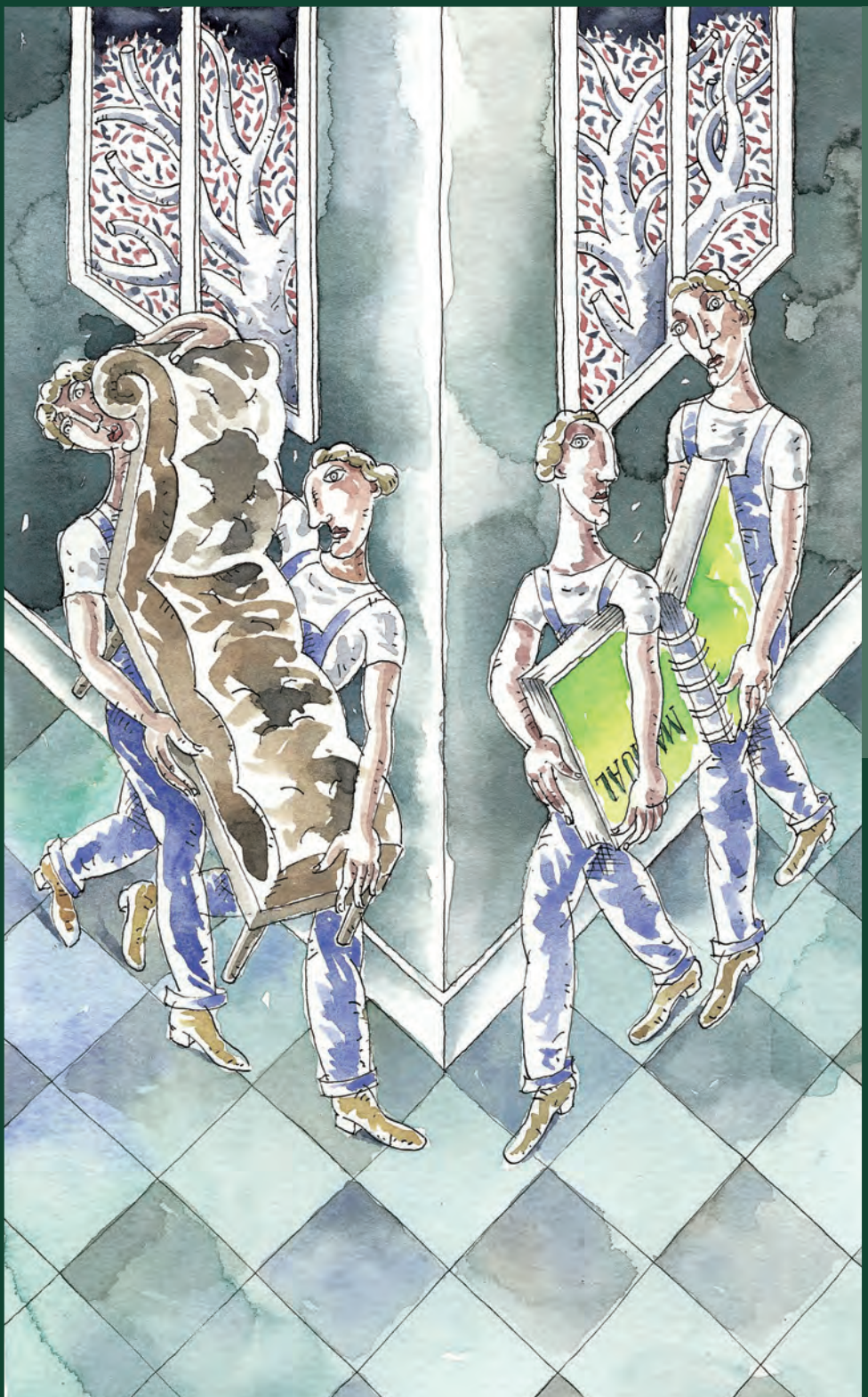
THE AMERICAN JOURNAL OF
PSYCHIATRY



What the BRAIN Initiative Means for Psychiatry
Cornelia I. Bargmann, Ph.D., and Jeffrey A. Lieberman, M.D. 1038

Out of Sight, Out of Mind: Mental Illness Behind Bars
David R. Rubinow, M.D. 1041

Exploration of the Patient-Therapist Relationship in Psychotherapy
Per Høglend, M.D., Ph.D. 1056

◀ **Long-Term Outcome of Psychodynamic Therapy and Cognitive-Behavioral Therapy in Social Anxiety Disorder**
Falk Leichsenring, D.Sc., et al. 1074

October 2014
Volume 171 • Number 10

Official Journal of the
AMERICAN PSYCHIATRIC ASSOCIATION

ajp.psychiatryonline.org

Evidence-Based Psychiatric Treatment

Exploration of the Patient-Therapist Relationship in Psychotherapy

Per Høglend, M.D., Ph.D.

Research from several domains indicates that genetic factors, childhood environment, and later interpersonal experiences are important sources of how patients relate to their therapists (transference). Transference work, a core specific technique in psychodynamic psychotherapy, focuses on exploring the patient-therapist relationship, with the idea that this may lead to improvement of the patients' relationships outside therapy. Many psychotherapy researchers hold the position that specific techniques do not contribute much to the outcome of psychotherapy. However, more than 30 studies have reported significant associations between transference work and outcome. These findings indicate that transference work interventions are indeed active ingredients (for better or worse). Naturalistic studies suggest that a high frequency of transference interventions may have negative effects. Randomized clinical trials indicate that transference-based treatments and alternative treatments work equally well with regard to symptom improvement. However, transference-based treatments appear to be much more effective with regard to interpersonal relations and other measures of personality functioning. The average between-groups effect size for the experimental studies listed in this article was large. Contrary to common clinical wisdom, transference interventions seem to be most important for (mainly female) patients with difficult interpersonal relationships and more severe personality pathology. Gain of insight may be a specific mechanism of change in dynamic psychotherapy, but only one treatment component study has linked transference work directly to gains in insight and subsequent improvement in interpersonal functioning. Research that examines how transference phenomena may be responded to in nondynamic therapies is scarce.

(Am J Psychiatry 2014; 171:1056–1066)

Research supports the value of psychotherapy. However, when it comes to understanding which technical ingredients are most important in different treatments, our knowledge is limited. Researchers from many domains hold the position that nonspecific common factors, such as patient expectancy, alliance, and therapist empathy, account for almost all change in psychotherapy. In this article the empirical evidence for the effects of one of the specific techniques in dynamic psychotherapy, transference work, is summarized.

In the dictionary from the American Psychoanalytic Association, *Psychoanalytic Terms and Concepts* (1), transference is defined as "the displacement of patterns of feelings, thoughts, and behaviour, originally experienced in relation to significant figures during childhood, onto a person involved in a current interpersonal relationship." Not only clinical theory but also empirical evidence indicates that transference phenomena do exist in all relationships (2) and all schools of psychotherapy (3).

In psychoanalysis and psychodynamic psychotherapy, exploration and interpretation of the content of transference, transference work, is seen as central to the therapeutic process. Influential theorists (4–6) have argued that interventions focused on conflicts and interpersonal patterns in the patients' relationships outside therapy, extratransference work, often invite intellectualized speculation. Transference interventions, on the other hand, are thought to be affectively immediate and compelling when they are accurate and may illuminate the "true" nature of problems in the patient's relationships outside of therapy (4–9). Particularly for patients with more severe interpersonal difficulties, there is a strong probability that their problems will be activated during treatment, in the form of difficulties with collaboration, avoidance, dependency, and a higher dropout rate (2–7). Therefore, working with the patient-therapist relationship may be a productive approach to enhancing self-awareness and understanding with regard to interpersonal difficulties. The ubiquity of transference phenomena has implications for therapy regardless of orientation (2, 3).

There is an enormous theoretical and clinical literature on the transference concept and transference phenomena. However, in this literature it is difficult to find consensus on exactly what transference is, what a transference interpretation sounds like, and when such interpretations are effective (4, 5, 7–13). The notion of transference as pure

This article is featured in this month's AJP Audio and is an article that provides Clinical Guidance (p. 1066)

enactments of early (family) relationships has been a matter of much debate in the psychodynamic literature (14–18). In recent decades relational theorists have focused more on transference as co-constructed by patient and therapist (14–17). Patients may also elicit certain responses from the therapist that fit their interpersonal expectations or fears (countertransference reactions) (12, 17, 19). Clinical theory emphasizes that the therapist is not in the privileged position of "determining the truth," especially about causal origins of the patient's experience and personality functioning (5–8, 12–14, 19). There *is* substantial continuity in personality functioning from childhood to adulthood (20, 21), but this may to a large extent be based on genetic or temperamental factors. Research in behavior genetics indicates that the heritability of borderline personality disorder, for example, may be in the range of 0.40 to 0.60. The estimated shared-in-families (familial) environmental effects are generally small (22). However, research in epigenetics (23), neurobiology (24, 25), social neuroscience (26), cognitive psychology (2, 18), and longitudinal epidemiological and clinical studies (21, 25, 27–30) has documented long-term effects of childhood environmental factors, although parsing out genetic effects on life events and parenting styles is difficult. It is also relatively well documented that genetic and biological factors can be activated, impeded, or transformed throughout life by a multitude of environmental factors and interpersonal experiences (2, 18, 31, 32), including psychotherapy (33–36).

Empirical studies of transference patterns taken together with developments in cognitive neuroscience (2, 37–40) suggest that patients' characteristic patterns of thinking and relating to others show an overlap between relationships outside therapy and the therapeutic relationship. Patients often show several or even many transference reactions over the course of treatment. The real characteristics of the therapist inevitably influence the patient's reactions and perceptions of the therapist (2, 3, 37–40).

We all bring something to a new encounter (we transfer), but since adult interpersonal functioning and behavior are determined by a multitude of genetic, biological, and interpersonal factors, I find it useful to adopt a broad definition of transference(s) and transference interpretation (5, 15). As such, transference(s) is defined as the patient's patterns of feelings, thoughts, perceptions, and behavior that emerge within the therapeutic relationship and reflect aspects of the patient's personality functioning (regardless of the developmental origin of these patterns). I use the terms "transference work" and "transference interventions" instead of "transference interpretation," to emphasize a broader definition. Transference work is any therapist intervention that points out, refers to, wonders about, or explains the patient's experience of the therapist and the ongoing patient-therapist interaction (4). There are important real aspects to the patient's experience (2–4), but the targets of transference interventions are often problematic aspects of the patient-therapist relationship, such as biased cognitions and inappropriate or strong affects (2, 4, 7, 9, 13).

Transference work can be operationalized as five categories of interventions with explicit reference to the therapist (R. Ulberg, S. Amlo, P. Høglend, unpublished scales, 2012):

1. The therapist addresses transactions in the patient-therapist relationship:

> **Therapist:** It sounds important what you're saying now. When you say you feel it in your body… that makes me curious.

2. The therapist encourages exploration of thoughts and feelings about the therapy, therapist, and the therapist's style and behavior:

> **Patient:** Well, … in a way it's just words. I feel it's silly to be that positive. Myself, I don't want to say something positive unless it's fully justified.
> **Therapist:** You think I'm too positive?
> **Patient:** Yes, I do think that…, to be perfectly honest.
> **Therapist:** So, you feel I'm not always truthful?
> **Patient:** Not exactly, but…
> **Therapist:** Manipulative?
> **Patient:** Maybe a little bit. Like in a therapeutic way.
> **Therapist:** I say things I don't mean?
> **Patient:** I think you do.
> **Therapist:** How do you feel about going to a therapist like that for help?

3. The therapist encourages the patient to discuss how he or she believes the therapist might feel or think about the patient:

> **Patient:** I always try to be my best around other people. My biggest problem is letting anyone see me sad and helpless.
> **Therapist:** I noticed! So… how do you think I should respond when you show me that side of yourself?

4. The therapist includes him- or herself explicitly in interpretive linking of dynamic elements (conflicts), direct manifestations of transference, and allusions to the transference:

> **Patient:** Others have shown me genuine care, and my reaction is to feel sad. I don't know if I want care or if it scares me. I don't like to be dependent on anyone, but…
> **Therapist:** Are you afraid our relationship will become so important to you that you run the risk of being terribly disappointed?
> **Patient:** It's different here…, but… I have been thinking a lot about the end of therapy. How will I manage on my own?

5. The therapist interprets repetitive interpersonal patterns (including relationships to parents) and links these patterns to transactions between the patient and the therapist:

Therapist: What should I expect?
Patient: That I show up on time, or else you'll get frustrated…, even angry.
Therapist: Like your father, or your new boss?
Patient: Yes… [sigh]… I feel others expect things of me, and that I have to fulfill their expectations immediately. Even when I know it's not really like that, that it's mostly in my own head.

These categories of transference work combine the constructivist or relational view of transference (12, 14, 15) with the traditional construct of transference in relation to historical (genetic) origins (1, 8, 15, 16). Using data from 12 studies, I found (41) that that transference work interventions can be operationalized and reliably rated by trained judges from audiotaped sessions. Data from these studies indicate that low levels of transference interventions seem to be on average 0–2 interventions per session, a moderate level is 3 or 4, and a high level is 5 or 6 (41).

More than 30 studies have been published that attempt to provide empirical evidence on the effects of transference work in dynamic psychotherapy. The studies are too heterogeneous to be analyzed by means of meta-analytic technique, so a brief summary of the studies will follow. The focus will be on treatment outcome rather than in-treatment effects, since the impact on clinical practice is more speculative when outcome is not part of the empirical investigation.

Naturalistic Studies

One of the earliest studies to examine transference interpretation was the Menninger project. Kernberg and colleagues reported that patients with low ego strength did best in dynamic psychotherapy focusing on transference interpretation, compared with psychoanalysis or supportive psychotherapy. Patients with high ego strength did equally well in the different treatments (42). Four early studies addressed, as a separate category, interpretations that linked the patient's feelings toward the therapist with the patient's feelings toward his or her parents (genetic transference interpretations). These studies reported positive correlations between the frequency of this type of interpretation and nonsymptom outcome, such as psychodynamic and interpersonal functioning (43–46). A high number of correlations between other categories of therapist interventions and many different outcome measures were computed in each of these studies. Thus, the findings are at best tentative.

Uncategorized Transference Interventions

Later correlational studies have not distinguished between different categories of transference interventions. Eight studies reported that a higher frequency of transference interventions was associated with less favorable outcome (47–54). This led researchers and empirically informed clinicians to view transference work as ineffective or even harmful (55). These studies suggest that a low frequency of transference interventions might be useful, whereas a higher frequency may lead to negative treatment effects. Only two studies have reported no association between transference work and outcome (56, 57). A limitation in these studies is that different categories of transference interventions, similar to what I proposed earlier, were not identified. Another methodological problem is the issue of therapist responsiveness (58). Findings from several studies indicate that therapists increase their use of transference interventions with more difficult patients in the context of a negative or hostile therapeutic process (48, 52, 53, 55). This may partly explain the inverse correlations between frequency of transference work and outcome.

Therapeutic Immediacy

One recent study found that greater early treatment focus on the patient-therapist relationship, termed "therapeutic immediacy," was positively associated with improved interpersonal functioning, especially among patients with more severe interpersonal problems (59). The average level of immediacy interventions in this study was found to be low to moderate. Conversely, Hill and colleagues reported no significant association between therapist immediacy and posttreatment interpersonal functioning (60). Therapist immediacy seems to involve more therapist strategic self-disclosure of emotions felt during the session (countertransference disclosure) than traditional transference work, as demonstrated in the following statements (59):

Therapist: How do you imagine I feel after hearing your story? [intervention category 3]
Therapist: As I listen to the story you just told me I also feel a deep sense of hopelessness and despair. [self-disclosure]
Therapist: Given your history it only seems reasonable that you'd be cautious in allowing yourself to become emotionally open with me, a man. [category 4]
Therapist: I feel privileged since you're sharing those feelings with me now. [self-disclosure]
Therapist: You seemed to be tearful just now when I noticed the positive things you have accomplished… can we try to understand that more together? [category 2]

A summary of the naturalistic studies of transference work and outcome is shown in Table 1.

Experimental Studies

An early study by my colleagues and me, in which the amount of transference work was experimentally manipulated, indicated that therapy with a low frequency of transference interventions (average, 1 per session) had a more favorable outcome than therapy with a high frequency of these interventions (average, 6 per session), suggesting a causal negative effect of frequent use of

TABLE 1. Naturalistic Studies of Transference Work

Study	Patients N	Patients Diagnoses	Treatment Duration	Outcome Measure	Effect Size (Pearson r)[a]
Kernberg et al., 1972 (42)	42	Mixed	Long-term	Dynamic change	—[b]
Studies of frequency of transference-parent linking interpretations					
Malan, 1976 (43)	22	Mixed	3–400 sessions	Dynamic change	0.40
Marziali and Sullivan, 1980 (44)	22	Mixed	3–400 sessions	Dynamic change	0.48
Marziali, 1984 (45)	25	Majority cluster C and B personality disorders	20 sessions	Dynamic change	0.57
Piper et al., 1986 (46)	21	Mixed; 33% personality disorders	23 sessions	Therapist-rated benefit	0.54
Studies of frequency of transference work interventions					
Marmar et al., 1989 (47)	52	Stress response syndromes	12 sessions	Alliance	–0.40
Piper et al., 1991 (48)	64	Mixed; 27% personality disorders	20 sessions	Symptoms and functioning	–0.58[c]
Høglend, 1993 (49)	43	Mixed; 34% personality disorders	9–53 sessions	Dynamic change	–0.49[c]
Connolly et al., 1999 (50)	29	Mixed; 56% personality disorders	16 sessions	Symptom change	–0.40[d]
Ogrodniczuc et al., 1999 (51)	40	Mixed; 66% personality disorders	20 sessions	Interpersonal functioning	–0.43[d]
Piper et al., 1999 (52)	44	Mixed; 45% personality disorders	20 sessions	Dropout rate	–0.30
Schut et al., 2005 (53)	14	Avoidant personality disorder	52 sessions	Dynamic change	–0.62
Ryum et al., 2010 (54)	49	Cluster C personality disorders	40 sessions	Interpersonal functioning	–0.33
McCullough et al., 1991 (56)	16	Cluster C personality disorders	27–53 sessions	Social adjustment	n.s.
Milbrath et al., 1999 (57)	20	Stress response syndromes	12 sessions	Symptoms	n.s.
Kuutmann et al., 2012 (59)	76	Mixed; 86% personality disorders	Up to 1 year	Interpersonal functioning	0.32
Hill et al., 2014 (60)	16	Mixed	10–59 sessions	Interpersonal functioning	n.s.

[a] Effect size: r=0.10, small; r=0.25, moderate; r=0.50, large.
[b] Unquantified positive correlation between number of transference interpretations and outcome.
[c] Within subgroup with high quality of object relations.
[d] Within subgroup with low quality of object relations.

transference interventions (61). The negative effect of frequent transference interventions tended to be stronger among patients with personality disorders (62).

Transference-Focused Psychotherapy

Two randomized controlled trials have examined the efficacy of transference-focused psychotherapy, an outpatient treatment designed for patients with personality disorders, particularly borderline personality disorder. The focus is on understanding how patients relate to their therapists, with the idea that this may improve the patient's relationships outside of therapy (6, 7). In one clinical trial, 90 patients (93% female) were randomly assigned to transference-focused psychotherapy, dialectical behavior therapy, and psychodynamic supportive psychotherapy. There were no significant differences among the three treatments on the primary outcome variables (63). However, transference-focused psychotherapy was superior with regard to nonsymptom outcome variables, such as metacognitive and social-cognitive capacities (attachment patterns and reflective function) (64). Another study of transference-focused therapy included 104 female patients with borderline personality disorder. The patients were randomly assigned to transference-focused therapy and treatment by experienced therapists in the community. The authors reported that transference-focused therapy was superior in reducing borderline symptoms and interpersonal problems but not anxiety and depression (65). The comparison groups in the two studies did not focus on transference work, although no formal assessment of treatment integrity was reported.

Following is an illustrative example of transference-focused therapy (F. Yeomans, E. Caligor, personal communication, Dec. 11, 2013):

> **Patient:** I know I was late for the session, but then you kept me waiting.
>
> **Therapist:** What were your thoughts and feelings while you were waiting? [category 2]
>
> **Patient:** You must have been mad that I was late. I was thinking, she's keeping me waiting to put me in my place, to exert control.
>
> **Therapist:** Hmm, this reminds me of our last session. You were talking about how you always feel inadequate when you talk to your brother. Now you feel I want to put you down, so… maybe you're afraid that I may be a lot like him. [category 5]
>
> But I'm also wondering about something else. Are you interested?
>
> **Patient:** Sure.

Therapist: I wonder if you also feel you want to put me down, or to be in control in some way, "put me in my place." [category 4]

Patient: I wasn't going to tell you, but walking over here I took my time. I knew I was late, but I thought, it's a beautiful day, let her wait for me!

Therapist: I'm noticing two things. One is that you're feeling more comfortable being open about some negative feelings toward me. The other is that we're moving away from what happened last session. You really opened up then, and there was a feeling of closeness between us. Today you come in anticipating a power struggle. I wonder if maybe it feels more comfortable, or safe somehow, to fight rather than feel close to me right now. What do you think? [category 4]

Mentalization-Based Treatment

Two studies of outpatient mentalization-based treatment, which has a strong individual therapy component in addition to group therapy, are included in this overview. In mentalization-based treatment, transference phenomena in the here and now are explored, but interpretation of repetitive interpersonal patterns is deemphasized. Strategic use of self-disclosure is encouraged (13, 66–68). In a study of 134 adult outpatients (80% female) with borderline personality disorders plus other comorbid personality disorders, patients were randomly allocated to 18 months of mentalization-based treatment or to structured clinical management, an individual supportive and problem-oriented therapy, which also includes group sessions. Mentalization-based treatment was superior with regard to both symptoms and personality functioning (68). In a study of 80 adolescents (85% female) with self-harm and comorbid depression, patients were randomly assigned to 1 year of mentalization-based treatment or to enhanced treatment as usual. Mentalization-based therapy was more effective in reducing self-harm and depression. It is interesting that both improved mentalization (reflective function) and reduced attachment avoidance explained (mediated) the treatment effects (69).

The following is an excerpt from session 25 of a patient's treatment (67):

Therapist: Ooh!… I wonder… could we say you just blew up at me and your therapy? [category 2]

Patient: Yes, the whole mentalizing perspective is a rotten attitude!

Therapist: I feel a bit lost…, it's difficult to think much right now. [self-disclosure]

Patient: [silence]

Therapist: I wonder if for you…, maybe it can be soothing. [category 4]

Patient: Well, probably…, not that I necessary notice it here and now.

Therapist: No, okay, because to me you seem calmer now. [category 1]

Patient: Maybe a little, but I usually notice it later, during the evening, that I can focus on something else and stuff.

Therapist: Okay, so you have noticed that when you talk about stuff with me, you think less about it when you come home? [category 2]

Patient: Yes.

Therapist: I'm happy to hear that. [self-disclosure]

Alliance-Focused Treatment

Alliance-focused treatment is a form of brief relational therapy based on principles from relational psychoanalysis (14). Its primary task is to track ruptures in the therapeutic alliance and encourage the patient, together with the therapist, to explore what is going on in the therapeutic relationship. Alliance-focused therapy also includes more therapist self-disclosure, and therapists are specifically encouraged to acknowledge responsibility for the therapist's own contribution to alliance ruptures and misunderstandings (70). In a study conducted by Muran and colleagues, 128 patients with cluster C personality disorders were randomly assigned to 30 sessions of brief relational therapy, short-term dynamic psychotherapy, and cognitive-behavioral therapy. The three treatments were equally effective, but brief relational therapy had fewer dropouts (71). In a pilot study, Crits-Christoph and colleagues (72) found support for training therapists in a 16-session alliance-fostering therapy. The treatment focus was on agreeing on goals, identifying alliance ruptures, and exploring underlying feelings in the patient's relationship to the therapist. The training produced small, nonsignificant improvements in symptoms but larger improvements in quality of life. Safran et al. provide the following example (73):

Therapist: In a way I feel pressured to ask you more questions, in part I think, as a way to keep things going smoothly between us. But I am also a bit concerned that if I continue to do this, it will get in your way, you won't be able to talk about what feels most immediate and important to you. [self-disclosure]

Patient: I don't know…. What do you think?

Therapist: It feels like I'm asking you to take the lead and you are asking me to take the lead. [self-disclosure]

Patient: I ask you because you are in charge here. You're the doctor.

Therapist: What does being the doctor mean to you? [category 2]

Patient: You're the expert, it's important for me to know what you want.

Therapist: We've talked a lot about how you want to know what boyfriends need so you can provide it…. I'm wondering, is something like that playing out here between you and me? [category 5]

Patient: I really don't understand.

Therapist: Well, I'm just wondering, if knowing what I want is more important to you than finding out what you want yourself, that could be a real dilemma. [category 4]

There are several limitations in these experimental studies. Their generalizability to everyday clinical practice may be limited. There are a number of other technique

TABLE 2. Experimental Studies of Transference Work

Study	Patients N	Patients Diagnoses	Treatment Duration	Treatment Comparison	Outcome	Effect size (Cohen's d)[a]
Høglend et al., 1993 (61)	43	Mixed; 33% personality disorders	9–53 sessions	Low frequency vs. high frequency of transference work	Dynamic change	1.3
Høglend, 1996 (62)	15	Personality disorders	12–50 sessions	Low frequency vs. high frequency of transference work	Dynamic change	1.5
Clarkin et al., 2007 (63)	90	Borderline personality disorder	1 year	Transference-focused psychotherapy vs. dialectical behavior therapy vs. supportive therapy	Symptoms, functioning	n.s.
Levy et al., 2006 (64)	90	Borderline personality disorder	1 year	Transference-focused psychotherapy vs. dialectical behavior therapy vs. supportive therapy	Reflective function	0.8
Doering et al., 2010 (65)	104	Borderline personality disorder	1 year	Transference-focused psychotherapy vs. treatment by experts in community	Dynamic change	1.6
Bateman and Fonagy, 2009 (68)	134	Borderline personality disorder	18 months	Mentalization-based treatment vs. individual supportive therapy	Symptoms Interpersonal functioning	0.6 0.7
Rossouw et al., 2012 (69)	80[b]	Depression	1 year	Mentalization-based treatment vs. enhanced treatment as usual	Self-harm Depression	0.6 0.3
Muran et al., 2005 (71)	128	Cluster C personality disorders	30 sessions	Brief relational therapy vs. dynamic therapy vs. cognitive therapy	Interpersonal	n.s.
Crits-Christoph et al., 2006 (72)	45	Mixed; 60% personality disorders	16 sessions	Before vs. after training in alliance-focused treatment	Quality of life	0.6
Høglend et al., 2006 (74)	100	Mixed; 46% personality disorders	1 year	Dynamic psychotherapy with vs. without transference work	Dynamic change	0.5[c]
Høglend et al., 2008 (75)	100	Mixed; 46% personality disorders	1 year	Dynamic psychotherapy with vs. without transference work	Dynamic change	0.6[c]
Høglend et al., 2011 (76)	46	Personality disorders	1 year	Dynamic psychotherapy with vs. without transference work	Interpersonal functioning	0.8
Ulberg et al., 2012 (77)	56[d]	Mixed; 52% personality disorders	1 year	Dynamic psychotherapy with vs. without transference work	Dynamic change	0.5

[a] Effect size (between-groups): d=0.20, small; d=0.50, moderate; d=0.80 large.
[b] Adolescents.
[c] Within subgroup with low quality of object relations.
[d] Female.

variables and process variables beyond the ones measured in these studies that may influence the effects of transference work. Furthermore, the studies did not report data on the frequency of transference interventions. Also, different categories of transference interventions were not identified. The comparison treatments in these studies are bona fide psychotherapies, but researcher allegiance effects cannot be ruled out .

A summary of the experimental studies of transference work and outcome is shown in Table 2.

First Experimental Study of Transference Work (FEST)

FEST was conducted by my colleagues and me and is, to our knowledge, the only dismantling randomized clinical trial specifically designed to investigate long-term effects of transference work in dynamic psychotherapy. We randomly assigned 100 patients to 1 year of dynamic psychotherapy with a low to moderate level of transference work or to the same type of therapy without transference work. The same therapists administered both treatments after extensive training. Treatment integrity was documented with ratings of more than 450 full sessions. The only component that differed between the two treatments was use of a low to moderate frequency of transference work interventions. Thus, the design makes it possible to study causal effects of transference work.

There was no overall effect of transference work. However, patients with a low quality of object relations benefited significantly more from therapy with transference work compared to therapy without transference

work (74). This effect was sustained during a 3-year follow-up period (75). Patients with mature relationships and greater psychological resources benefited equally well from both treatments. Furthermore, female patients responded significantly better than men to therapy with transference work (77, 78). Among the 46 patients with one or more personality disorders, 17 of 23 patients (74%) no longer met diagnostic criteria for any personality disorder in the transference group, versus 10 of 23 patients (43%) in the comparison group (76). The dropout rate was 0% in the transference group and 22% in the comparison group. Patients who did not receive transference work had about four times more additional mental health specialist treatment during the 3-year follow-up period, compared with patients who received transference work. All the therapists in this study had extensive experience and were specifically trained to deliver the two treatments, which limits generalizability to ordinary clinical practice.

The long-term effect of transference work among patients with low-quality object relations was mediated (explained) by increased gain of insight during therapy (79). Several studies suggest that changes in insight or self-understanding are specific to dynamic psychotherapy and are not associated with other treatments, such as cognitive-behavioral therapy or antidepressant medication (80–82). FEST extended this work by linking the use of specific techniques to gains in insight and subsequent improvement in interpersonal functioning (79). These findings are consistent with the clinical theory that insight may be a specific mechanism of change in dynamic therapy. It should be noted, however, that the association between insight and outcome cannot be experimentally controlled. The true causal mechanism of change could be some unknown variable correlated with insight. This is an inevitable limitation, to date, in mediator studies.

The following vignette, from session 29 of treatment, illustrates how work within the transference may promote that insight (S. Amlo, R. Ulberg, P. Høglend, 2012):

> **Therapist:** So, here we are now. [category 1]
>
> **Therapist:** What effect do you think our conversations have had on your relationship to your mother? [category 2]
>
> **Patient:** I'm still struggling. My mother called this morning. I interrupted her right away and told her that if it wasn't super important, I couldn't talk now. I hung up, but I felt terrible afterward.
>
> **Therapist:** When you tell me this, what do you think I feel about you? [category 3]
>
> **Patient:** You think I'm a selfish person.
>
> **Therapist:** Could that be how you feel about yourself?
>
> **Patient:** I get a bad conscience, even for the smallest things.
>
> **Therapist:** You have talked about how hard it is to say "no" at work and think of your own needs. You've had problems setting limits with colleagues, your mother, and father, because you were afraid of being rejected or punished. But today you managed to tell me that our next session had to be changed because of your meetings at school and work. [category 5]
>
> **Patient:** I have to be focused here. Forty sessions is not a very long time. I can see I do hesitate to trust other people, but my husband is supportive, and I try to talk some sense into myself.
>
> **Therapist:** And now—this morning you were able to hang up on your mother, and you got me to change our next appointment. Maybe you are developing less fear and more trust? [category 4]

My colleagues and I have also explored the long-term effects of transference work in the context of therapeutic alliance and patients' quality of object relations (83). Alliance was a positive predictor of outcome, independent of transference work. However, the specific effect of transference work on psychodynamic functioning was most positive for patients with low quality of object relations within the context of a weak therapeutic alliance. For patients with more mature object relations and high alliance, we observed a negative effect of transference work. These findings contrast with what is maintained in mainstream clinical theory, that only patients with a solid therapeutic alliance gain greater benefit from transference work. One way of understanding the findings is that more disturbed patients have trouble establishing a trusting therapeutic relationship. A thoughtful exploration of transference issues and alliance ruptures may disprove negative interpersonal expectations and strengthen alliance, self-understanding, and ultimately outcome. On the other hand, when treatment is going well for high-functioning patients, a focus on the therapeutic relationship can be awkward or seem like an indulgence for the therapist.

My colleagues and I also reported that therapist parental countertransference interacted with patients' personality disorder pathology in predicting the long-term outcome of transference work (84). When therapists' parental feelings were more intense, the effect of transference work was very positive for patients with high levels of personality disorder pathology, but the effect was negative for patients with low levels of personality disorder pathology. One might speculate that a more parental role is experienced as intrusive, infantilizing, or unnecessary by patients with low levels of personality pathology, whereas for patients with more severe personality pathology a parental role in the therapist provides a source of support, nurturing, and empathic validation that is felt as missing in other relationships.

The complex moderation effects reported in the preceding may help in our understanding of some of the individual variability in response to transference work. However, until the findings are replicated in future studies with larger study groups, they must be considered preliminary.

Classical (Genetic) Transference Interpretations

In earlier psychoanalytic theory, transference-parent linking interpretations were seen as a necessary cornerstone of technique. However, a number of studies providing data on "dosage" levels of transference work (43–46, 59, 60, 85–88) indicate that transference-parent linking interpretations are used very seldom, if at all. Over time the use of classical linking interpretations seems to have fallen out of fashion, whereas use of self-disclosure seems to have gained in popularity. The phenomena of transference work in different studies may be more similar in practice than different clinical theories indicate. The clinical vignettes also illustrate the many similarities. Furthermore, the vignettes illustrate how transference phenomena should be explored in a spirit of inquisitive curiosity, inviting the patient to speculate together with the therapist.

Transference Work in Nondynamic Treatments

Gelso and Bhatia (3) reviewed 16 studies on nondynamic therapies. They described how transference influences nondynamic treatments and also often interferes with the treatment process in a negative way. Nondynamic therapists are able to assess transference phenomena when asked about it. However, research that examines how transferences of different types may be responded to in nondynamic therapies is very limited.

Castonguay and colleagues developed integrative cognitive therapy, which integrates a focus on alliance ruptures into cognitive therapy. In a pilot study, the results of integrative cognitive therapy compared favorably to previous findings from cognitive therapy (89). In a small randomized clinical trial, comparing integrative cognitive therapy to cognitive therapy, the integrative treatment produced greater improvement in depression and global symptoms (90).

In a large-scale study of the cognitive-behavioral analysis system of psychotherapy for patients with severe chronic depression, 40 psychotherapists reported on the relative degree to which they emphasized each of five listed intervention categories. These categories were cognitive interventions, behavioral interventions, agreement on goals, exploration of the patient-therapist relationship, and focus on developmental origins of symptoms. The only positive predictor of outcome was the overall degree of emphasis placed on discussing the patient-therapist relationship (91).

Functional analytic psychotherapy is a contemporary cognitive-behavioral therapy that focuses on how the patient's interpersonal problems are played out in the therapy relationship (clinically relevant in-session behavior). In a pilot study (92), greater use of the patient-therapist relationship was associated with more favorable outcomes.

Future Research

Ideally, we need research that links specific transference interventions to outcome while controlling for other variables. Treatment component studies should be prioritized, especially with regard to the value of transference-parent linking interpretations and of therapist self-disclosure. If we can isolate specific components that are most effective, the search for mechanisms (mediators) may be narrowed. The study of mechanisms, such as insight, reflective function, self-assertion, or social avoidance, may improve basic knowledge.

Intensive process research is needed before we can understand the full impact of transference interventions and how they work. The presence or absence of such interventions, or their frequency, is not sufficient. The timing and quality of specific interventions are difficult to evaluate but may be crucial to how well the intervention is received by the patient (88). Interventions that precede transference work, in addition to those that follow, may carry weight as well. We also need studies of moderators and other contextual variables such as alliance (83) and therapist factors such as countertransference reactions (84), which may influence the effectiveness of transference interventions (84). More research on therapies that integrate transference work into other psychotherapy modalities is urgently needed.

Social processes are a candidate research domain in the Research Domain Criteria (RDoC) framework, based on the National Institute of Mental Health Strategic Plan (93). Social relationships are critical because interpersonal manifestations may be the most central observation of psychopathology, and the influence of poor social relationships on risk for mortality is comparable to, or even more important than, well-established risk factors, such as smoking (94). Research on the components, processes, and mechanisms of transference-based psychotherapies may improve basic knowledge about psychological aspects of interpersonal functioning. In addition, methods from social neuroscience (24, 26, 95), brain imaging (33–35, 40, 96–99), and genetics (23, 30, 36) may help in integrating psychological and biological explanations of interpersonal behavior, in order to ultimately improve treatment of disordered relationships.

Conclusions

The findings summarized in this article strongly suggest that transference interventions are *active* ingredients. Almost all the studies reviewed have shown significant associations between transference work and interpersonal and psychodynamic change. The average between-groups effect size in the experimental studies listed was 0.8 (large) and favored transference-based treatments.

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The author reports no financial relationships with commercial interests.

Supported by Diakonhjemmet Hospital, Vestre Viken Health Trust, and the University of Oslo.

The author thanks Paul Crits-Christoph, Mark Hilsenroth, and Glen Gabbard for their comments on this article.

References

1. Moore BE, Fine BD: Psychoanalytic Terms and Concepts. New Haven, Conn, Yale University Press, 1990
2. Andersen SM, Przybylinski E: Experiments on transference in interpersonal relations: implications for treatment. Psychotherapy (Chic) 2012; 49:370–383
3. Gelso CJ, Bhatia A: Crossing theoretical lines: the role and effect of transference in nonanalytic psychotherapies. Psychotherapy (Chic) 2012; 49:384–390
4. Gill MM: Analysis of Transference. New York, International Universities Press, 1982
5. Gabbard GO, Westen D: Rethinking therapeutic action. Int J Psychoanal 2003; 84:823–841
6. Kernberg OF, Diamond D, Yeomans FE, Clarkin JF, Levy KN: Mentalization and attachment in borderline patients in transference focused psychotherapy, in Mind to Mind: Infant Research, Neuroscience, and Psychoanalysis. Edited by Jurist E, Slade A, Berger S. New York, Other Press, 2008, pp 167–201
7. Levy KN, Scala JW: Transference, transference interpretations, and transference-focused psychotherapies. Psychotherapy (Chic) 2012; 49:391–403
8. DeFife JA, Hilsenroth MJ, Kuutman K: Beyond transference: fostering growth through therapeutic immediacy, in Handbook of Contemporary Psychodynamic Approaches to Psychopathology. Edited by Luyten P, Mayes LC, Fonagy P, Target M, Blatt SJ. New York, Guilford (in press)
9. Høglend P, Gabbard GO: When is transference work useful in psychodynamic psychotherapy? a review of empirical research, in Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence. Edited by Levy A, Ablon JS, Kächele H. New York, Springer, 2012, pp 449–467
10. Michels R: The theory of therapeutic action. Psychoanal Q 2007; 76(Oct suppl):1725–1733
11. Frances A, Perry S: Transference interpretations in focal therapy. Am J Psychiatry 1983; 140:405–409
12. Binder JL, Strupp HH: "Negative process": a recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. Clin Psychol Sci Pract 1997; 4:121–139
13. Bateman A, Fonagy P: The use of transference in dynamic psychotherapy (letter). Am J Psychiatry 2007; 164:680
14. Mitchel S: Relational Concepts in Psychoanalysis: An Integration. Cambridge, Mass, Harvard University Press, l988
15. Westen D, Gabbard GO: Developments in cognitive neuroscience, II: implications for theories of transference. J Am Psychoanal Assoc 2002; 50:99–134
16. Gabbard GO: Long-Term Psychodynamic Psychotherapy: A Basic Text, 2nd ed. Arlington, Va, American Psychiatric Publishing, 2010
17. Sandler J: Countertransference and role-responsiveness. Int Rev Psychoanal 1976; 3:43–47
18. Westen D: The scientific legacy of Sigmund Freud: toward a psychodynamically informed psychological science. Psychol Bull 1998; 124:333–371
19. Marmarosh CL: Empirically supported perspectives on transference. Psychotherapy (Chic) 2012; 49:364–369
20. Caspi A: The child is father of the man: personality continuities from childhood to adulthood. J Pers Soc Psychol 2000; 78: 158–172
21. Fonagy P, Target M: Psychoanalytic Theories: Perspectives From Developmental Psychopathology. London, Whurr, 2003
22. Reichborn-Kjennerud T, Ystrøm E, Neale MC, Aggen SH, Mazzeo SE, Knudsen GP, Tambs K, Czajkowsky NO, Kendler KS: Structure of genetic and environmental risk factors for symptoms of DSM-IV borderline personality disorder. JAMA Psychiatry 2013; 70:1206–1214
23. Suderman M, McGowan PO, Sasaki A, Huang TCT, Hallett MT, Meaney MJ, Turecki G, Szyf M: Conserved epigenetic sensitivity to early life experience in the rat and human hippocampus. Proc Natl Acad Sci USA 2012; 109(suppl 2):17266–17272
24. Danese A, Moffit TE, Harrington H, Milne BJ,, Polanczyk G, Pariante CM, Poulton R, Caspi A: Adverse childhood experiences and adult risk factors for age-related disease: depression, inflammation, and clustering of metabolic risk makers. Arch Pediatr Adolesc Med 2009; 163:1135–1143
25. Weiss EL, Longhurst JG, Mazure CM: Childhood sexual abuse as a risk factor for depression in women: psychosocial and neurobiological correlates. Am J Psychiatry 1999; 156:816–828
26. Harmon-Jones E, Winkielman P: Social Neuroscience: Integrating Biological and Psychological Explanations of Social Behavior. New York, Guilford, 2007
27. Bowlby J: Separation anxiety. Int J Psychoanal 1960; 41:89–113
28. Kendler KS, Neale MC, Prescott CA, Kessler RC, Heath AC, Corey LA, Eaves LJ: Childhood parental loss and alcoholism in women: a causal analysis using a twin-family design. Psychol Med 1996; 26:79–95
29. Henderson CR Jr, Cole R, Eckenrode J, Kitzman H, Luckey D, Pettitt L, Sidora K, Morris P, Powers J: Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized controlled trial. JAMA 1998; 280:1238–1244
30. Kaufman J, Yang B-Z, Douglas-Palumberi H, Houshyar S, Lipschitz D, Krystal JH, Gelernter J: Social supports and serotonin transporter gene moderate depression in maltreated children. Proc Natl Acad Sci USA 2004; 101:17316–17321
31. Kendler KS, Halberstadt LJ: The road not taken: life experiences in monozygotic twin pairs discordant for major depression. Mol Psychiatry 2013; 18:975–984
32. Kendler KS, Ohlsson H, Sundquist K, Sundquist J: Within-family environmental transmission of drug abuse: a Swedish national study. JAMA Psychiatry 2013; 70:235–242
33. Roffman JL, Marci CD, Glick DM, Dougherty DD, Rauch SL: Neuroimaging and the functional neuroanatomy of psychotherapy. Psychol Med 2005; 35:1385–1398
34. Karlsson H, Hirvonen J, Salminen J, Hietala J: Increased serotonin receptor 1A binding in major depressive disorder after psychotherapy, but not after SSRI pharmacotherapy, is related to improved social functioning capacity. Psychother Psychosom 2013; 82:260–261
35. McGrath CL, Kelley ME, Holtzheimer PE, Dunlop BW, Craighead WE, Franco AR, Craddock RC, Mayberg HS: Toward a neuroimaging treatment selection biomarker for major depressive disorder. JAMA Psychiatry 2013; 70:821–829
36. Perroud N, Salzmann A, Prada P, Nicastro R, Hoeppli M-E, Furrer S, Ardu S, Krejci I, Karege F, Malafosse A: Response to psychotherapy in borderline personality disorder and methylation status of the BDNF gene. Transcult Psychiatry 2013; 3:e207
37. Crits-Christoph P: The interpersonal interior of psychotherapy. Psychother Res 1998; 8:1–16

38. Bradley R, Heim AK, Westen D: Transference patterns in the psychotherapy of personality disorders: empirical investigation. Br J Psychiatry 2005; 186:342–349
39. Multon KD, Patton MJ, Kivlighan DM: Development of the Missouri Transference Scale. J Couns Psychol 1996; 43:243–252
40. Loughead JW, Luborsky L, Weingarten CP, Krause ED, German RE, Kirk D, Gur RC: Brain activation during autobiographical relationship episode narratives: a core conflictual relationship theme approach. Psychother Res 2010; 20:321–336
41. Høglend P: Analysis of transference in psychodynamic psychotherapy: a review of empirical research. Can J Psychoanal 2004; 12:279–300
42. Kernberg OF, Burstein E, Coyne L, Applebaum A, Horwitz L, Voth H: Psychotherapy and Psychoanalysis: Final Report of the Menninger Foundation's Psychotherapy Research Project. Topeka, Kan, Menninger Foundation, 1972
43. Malan DH: Toward the Validation of Dynamic Psychotherapy. New York, Plenum, 1976
44. Marziali EA, Sullivan JM: Methodological issues in the content analysis of brief psychotherapy. Br J Med Psychol 1980; 53: 19–27
45. Marziali EA: Prediction of outcome of brief psychotherapy from therapist interpretive interventions. Arch Gen Psychiatry 1984; 41:301–304
46. Piper WE, Debbane EG, Bienvenu J-P, de Carufel F, Garant J: Relationships between the object focus of therapist interpretations and outcome in short-term individual psychotherapy. Br J Med Psychol 1986; 59:1–11
47. Marmar CR, Weiss DS, Gaston L: Toward the validation of the California Therapeutic Alliance Rating System. Psychol Assess 1989; 1:46–52
48. Piper WE, Azim HF, Joyce AS, McCallum M: Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. Arch Gen Psychiatry 1991; 48:946–953
49. Høglend P: Transference interpretations and long-term change after dynamic psychotherapy of brief to moderate length. Am J Psychother 1993; 47:494–507
50. Connolly M, Crits-Christoph P, Shappell S, Barber J, Luborsky L, Shaffer C: Relation of transference interpretations to outcome in the early sessions of brief supportive-expressive psychotherapy. Psychother Res 1999; 9:485–495
51. Ogrodniczuk JS, Piper WE, Joyce AS, McCallum M: Transference interpretations in short-term dynamic psychotherapy. J Nerv Ment Dis 1999; 187:571–578
52. Piper WE, Ogrodniczuk JS, Joyce AS, McCallum M, Rosie JS, O'Kelly JG, Steinberg PI: Prediction of dropping out in time-limited, interpretive individual psychotherapy. Psychotherapy 1999; 36:114–122
53. Schut AJ, Castonguay LG, Flanagan KM, Yamasaki AS, Barber JP, Bedics JD, Smith TL: Therapist interpretation, patient-therapist interpersonal process, and outcome in psychodynamic psychotherapy for avoidant personality disorder. Psychotherapy 2005; 42:494–511
54. Ryum T, Stiles TC, Svartberg M, McCullough L: The role of transference work, the therapeutic alliance, and their interaction in reducing interpersonal problems among psychotherapy patients with Cluster C personality disorders. Psychotherapy (Chic) 2010; 47:442–453
55. Henry WP, Strupp HH, Schacht TE, Gaston L: Psychodynamic approaches, in Handbook of Psychotherapy and Behavior Change. Edited by Bergin AE, Garfield S. New York, Wiley, 1994, pp 467–508
56. McCullough L, Winston A, Farber BA, Porter F, Pollack J, Laikin M, Vingiano W, Trujillo M: The relationship of patient-therapist interaction to the outcome in brief dynamic psychotherapy. Psychotherapy 1991; 28:525–533
57. Milbrath C, Bond M, Cooper S, Znoj HJ, Horowitz MJ, Perry JC: Sequential consequences of therapists' interventions. J Psychother Pract Res 1999; 8:40–54
58. Crits-Christoph P, Connolly Gibbons MB, Mukherjee D: Psychotherapy process-outcome research, in Bergin and Garfield's Handbook of Psychotherapy and Behavior Change. Edited by Lambert MJ. New York, Wiley, 2013, pp 298–340
59. Kuutmann K, Hilsenroth MJ: Exploring in-session focus on the patient-therapist relationship: patient characteristics, process and outcome. Clin Psychol Psychother 2012; 19:187–202
60. Hill CE, Gelso CJ, Chui H, Spangler PT, Hummel A, Huang T, Jackson J, Jones RA, Palma B, Bhatia A, Gupta S, Ain SC, Klingaman B, Lim RH, Liu J, Hui K, Jezzy MM, Miles JR: To be or not to be immediate with clients: the use and perceived effects of immediacy in psychodynamic/interpersonal psychotherapy. Psychother Res 2014; 24:299–315
61. Høglend P, Heyerdahl O, Amlo S, Engelstad V, Fossum A, Sørbye Ø, Sørlie T: Interpretations of the patient-therapist relationship in brief dynamic psychotherapy: effects on long-term mode-specific changes. J Psychother Pract Res 1993; 2:296–306
62. Høglend P: Analysis of transference in patients with personality disorders. J Pers Disord 1996; 10:122–131
63. Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF: Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry 2007; 164:922–928
64. Levy KN, Meehan KB, Kelly KM, Reynoso JS, Weber M, Clarkin JF, Kernberg OF: Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. J Consult Clin Psychol 2006; 74:1027–1040
65. Doering S, Hörz S, Rentrop M, Fischer-Kern M, Schuster P, Benecke C, Buchheim A, Martius P, Buchheim P: Transference-focused psychotherapy v treatment by community psychotherapists for borderline personality disorder: randomised controlled trial. Br J Psychiatry 2010; 196:389–395
66. Bateman A, Fonagy P: Mentalization-Based Treatment: Practical Guide. Oxford, UK, Oxford University Press, 2006
67. Morken K, Karterud S, Arefjord N: Transforming disorganized attachment through mentalization-based treatment. J Contemp Psychother 2014; 44:117–126
68. Bateman A, Fonagy P: Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. Am J Psychiatry 2009; 166:1355–1364
69. Rossouw TI, Fonagy P: Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial. J Am Acad Child Adolesc Psychiatry 2012; 51:1304–1313, e3
70. Safran JD, Muran JC: Negotiating the Therapeutic Alliance: A Relational Treatment Guide. New York, Guilford, 2000
71. Muran JC, Safran JD, Samstag LW, Winston A: Evaluating an alliance focused treatment for personality disorders. Psychotherapy 2005; 42:532–545
72. Crits-Christoph P, Connolly Gibbons MB, Crits-Christoph K, Narducci J, Schamberger M, Gallop R: Can therapists be trained to improve their alliances? a preliminary study of alliance-fostering psychotherapy. Psychother Res 2006; 16:268–281
73. Safran JD, Muran JC, Eubanks-Carter C: Repairing alliance ruptures. Psychotherapy (Chic) 2011; 48:80–87
74. Høglend P, Amlo S, Marble A, Bøgwald K-P, Sørbye Ø, Sjaastad MC, Heyerdahl O: Analysis of the patient-therapist relationship in dynamic psychotherapy: an experimental study of transference interpretations. Am J Psychiatry 2006; 163:1739–1746
75. Høglend P, Bøgwald K-P, Amlo S, Marble A, Ulberg R, Sjaastad MC, Sørbye Ø, Heyerdahl O, Johansson P: Transference interpretations in dynamic psychotherapy: do they really yield sustained effects? Am J Psychiatry 2008; 165:763–771

76. Høglend P, Dahl HS, Hersoug AG, Lorentzen S, Perry JC: Long-term effects of transference interpretation in dynamic psychotherapy of personality disorders. Eur Psychiatry 2011; 26: 419–424
77. Ulberg R, Høglend P, Marble A, Johansson P: Women respond more favorably to transference intervention than men: a randomized study of long-term effects. J Nerv Ment Dis 2012; 200: 223–229
78. Ulberg R, Johansson P, Høglend P: Patient sex as moderator of effects of transference interpretation in a randomized controlled study of dynamic psychotherapy. Can J Psychiatry 2009; 54:78–86
79. Johansson P, Høglend P, Ulberg R, Amlo S, Marble A, Bøgwald KP, Sørbye Ø, Sjaastad MC, Heyerdahl O: The mediating role of insight for long-term improvements in psychodynamic therapy. J Consult Clin Psychol 2010; 78:438–448
80. Connolly MB, Crits-Christoph P, Shelton RC, Hollon S, Kurtz JE, Barber JP, Butler SF, Baker S, Thase ME: The reliability and validity of a measure of self-understanding of interpersonal patterns. J Couns Psychol 1999; 46:472–482
81. Gibbons MB, Crits-Christoph P, Barber JP, Wiltsey Stirman S, Gallop R, Goldstein LA, Temes CM, Ring-Kurtz S: Unique and common mechanisms of change across cognitive and dynamic psychotherapies. J Consult Clin Psychol 2009; 77:801–813
82. Kallestad H, Valen J, McCullough L, Svartberg M, Høglend P, Stiles TC: The relationship between insight gained during therapy and long-term outcome in short-term dynamic psychotherapy and cognitive therapy for cluster C personality disorders. Psychother Res 2010; 20:526–534
83. Høglend P, Hersoug AG, Bøgwald K-P, Amlo S, Marble A, Sørbye Ø, Røssberg JI, Ulberg R, Gabbard GO, Crits-Christoph P: Effects of transference work in the context of therapeutic alliance and quality of object relations. J Consult Clin Psychol 2011; 79: 697–706
84. Dahl HS, Røssberg JI, Crits-Christoph P, Hersoug AG, Gabbard GO, Perry JC, Ulberg R, Høglend P: Long-term effects of analysis of the patient-therapist relationship in the context of patients' personality pathology and therapists' parental feelings. J Consult Clin Psychol (Epub ahead of print, Mar 24, 2014)
85. Rosser RM, Moynihan CM, Denford J, Heslop A, Muir B, Macklin D, Guz A: The Charing Cross-Cassel Focal Psychotherapy Research Project: method of content analysis. Psychother Psychosom 1983; 40:81–94
86. Caligor E, Hilsenroth MJ, Devlin M, Rutherford BR, Terry M, Roose SP: Will patients accept randomization to psychoanalysis? a feasibility study. J Am Psychoanal Assoc 2012; 60:337–360
87. Banon E, Perry JC, Semeniuk T, Bond M, de Roten Y, Hersoug AG, Despland J-N: Therapist interventions using the Psychodynamic Interventions Rating Scale (PIRS) in dynamic therapy, psychoanalysis and CBT. Psychother Res 2013; 23:121–136
88. Ulberg R, Amlo S, Critchfield KL, Marble A, Høglend P: Transference interventions and the process between therapist and patient. Psychotherapy (Epub ahead of print, March 17, 2014)
89. Castonguay LG, Schut AJ, Aikins D, Constantino MJ, Lawrenceau JP, Bologh L, Burns DD: Repairing alliance ruptures in cognitive therapy: a preliminary investigation of an integrative therapy for depression. J Psychother Integration 2004; 14:4–20
90. Constantino MJ, Marnell ME, Haile AJ, Kanther-Sista SN, Wolman K, Zappert L, Arnow BA: Integrative cognitive therapy for depression: a randomized pilot comparison. Psychotherapy (Chic) 2008; 45:122–134
91. Vocsiano C, Klein DN, Arnow B, Rivera C, Blalock JA, Rothbaum B, Viviian D, Markowitz JC, Koscis JH, Manber R, Castonguay L, Rush AJ, Borian F, McCullough JP, Kornstein SG, Riso LP, Thase ME: Therapist variables that predict symptom change in psychotherapy with chronically depressed outpatients. Psychotherapy 2004; 41:255–265
92. Kanter JW, Tsai M, Holman G, Koerner K: Preliminary data from a randomized pilot study of web-based functional analytic psychotherapy therapist training. Psychotherapy (Chic) 2013; 50:248–255
93. Sanislow CA, Pine DS, Quinn KJ, Kozak MJ, Garvey MA, Heinssen RK, Wang PS-E, Cuthbert BN: Developing constructs for psychopathology research: research domain criteria. J Abnorm Psychol 2010; 119:631–639
94. Holt-Lunstad J, Smith TB, Layton JB: Social relationships and mortality risk: a meta-analytic review. PLoS Med 2010; 7: e1000316
95. Kosfeld M, Heinrichs M, Zak PJ, Fischbacher U, Fehr E: Oxytocin increases trust in humans. Nature 2005; 435:673–676
96. Buchheim A, Viviani R, Kessler H, Kächele H, Cierpka M, Roth G, George C, Kernberg OF, Bruns G, Taubner S: Changes in prefrontal-limbic function in major depression after 15 months of long-term psychotherapy. PLoS ONE 2012; 7:e33745
97. Abbass AA, Nowoweiski SJ, Bernier D, Tarzwell R, Beutel ME: Review of psychodynamic psychotherapy neuroimaging studies. Psychother Psychosom 2014; 83:142–147
98. Kerr JN, Denk W: Imaging in vivo: watching the brain in action. Nat Rev Neurosci 2008; 9:195–205
99. Tye KM, Deisseroth K: Optogenetic investigation of neural circuits underlying brain disease in animal models. Nat Rev Neurosci 2012; 13:251–266

Clinical Guidance: Which Patients Benefit From Transference Work?

Exploring the patient-therapist relationship in psychodynamic psychotherapy appears to be most helpful for female patients with difficult interpersonal relationships or severe personality pathology. Studies reviewed by Høglend indicate that transference work is an active therapeutic ingredient and that transference-based treatments have more benefit than other treatments for personality functioning. Transference interventions may have negative effects if used too frequently or with patients having more mature relationships.