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Transference and counter-transference variations in the course of the cognitive–analytic therapy of two borderline patients: The relation to the diagrammatic reformulation of self-states

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The cognitive–analytic therapy of two patients with borderline personality disorder is described. Patients and therapists completed post-sessional questionnaires which yielded measures of transference and counter-transference. The relation of changes in these to the sequential diagrammatic reformulation of the patients' self-states is considered.

This paper reports data from the therapy of two patients with borderline personality disorder (BPD). The aim is to describe measures of transference and counter-transference and to relate variation in these through the course of therapy to the model of personality constructed by the patient and therapist in the early sessions and summarized in the self-states sequential diagram (SSSD). These patients are the first of an accumulating series being treated with 16–24 sessions of cognitive–analytic therapy (CAT). The use of this approach in BPD is described in Ryle (1990), Ryle, Spencer & Yawetz (1992), Ryle & Low (1993) and Ryle & Beard (1993). The two cases were treated by advanced trainees under the author's supervision.

Sequential diagrammatic reformulation

A number of authors have demonstrated how the content of therapy sessions can be shown to refer to a limited range of core issues (Horowitz & Eells, 1993; Luborsky, Barber & Diguer, 1992; Strupp & Binder, 1984). CAT differs from these approaches in that the identification of these themes is carried out early and with active patient participation and in the use of diagrammatic descriptions of sequences as the main tool through which the patient's capacity for self-observation is enhanced and the therapist's counter-transference is anticipated and understood.

In this approach the patient's personality and relationships are understood to be expressions of a characteristic 'core repertoire' of 'reciprocal role relationships', derived from early experience. Procedures generated from the core may express or serve to avoid the core roles, both in relation to others and in self-management.

Neurotic procedures are characterized by being damaging or ineffective but resistant to revision due to self-confirming patterns; these are represented in sequential diagrams by tracing how the consequences of the individual's role enactments are to reinforce, in some way, the existing core repertoire.

In the case of BPD a further refinement is called for to account for the confusing shifts in behaviour and experience occurring in these patients. These are understood to reflect a personality made up of two or more relatively dissociated 'self-states', each with its characteristic repertoire of reciprocal roles and associated mood and degree of access to, or control of, emotion. These correspond to the 'states of mind' described by Horowitz (1979).

The self-states sequential diagram (SSSD) is a jointly created tool rather than an observer's analysis of process. In a study of five cases, including the two reported here, Ryle & Marlowe (in press) described how self-states, identified by the therapists and through patient self-monitoring, were made the elements of a repertory grid completed by the patients. Self-states were shown to be discriminated in terms of mood, access to feeling and sense of self and others and to be compatible with the SSSD in most respects. Discrepancies between the SSSD and grid data in the cases presented here will be mentioned. A paper by Bennett & Parry (in preparation) provides support for the accuracy of the SSSD, through a study of Case 2 (see below) in which audiotapes of early sessions were analysed with the core conflictual relationship theme method (Luborsky & Crits-Cristoph, 1989) and the structural analysis of social behaviour-cyclic maladaptive pattern (Benjamin, Foster, Roberto & Estroff, 1986). They concluded that the SSSD was a valid representation of recurrent relationship patterns identified by these analyses. This has been confirmed in three further case studies (Bennett, personal communication).

The theory of borderline personality and the implications for treatment

The essential features of the theory of BPD are implicit in the form of the SSSD described above. Counter-transference confusions are seen to derive from the patient's shifting between states, with differing pressures to reciprocate, an understanding which incorporates the concept of projective identification (Ryle, 1994). The confusion experienced by BPD patients and induced in those in contact with them is not due to random variation or 'identity diffusion'; it is derived from shifts between a discrete number of recurring self-states, such shifts often occurring without evident provocation but being, in fact, understandable once they can be identified and described. Each self-state being relatively precarious, with a narrow range of reciprocal role procedures, the pressure exerted on others to reciprocate is both narrow and intense. The persistence of BPD is seen to be due to the individual's capacity to exact reciprocation, by overt or covert means, and by the fact that, if such reciprocation is not forthcoming, the response will be a shift to another state rather then the revision of the procedural repertoire.

The key to the treatment of patients with BPD is therefore the creation of an accurate SSSD by means of which the patient can learn to observe and link all his or her states, and through the use of which the therapist can avoid or correct collusion

with the patient. The joint work in creating and using the SSSD is, in addition, a collaborative act not subsumed under the patient's existing repertoire.

Method

The two patients described here had agreed to have their therapies audiotaped and had been encouraged to have copies of the tapes themselves. They had consented to the publication of material, suitably disguised, from their therapies and saw preliminary versions of the text. Questionnaires completed by the patients and the therapists provided measures of transference and counter-transference.

The measurement of transference

Patients completed the Therapy Experience Questionnaire (TEQ) after each session; it was not seen by the therapist. The TEQ (reproduced in Appendix 1) was derived from the version used as a post-therapy measure in the study by Brockman, Poynton, Ryle & Watson (1987), modified to refer to the last session. Each session was rated on the 16 items and the completed record of the therapy was processed as a repertory grid and analysed with a principal component analysis, allowing the loadings of the sessions on the principal components to be plotted. In retrospect, it is clear that the range of provided constructs in the TEQ is narrow and in current practice a more elaborate instrument is used.

The measurement of counter-transference

Therapists completed the Sessional Grid (Appendix 2) after each session, except that this was not introduced until session 5 in the two cases considered here. Constructs refer to the therapist's own feelings and to judgements about the patient's feelings. Space was left for the therapist to add additional constructs. The results were analysed and plotted in the same way as the TEQ. The supplied constructs were provided by the author on the basis of experience supervising borderline therapies; again in retrospect a fuller range might have been preferable. The constructs referred to 'during this session', and hence to any experience during the session, whether brief or prolonged.

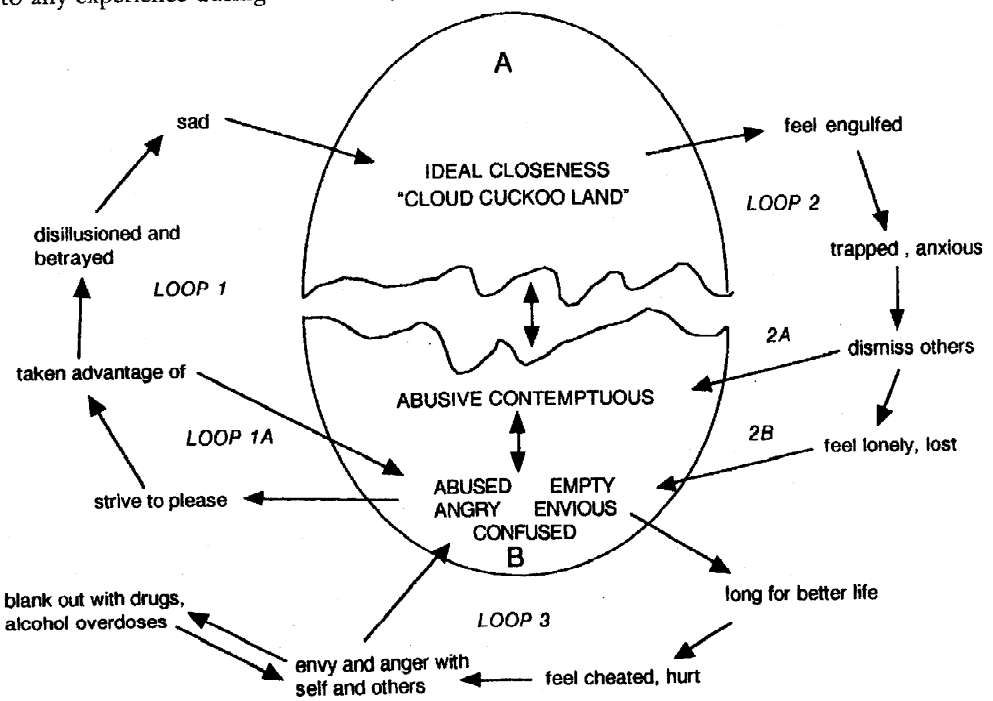

Figure 1. Sequential diagram of Case 1 (Nick).

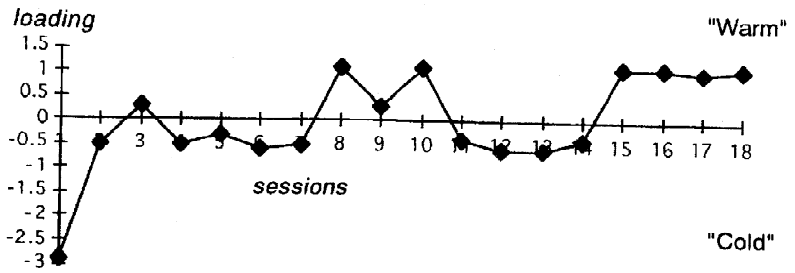

Figure 2A. Therapy Experience Questionnaire: Principal component 1.

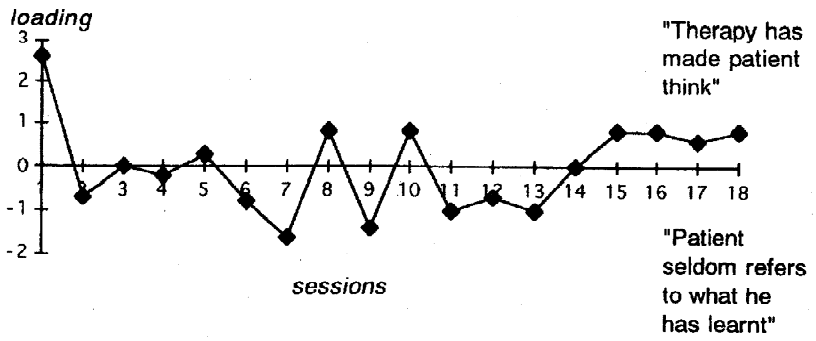

Figure 2B. Therapy Experience Questionnaire: Principal component 2.

Nick TEQ. Construct loadings on first two components.

Construct[a]	C1 (64%)	C2 (14%)
1. Friendly informal therapist	.940	−.005
2. Therapist respected	.833	.166
3. Hardly thought about self	.706	.603
4. Therapy stirred feelings	.930	−.101
5. Therapist cold, distant	−.888	.357
6. Therapist interested in helping	.665	.224
7. Therapy has made me think	.422	.807
8. Emotionally involved in therapy	−.886	.134
9. Warmth in therapist's way of talking	.926	−.062
10. Not feeling accepted by therapist	−.855	−.082
11. Seldom refer to what I have learned	−.542	−.682
12. Do not manage feelings better	−.818	−.191
13. Therapist's tone cold	−.818	.392
14. Do not trust therapist's integrity	−.809	.084
15. Therapy has given understandings	.827	−.400
16. Therapy put in touch with feelings	.756	−.448

[a] See Appendix 1 for full wording.

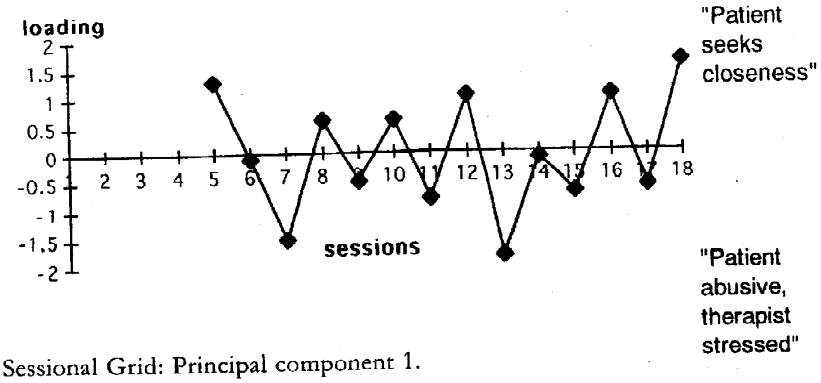

Figure 2C. Sessional Grid: Principal component 1.

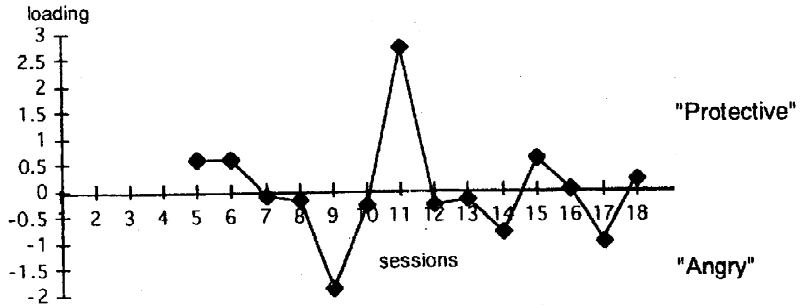

Figure 2D. Sessional Grid: Principal component 2.

Nick Sessional Grid. Construct loadings on first two components.

Construct[a]	C1 (27%)	C2 (19%)
I felt angry	.669	−.285
Patient felt helped	−.531	.675
I felt confused	.632	−.233
I felt protective	.250	.714
Patient felt sad	.154	.661
I felt stressed	.842	.012
I felt useless	−.032	.493
Patient covertly angry	.061	.489
I felt hopeful	.456	.110
I felt defensive	.584	−.157
Patient felt muddled	.507	.566
I used SSSD well	−.223	.741
Patient openly angry	.309	−.024
Patient mistrustful	.402	.524
Patient felt abused	.724	.241
Patient was abusive	.869	−.051
Patient seeking closeness	−.580	−.134

[a] See Appendix 2.
Note. 'I felt bored' dropped, as all ratings equal.

Results: The two cases

Clinical details, the SSSDs and the results of the TEQ and Sessional Grid analyses are presented for each patient.

Case 1. ('Nick')

Nick was a 32-year-old clerical worker complaining of depression and reporting episodes of out-of-control anger as a result of which his partner of five years' standing had left him. His childhood was marked by poverty and much physical abuse from his father. In his early 20s his marriage failed with much bitterness and his father died shortly after a better relationship had seemed to be developing. Following this, Nick overdosed and spent three months as a psychiatric in-patient. Since that time he had regularly abused alcohol and cannabis. On the basis of the Personality Assessment Schedule (PAS) (Tyrer, 1988) Nick met DSM-III-R criteria for borderline, histrionic and antisocial personality disorders (APA, 1987).

Nick's SSSD is reproduced in Fig. 1. It describes two self-states, A being labelled as 'cloud cuckoo land' and B characterized by an 'abusing–abused' pattern. Procedural loop 1, emerging from B, describes placation leading to being taken advantage of and to a sense of betrayal. To escape from the ensuing sadness, care of an unrealistic kind is sought (state A), which provokes a feeling of being engulfed and trapped. Loop 2 traces how this can lead back to state B. Loop 3 describes the use of alcohol and drugs as a means of escaping the pain of that state. The eyes placed between states A and B were Nick's way of reminding himself of the need to keep an eye on all aspects of himself. Nick's grid of self-states (Ryle & Marlowe, in press) was fully compatible with this SSSD.

Nick worked hard in his therapy to complete and apply the SSSD to daily life and to the therapy relationship. In the course of therapy he wrote a moving farewell letter to his father which enabled him to complete a mourning process; in it he expressed both deep anger and love.

Figures 2A and 2B are based on the TEQ for the 18 sessions of Nick's therapy; he opted to stop at that point rather than take up the full 24 sessions offered in the contract. Figure 2A records the loadings of the 18 sessions of the first principal component, which accounted for 64 per cent of the total variance. It contrasts essentially emotional involvement with a therapist seen as warm and non-involvement with a therapist seen as cold. An initially negative attitude became positive over the first eight sessions; the positive state was maintained until an abrupt fall at session 11, being re-established by session 15. Figure 2B presents the second component: except in the first session thoughtfulness varies in parallel with warmth on the first component. Figures 2C and 2D are based on the sessional grid. The first component (27 per cent of variance) contrasts a therapist seeing the patient as seeking closeness with a stressed therapist relating to an abusive patient, who feels abused. The second component (19 per cent of variance) contrasts a protective therapist with one feeling angry and confused.

Interpreting these results in relation to the SSSD one can understand the TEQ as initially recording the assumptions of self-state B, with a subsequent movement along loop 1. This leads in due course to self-state A, the idealized state, and then to an

abrupt negative shift in session 11 suggesting that the engulfment of loop 2 had been experienced.

The source of this shift may be indicated by the Sessional Grid (Fig. 2D) which records, in this session, the highest loading for counter-transference protectiveness. By session 13 the therapist is feeling stressed in relation to a patient experienced as abusive. The TEQ records a positive state for the last four sessions, while the counter-transference is recorded as more variable.

At termination and at follow-up at 1, 2, 3 and 6 months the patient reported no further episodes of violence, a greatly reduced frequency of substances abuse (loop 3 in Fig. 1) and a new sense of control and self-understanding. A repeat PAS interview towards the end of this period showed that caseness criteria for all axis 2 personality disorders were no longer met during the post-therapy period. One year later the patient reported further progress.

The course of therapy had included the manifestation of Nick's two main states and all his procedural loops. The recorded counter-transference gave evidence of the pressure to collude, notably in session 11, but the understanding provided by the diagram had prevented persistent reciprocation of the negative procedures and the patient was able to keep track of his shifts and control his long-standing destructiveness.

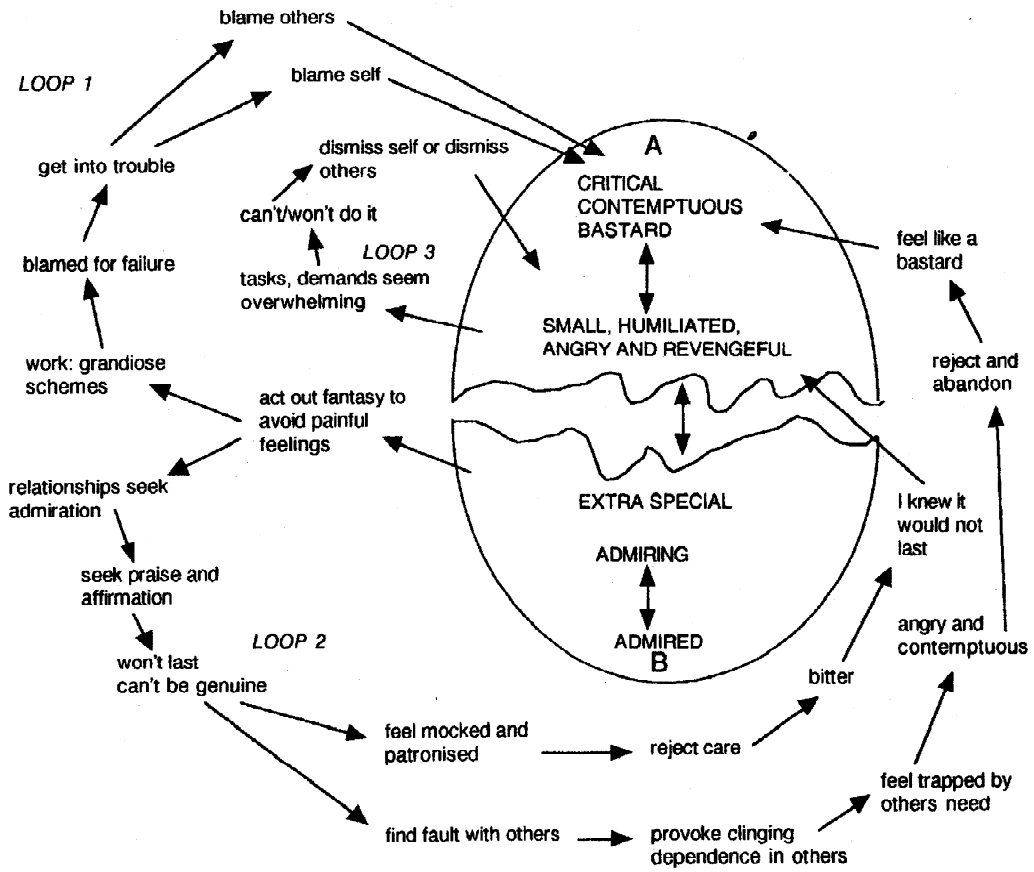

Figure 3. Sequential diagram of case 2 (Neil).

Case 2. ('Neil')

Neil was a 30-year-old actor in fringe theatre, complaining of depression related to career problems and to his failure to sustain relationships with women. He described his early childhood as dominated by his authoritarian father.

He was sent to boarding school at the age of seven, where he was miserable, enuretic and much bullied. In adolescence he became a non-compliant rebel and he left school with no qualifications. His professional life was precarious and his relationships with colleagues and with sexual partners were characterized by patterns of high expectations and angry disillusion.

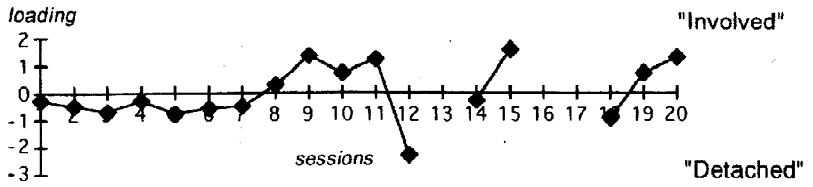

Figure 4A. Therapy Experience Questionnaire: Principal component 1.

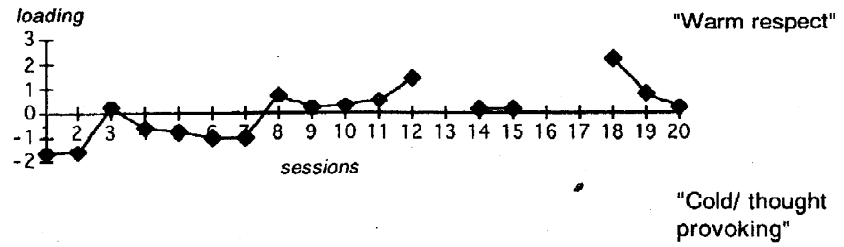

Figure 4B. Therapy Experience Questionnaire: Principal component 2.

Neil TEQ. Construct loadings on first two principal components.

Construct[a]	C1 (42%)	C2 (28%)
1. Friendly informal therapist	.601	−.581
2. Therapist respected	.661	−.648
3. Hardly thought about self	−.812	−.488
4. Therapy stirred feelings	.739	.400
5. Therapist cold, distant	−.300	.708
6. Therapist interested in helping	.671	−.543
7. Therapy has made me think	.502	.615
8. Emotionally involved in therapy	−.724	−.571
9. Warmth in therapist's way of talking	.745	−.452
10. Not feeling accepted by therapist	−.662	.515
11. Seldom refer to what I have learned	−.718	−.503
12. Do not manage feelings better	−.383	−.183
13. Therapist's tone cold	−.652	.622
14. Do not trust therapist's integrity	−.045	.568
15. Therapy has given understandings	.812	.305
16. Therapy put in touch with feelings	.799	.471

[a] See Appendix 1 for full wording.

Neil, on the basis of the PAS, met DSM-III-R criteria for antisocial, borderline and histrionic personality disorders (APA, 1987).

Neil's SDR is reproduced in Fig. 3. Two self-states are described, A, characterized by a pattern of critical contempt in relation to angry humiliation and B, described as the 'extra special' state, defined by an admiring–admired pattern. The latter state is described as generating unrealistic, grandiose work plans (loop 1) and unrealistic expectations in relationships (loop 2). In both loops, failure and disappointment can lead either to blame and anger for others, or for the self, and in relationships this could involve contemptuous anger, largely in the form of destructive fantasy.

Neil's self-state grid (Ryle & Marlow, submitted) identified 'rage' as a state, whereas in the SDR it appears as a point on loop 2. The grid identified three other

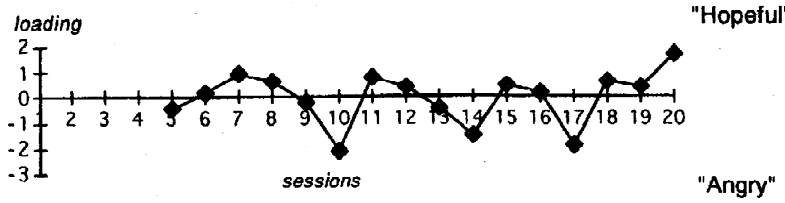

Figure 4C. Sessional Grid: Principal component 1.

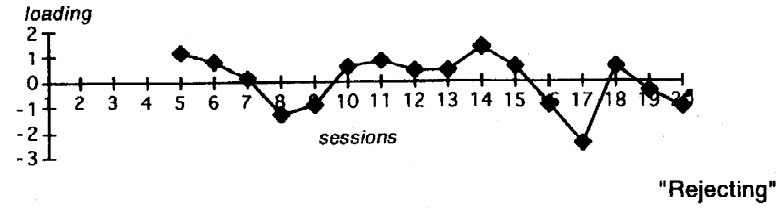

Figure 4D. Sessional Grid: Principal component 2.

Neil Sessional Grid. Construct loadings on first two components.

Construct[a]	C1 (36%)	C2 (18%)
I felt angry	.785	−.317
Patient felt helped	−.879	.004
I felt confused	.264	−.239
I felt protective	−.184	.692
Patient felt sad	.298	.830
I felt stressed	.472	.266
I felt useless	.796	−.255
Patient covertly angry	.814	.142
I felt hopeful	−.670	−.252
I felt defensive	.696	−.057
Patient felt muddled	.554	.408
I used SSSD well	.115	.876
I felt rejecting	.743	−.442
Patient was openly angry	.615	.126
Patient was mistrustful	.236	−.206

[a] See Appendix 2.

states, one called 'extra special' being contrasted with 'responsible' and 'fear rejection'. These latter two are seen as sad and in control of others and may correspond to the outer route of loop 2 after the bifurcation, described as 'provoke clinging dependence in others'. This could be interpreted as a means of avoiding for the self the humiliated role described in self-state A.

Figures 4A and 4B record the TEQ results; sessions 13, 16 and 17 are missing, the last due to non-attendance. The first principal component (42 per cent of variance) contrasts 'involved' with 'detached' and the second (28 per cent of variance) contrasts 'warm respect' with 'cold, thought provoking'. Four phases may be described. The first, up to session 7, describes the patient as detached from a therapist seen as increasingly cold and thought provoking. The second phase (sessions 8 to 11) is marked by more involvement and warmth. At session 12 there is a marked shift towards detachment, which may be linked to the non-return of three of the next five TEQs, although sessions 14 and 15 were more involved. The last sessions (18–20) showed increased warmth and involvement and then a dip to a median position.

Figures 4C and 4D are derived from the first and second components of the sessional grid. The first (36 per cent of variance) contrasts hopeful with angry feelings towards the patient. The second (18 per cent of variance) contrasts protectiveness and good use of the SSSD with rejection. During the first phase of this therapy the counter-transference became slowly more hopeful, but in sessions 8 to 10 there was a shift towards anger. The negative shift in the transference at session 12, indicated by the TEQ, is not echoed in the counter-transference, but this becomes increasingly negative in sessions 15 and 16. The patient failed to attend session 17 but the therapist completed the Sessional Grid, demonstrating a further negative shift. Both TEQ and the Sessional Grid record a return to more positive levels over the final sessions.

Relating these findings to the SSSD, it would seem that Neil avoided emotional involvement but was made to think during the early sessions. In bidding for extra special status in the therapy and in becoming involved he follows loop 2 of the SSSD, with its ensuing ambivalence and the passive anger of the third phase. The therapist's stress and anger in phase 2 could reflect resistance to idealization, or may have been a response to the passive anger manifest more directly in phase three, evoked in the patient by his sense of vulnerability and in his becoming contemptuous rather than humiliated (state A).

As in the first case, the therapy relationship as described by both patient and therapist can be understood as reflecting the patient's long-term problem as described in the SSSD, and as in the first case the experience, combined with the understanding offered by the reformulation and conveyed in commenting on the relationship, allowed the patient to greatly reduce the damaging procedures, a change reflected in his forming of a new relationship on mutual terms and in realistic changes in his professional life. At the follow-up evaluation he no longer met the criteria for any DSM-III-R (APA, 1987) personality disorder. Improvement was maintained at the one-year follow-up.

Discussion

The results of the present study lend support to the claim that the SSSD can describe the main features of the patient's self-states and procedures and can anticipate the

likely evolution of the therapy relationship. Insofar as counter-transference can be understood as representing the patient's elicitation from the therapist of reciprocations which confirm the patient's damaging and restrictive repertoire, the active use of the SSSD in sessions can greatly reduce the likelihood of the therapist being drawn into unhelpful patterns of response.

The need to evoke and recognize negative transference is, of course, widely recognized in psychoanalysis. Safran (1993), describing these phenomena as potential 'ruptures in the therapeutic alliance', has suggested that the resolution of these plays a crucial role in therapies of many different kinds. Recognition and, even more, containment are, however, particularly difficult in BPD. While the complementary and at times contradictory insights of Kernberg and Kohut have contributed much to understanding, their treatment models are impractical in terms of duration and uncertain in terms of effectiveness (Kernberg, 1975; Kernberg, Selzer, Koenigsberg, Carr & Appelbaum, 1989; Kohut, 1971, 1977). It may be, as I have suggested (Ryle, 1992, 1993) in respect of Kleinian analysis, that the emphasis on interpreting and on the induction of regression serve to reinforce borderline mechanisms and fail to recruit the patient's capacity for self-care and understanding.

The theoretical difference between CAT and analytical writers such as those reviewed by Higgitt & Fonagy (1992) is in the central emphasis on the model of discrete self-states. Concepts such as 'stable lability' or the 'metabolism' of projections are clearly linked with the self-state model but they do not provide the therapist with the same clarity. In terms of practice the contrast is even more marked; the early emphasis on jointly negotiated descriptions and the focus on recognition of the occurrences of the processes described offer patients, from the beginning of therapy, a sense of new understanding and possible change. And the corrective emotional experience of a cooperative relationship in which collusion is avoided or recognized with the help of the SSSD seems to foster with surprising rapidity a new ability for continuous self-observation. The data in this paper offer some support for the belief that the use of the diagrams in this way can make sense of, and make manageable, the confusions generated by the borderline's shifts between contrasting self-states.

The present paper has focused on the SSSD and the recognition of separate self-states because it is considered that these are important contributions at the practical and theoretical level. It should be noted, however, that other aspects of CAT practice, notably the reformulation letter which retells the patient's life history and which usually precedes or accompanies the production of the SSSD, serve also to forge a strong working alliance. In this respect technique supports but does not replace the need, in any therapy, to create a relationship with the patient which is adequately complex, respecting and human. Borderline patients can easily destroy relationships by sowing confusion and destruction and they are often met with rejection and counter-hostility. It is the aim of this paper to demonstrate one means whereby these responses can be replaced by comprehension and respect, with positive therapeutic effects.

The limitations of this study should be noted, in particular the narrow range of constructs provided in the TEQ and Sessional Grid. Despite these limitations the study has demonstrated that a model of personality, jointly formed and used by patient and therapist, can predict or make sense of the ensuing course of therapy.

From the research point of view the techniques used can identify crucial phases of therapy and indicate where detailed process studies may be most usefully carried out.

Acknowledgements

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Appendix 1. Therapy Experience Questionnaire (TEQ)

Name: ..... Date: .....

Score each statement with a number from 1–5 where

1 = definitely not true
2 = not true
3 = may or may not be true
4 = true
5 = definitely true

Please fill this in before each therapy session, referring to how you have felt since the last session.

1. I felt that my therapist was really friendly and informal [ ]
2. I felt convinced that my therapist respected me as a person [ ]
3. I hardly ever thought about myself in the ways I do during my sessions [ ]
4. Therapy has certainly stirred up my feelings [ ]
5. I felt that my therapist's general attitude was rather cold and distant [ ]
6. I felt that my therapist was generally interested in helping me [ ]
7. I am aware that therapy has certainly made me think [ ]
8. I have not felt emotionally involved in my therapy [ ]
9. I felt that there was really a good deal of warmth in the way my therapist talked with me [ ]
10. I did not feel fully accepted by my therapist [ ]
11. I seldom consciously referred to what I have learned in therapy [ ]
12. I did not manage my feelings any better as a result of therapy [ ]
13. I remembered the tone of my therapist's statements as being rather cold [ ]
14. I felt I could not fully trust my therapist's integrity as a person [ ]
15. I felt that therapy had given me some clear new understandings about myself [ ]
16. I felt that therapy had helped me to get in touch with my feelings [ ]

Appendix 2. Sessional Grid: Rate each session (5 = applies strongly, 4 = applies, 3 = +/−, 2 = does not apply, 1 = does not apply at all).

Patient's name: Therapist's name: Date/Session number:

During this session	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1. I felt bored																								
2. I felt angry with Pt.																								
3. The Pt. felt helped																								
4. I felt confused																								
5. I felt protective																								
6. The Pt. felt sad																								
7. I felt stressed																								
8. I felt useless																								
9. Pt. felt covertly angry																								
10. I felt hopeful																								
11. I felt defensive																								
12. Pt. felt muddled																								
13. I used SSSD well																								

14. I felt rejecting

15. Pt was openly angry

16.

17.

18.

19.

Appendix 3.
Nick: Grid data TEQ[a].

Session number .....

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1	2	4	5	4	4	3	4	5	4	5	4	4	4	4	5	5	5	5
2	3	4	5	4	4	3	4	5	4	5	4	4	4	4	5	5	4	5
3	4	4	4	4	4	4	3	5	4	5	4	4	4	4	5	5	5	5
4	1	4	5	4	4	4	3	5	4	5	4	4	4	4	5	5	5	5
5	5	2	1	2	2	2	1	1	1	1	2	2	2	3	1	1	1	1
6	4	5	5	4	4	4	5	5	4	5	4	4	4	4	5	5	5	5
7	5	4	5	4	5	4	4	5	4	5	4	4	4	4	5	5	5	5
8	5	2	2	2	2	2	3	1	1	1	2	3	2	1	1	1	1	1
9	1	4	5	3	4	3	3	5	5	5	4	4	3	4	5	5	5	5
10	5	2	3	4	3	3	4	1	2	1	2	2	3	2	1	1	1	1
11	2	4	3	2	2	2	3	1	3	1	3	3	3	2	1	1	1	1
12	4	4	3	2	2	2	3	1	1	1	3	3	3	2	1	1	1	1
13	4	2	2	2	2	2	1	1	1	1	1	1	2	2	1	1	1	1
14	4	2	1	1	2	2	1	1	1	1	3	3	3	2	1	1	1	1
15	2	4	5	4	4	5	5	5	5	5	4	4	5	4	5	5	5	5
16	2	4	4	4	5	5	5	5	5	5	5	4	5	4	5	5	5	5

[a] See Appendix 1 for constructs.

Nick: Sessional grid

Session number .....

Constructs		*	1	2	3	4	5	6	7	8	9	10	11	12	13	14
I felt bored	1	*	1	1	1	1	1	1	1	1	1	1	1	1	1	1
I felt angry with Pt	2	*	2	2	2	1	2	1	1	1	3	2	2	1	2	1
The Pt felt helped	3	*	5	4	4	4	3	4	5	4	3	4	4	4	4	5
I felt confused	4	*	2	2	3	3	2	2	2	2	3	2	2	2	3	1
I felt protective	5	*	3	3	4	2	2	3	4	3	3	2	4	3	2	3
The Pt felt sad	6	*	4	4	4	3	2	4	5	2	4	3	5	5	4	4
I felt stressed	7	*	2	2	3	2	3	2	3	2	3	2	3	2	3	2
I felt useless	8	*	1	1	1	1	1	1	2	2	1	1	1	1	1	1
Pt felt covertly angry	9	*	3	4	2	4	2	3	5	2	5	4	4	4	4	5
I felt hopeful	10	*	4	3	4	4	3	3	3	4	3	3	4	4	3	4
I felt defensive	11	*	1	2	4	2	2	2	2	1	2	2	2	2	3	2
Pt felt muddled	12	*	2	4	2	3	3	2	5	2	4	2	3	2	2	2
I used tpp/sdr well	13	*	5	5	4	5	3	4	5	4	4	4	4	4	3	4
I felt rejecting	14	*	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Pt was openly angry	15	*	1	4	4	2	1	1	2	3	4	3	4	5	5	3
Pt was mistrustful	16	*	4	4	4	3	3	3	5	3	3	3	3	3	4	2
Pt felt abused	17	*	3	4	5	4	3	4	4	3	5	4	5	3	3	3
Pt was abusive	18	*	2	3	5	3	4	3	4	3	4	4	4	2	3	2
Pt seeking closeness	19	*	5	5	4	5	3	5	2	3	2	3	4	5	5	5

Neil: Grid data. TEQ[a]

Session number .....

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	4	4	4	4	4	4	3	5	5	4	5	4	4	5	5	5	5
2	4	3	4	4	4	4	4	5	5	5	5	4	4	5	5	5	5
3	2	2	3	2	2	2	2	2	1	2	2	4	2	1	4	2	1
4	5	4	4	5	4	4	4	5	5	5	5	2	4	5	3	4	4
5	2	2	1	1	2	2	1	1	1	1	1	1	1	1	1	1	1
6	4	4	4	5	4	4	4	5	5	5	5	4	5	5	5	5	5
7	5	5	5	5	4	4	5	4	5	5	5	3	4	5	3	4	4
8	1	1	2	1	2	2	2	2	1	2	1	4	2	1	3	2	1
9	3	4	4	4	4	4	4	5	5	5	5	4	4	5	4	5	5
10	2	2	2	2	2	2	2	2	1	1	1	2	1	1	1	1	1
11	1	2	4	2	3	2	2	3	1	2	1	4	2	1	4	2	2
12	3	3	3	4	4	2	2	4	5	3	2	4	2	1	4	2	1
13	2	2	1	2	2	2	2	1	1	1	1	2	2	1	1	1	1
14	2	2	1	2	2	2	2	2	1	2	1	1	2	1	1	2	2
15	4	4	4	3	4	4	4	4	5	4	4	2	3	5	3	4	5
16	4	4	3	3	4	4	4	3	5	4	4	2	3	5	2	4	5

* See Appendix 1 for constructs.

Neil: Sessional grid

Session number .....

Constructs		*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
I felt angry with pt	1	*	2	2	1	1	1	1	1	1	1	2	1	1	5	1	1	1
Pt felt helped	2	*	3	4	4	4	4	2	4	3	2	1	4	3	1	4	3	5
I felt confused	3	*	3	1	2	2	4	2	1	1	1	1	1	1	2	1	1	1
I felt protective	4	*	4	3	3	3	2	3	3	2	2	4	3	2	1	4	3	3
Pt felt sad	5	*	5	5	4	2	4	5	5	4	4	5	4	3	3	4	4	3
I felt stressed	6	*	2	2	2	2	3	4	2	2	2	3	2	2	1	1	1	1
I felt useless	7	*	1	1	1	2	3	4	1	1	2	3	1	2	3	2	2	4
Pt covertly angry	8	*	3	3	2	2	3	4	2	3	4	5	4	3	5	3	3	1
I felt hopeful	9	*	3	4	5	4	4	2	4	4	3	4	5	1	4	4	4	5
I felt defensive	10	*	2	2	1	2	3	4	1	1	2	2	1	2	2	2	2	1
Pt felt muddled	11	*	4	3	2	2	2	2	2	3	3	4	2	2	3	2	2	1
I used SSSD well	12	*	4	4	4	3	3	4	4	4	4	4	4	3	3	4	3	3
I felt rejecting	13	*	1	1	1	1	1	2	1	1	1	1	1	1	4	1	1	1
Pt openly angry	14	*	1	1	1	1	1	2	1	1	1	3	3	2	2	1	1	1