic psychotherapy – once weekly sessions lasting 45 to 50 minutes, always at the same place and time. Therapy was not manualized and transference interpretations were not used. After each session, the therapist extracted relationship episodes including patient-therapist interactions and patient's spontaneous as well as elicited comments about this relationship. After the 4th session a patient and the therapist independently filled in the Working Alliance Inventory-short version (WAI S) for the patient and the therapist [13–16], revision from 1989 [17]. The therapist also scored relationship episodes of the therapeutic relationship using CCRT-LU categories. The patients have continued psychodynamic psychotherapy treatment after this research.

A total of 14 patients dropped out the treatment before the 5th session. They were assigned to the dropout or D group. The rest of the patients (47 of them) were assigned to the therapeutic or T group, which was divided into 3 subgroups in respect to the WAI S patient's score – T1 group of patients with low WAI S – 13 patients, T2 group with medium WAI S – 20 patients and T3 group with high WAI S – 14 patients. Cut off values between the groups were 25th and 75th percentiles of the WAI S scores (recommended by the author of WAI – Horvath AO). The groups were compared on socio-demographic, clinical variables and number of disharmonious categories of wish, reaction of self and reaction of others in relationships with important others and with the therapist. For input of data, graphs and tables we used a Microsoft Excel personal computer (PC) software. Quantitative statistical analysis was done by PC software SPSS 15.0. Mean values for numerical variables were compared using the Kruskal-Volis test. Attributive variables were compared using the Mantel-Hansel χ^2 test or Fisher's test when the frequency was lower than 5. Values $p < 0.05$ were considered statistically significant.

This research was approved by the Ethics Committee of Medical Faculty, University of Niš.

Results

Our investigation included 61 patients in the process of individual psychoanalytic psychotherapy. Socio-demographic characteristics – gender, age, education, employment, marital status and economic status are shown in Table 1.

Table 2 shows clinical characteristics – diagnostic groups and GAF of the patients in our sample.

The distribution of frequencies for socio-demographic characteristics and results of comparison of groups T1, T2, T3 and D by age, gender, occupation, marital status, employment and average monthly income *per* person of household are shown in Table 3. There was no significant difference between the groups compared by these socio-demographic variables.

The parameters of clinical diagnosis did not differ significantly in the groups T1, T2, T3 and D. The clinical characteristics and the results of group comparison are shown in Table 4.

The mean patients score for the whole T group on WAI S was 61.53 ± 6.99, and the mean therapist score was 67.38 ± 11.18. The mean value of WAI S for the T1 group was 52.92 ± 6.946, for the T2 group 68.65 ± 4.580 and for the T3 group 79.00 ± 3.211.

Table 1

Socio-demographic characteristics of the whole sample of patients

Age in years (mean ± stand.dev.)	27.39 ± 6.230
Gender (n, %)	
female	49 ± (80.3)
male	12 ± (19.7)
Education (n, %)	
attending high school	3 (4.9)
high school education	17 (27.9)
university student	21 (34.4)
bachelor degree	7 (11.5)
master degree	13 (21.3)
Marital status (n, %)	
not married	46 (75.4)
Married	15 (24.6)
Employment status (n, %)	
unemployed	44 (72.1)
Employed	17(27.9)
Average monthly income in Euro (E) (*per* person of household) (n, %)	
without income	1 (1.6)
under 50 E	5 (8.2)
under 80 E	24 (39.3)
under 100 E	17 (27.9)
under 150 E	10 (16.4)
under 200 E	3 (4.9)
over 200 E	1 (1.6)

Table 2

Clinical characteristics of the whole sample of patients

Prevalent diagnosis	n	%
Neurotic (F40-F48)	20	32.8
Depressive (F32.0-F32.2)	12	19.7
Personality disorder	29	47.5
With comorbid diagnosis	21	34.4
Without comorbid diagnosis	40	65.6
Total	61	100.00
GAF score, mean ± st. deviation	66.18	8.68

GAF – global assessment of functioning.

Table 3

Socio-demographic parameters in the groups of patients: distribution of frequencies and the results of group of patients comparison

Parameter	Number (%) of patients in the group				Results of group comparison			
	T1	T2	T3	D	Pearson χ^2	df	*p*	phi
Age (years)								
18–25	6 (46.2)	12 (60.0)	5 (35.7)	6 (42.9)				
26–34	6 (46.2)	4 (20.0)	7 (50.0)	5 (35.7)	4.701	6	0.583	0.278
35–45	1 (7.7)	4 (20)	2 (14.3)	3 (21.4)				
Gender								
female	9 (69.2)	15 (75.0)	13 (92.9	12 (85.7)	3.020	3	0.389	0.223
male	4(30.8)	5 (25.0)	1 (7.1)	2 (14.3)				
Education								
attending high school	0 (0.0)	2 (10.0)	0 (0.0)	1 (7.1)				
high school	2 (15.4)	3 (15.0)	7 (50.0)	5 (35.7)				
university student	7 (53.8)	8 (40.0)	3 (21.4)	3 (21.4)	15.112	12	0.235	0.498
bachelor degree	2 (15.4)	1 (5.0)	3 (21.4)	1 (7.1)				
master degree	2 (15.4)	6 (30.0)	1 (7.1)	4 (28.6)				
Marital status								
not married	10 (76.9)	14 (70.0)	11 (78.6)	11 (78.6)	0.483	3	0.923	0.089
married	3 (23.1)	6 (30.0)	3 (21.4)	3 (21.4)				
Employment								
unemployed	9 (69.2)	15 (75.0)	11 (78.6)	9 (64.3)				
employed	4 (30.8)	5 (25.0)	3 (21.4)	5 (35.7)	0.584	3	0.837	0.118
without	0 (0.0)	1 (5.0)	0 (0.0)	0 (0.0)				
Average monthly income in Euro (per person of household)								
under 50 E	2 (15.4)	1 (5.0)	2 (14.3)	0 (0.0)				
under 80 E	2 (15.4)	8 (40.0)	7 (50.0)	7 (50.0)				
under 100 E	7 (53.8)	6 (30.0)	2 (14.3)	2 (14.3)	21.385	18	0.260	0.592
under 150 E	1 (7.7)	4 (20.0)	2 (14.3)	3 (21.4)				
under 200 E	1 (7.7)	0 (0.0)	0 (0.0)	2 (14.3)				
over 200 E	0 (0.0)	0 (0.0)	1 (7.0)	0 (0.0)				

T1 – the group with a low Working Alliance Inventory – short version (WAIS) score; T2 – the group with a medium WAIS score; T3 – the group with a high WAIS score; D – the dropout group.

Table 4

Clinical parameters in the groups of patients: distribution of frequencies and the results of group comparison

Parameter	Number (%) of patients in the group				Results of group comparison			
	T1*	T2*	T3*	D*	Pearson χ^2	df	*p*	phi
Diagnostic category								
neurotic disorder	4 (30.8)	8 (40.0)	3 (21.4)	5 (35.7)				
depressive disorder	0 (0.0)	4 (20.0)	5 (35.7)	3 (21.4)	6.988	6	0.322	0.338
personality disorder	9 (69.2)	8 (40.0)	6 (42.9)	6 (42.9)				
Presence of comorbidity	2 (15.4)	9 (45.0)	3 (21.4)	7 (50.0)	5.630	3	0.131	0.304
absent	11 (84.6)	11 (55.0)	11 (78.6)	7 (50.0)				
present								
GAF score	26.23	33.88	28.39	33.93	2.210	3	0.530	0.28
mean range	60.00	70.00	62.50	67.50				

***For explanation see under Table 3; GAF – global assessment of functioning.**

The results on CCRT-LU categorical system show that frequency of disharmonious wish is much higher in the patient-therapist relationship in the T1 group compared to the other groups (Table 5).

In the group D there was a statistically significant higher frequency of disharmonious categories of reaction of other in patient-therapist relationship. In the group T2 frequencies were lower than expected (Table 6).

The frequencies of CCRT-LU disharmonious categories of reaction of self were significantly higher in the group D, while at the same time, their frequencies in the groups T2 and T3 were lower than expected (χ^2 =13.476, df = 3, $p < 0.01$, phi = 0.470) (Table 7).

Table 5

Frequencies of conflictual relationship theme category system (CCRT-LU) disharmonious categories of wish (W) in patient-therapist relationship

CCRT-LU W patient-therapist relationship	Patient group				Total
	T1*	T2*	T3*	D*	
Harmonious					
count	7	18	13	13	51
expected count	10.9	16.7	11.7	11.7	51.0
% within group	53.8	90.0	92.9	92.9	83.6
Disharmonious					
count	6	2	1	1	10
expected count	2.1	3.3	2.3	2.3	10.0
% within group	46.2	10.0	7.1	7.1	16.4

***For explanation see under Table 3; $\chi^2 = 10.745$; df = 3; $p = 0.004$; phi = 0.420.**

Table 6

Frequencies of conflictual relationship theme category system (CCRT-LU) disharmonious categories of reaction of others (RO) in patient-therapist relationship

CCRT-LU RO patient-therapist relationship	Patient group				Total
	T1*	T2*	T3*	D*	
Harmonious					
count	11	19	12	8	50
expected count	10.7	16.4	11.5	11.5	50.0
% within group	84.6%	95.0%	85.7%	57.1%	82.0%
Disharmonious					
count	2	1	2	6	11
expected count	2.3	3.6	2.5	2.5	11.0
% within group	15.4%	5.0%	14.3%	42.9%	18.0%

***For explanation see under Table 3; $\chi^2 = 8.330$; df = 3; $p = 0.04$; phi = 0.370.**

Table 7

Frequencies of conflictual relationship theme category system (CCRT-LU) disharmonious categories of reaction of self in patient-therapist relationship

CCRT-LU RS patient-therapist relationship	Patient group				Total
	T1*	T2*	T3*	D*	
Harmonious					
count	6	13	11	2	32
expected count	6.8	10.5	7.3	7.3	32.0
% within group	46.2	65.0	78.6	14.3	52.5
Disharmonious					
count	7	7	3	12	29
expected count	6.2	9.5	6.7	6.7	29.0
% within group	53.8	35.0	21.4	85.7	47.5

***For explanation see under Table 3; $\chi^2 = 13.476$; df = 3; $p = 0.004$; phi = 0.470.**

Discussion

Our sample of patients consisted mainly of young patients in the post-adolescent age, the majority of them were students. This is in accordance with our psychotherapeutic clinical practice, as well as with the findings of other authors [18, 19], which also underlined the great need for psychotherapy in this population. Young people are also those who are the most interested in psychotherapy and, at the same time, the most susceptible to personal change and growth that psychotherapy enables. Post-adolescence is the developmental phase when individuality is finally shaped, and independence of personality achieved. We could state that psychotherapy is often "the treatment of choice" for these patients. At the same time, this developmental phase is also very vulnerable, because it makes visible all of the deficits and failures of previous developmental stages, so that psychiatric and psychotherapeutic treatment often becomes necessary.

A review of clinical parameters of our sample points to the fact that the most frequent diagnostic category was personality disorder, and also, that there was a high frequency of comorbidity. This finding is understandable having in mind that personality disorders prevalence is greatest in adolescents and young adults. It is also well-known that 50% of patients with personality disorder have the comorbid diagnosis on Axis I (clinical syndromes) [20–24].

Therapeutic or working alliance has been proven to be a critical feature of all successful or effective psychotherapies [25]. Our results show the difference in estimation of working alli-

ance between the patient and therapist. The patients consistently estimated alliance with higher scores than therapists. This finding conforms to the findings of many other authors [26–28], but in spite of this fact, it was not finally explained. It is possible to assume that discrepancy in scoring of working alliance could be consequence of different observing perspectives of patients and therapists.

Development of therapeutic alliance passes through several phases, but the most vulnerable one is the initial phase of psychotherapy, because of many influences on the part of a patient and the therapist which come into their emerging relationship [29]. Working alliance thus becomes a mirror of therapeutic relationship trends. We hypothesized that one of the most powerful influences on working alliance comes from the patterns of interpersonal relationships or transference patterns which patient brings to the therapy relationship. Transference patterns are enduring relational patterns, repeated or enacted in the therapeutic relationship. One of the first methods for the estimation of transference patterns was the Core Conflictual Relationship Theme Method by Luborsky [11]. It was later further developed and transformed in the model CCRT-LU [12]. It enables differentiation of 3 elements of the relationship that could make relationship dysfunctional. In our research, the Core conflictual relationship method – LU version, was the useful instrument for the assessment of interpersonal relationships and early detection of dysfunctional therapeutic relationship.

Our results show that disharmoniousness of every one of these elements – wish, reaction of other and reaction of self – was more frequent in the patients with lower level of working alliance, or with dropout of therapy. Early psychotherapy dropout is considered the most extreme manifestation of disturbance in working alliance.

Higher frequencies of disharmonious categories of dominant wish in the therapeutic relationship were evidenced in patients with low WAI S patient's score. This could be explained with the fact that the patients who form weak therapeutic alliance more frequently have unrealistic expectancies (wishes) from the therapist they meet, maybe even stronger if they already had insufficient or deficient relationships in their past. There could be a wish to "compensate" or repair this deficiency in idealized therapeutic relationship. These patients are not ready for true psychotherapeutic work and personal change, instead, they expect much more "corrective emotional experience".

The second element of dysfunctional relationship pattern enacted in therapeutic relationship is the way a patient experiences reaction of the therapist to his dominant wish. Our results show that patients with disharmonious experience on this dimension of relationship are prone to dropout of therapy. On the other hand, patients with good therapeutic alliance have no disharmonious experience to this extent. Disharmonious experience in the relationship with therapist could be a consequence of coloring of actual experience according to the experiences in the patient's past. Patients with interpersonal problems (especially with diagnosis of personality disorder), have very deep feeling of misunderstanding and maltreatment by the others in previous or actual relationships. Often, it is the sense that the other people do not accept their needs and wishes, or do not want to answer them appropriately. Often, it is possible to trace this experience to the earliest developmental phases and internalized object relations. Sometimes, as our previous results show, interpersonal disappointment of a patient arises from the inadequate wish, inappropriate in actual relationship.

Connecting previous experiences with the actual ones, and discussing with patient about their differences, could help a patient to understand the nature of his interpersonal problems. This technical tool in psychoanalytic psychotherapy, named transference interpretation, emphasizes interpersonal perspective in the "here and now" situation.

Our findings are similar to those of Beretta et al. [30] who used the CCRT method in their research showing that therapeutic alliance is connected with the patient's wish to be close to someone, to experience others as supporting and confident, but at the same time, they perceive the answers from others as negative, because their object representations are not confident and are hurting [30].

The final element of dysfunctional relationship pattern is the reaction of the self of the person after receiving answer from others to his dominant wish. Our results are similar in this dimension as in the previous one – disharmonious type of reaction of the self was more frequently present in the dropout group of patients, and less frequent in the groups with middle and high WAI S scores. Patients who react to interpersonal disappointment with disharmonious attitudes or behaviors are more prone to splitting of experience and relationships [31, 32].

The dropout group was prominent by its differences in the frequencies of disharmonious categories on dimensions – reaction of other and reaction of self, even without higher frequencies of disharmonious wish. It means that these patients do not have unrealistic expectations in therapeutic relationship, but they still experience the therapist (mostly on the basis of transference experience) as unaccepting, malicious, distant, unhelpful, etc. and than react to these experiences withdrawing from the relationship. It is considered a manifestation of bad early object relationship. We considered these results especially important because of the practical reasons – prevention of patient attrition from psychotherapy. Prevention becomes more important if we have in mind that these patients actually need therapy even more than the others, because of their cumulative interpersonal problems. Early detection of dysfunctional relationship patterns would be of decisive importance in this regard.

Our results lead to the conclusion that in the early phase of psychotherapy, with patients who have difficulties in interpersonal relationships, we need some adjustments in technique in order to prevent dropouts and poor working alliances. The results of Hoglend et al. [33], suggest the importance of transference work in this regard. In his study, Jarry [34] has investigated effectiveness of CCRT-based guided psychotherapy. In spite of the small sample size (6 patients) in this research, the results are promising suggesting possibility that psychotherapy can change dysfunctional relationship patterns even in short-term treatments.

For patients with prominent interpersonal dysfunctionality, treatments like this one could be a preparation for long-term psychotherapy.

In spite of the fact that our groups of patients did not differ significantly by clinical parameters, important limitation of our study concerns diagnostic heterogeneity of the sample of patients. For increasing of data generalizability, it would be important to conduct research on larger and diagnostically more homogenous samples of patients. Further research should also include more frequent working alliance assessments, because trends of working alliance increase or decrease could give more valuable data. Including observer's ratings, in order to control possible counter transference influences, would be also recommended for future research.

Conclusion

There is a significant difference between the groups of patients with low, middle, and high working alliance inventory scores and the dropout group on the variable – transference patterns in therapeutic relationship. Disharmonious transference patterns are more frequent in patients who form poor therapeutic alliance or early dropout psychotherapy. It is of great importance to recognize patient's transference patterns at the beginning of the psychotherapeutic process, because of their potentially harmful influence on the quality of working alliance. Early detection of a dysfunctional therapeutic relationship opens up the space for further improvements in therapeutic interventions and techniques in the early phase of psychotherapy.

R E F E R E N C E S

1. *Bordin ES*. Building therapeutic alliances: The base for integration. Paper presented at the Society for Psychotherapy Research. Berkley, CA: University of California Press; 1989.
2. *Horvath AO, Bedi RP*. The alliance. In: *Norcross JC*, editor. Psychotherapy relationships that work. New York: Oxford University Press; 2002.
3. *Horvath AO, Del Re AC, Fluckiger C, Symonds DB*. Alliance in individual psychotherapy. In: *Norcross JC* editor. Psychotherapy relationships that work. 2nd ed. New York: Oxford University Press; 2011.
4. *Martin DJ, Garske JP, Davis KM*. Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. J Consult Clin Psychol 2000; 68(3): 438−50.
5. *Bordin ES*. Theory and research on the therapeutic working alliance: New directions. In: *Horvath AO, Greenberg LS,* editors. The working alliance: theory, research, and practice New York: Wiley; 1994. p. 13–37.
6. *Erić Lj*. Psihoanaliza i psihoanalitička psihoterapija. In: *Erić Lj*, editors. Psihoterapija. Belgrade: Faculty of Medicine, University of Belgrade; 2001.
7. *World Health Organization*. The ICD 10 Classification od mental and behavioral disorders: clinical descriptions and diagnostic guidelines. Geneva: WHO; 1992.
8. *Sheehan DV, Lecubrier Y, Sheehan KH, Amorim P, Janavs J, Weiller E,* et al. The Mini International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM IV and ICD10. J Clin Psychiatry 1998; 59(Suppl 20): 22−33; quiz 34−57.
9. *Ramirez A, Ekselius L, Ramklint M*. Axis V - Global Assessment of Functioning scale (GAF), further evaluation of the self-report version. Eur Psychiatr 2008; 23(8): 575−9.
10. *OPD Task Force*. Operationalized Psychodynamic Diagnosis OPD-2- Manual of Diagnosis and Treatment Planning. USA, Toronto: Hogrefe and Huber; 2008.
11. *Luborsky L*. The relationship anecdotes paradigm (RAP) interview as a versatile source of narratives. In: *Luborsky L, Crits-Christoph P*, editors. Understanding Transference - The Core Conflictual Relationship Theme Method. 2nd ed. Washington DC: American Psychological Association; 1998.
12. *Albani C, Pokorny D, Blaser G, Kachele H*. Beziehungsmuster und Beziehungskonflikte-Theory, Klinik und Forschung. Gottingen: Vandenhoeck & Ruprecht; 2008.
13. *Horvath AO*. Working Alliance Inventory (WAI) Home Page. Available from: http://www.educ.sfu.ca/alliance/allianceA. [cited 1986].
14. *Horvath AO, Greenberg LS*. The working alliance: Theory, Research and Practice. New York: John Wiley and Sons; 1994.
15. *Horvath AO*. The therapeutic relationship: from transference to alliance. J Clin Psychol 2000; 56(2): 163−73.
16. *Horvath AO, Greenberg LS*. Development and validation of the Working Alliance Inventory. J Couns Psychol 1989; 36(2): 223−33.
17. *Tracey TJ, Kokotovic AM*. Factor structure of the Working Alliance Inventory. J Clin Consult Psychol 1989; 1: 207−10.
18. *Fazlagić A, Rakić-Bajić G*. Attitudes of students toward psychotherapy. PONS Med J 2011; 8(2): 48−52. (Serbian)
19. *Gavrilov-Jerković V*. Modern tendencies in psychotherapy: The specialisation of practice and knowledge integration. Psihologija 2003; 36(1): 7−38. (Serbian)
20. *Lenzenweger MF, Lane MC, Loranger AW, Kessler RC*. DSM-IV personality disorders in the National Comorbidity Survey Replication. Biol Psychiatry 2007; 62(6): 553−64.
21. *Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE*. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; 62(6): 593−602.
22. *Zimmerman M, Chelminski I, Young D*. The frequency of personality disorders in psychiatric patients. Psychiatr Clin North Am 2008; 31(3): 405−20.
23. *Krueger RF*. Continuity of axes I and II: toward a unified model of personality, personality disorders, and clinical disorders. J Pers Disord 2005; 19(3): 233−61.
24. *Durrett C, Westen D*. The structure of axis II disorders in adolescents: a cluster- and factor-analytic investigation of DSM-IV categories and criteria. J Pers Disord 2005; 19(4): 44061.
25. *Barber JP, Connolly MB, Crits-Christoph P, Gladis L, Siqueland L*. Alliance Predicts Patients' Outcome Beyond In-Treatment Change in Symptoms. Pers Disord: Theory, Res Treatment 2009; S(1): 80−9.
26. *Fitzpatrick MR, Iwakabe S, Stalikas A*. Perspective divergence in the working alliance. Psychother Res 2005; 15(1−2): 69−79.
27. *Tryon GS, Blackwell S, Hammel E*. A meta analytic examination of client therapist perspectives of the working alliance. Psychother Res 2007; 17(6): 629−42.
28. *Tryon GS, Blackwell SC, Hammel EF*. The magnitude of client and therapist working alliance ratings. Psychotherapy (Chic) 2008; 45(4): 546–51.
29. García Y, Botella L. Differential Analysis of Psychotherapy Outcome and Process:Correlates of Initial Disturbance (Anxiety vs. Depression). Int J Psychol Psychological Therapy 2011; 11(3): 347−58.

30. *Beretta V, Despland JN, Drapeau M*, *Michel L, Kramer U, Stigler M*, et al. Are relationship patterns with significant others reenacted with the therapist? A study of early transference reactions. J Nerv Ment Dis 2007; 195(5): 443−50.
31. *Barret MS, Chua WJ, Crits-Christoph P Gibbons MB, Casiano D, Thompson D*. Early withdrawal from mental health treatment: implications for psychotherapy. Psychotherapy 2008; 45(2): 247–67.
32. *Ardito RB, Rabellino D*. Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. Front Psychol 2011; 2: 270.
33. *Høglend P, Hersoug AG, Bøgwald KP, Amlo S, Marble A, Sørbye Ø,* et al. Effects of Transference Work in the Context of Therapeutic Alliance and Quality of Object Relations. J Consult Clin Psychol 2011; 79(5): 697−706.
34. *Jarry JL*. Core conflictual relationship theme - guided psychotherapy: Initial effectiveness study of a 16-session manualized approach in a sample of six patients. Psychol Psychother 2010; 83(4): 385−94.

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