Metadata of the chapter that will be visualized online

Series Title	Current Clinical Psychiatry	
Chapter Title	When Is Transference Work Useful in Psychodynamic Psychotherapy? A Review of Empirical Research	
Chapter SubTitle		
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Abstract	The technical use of transference interpretations in psychoanalysis and psychodynamic psychotherapy has been debated extensively over a period of 100 years. More than 8,000 papers and book chapters have discussed the concept of transference. Up to year 2000, ten studies of brief dynamic psychotherapy had explored the association between dosage levels of transference interpretations and therapy outcome. Six studies reported negative correlations, and one initial study by Malan reported a positive correlation, between frequency of transference interpretations and outcome. All of the studies have more or less faulty designs. In this chapter, we present a study of immediate effects of transference interpretation Gabbard (Harvard Rev Psychiatry 1994;2:59–69) and a recent large-scale dismantling randomized clinical trial specifically designed to study long-term effects of transference interpretation Høglend (Am J Psychiatry 2006;163:1,739–46), Høglend (Am J Psychiatry 2008;165:763–71).

Keywords (separated by '-')	In-session outcome - long-term outcome - mediators - moderators - psychodynamic psychotherapy - transference work

Chapter 23
When Is Transference Work Useful in Psychodynamic Psychotherapy? A Review of Empirical Research

Per Høglend and Glen O. Gabbard

Keywords In-session outcome • Long-term outcome • Mediators • Moderators • Psychodynamic psychotherapy • Transference work

Analysis of transference has been considered the heart of psychoanalysis and psychoanalytically oriented psychotherapy since Freud introduced the term (Uebertragung) in 1,895. The concept of transference was seen by Freud as a living reconstruction of the patient's repressed historical past "transferred" onto current relationships, especially the relationship with the therapist. In his first use of the term, he described it as a "false connection" ([1, p. 302]). In other words, the patient would displace feelings associated with a past figure in the patient's life onto the analyst. The first detailed clinical description of transference was the famous "Dora" case [1]. Dora dropped out of psychotherapy after 3 months. Freud wrote in the epilog: "I did not succeed in mastering the transference in good time…At the beginning it was clear that I was replacing her father in her imagination."

Since Freud's death, there have been a number of contributions about transference that reflect theoretical disagreements. Some have argued that additional concepts, such as therapeutic alliance and the real relationship to the therapist, may be needed to account for the patient's reactions to the therapist [2]. There has also been disagreement about the degree to which transference should be viewed as an enactment of an earlier relationship or partly a new experience [3]. The constructivist view [4] focuses on the analyst's personal involvement and sees the analyst as having a continuous effect on what the analyst understands about the patient and the interaction. In other words, the analyst's actual behavior is always influencing the patient's experience of the analytic situation. Some intersubjectivists [5] have argued that in addition to the repetitive aspect of transference, there is also an unconscious wish in the patient for a healing and reparative new object embedded in transference.

The psychoanalytic literature originally defined interpretations as therapist interventions intended to bring unconscious material into consciousness. Whether or not certain material is really out of the patient's awareness (unconscious) is difficult to judge, not only for researchers listening to taped sessions, but also for the psychotherapist treating the patient.

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R.A. Levy et al. (eds.), *Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence*, Current Clinical Psychiatry,
DOI 10.1007/978-1-60761-792-1_23, © Springer Science+Business Media, LLC 2012

More recently, clinical theorists and researchers have relied on broader definitions of interpretations that are more "experience near," recognizing that many interpretations are actually focused on material that is preconscious rather than truly unconscious. The many somewhat different definitions in the literature are beyond the scope of this article. There seems, however, to be general agreement in the psychodynamic tradition that interpretations include interventions that aim to establish connections (by cause or analogy) between different internal dynamic components (wishes, needs, motives, affects, defences, anxiety) and past or present objects (persons). Transference interpretations are a subgroup of interpretations that also includes an explicit link to the patient–therapist interaction. The alternative to transference interpretation is to interpret conflicts and/or interpersonal patterns in the patient's contemporary relationships or search for memories of past relationships, without including a reference to the patient–therapist interaction (extra-transference interpretation). An example of such an interpretation may be: "I noticed that you tend to avoid talking about your sadness and anger after your divorce. Maybe because those memories make you uncomfortable?" An interpretation of the same material may include an explicit reference to the patient–therapist interaction (transference interpretation): "It occurs to me that you have avoided talking about your sadness and anger after your divorce, because it makes you feel uncomfortable. Maybe you hesitate to talk to me about your feelings concerning the end of therapy for the same reasons?"

Almost all of a patient's associations may theoretically have some meaning in the transference, the awareness of which (it is maintained) is often resisted. An example of an interpretation of such resistance may be: "You told me your colleague is doing less than her share of the job, which gave you a headache that has bothered you since our last session. Could this be related to a feeling you have that I don't do my share of the analytic work? It may be difficult for you to say this directly to me." An interpretation of this material may also be given without a reference to the transference: "You feel that your colleague is exploiting the situation, which may be difficult to say to her directly, so your headache builds up."

It has been argued by influential theorists that extra-transference interpretations lend themselves to defensive intellectualization by both the patient and the therapist, and at best will bring about unstable long-term changes [6, 7]. Analysis of transference, on the other hand, makes it possible for the patient (and analyst) to become directly aware of the distinction between what is real in the situation and what is fantasy influenced by past experience. A focus on the conflicts and themes that arise in the therapeutic relationship will therefore have immediate affective resonance and illuminate the true nature of problems in the patient's relationships outside of therapy. Transference interpretations are thought to set in motion a chain of events that bring about insight and change that may protect against future stressful events, enable the patient to make better plans for his future, and over time improve the quality of interpersonal relationships.

The technical use of transference interpretations in psychodynamic therapy has been discussed extensively over a period of 100 years. Strikingly different positions have been taken by influential psychoanalysts on the relative importance of transference interpretations versus extra-transference interpretations.

The "Conservative" Position

At one point, Freud viewed the resolution of transference through interpretation as a sine qua non of therapeutic change [1]. Subsequently, however, Freud and other analysts regarded analysis of transference as ancillary (secondary) to work outside the transference. Transference interpretations were mainly used to overcome resistance [8]. Strachey [6] consolidated this view in his influential

paper, "The nature of the therapeutic action of psychoanalysis." He maintained that the majority of interpretations that analysts actually make are outside the transference. Until an intense "transference neurosis" develops through the patience and neutrality of the therapist (and it does not in brief therapy), transference interpretations are "premature." Glover [9] and others warned against overemphasis on transference interpretations, especially early in treatment. Others believed that a moderate use of transference interpretations might be indispensable in psychoanalysis and long-term dynamic psychotherapy, but should be completely avoided in brief psychotherapy [10–12].

The most important arguments in the clinical literature against a frequent use of transference interpretations generally are that transference interpretations may be anxiety provoking or perceived as critical. The patient may feel that focusing on the relationship to the therapist comes at the expense of problems with significant others and reality concerns. Furthermore, transference phenomena are often resisted by the patient and are therefore difficult to interpret. The patient's main interpersonal conflicts and patterns may not be duplicated (expressed) in the relationship to the therapist [13, 14]. Stone [15], for example, maintained that patients' relationships to individuals other than the therapists often provide indispensable data for interpretation, because of the sheer variety of references, many of which will never be reproduced in the relationship to the therapist. In addition, data from neuroscience suggest that the notion of transference neurosis may be misleading. Neural network theory supports the idea that there are multiple networks in the brain with diverse self and object representations contained within them. Different representations are triggered by different elements of the therapist. Hence, it is more accurate to speak of "transferences" rather than "THE transference" [16].

The "Radical" Position

On the other hand, the notion of a high level of focus on analysis of transference is almost as old as psychoanalysis itself. Seminal figures such as Rank, Ferenzci, Reich, and Sullivan, among others, have maintained that transference interpretations should be used more often [17–19]. Advocates of brief dynamic psychotherapy have consistently recommended that transference manifestations and also allusions to the transference in the patient's material should be identified and interpreted as soon as they appear [20–22]. The state of affairs urged Rangell [23] to raise the question: "Is it still resistance and defences first, as it has been with Freud, Anna Freud, Fenichel and others? Or have we now moved to what is promulgated by many as transference first, or even transference only?" Gill [7] reviewed the extensive discussion about use of transference interpretation in his monograph *Analysis of Transference: Volume 1*. He argued that most interpretations should be about the transference in the here and now, regardless of the length and format of therapy [24]. Gill concluded, however, that different positions on the relative roles of transference interpretations versus extra-transference interpretations have faded in and out of prominence in psychoanalysis and have been discovered again and again. The most important reason for this, in his opinion, was the almost total absence of systematic and controlled research in the psychodynamic tradition. Gabbard and Westen [25] concluded, more than 20 years later: "In psychoanalysis, we write about therapeutic action as if somehow the question of what is therapeutic…can be settled by logical argument and debate. In fact, it is an empirical question…We do not know whether one technical stance works better than any other…" While there has been an historical debate on whether the primary vehicle of change involves internalization of the (total) therapeutic relationship or acquisition of insight through transference interpretation, that dialectic of "either/or" has waned in recent years as there is wide recognition that both modes of therapeutic action are important and may operate synergistically [25, 26].

The "Empirical" Position

It should be noted that many psychotherapy researchers (if not most) have supported for a long time the position that specific techniques do not contribute much to therapeutic change. Non-specific factors, such as understanding, attention, and a good relationship between the therapist and patient, account for all, or almost all change [27–30].

The Empirical Literature 1976–1999

Given the importance of transference interpretation in the psychodynamic tradition, relatively few empirical studies have been published, which attempt to provide some systematic evidence with regard to the technical use of transference interpretations. The studies are too heterogeneous to allow meta-analytic technique, so a brief review of the studies will follow.

In-Treatment Effects of Transference Interpretation

Several studies have indicated that transference interpretations do not elicit more positive immediate patient responses compared to other interpretations [31–34], but on the contrary, tend to increase the risk of defensive responses [35–37], a less favorable alliance [38, 39], and less patient involvement [40]. Piper et al. [41] reported that 22 patients who dropped out of interpretive therapy were lower on therapist-rated therapeutic alliance, lower on patient exploration, and higher on therapist and patient focus on transference, than 22 matched completers.

Gabbard et al. [42, 43] studied the detailed process of representative sessions from three cases of long-term dynamic therapy of borderline patients at the Menninger Clinic. All sessions of the three psychotherapy processes were audio-taped, and two sets of investigators worked from typed transcripts of randomly selected psychotherapy hours. A team of three clinician-researchers rated the interventions on the basis of their degree of expressiveness or supportiveness. From the expressive end of the continuum to the supportive end, the interventions were rated as follows: interpretation, confrontation, clarification, encouragement to elaborate, empathic validation, advice and praise, and affirmation. Each of these seven interventions was also classified as having a focus on either transference or extra-transference issues. A separate team of three clinical judges assessed the patient's collaboration with the therapist as a measure of the therapeutic alliance. The judges were primarily interested in detecting upward or downward shifts in the patient's collaboration with the therapist, a marker of the therapeutic alliance, in response to the therapist's interventions.

An excerpt from a transcript of session 32 from one of the patients will illustrate this method:

Therapist: Um-hum. Maybe you're feeling, uh, kind of disengaged now?
Patient: Yeah, that's a very good word for it. It's just, it's strange 'cause when you say things, you know, I can tell that they're true but when you ask me to give an example, I can't really think of one.
Therapist: Um-hum. See, I think, uh, one….one way you have of becoming engaged with me, for example, is by being angry.
(This transference interpretation leads to a downward shift in the therapeutic alliance).
Patient: Wh-when did I…become angry…with you? I don't understand what you mean by that.
Therapist: You can't recall being angry with me?
Patient: That on…that, but that was…because I had taken drugs…that one time.
Therapist: Uh-huh, yeah, that wa…well, that's a prime instance.

Patient: Yeah.
Therapist: As I remember you saying at the time that you were feeling in a way good about what was going on.
Patient: Um-hum. Well, when I took drugs here, it just, you know, it just, I don't, I don't know how to descri be it, it just, uh, made me more aware of how I was feeling.

This patient tended to respond negatively to transference interpretations. Of the upward shifts in her collaboration with the therapist, only 29% could be linked to an interpretation of the transference. The two other patients tended to respond more positively. In one case, 63% of the upward shifts could be related to transference interpretation, and in a third case, 81% of the upward shifts were tied to transference focus. All three patients had good outcomes [44], but one of the key findings was that transference interpretations had a greater impact—both positive and negative—than other interventions. As a result, Gabbard et al. [42] coined the term high risk–high gain to characterize transference interpretations in the psychotherapy of borderline patients.

From this research, the investigators stressed the need to tailor the use of transference interpretations to the characteristics of the particular patient. Patients with early trauma may need to externalize aggression and will not take well to the attribution of anger or hostility to them. The research suggested that paving the way for transference interpretation with affirmative appreciation of the patient's internal experience may be crucial. Surgeons need anesthesia before they can operate. The psychotherapist may need to create a holding environment through empathic validation of the patient's experience before offering an interpretation of unconscious issues. With patients who are more internalizing and have lesser degrees of trauma in childhood, transference interpretation may be more palatable [42].

Transference Interpretation and Outcome

Process studies can help therapists make choices within sessions by assessing the "mini-outcomes" of their interventions. However, outcome studies are badly needed to look at the long-range outcomes of strategies that emphasize transference work compared to those that do not. Malan and colleagues at the Tavistock Clinic [21, 45] reported from two studies a positive correlation between transference-parent linking interpretations and good long-term outcome. Malan scored the treatment process by reviewing therapists' notes, which had been dictated from memory after sessions. Malan's findings created enthusiasm for empirical research within the psychodynamic tradition. Marziali and Sullivan [46] re-evaluated the 22 therapies from Malan's replication study and were able to replicate his findings. However, only 9 of the 22 therapies contained separate interpretations of transference-parent links, and in very small proportions.

Marziali [47] rated audio-taped sessions of 25 patients. Transference-parent linking interpretations predicted good outcome on one of seven outcome measures. Piper et al. [48] reported that transference interpretations were uncorrelated with outcome. McCullough et al. [35] examined therapist–patient interactions in 16 cases of brief dynamic psychotherapy. Transference interpretations followed by an affective response from the patient were positively correlated with a composite outcome score. It should be noted, however, that transference interpretations were followed by a defensive response from the patient five times as often as an affective response.

Rosser et al. [49] studied 32 patients with chronic obstructive airway disease. All patients were treated by two experienced psychoanalysts. Sixteen patients were randomized to eight sessions of analytic psychotherapy. The analysts were instructed to make free use of transference interpretations. The other 16 patients received eight sessions of dynamic psychotherapy, by the same two analysts, who were instructed to withhold transference interpretations in this group. Change in psychiatric symptoms was significantly greater in the psychotherapy without transference interpretations. However, these patients were not primarily seeking psychological treatment, and treatments were ultra-short.

Piper et al. [39] studied the relationships between concentration of transference interpretations, and both therapeutic alliance and therapy outcome in a sample of 64 outpatients who received approximately 20 sessions of brief dynamic psychotherapy by experienced psychotherapists. Within the subsample of patients with high quality of object relations (QOR) [50], negative correlations were reported. At one extreme (upper quartile of concentration of transference interpretations), nearly ten transference interpretations were given per session. The percentage of patients evaluated as recovered in this subsample was 25%. In the lower quartile of transference interpretations (less than two transference interpretations per session), 100% of the patients traversed the criterion of recovery.

In a Norwegian study of 43 patients [51], those patients who scored above a predetermined cut-off score on QOR were treated with a high frequency of transference interpretations (on average six per session), whereas patients who fell below the cut-off score were treated with dynamic psychotherapy with few transference interpretations. Contrary to expectations, the study found a negative long-term effect of a high frequency of transference interpretations given to highly "suitable" patients. A limitation of the study was the sample size. The true effects in the population could be small to very large. Since the two groups were unequal, potential selection maturation effects preclude definitive causal interpretations. That is, the patients in the comparison group might have been more amenable to any treatment.

Connoly et al. [52] found that patients with low quality of current interpersonal functioning showed less favorable improvement even with low levels of transference interpretations (0–2 per session). Ogrodniczuk et al. [53] studied 40 patients in interpretive psychotherapy. Significant negative correlations between moderate use of transference interpretation (2–4 per session) and both alliance and outcome were found for patients with low QOR.

Based on these studies, the future of transference interpretation looked rather bleak. In *Handbook of Psychotherapy and Behaviour Change* [54], Henry et al. concluded: "Although transference interpretations are the theoretical linchpin of psychodynamic technique, attempts to demonstrate their unique value seem doomed to failure and will contribute little to new knowledge." This may be a bit premature. Most of the studies reviewed are observational studies (naturalistic studies). Despite some replications, within-group correlations are open to several interpretations [55]. One reason for the negative associations reported may be that the encouragement to focus on transference interpretations may unwittingly encourage therapists to offer critical transference interpretations in order to overcome mounting resistance, or "overdose" the patient trying to force insight, rather than help patients when ready. Six of ten studies had treatment formats of 20 sessions or less. It could be argued that these therapies were too short for transference work. The research base reviewed previously is therefore too sparse to give technical guidelines about the use of transference interpretation in psychodynamic therapy. However, despite the limitations in the studies, it seems fair to conclude that clinicians should be aware that a high dosage level of transference interpretations (on average four–six or more per session) does not seem to overcome patient resistance and defensiveness and may in fact contribute to a negative therapeutic process.

The First Experimental Study of Transference Interpretations (FEST)

The FEST study [56–58] is a dismantling randomized clinical trial, specifically designed to study long-term effects of transference interpretations in dynamic psychotherapy. Patients from general practice, private specialist practices, and psychiatric outpatient departments were referred to the study therapists and assessed for eligibility. Inclusion criteria were liberal. One hundred patients were randomized to dynamic psychotherapy of 1 year's duration with transference interpretation or therapy without such interventions.

Since the main aim of transference interpretation is long-term improvement of adaptive and interpersonal functioning, all patients have been followed up 1 and 3 years after treatment termination. It is an important methodological aspect of the study that the patients were not told about the main hypothesis. In other words, they did not know that they were randomized to two different treatments. They were told that that the aim of the study was to explore long-term effects of dynamic psychotherapy. The clinicians evaluating outcome were blind to treatment groups. The randomization procedure was successful. No significant differences were detected between the two groups with regard to baseline characteristics.

The Psychodynamic Functioning Scales (PFS) was the primary outcome measure in this study. The six scales, with the same format as the Global Assessment of Functioning, were used to measure psychological functioning over the 3 previous months. Three of the scales measure interpersonal aspects: Quality of Family Relationships, Quality of Friendships, and Quality of Romantic/Sexual Relationships. The other three measure intrapersonal functioning: Tolerance for Affects, Insight, and Problem Solving Capacity. Aspects of content validity, internal domain construct validity, discriminant validity from symptom measures, and sensitivity for change in dynamic therapy have been established in different samples of patients and evaluators [59–63]. The reliability of single, randomly drawn experienced raters have ranged from 0.65 to 0.79. In this study, three clinical raters were used on each case, blind to treatment group, who made evaluations at pre-treatment, and again 1 year, 2 years, and 4 years after the start of therapy. The inter-rater reliability estimates (ICC) for average scores of three raters varied from 0.87 to 0.93 for the PFS. All follow-up assessments were completed by December 2005. The total mean score of the Inventory of Interpersonal Problems-Circumplex version [64] was used to assess patients' self-reported interpersonal problems at pre-treatment, mid-treatment, post-treatment, 1-year follow-up, and 3-year follow-up. At all evaluations, patients rated 24 life events on a scale from –3 (extremely negative) to +3 (extremely positive) [65]. Additional treatments, such as contact with mental health professionals, psychotherapy, psycho-pharmacological treatment, and sick leave, were recorded.

Psychotherapy researchers are constantly confronted with questions that concern how individuals differ in their response to treatment. For what types of patients or for what patient characteristics/aptitudes are treatments maximally or minimally effective [66]? Two patient characteristics were chosen a priori as possible moderators of treatment effects [67]: the QOR Scale [50, 68, 69] and the presence versus absence of personality disorders (PD). The QOR measures the patient's lifelong tendency to establish certain kinds of relationships with others, from mature to primitive, using three 8-point scales. The predetermined cut-off score for differentiating high versus low QOR scores was 5.00. QOR scores above the cut-off means that recent relationships may be difficult but there is evidence for at least one mature relationship in the patient's history. QOR scores at or below the cut-off means a history of less gratifying relationships, characterized by less emotional investment, less stability, and need for dependency or over-control. Inter-rater reliability (ICC) for the average QOR scores of three raters was 0.84.

Treatment Process

Both treatments employed use general psychodynamic principles. One treatment avoided an interpretive focus on the ongoing patient–therapist interaction (comparison group). The other treatment used material from the patient–therapist interaction as an important vehicle for clarifications, confrontations, and interpretations (transference group). The design of the study is a so-called constructive or dismantling design, in which a single component (analysis of transference) is added (or subtracted) to an existent treatment package. Thus, the causal efficiency of a specific technique can be identified. The specific techniques used for transference work is shown in Table 23.1. Items 1–3

t1.1 **Table 23.1** Specific transference techniques

t1.2 1. Therapist addresses transactions in the patient–therapist relationship
t1.3 2. Therapist encourages exploration of thoughts and feelings about the therapy and the therapist and repercussions
t1.4 on transference by (high) therapist activity
t1.5 3. The therapist encourages the patient to discuss how the therapist might feel or think about the patient
t1.6 4. The therapist explicitly includes himself in interpretive linking of dynamic elements (conflicts), direct manifesta-
t1.7 tions of transference, and allusions to the transference
t1.8 5. The therapist interprets repetitive interpersonal patterns, including genetic interpretations, and links to transference

t2.1 **Table 23.2** Treatment integrity (sessions rated = 452)

t2.2					Transference	Comparison
t2.3					$N=52$	$N=48$
t2.4	Transference interpretation (five items)***				1.7 (0.7)	0.1 (0.2)
t2.5	Extra-transference interpretations (five items)***				2.4 (0.5)	2.7 (0.6)
t2.6	Supportive interventions (seven items)				0.7 (0.3)	0.7 (0.3)
t2.7	General skill (eight items)				3.6 (0.2)	3.6 (0.3)
t2.8	Scale format:					
t2.9	No emphasis	Minor	Moderate	Considerable	Major emphasis	
t2.10	0	1	2	3	4	

t2.11 ***$p<0.005$

299 are preparatory interventions, and items 4 and 5 are transference interpretations in a stricter sense.
300 In the comparison group, the therapists consistently used material about interpersonal relationships
301 outside of therapy as the basis for similar interventions (extra-transference interpretations), without
302 any links to the patient–therapist relationship.
303 The therapists were specifically trained in order to enable them to provide treatment with a mod-
304 erate level of transference work (an average of two transference interpretations per session) and
305 treatment without such interpretations, with equal ease and mastery. Treatment fidelity or treatment
306 integrity was extensively documented with ratings of four–five full sessions from each treatment by
307 two raters, blind to treatment group (sessions $n=452$) [56, 70–72]. Treatment integrity was excel-
308 lent. Only use of transference interpretations was significantly different between the two treatments.
309 The average score of transference work was 1.7, indicating moderate use, as outlined in the study
310 protocol. Use of extra-transference interpretations was given somewhat more often in the compari-
311 son group, but also in the transference group extra-transference interventions were more often given
312 than transference interventions, as shown in Table 23.2.
313 Comprehensive treatment integrity checks are advisable, especially in dismantling studies. When
314 therapists are "forced" to add or withhold one treatment component, they may make other intuitive
315 adjustments in one or both treatment groups.

316 *Case Illustration*

317 The patient was a 50-year-old sociologist. He wanted psychotherapy for anxiety and somatization
318 symptoms which had developed after he left his wife some months prior to the start of therapy. He
319 constantly ruminated about going back in order to please her. He was diagnosed with adjustment
320 disorder and avoidant PD.

Psychodynamic Formulation

The patient had identified with his mildly depressed, submissive mother and was ambivalent about a dominating but distant father. He had learned to avoid conflicts and instead bury himself with hard work. He wanted to "repair" disagreements with his wife by being submissive. At work, he tried to solve conflicts by supporting the "weak" part. Being assertive meant for him "bloody aggression," leading to guilt feelings for him and imagined unhappiness for others. Even when others made very unreasonable demands, he wanted to comply. Excerpts of a session are presented here:

Session 16

Patient: Should I go back home? I am so afraid of hurting Nancy (wife). Moreover she would be very angry…and what would the kids say?

Therapist: What do you imagine that I think that you ought to do?

Patient: I don't know.

Therapist: What would you prefer me to think?

Patient: Damn…I don't know. You would say: "Get you home to Nancy!"

Therapist: Did you notice that you spoke dialect just now? You usually speak standard Norwegian.

Patient: Yes…Yes.

Therapist: You have this with you from earlier on. Maybe you see me as an authority from the past: "That just isn't the way things are done my boy." You seem to put me in this authority position.

(Long pause)

Therapist: I believe you grasp this well enough and are able to look at it, also between sessions, and even if I'm not there anymore.

Patient: Well, yes, I….

Therapist: You are more catholic than the Pope.

Patient: What?

Therapist: I'm thinking, you feel almost absolutely committed to everybody, even everything that your parents might think. But you are the most demanding of yourself, you are the one who is absolutely categorical. "Get you back home."

Patient: Well, yes,…(sigh)….

…At times I want to be happy, but I don't know, is that to stay out of conflicts and problems? When I am able to avoid a possible conflict I feel relieved…for a while. Is that my goal in life…am I so blunted?

Therapist: Maybe (it's something like this) you feel that you don't deserve more? …Would it be helpful if I told you what to do?

Patient: yes, I agree….

(later in the session)

Patient: A colleague wrote a recommendation letter for one of our secretaries. He showed it to me,…probably to ask my opinion. It was a very poor piece of work, and unfair to the secretary! I did not dare to tell him, even though he is an OK guy.

Therapist: Would it have been possible for you to correct me?

Patient: Never occurred to me. You just get me started, so to criticize you would be to criticize myself.

Therapist: Isn't that something you do all the time?…Three sessions ago you said that you wanted to prolong therapy. I reminded you about our plan to terminate, and you immediately backed off.

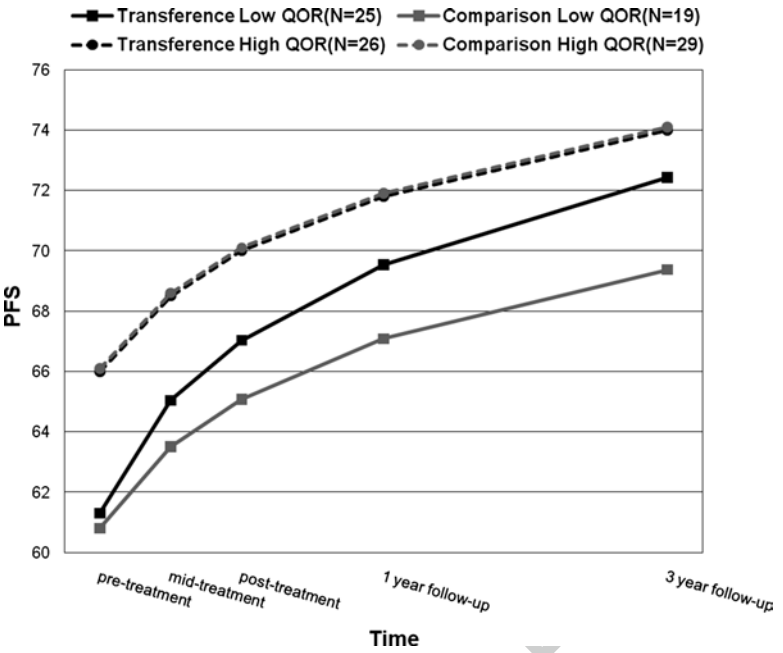

Fig. 23.1 Despite the fact that patients in the comparison group received more than twice as much additional treatment, compared to the transference group, the effect of transference interpretation was sustained over a 3-year follow-up period. Patients with mature interpersonal relationships benefitted equally well from both treatments

Patient: I don't know, I haven't thought about it anymore, it's probably OK.
Therapist: You don't make me authoritarian, but you make me into an authority figure, who knows what is best for you,—maybe you do this in order to avoid being in opposition?
Patient: Do you think so?
Therapist: I don't know, what do you think?
Patient: No …well….
Therapist: Maybe you disagree a little (on termination)?
Patient: Yes, I do have a need for more…There are things that I feel I should go more into. In the beginning of therapy you said I could become frustrated and angry and so on. But you have mostly given me back my own opinions, maybe with different words.

Outcome

The first a priori hypothesis in this study was that transference interpretation will have specific long-term effects, at least for patients with more mature relationships, more psychological resources, and less psychopathology. However, contrary to conventional clinical wisdom, we found that the subsample of patients with low QOR benefitted significantly more from therapy with transference interpretation than without [56]. Despite the fact that patients in the comparison group received more than twice as much additional treatment, compared to the transference group, the effect of transference interpretation was sustained over a 3-year follow-up period [57], shown in Fig. 23.1.

As also seen in Fig 23.1, patients with mature interpersonal relationships benefitted equally well from both treatments.

We also divided the sample into two other subsamples, patients with GAF above 61 (mild psychopathology) and patients with GAF below 61 (moderate to severe psychopathology). A small negative

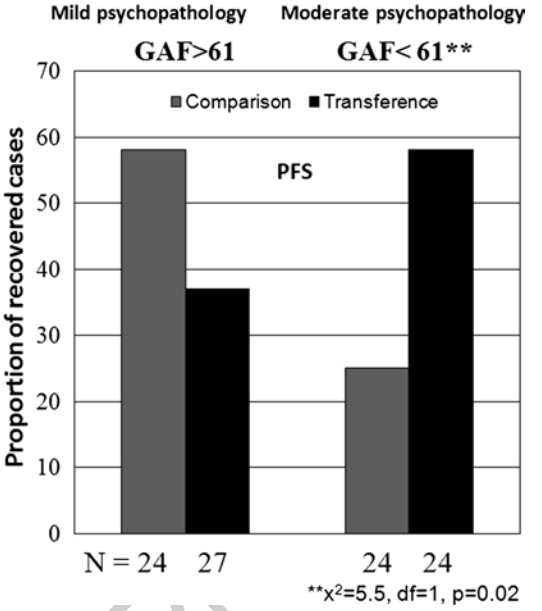

Fig. 23.2 Within this subsample discussed in the text, almost three times as many patients were recovered on PFS after therapy with transference interpretation compared to therapy without

effect (non-significant) of transference interpretation was observed within patients with mild psychopathology and a substantial positive effect for patients with more severe psychopathology. Within this subsample, almost three times as many patients were recovered on PFS after therapy with transference interpretation compared to therapy without [58], as shown in Fig 23.2.

Healthier patients may present more subtle transference cues, thus forcing therapists to base transference interpretation more on inference than concrete evidence. Glover [9] has pointed out that the early "spontaneous" transference enactments of less healthier patients, such as fear of rejection, dependency/counter-dependency, idealization/devaluation, may take on a "dependant" or "pathological" form that is more suitable to transference interpretations. Our findings may correspond to Levy et al. [73]. They reported that 1 year of transference-focused psychotherapy for borderline patients was more favorable than dialectical behavior therapy or supportive therapy with regard to attachment patterns and reflective functioning.

Gender Differences in FEST

The effects of gender have received a lot of attention in clinical theory. For instance, analysts recognize that sex contributes to transference [74], although several research reviews indicate that, on average, men and women respond similarly across different types of psychotherapy [75]. Almost all studies have explored sex as a general predictor. Only two studies have explored sex as a moderator in individual psychotherapy, testing whether men and women responded differentially to different psychotherapies. Zlotnick et al. [76] reported no moderator effects of patient gender. Ogrodniczuk et al. [77] reported that men responded more favorably to interpretive psychotherapy, while females responded better to supportive therapy.

In FEST, women and men responded equally to both treatments in the whole sample ($N = 99$), consistent with earlier research findings. However, women responded significantly better than men to transference interpretation, and men responded significantly better than women to therapy without transference interpretation [78]. When the moderator effects of QOR and gender were combined, a strong positive effect of transference interpretation among female patients with low

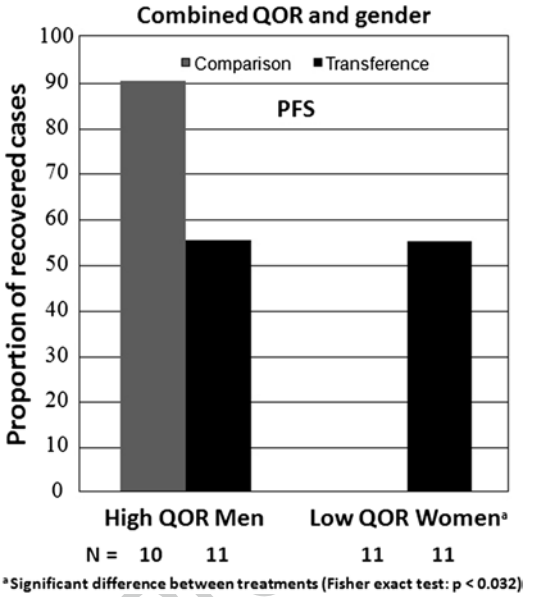

Fig 23.3 No females with low QOR scale scores were recovered (clinically significant change) after therapy without transference work

QOR scale scores appeared, versus a negative effect of transference interpretation for male patients with high QOR scale scores. As can be seen in Fig. 23.3, no females with low QOR scale scores were recovered (clinically significant change) after therapy without transference work.

The findings in FEST seem inconsistent with the findings in earlier naturalistic studies. This may be due to differences in design. In FEST, the level of transference work varied substantially from case to case. When we analyzed the subgroups as done in naturalistic studies, that is, computed within-group correlations between transference interpretations and outcome, we found a significant negative correlation ($r = -0.40$) between level of early transference work and outcome, precisely *within the subgroup of low QOR patients receiving transference interpretations* ($N = 25$), the subgroup that showed a positive response to a moderate level of transference interpretation compared to therapy with no transference interpretation. Within group correlations indicate that high levels of transference interpretations, at least to some patients, may contribute to a negative therapeutic process, or that many transference interpretations are given to "poor prognosis" patients in unsuccessful attempts to overcome resistance, defensiveness, or hostility. Naturalistic studies may not give the "whole picture" and may lead to erroneous conclusions about the effects of transference interpretation [55]. Experimental manipulation of treatment techniques is the only method available, to date, for studying causal effects.

The findings in FEST seem to be partly consistent with a previous quasi-experimental study by Høglend et al. [79]. That study reported a negative effect of a high frequency of transference interpretations (on average six per session) to highly suitable patients, versus a positive effect of a low frequency of transference interpretations (less than one per session) to less suitable patients. There was no comparison group treated without transference interpretation, however.

Mechanisms of Change

The second aim of this study was to determine whether or not long-term changes in interpersonal functioning are mediated [67, 80] through increased insight or through the patient's identification with the therapist (therapist representations).

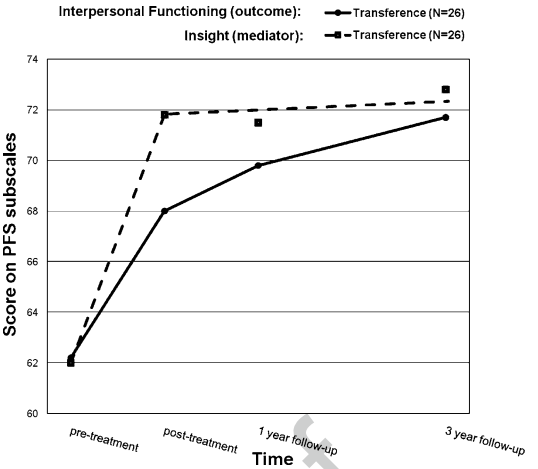

Fig. 23.4 In the subsample of patients with low QOR scale scores that received transference interpretation ($N=26$), insight is improved substantially during treatment, while interpersonal functioning continues to improve over the 3-year follow-up period after treatment termination

Stable dynamic changes after therapy must not be dependent on the therapist's physical presence, but continue because of increased insight or in the form of therapist representations [81]. Representations reflect the patient's identification with the therapist's knowledge, attitudes and behavior [82]. Geller et al. [83] have constructed a self-report instrument for measuring therapist representations, which they have termed The Therapist Representation Inventory. Access to therapist representations makes self-analysis possible [84, 85]. Psychoanalytic theorists emphasize therapeutic dialog through activation of therapist representations in times of crises as an important mediator of long-term changes [80, 86]. Others, such as Blum [87], maintain that "the critical agent of change is insight." Rangell [88] noted that insight is important, but not sufficient. The internalization of the "total relationship" to the therapist may be more important. In our study, both insight measured by clinical evaluators [62] and "therapeutic dialog" measured by five items in the Therapist Representation Inventory (patient self-report) were analyzed as possible mediators of long-term interpersonal functioning.

Insight is defined as cognitive and emotional understanding of the main dynamics of inner conflicts, the related interpersonal patterns and repetitive behaviors, and connection to past experiences. An ability to understand and describe one's own vulnerabilities and strengths is also part of this dimension, see Appendix 23.1.

Therapeutic dialog contains items such as "When I am having a problem, I try to work it out with my therapist in my mind" and "I try to solve my problems in the way my therapist and I worked on them in psychotherapy."

Figure 23.4 illustrates that, in the subsample of patients with low QOR scale scores that received transference interpretation ($N=26$), insight is improved substantially during treatment, while interpersonal functioning continues to improve over the 3-year follow-up period after treatment termination.

Of the 26 patients in the transference group with scores below the mean score on the QOR Scale, 18 (69%) changed more (faster) on the Insight Scale than on the Interpersonal Scales during the 1-year treatment period. During the 1 year after treatment, only eight (32%) of the same patients changed more on the Insight Scale than on the Interpersonal Scales ($\chi^2=8.01$, df = 1, $p=0.005$). In the comparison group, interpersonal functioning and insight changed in closely parallel lines. Insight may have an important function for interpersonal functioning also in the other subgroups of patients, but we could not determine what came first in these groups.

In our opinion, the causal associations between transference interpretation—insight—and outcome bridge the gap between clinical theory and empirical research [89].

Therapeutic Dialog did not change more in the low QOR transference group than in the low QOR comparison group, indicating that internalization of the "total relationship" to the therapist is not a mechanism linking transference interpretation to long-term outcome. Internalization of the "total relationship" to the therapist may be important for improvement after psychotherapy. We could not document, however, that this putative mechanism was a result of transference work.

Case Vignette

A 40-year-old female secretary wanted psychotherapy because of depression and binge eating that developed after her divorce 7 years ago. She had two teenage children and was concerned about her lack of stability in her relationships with men. She was living with her fourth partner. She was diagnosed with depression and eating disorder. She was randomized to psychodynamic psychotherapy with transference interpretation.

She was the youngest of three children with a dominant and verbally aggressive father and a depressive, negative mother who was also an alcoholic. The family had limited ability to verbalize emotions. She was given little understanding by her parents. During childhood, her talent in sports provided self-esteem.

At the time of therapy, she had difficulties in expressing her feelings. When she had disagreements with her partner, instead of being angry or sad, she ate huge amounts of ice cream alternating with a very strict low-calorie diet. She contemplated leaving her partner. The patient hoped psychotherapy could help her to feel more independent.

In the initial phase of the therapy, the patient felt that the therapist was understanding and no disagreement occurred between the two of them. Using transference interpretation, the therapist focused on her dependency needs:

Therapist: In your relationships everything is quiet and peaceful. So I can look forward to the same in our relationship. I can feel safe, there will be no conflicts between us.

Patient: Yes that…uh, that depends. With my sisters…we never have arguments.

Therapist: So you have very little practice in standing up for yourself. Your mother was afraid of conflicts, and you learned to be afraid too. In our relationship you may also get disappointed, withdraw and overeat, as you did with her and others, but you do not get irritated. Have you thought about that? I don't give you the advice or reassurance you have asked for.

Patient: I'm not sure what I can ask of others, like with my children, and wonder what other people would do

Therapist: Can you think what I might have done in your situation?

Patient: If I can think of what you would do? I don't get any answers here.

Therapist: How do you feel about that?

Patient: I don't know.

Therapist: No, but maybe you get disappointed, withdraw or overeat instead of feeling irritated or angry.

As therapy progressed, the patient more often expressed her own point of view:

Therapist: What do you feel about me, leading you onto thin ice so to speak, pointing out that you don't say what you mean?

Patient: I'm not sure how I feel. I see that I suddenly changed and became a bit too opinionated. So why not try something in between?

When asked at treatment termination whether or not she had learned something new about herself, she said that, before therapy, she had not been aware of how much she automatically disavowed her own feelings, especially negative ones. Prior to treatment, she was to some extent aware

of a connection between stress and binge eating. After treatment, she could give a much more detailed account of the associations between specific stressors, negative emotions, and binge eating, and the way this had interfered with her daily life.

At the 3-year follow-up, the patient emphasized that the focus on exploring how she repeated her feelings toward parents in her relationship with the present partner and also toward the therapist had been helpful. She no longer found herself dependent on advice from others, was no longer depressed, and the binge eating had stopped. The relationship with her partner was much improved although she sometimes withdrew after disputes.

Conclusions

What can we conclude from this overview of research that may help us answer the questions posed at the beginning of the chapter?

A mainstream clinical theory in the psychodynamic tradition is supported by empirical research. A moderate use of transference interpretation has specific effects on long-term functioning, mediated by increase in insight during therapy.

However, a high frequency of transference interpretations does not seem to overcome defensiveness, resistance or hostility in "difficult patients." Such patients, many who suffer from severe PD, may experience such interventions as attacks on their defences that they view as needed to protect the self. As a result, excessive transference interpretation may result in a fortification of defences to ward off the perceived attacks. Research suggests that paving the way for transference interpretation with affirmative appreciation of the patient's internal experience may be critical at least for patients with cluster B pathology.

Moderate emphasis on transference work may be particularly useful when treating patients with PD pathology and more severe and chronic difficulties in establishing stable and fulfilling relationships. It is well established that these patients are subject not only to reduced psychological well-being, but also higher overall mortality as shown in a large body of epidemiological research.

Future Research

A lot of research is still needed before we can understand the full impact of transference interpretations and how they work. The presence or absence of transference interpretations, or their frequency, are not by themselves sufficient. The effect of interpretations may be dependent on several characteristics of the interpretations themselves, such as accuracy, i.e., the degree to which an intervention is congruent, accurate or consistent with an independently derived psychodynamic formulation about the patient [14, 90, 91]; and affiliation, i.e., the degree of caring versus hostility communicated to the patient through the intervention [92]; and content, i.e., which dynamic conflict or relationship components are included in the intervention: wishes, defences, anxieties, current others, parental figures, therapist. The depth of interpretation may be seen as one aspect of content [93].

Also, the context in which transference interpretations are offered may be important, such as stage of therapy (initial, middle, late), and the quality of other interventions. Non-interpretive interventions that precede transference interpretation, in addition to those that follow, may carry weight as well [42]. The state of the therapeutic alliance may be important at the time an interpretation is offered. The timing and quality of interventions are probably the most difficult aspect to evaluate, but are probably crucial to how well an interpretation is received and considered by the patient.

Furthermore, the attitude and subjectivity of the therapist and counter-transference reactions may have an impact on the quality of interpretations [40, 94].

To understand more in depth how and why dynamic psychotherapy works, more treatment component studies should have priority. If we can isolate specific components that are most effective, be it specific techniques or common factors, the search for mechanisms (mediators) may be narrowed down from a vast number of putative mechanisms. The study of mechanisms and interaction of mechanisms, such as therapeutic alliance, tolerance for affects, self-esteem, self-efficacy, social avoidance, coping (problem solving capacity), and use of defences, may improve basic knowledge.

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Appendix 23.1

The Insight Scale. This dimension covers cognitive *and* emotional understanding of the main dynamics of inner conflicts, the related interpersonal patterns and repetitive behaviors, and connection to past experiences. Ability to understand and describe own vulnerability, reactions to stress, and coping abilities.

100	Unusual ability to describe genuinely personal wishes, fears, defences, and the related behavior and	t3.1
91	connections to earlier (childhood) experiences. High awareness of own vulnerability, attitudes, and	t3.2
	interpersonal patterns, secondary gains. Open and curious about and reflects on the multiple levels	t3.3
	and meanings of experience. Realistic judgment of self and others	t3.4
90	Can account for inner conflicts, the related problems and repetitive behaviors, and connections to earlier	t3.5
81	experience. Aware of own vulnerability and reactions to stress. A tolerant and realistic sense of self	t3.6
	and others in interpersonal disputes. May feel disillusionment but no bitterness or hopelessness	t3.7
80	Can account for most important inner conflicts, related problems and repetitive behavior patterns, and	t3.8
71	personal attitudes. Connections to earlier experience may partly be forgotten. Aware of own	t3.9
	vulnerability, stress reactions, and coping abilities. May blame self or others too much in interper-	t3.10
	sonal disputes but reflects freely and observes own reactions and learns from it (integration).	t3.11
	Generally curious and tolerant. Realistic expectations about the future	t3.12
70	Recognizes but cannot clearly describe the complex association between past experience, inner conflicts	t3.13
61	and present problems, and repetitive patterns. Reasonably aware of own vulnerability and strength	t3.14
	and reactions to stress. Tendency to blame self or others too much in disputes. Occasionally, behavior	t3.15
	and attitude may be unrecognized, but reflects and observes self in other areas	t3.16
60	Understanding of inner conflicts and associations to past and present experience and behavior is	t3.17
51	somewhat unclear, or less emotionally integrated, or "learned." Inadequate judgment of self and	t3.18
	others but ability to observe and reflect with time. Vulnerability and stress reactions sometimes a	t3.19
	surprise. Some defensive, unrecognized attitudes and behaviors. Rigid views of rights and wrongs.	t3.20
	May look for superficial solutions. Recognizes symptoms as sign of disturbance	t3.21
50	Superficial "learned" or misleading ideas of inner conflicts and past and present experience. Distortions	t3.22
41	of judgment of self versus others also when no disputes. Painful feelings accompanied by harsh	t3.23
	self-blame or incorrectly ascribed to external factors. Little or no reflection on personal motives,	t3.24
	unaware of important aspects of attitudes and behaviors (fundamentalism). May deny symptoms as	t3.25
	sign of disturbance. Excessive pessimism or optimism	t3.26
40	Does not recognize associations between behavior and internal dynamic components. Severely distorted	t3.27
31	perceptions/judgment of self or others. Disavows painful personal reactions. Can describe internal	t3.28
	experiences but in a stereotyped, confusing, or misleading way. Denies signs of mental disturbance	t3.29
30	Great difficulty describing internal experiences. Does not acknowledge associations between internal	t3.30
21	experiences and own behavior. Severe distortions/delusional ideas may be present	t3.31
20	Disorganized or fragmented mental functioning. Breakdown of reality testing. Need outside assistance	t3.32
11		t3.33
10	Continuously disorganized in need of constant assistance for days	t3.34

Author Query

Chapter No.: 23 0001331403

Queries	Details Required	Author's Response
AU1	Please update Ref. [89].	