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Effects of Transference Work in the Context of Therapeutic Alliance and Quality of Object Relations

Per Høglend and Anne Grete Hersoug
University of Oslo

Kjell-Petter Bøgwald
Diakonhjemmet Hospital

Svein Amlo
Vestre Viken Hospital

Alice Marble
University of Oslo

Øystein Sørbye and Jan Ivar Røssberg
Ullevål University Hospital

Randi Ulberg
Vestfold Mental Health Care Trust

Glen O. Gabbard
Baylor Psychiatric Clinic

Paul Crits-Christoph
Center for Psychotherapy Research

Objective: Transference interpretation is considered as a core active ingredient in dynamic psychotherapy. In common clinical theory, it is maintained that more mature relationships, as well as a strong therapeutic alliance, may be prerequisites for successful transference work. In this study, the interaction between quality of object relations, transference interpretation, and alliance is estimated. ***Method:*** One hundred outpatients seeking psychotherapy for depression, anxiety, and personality disorders were randomly assigned to 1 year of weekly sessions of dynamic psychotherapy with transference interpretation or to the same type and duration of treatment, but without the use of transference interpretation. Quality of Object Relations (QOR)–lifelong pattern was evaluated before treatment (P. Høglend, 1994). The Working Alliance Inventory (A. O. Horvath & L. S. Greenberg, 1989; T. J. Tracey & A. M. Kokotovic, 1989) was rated in Session 7. The primary outcome variable was the Psychodynamic Functioning Scales (P. Høglend et al., 2000), measured at pretreatment, posttreatment, and 1 year after treatment termination. ***Results:*** A significant Treatment Group × Quality of Object Relations × Alliance interaction was present, indicating that alliance had a significantly different impact on effects of transference interpretation, depending on the level of QOR. The impact of transference interpretation on psychodynamic functioning was more positive within the context of a weak therapeutic alliance for patients with low quality of object relations. For patients with more mature object relations and high alliance, the authors observed a negative effect of transference work. ***Conclusion:*** The specific effects of transference work was influenced by the interaction of object relations and alliance, but in the direct opposite direction of what is generally maintained in mainstream clinical theory.

Keywords: quality of object relations, transference interpretation, alliance, outcome

In the psychotherapy clinical and research literature in general, the role of unspecific factors (e.g., the alliance) versus technique factors (e.g., transference interpretation) in producing change continues to be a source of controversy (Barber, 2009; Beutler & Kendall, 1995; Crits-Christoph & Connolly, 1999; Weinberger, 1995). In the research literature, all too often these components have been pitted against one another, fostering the idea that it is either technique or alliance that is most responsible for change (Barber, 2009; Goldfried & Davila, 2005). There are only a few studies exploring alliance and technique within the same study,

Per Høglend, Anne Grete Hersoug, and Alice Marble, Department of Psychiatry, University of Oslo, Norway; Kjell-Petter Bøgwald, Department of Research and Education, Diakonhjemmet Hospital, Oslo, Norway; Svein Amlo, Vestre Viken Hospital, Akershus, Norway; Øystein Sørbye, Child and Adolescent Mental Health Clinic, Ullevål University Hospital, University of Oslo, Norway; Jan Ivar Røssberg, Department of Psychiatry, Ullevål University Hospital, University of Oslo; Randi Ulberg, Vestfold Mental Health Care Trust, Tønsberg, Norway; Glen O. Gabbard, Baylor Psychiatric Clinic; Paul Crits-Christoph, Center for Psychotherapy Research, Philadelphia, PA.

The first author is the principal investigator. An independent statistician, Joseph Sexton, Department of Biostatistics, University of Oslo, has supervised data analyses and has given valuable statistical advice. Trial registry name: First Experimental Study of Transference-interpretation (FEST307/95). Registration number: NCT00423462 URL: https://register.clinicaltrials.gov

Correspondence concerning this article should be addressed to Per Høglend, Department of Psychiatry, Vinderen, University of Oslo, P.O. Box 85, Vinderen, N-0319 Oslo, Norway. E-mail: p.a.hoglend@medisin.uio.no

and even fewer actually studying the interaction of technique and alliance.

Transference has been a core concept in dynamic psychotherapy for over a century (Freud, 1905/1953). Freud originally regarded transference as a living reconstruction of the patient's repressed historical past "transferred" onto the relationship with the therapist. Later theorists have questioned the notion of transference as a pure enactment of early relationships and emphasized how transference is partly a new experience (Cooper, 1987). Dynamic psychotherapy is interpersonal in nature, and the transference is also influenced by the therapist. Additional concepts such as the therapeutic alliance and the real relationship with the therapist may be needed to account for the patient's reactions to the therapist (Ehrenreich, 1989; Gabbard & Westen, 2003). More recently, clinical theorists and researchers have relied on broader definitions of transference and transference interpretation that are more experience near. In this study, we define *transference work* as all therapist interventions with explicit linking to the patient–therapist interaction (Høglend, 1993b; Piper, Azim, Joyce, & McCallum, 1991). Influential theorists maintain that the ongoing interaction between patient and psychotherapist is influenced by the patient's past or current relationships and affective experiences. Therefore, focusing on the themes and conflicts that arise in the therapeutic relationship will have immediate affective resonance and illuminate the true nature of problems in the patient's relationships outside of therapy (Kernberg, Diamond, Yeomans, Clarkin, & Levy, 2008; Strachey, 1934). Focus on transference can enable the patient (and therapist) to distinguish what is real in the therapeutic relationship from what are enactments influenced by earlier experiences. Analysis of transference may increase insight regarding intrapsychic conflicts and problematic relations, which may in turn lead to better adaptive and interpersonal functioning (Gabbard & Westen, 2003; McGlashan & Miller, 1982; Messer & McWilliams, 2007; Strachey, 1934).

As psychoanalytic thinking has broadened to include more relational perspectives, the importance of the alliance has increased substantially (Messer & Warren, 1995). Most contemporary models of exploratory dynamic psychotherapy suggest that the effects of specific techniques are dependent on a positive therapeutic alliance (Crits-Christoph & Barber, 1991; Luborsky, 1984; Malan, 1976; Strupp & Binder, 1984). The term *working alliance* was introduced by Greenson (1965), who emphasized the patient's capacity to work purposefully in the treatment situation. Bordin (1976) proposed a pantheoretical conceptualization of working alliance that incorporated a mutual understanding of the purpose of therapy (goal); agreement on how to work together toward the goal (task); and the patient's personal liking, trusting, and valuing of the therapist (bond) (Bordin, 1976; Gabbard et al., 1994; Horvath & Greenberg, 1986, 1989).

Several studies have included both technique and alliance variables, but without actually studying the interaction of alliance and technique (Barber, Crits-Christoph, & Luborsky, 1996; Marmar, Gaston, Gallagher, & Thompson, 1989; Ogrodniczuk, Piper, Joyce, & McCallum, 2000; Piper, McCallum, Azim, & Joyce, 1993; Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007).

Other studies that did examine interactions between the alliance and techniques have yielded mixed results. Crits-Christoph, Cooper, and Luborsky (1988) failed to find a significant interaction between accuracy of interpretation and the alliance in the prediction of outcome of moderate length dynamic therapy. Svartberg and Stiles (1994) reported no interaction of alliance and competently delivered interventions in short-term dynamic psychotherapy. Similarly, Gaston, Piper, Debbane, Bienvenu, and Garant (1994) reported no significant interaction between working and therapeutic alliance and exploratory technique in short-term therapy. In long-term therapy, however, the interaction of working alliance and exploratory interventions significantly predicted both symptoms and interpersonal problems at termination. These interactions were in the direction of better outcome associated with the use of exploratory interventions in the context of a good alliance. However, the sample size in the study was small ($N = 15$ in long-term therapy). In another study, Gaston, Thompson, Gallagher, Cournoyer, and Gagnon (1998) found that in Session 10, exploratory interventions provided in the context of better alliances tended to be associated with lower depression at termination. However, Gaston et al. (1998) also reported that in behavior therapy and cognitive therapy, more exploratory interventions worked best in the context of poorer alliance. Barber et al. (2006) reported that high adherence to the techniques of drug counseling worked best when the alliance was weak.

Patient characteristics are important to consider as moderating factors in the relationship between transference interpretations and outcome. Luborsky (1984) recommended that exploratory-interpretive work in psychodynamic therapy (including transference interpretation) should be emphasized with patients who have good ego strength, anxiety tolerance, and a capacity for reflection about their interpersonal relationships, whereas supportive (alliance-building) techniques should be emphasized with patients who lack these capacities.

Earlier naturalistic studies have indicated that the frequency of transference interpretations has a nonsignificant, or a negative correlation with treatment outcome (Høglend, 2004). Several of these studies have examined when the impact of the use of transference interpretations on outcome is moderated by patient "quality of object relations" (QOR) or interpersonal functioning. In short-term interpretative psychotherapy, Piper et al. (1991) found an inverse relationship between high levels of transference interpretations and outcome for patients who were characterized by high QOR. Høglend (1993b) also found that frequency of transference interpretations was inversely related to better outcome for patients with high QOR. However, two other studies (Connolly et al., 1999; Ogrodniczuk, Piper, Joyce, & McCallum, 1999) reported that patients with relatively poorer interpersonal functioning had a less favorable outcome when transference interpretations were used more frequently.

Although some of the above studies are suggestive of an interaction between alliance and techniques, and quality of object relations and techniques, none of the studies explored the three-way interaction of transference work, alliance, and object relations. Furthermore, none of the studies used an experimental dismantling design. As Stiles and Shapiro (1994) have argued, correlational studies attempting to link levels of process components to outcome can be problematic. To the extent that therapists actually respond to patient needs and requirements, process–outcome correlations can be misleading. The therapeutic alliance may change directly as a consequence of technique (Foreman & Marmar, 1985), and/or the use of interpretations may be influenced by the strengths of the

alliance (Marmar, Weiss, & Gaston, 1989). Crits-Christoph and Connolly (1999) and Webb, DeRubeis, and Barber (2010) suggest that more studies of the interaction of alliance and techniques using experimental designs are needed. Ideally, one process component should be experimentally manipulated (e.g., high rates of transference interpretation vs. low rates), whereas all others are held constant, and patients are randomly assigned. Such rigorously designed studies might help in establishing causal connections. Crits-Christoph and Connolly (1999) add that several factors such as initial health or quality of object relations, the alliance, techniques, and improvement over time should be examined within the same study. Sample sizes larger than those used to date, in this area, would be needed to provide strong tests of hypotheses and to explore possible three-way interactions.

Høglend et al. (2006) reported the results of a study using a randomized experimental design. This study was the first dismantling, randomized clinical trial to test the long-term effects of transference interpretation. One hundred patients were randomized to 1-year dynamic psychotherapy with a moderate level of transference work or to the same type of therapy without use of transference work. There was no overall effect of transference work. However, patients with low QOR benefited significantly more from therapy with transference interpretation than without (Høglend et al., 2006). This effect was sustained during a follow-up period (Høglend et al., 2008). Patients with mature relationships and greater psychological resources benefited equally well from both treatments.

The goal of the present article was to further clarify these findings by examining the interaction between quality of object relations, transference work, and therapeutic alliance in relation to treatment outcome over time. Specifically, our aim was to examine whether or not the association between alliance and the specific effects of transference work changed as a function of different levels of QOR. Our focus in particular was how these interactions relate to change in psychodynamic functioning, over the 2-year study period. On the basis of the clinical literature and the limited research, our hypothesis was that the effects of transference interpretations on outcome will increase with stronger alliance. Moreover, for the typical patient with low QOR, we hypothesized that the effect of transference work would be stronger in the context of a high alliance, but for patients with more mature relationships, alliance might be less important.

Method

Patients

From 1994 to 2001, 122 patients were referred to the study therapists by primary care physicians, private specialist practitioners, and public outpatient departments. These patients sought psychotherapy due to depressive disorders, anxiety disorders, personality disorders, and interpersonal problems. The study therapists assessed the patients for eligibility. Patients with psychosis, bipolar illness, organic mental disorder, or substance abuse were excluded. Patients with mental health problems that caused long-term inability to work (>2 years) were also excluded. Written informed consent was obtained from each of the 100 participants included in the study.

Treatment Conditions and Therapists

The Regional Ethics Committee, Health-region 1, Norway, approved the study protocol. Patients were allocated by simple randomization, without stratification, to two treatment groups after completion of the pretreatment ratings. Only the patients' therapist learned the result of the random assignment procedure. The random assignment code was kept on a separate computer, which belonged to our research assistant. The other clinicians remained blind to the patient's treatment group. Fifty-two patients were assigned to dynamic psychotherapy with low to moderate use of transference work (transference group). Forty-eight patients were assigned to dynamic psychotherapy of the same kind but without transference work (comparison group).

Patients were assigned to one of seven therapists based on availability. The clinical research team consisted of six psychiatrists and one clinical psychologist, all of whom had 10–25 years of experience in practicing psychodynamic psychotherapy. Four were fully trained psychoanalysts. Each therapist treated from 10 to 17 patients in the study. All therapists treated patients from both groups. The patients were offered 45-min sessions weekly for up to 1 year. All sessions were audio recorded. Treatment manuals were used for both treatment conditions (Høglend, 1990). Manuals in dynamic psychotherapy are manuals of principles, not step-by-step procedures. Our treatment model was based on general psychodynamic treatment techniques, such as focus on affects, exploration of warded off material, focus on current relationships, past relationships and the therapeutic relationship, interpretations of wishes, needs and motives, and the principles outlined by Malan and Ferruccio (1992) and Sifneos (1992). In the pilot phase of the study, the therapists were trained for up to 4 years to enable them to provide treatment with a low to moderate level of transference work and treatment without such interventions with equal ease and mastery.

Transference work included the following specific techniques: (a) The therapist was to address transactions in the patient–therapist relationship; (b) the therapist was to encourage exploration of thoughts and feelings about the therapy and therapist including repercussions on the transference by high therapist activity; (c) the therapist was to encourage the patient to discuss how he or she believed the therapist might feel or think about him or her; (d) the therapist was to include himself or herself explicitly in interpretive linking of dynamic elements (conflicts), direct manifestations of transference, and also allusions to the transference; and (e) the therapist was to interpret repetitive interpersonal patterns (including genetic interpretations) and link these patterns to transactions between the patient and the therapist. The first three techniques are not interpretations per se, but preparatory interventions. In contrast, in the comparison group, the therapist consistently focused on interpersonal relationships outside of therapy as the basis for similar interventions (extratransference work) and did not link these patterns to the interaction between the patient and the therapist. For both treatment groups, psychotherapy was exploratory in nature: Patients were encouraged to explore sensitive topics that often involved uncomfortable emotions, and the therapist abstained from giving advice, praise, or reassurance. The small to moderate level of transference interventions recommended in the treatment manual was based on 10 previous studies. The level of transference interpretation in those studies varied from 1 to 6, on

average per session (Høglend, 2004). The patients were not informed about which technique was used or the study hypotheses. They were told that the aim of this study was to explore the long-term efficacy of psychodynamic psychotherapy. Treatment completers were patients who terminated treatment in agreement with the therapist.

Treatment Fidelity

Treatment fidelity was assessed by three blind, independent raters, using a manual for process ratings (Høglend, 1994). The raters, two psychiatrists and one psychologist, had 15–30 years of clinical experience as dynamic psychotherapists. Two of them were fully trained psychoanalysts. The training period for the raters included 15 full sessions from each treatment group. A global rating method was used rather than rating the exact frequency of different interventions. The frequency of a certain intervention does not necessarily give a valid measure of how important this type of intervention was in a given session. Both how clearly an intervention is offered and how much it is emphasized should be given weight in the rating process. All items in the manual therefore use a 5-point Likert scale ranging from 0 (*not at all used*), 2 (*moderately used*), to 4 (*very much used*). Four or five full sessions of each therapy (452 sessions total) were rated by two of the raters. Using average scores of the two raters, the reliability estimates (intraclass correlation [ICC]) was above .70 for all items. Treatment integrity was excellent (Bøgwald, Høglend, & Sørbye, 1999; Høglend et al., 2006, 2008). The only difference between the two treatments was use of the specific transference interventions. The average score across the five specific interventions was 1.7 ($SD = 0.7$) in the transference group, indicating moderate use of transference work, and 0.1 ($SD = 0.2$) in the comparison group, indicating nearly no use at all, $t(58.2) = 14.8$, $p < .005$. The average use of supportive interventions was low and equal in the two treatment groups. The therapists' skill in delivering the interventions was high and equal in the two treatment groups.

Assessments

Before randomization, each patient had a 2-hr semistructured psychodynamic interview, modified from Sifneos (1992) and Malan and Ferruccio (1992), with an independent evaluator. The interview was audio recorded, and also two other clinicians rated the interview using the Quality of Object Relations Scale (QOR; Høglend, 1993a; Piper et al., 1993), motivation for active change and self-understanding (Høglend, 1994), and the Psychodynamic Functioning Scales (PFS; Høglend et al., 2000). The PFS was also used at treatment termination and at follow-up 1 year after treatment termination. The raters were independent (i.e., not the patient's therapist) and blind with regard to treatment group. No structured interview was used in this study to determine Axis I diagnoses. These diagnoses were based on the clinical history and assessment of background variables by the patient's therapist. Diagnoses according to the *Diagnostic and Statistical Manual of Mental Disorders*, third edition revised (DSM–III–R; American Psychiatric Association, 1987) criteria were discussed before randomization until consensus was reached (Spitzer, 1983). Axis II diagnoses were determined before the start of therapy by the patient's therapist, using the Structured Clinical interview for DSM-III-R (SCID-II; Spitzer, Williams, Gibbon, & First, 1990). All therapists were trained to use SCID-II. The patient filled in an expectancy measure (Battle, Imber, Hoehn-Saric, Nash, & Frank, 1966).

Outcome Measure

Change on the PFS from baseline to 1 year after treatment termination was the primary outcome measure in this study, chosen a priori. Six scales are used in the PFS, with the same format as the Global Assessment of Functioning (American Psychiatric Association, 1987), 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. Interrater reliability (ICC) for the average scores of three raters on PFS was 0.91. 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 (Bøgwald & Dahlbender, 2004; Hagtvet & Høglend, 2008; Hersoug, 2004; Høglend, 2004; Høglend et al., 2000).

Moderator

The primary putative moderator, QOR, was chosen a priori. The most common definition of object relations in the literature appears to be an individual's representations of self and other, and affect associated with these representations. This leads to relatively stable patterns of interpersonal functioning (Huprich & Greenberg, 2003). QOR is the best studied predictor or moderator of treatment response and seems to offer better utility than conventional diagnostic categories in predicting outcome (Connolly et al., 1999; Høglend, 1993b; Høglend et al., 2006, 2008; Piper et al., 1991). QOR was measured on three 8-point scales: Evidence of at Least one Stable and Mutual Interpersonal Relationship in the Patient's Life, History of Adult Sexual Relationships, and History of Nonsexual Adult Relationships (Høglend, 1994; Høglend, 1993a; Piper et al., 1993). QOR measure the patient's lifelong tendency to establish relationships with others, ranging from mature to primitive, using the average of the three scales. Higher QOR Scale scores indicate evidence of at least one stable and mutual interpersonal relationship in the patient's history. Lower scores indicate a lifelong history of less gratifying relationships characterized by less stability, less emotional investment, and need for dependency or overcontrol. Interrater reliability (ICC) for the average QOR scores of three raters was 0.84. The mean score in the sample was 5.1 ($SD = 0.8$; range = 2.6–7.3). Sixty percent of the patients with QOR Scale scores below mean had one or more personality disorders in this study.

The Working Alliance Inventory, short form, with 12 items (WAI-S; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989), is the most widely used measure of alliance in psychotherapy research and captures Bordin's three aspects of alliance: task, goal, and bond (Bordin, 1976). The WAI was reported by patients in Session 7, which is assumed to more clearly represent the actual collaborative process between the patient and the therapist than alliance in the very first sessions, which may reflect mainly the

bond aspect of alliance. We assume that alliance is a relatively stable aspect of the therapy process, as is usually reported in the research literature (Horvath & Symonds, 1991). Total scores of the WAI were used. Cronbach's alpha was 0.76. The mean score in the study sample was high: 5.2 at Session 7 ($SD = 0.7$; range = 3.4–6.6).

Motivation for active change and self-understanding (Høglend, 1994) was rated by at least three clinicians, using four 8-point scales. Interrater reliability (ICC) of average scores was 0.77. The patients' own target objectives for therapy were formulated and scored using the method developed by Battle et al. (1966). Prior to treatment, the patients formulated their main target objectives for therapy and the expected improvement for this. Target Expectancy was rated on a 12- point Likert scale ranging from 1 (*deteriorate*) to 12 (*disappear totally*).

Statistical Analysis

One outlier in the transference group was deleted from analyses of longitudinal data as it became clear during treatment that this patient had been abusing sedatives and painkillers over many years. Including this case also significantly worsened goodness-of-fit measures (change in −2 log likelihood).

Longitudinal analyses were performed on 99 patients. Linear mixed models were used to analyze longitudinal data (SPSS version 16.0). "Subject" was treated as a random effect. That is, randomly distributed intercepts and slopes were fitted for each patient. The highest rate of improvement was during therapy, with diminishing returns over time following the end of therapy. Time was coded 1, 3, and 5, with one step for each (1/2) year, and transformed to a natural logarithm. Time at baseline thereby became 0. The log transformation of time fit the data discernibly better than a linear time slope (change in −2 log likelihood). Intercept and time were treated as both random and fixed effects, whereas treatment group (coded 1, 0) was treated as a fixed effect. A variance component covariance matrix yielded the best goodness-of-fit measures.

In order to test the possible combined, interactive influence of QOR and WAI on the effect of transference work, the following composite model equation was used:

$$\begin{aligned} Y_{ij} = {} & B_0 + B_1 TIME_{ij} + B_2\,(TIME_{ij} \times TREATMENT_i) \\ & + B_3 QOR_i + B_4\,(QOR_i \times TIME_{ij}) + B_5\,(QOR_i \\ & \times TIME_{ij} \times TREATMENT_i) + B_6\,WAI_i \\ & + B_7\,(TIME_{ij} \times WAI_i) + B_8\,(WAI_i \times TIME_{ij} \\ & \times TREATMENT_i) + B_9\,(QOR_i \times WAI_i \times TIME_{ij} \\ & \times TREATMENT_i) + [\zeta_{oi} + \zeta_{1i} TIME_{ij} + \varepsilon_{ij}]. \end{aligned}$$

Y_{ij} is change of PFS over the 2-year study period. $B_0 - B_9$ are the fixed effects, and $\zeta_{oi} + \zeta_{1i} TIME_{ij} + \varepsilon_{ij}]$ are random intercept, random time, and error term, respectively. By design, treatment group means were equal at baseline. The statistical model forces both treatments to have a common intercept. This model is more powerful and is routinely recommended for analysis of randomized clinical trials (Fitzmaurice, Laird, & Ware, 2004; Kenny et al., 2004).

QOR and WAI were centered at their overall mean values. The relevant parameters are B_2, the treatment effect (difference in slopes between the two treatment groups) for the typical patient in the sample. B_5 (QOR × Time × Treatment) indicates how that treatment effect changes for the patients with typical (average) WAI as a function of QOR. B_8 (WAI × Time × Treatment) indicates how the treatment effect changes for the patients with typical QOR as a function of WAI. B_9 tests whether the interaction of QOR and WAI influence the treatment effect—or put differently, whether the association between WAI and the treatment effect changes as a function of different levels of QOR. No statistical analyses were done on subgroups of patients. The full sample of patients ($N = 99$) was used in all analyses.

Effect sizes (converted to Cohen's *d*), derived from the *F* test for mixed effects model, were calculated as $d = 2\sqrt{\frac{F}{df}}$, where *F* is the *F* test statistic for the effect of interest in the repeated model as well as other multilevel designs (Rosenthal & Rosnow, 1991; Verbeke & Molenberg, 2000).

Results

Figure 1 shows the flow of patients in the study. Five patients, all of them in the comparison group, dropped out of therapy before Session 16. Only two of them dropped out before Session 9. The mean (and *SD*) number of sessions was 34 (6.1) for the transference group, and 33 (6.6) for the comparison group. We could detect no significant differences in patient characteristics between the two treatment groups at baseline (see Table 1).

In the whole study sample, there was no overall difference in long-term outcomes between the two treatments (Høglend et al., 2008). The mean WAI in the transference group was 5.2 ($SD = 0.7$) and 5.1 ($SD = 0.7$) in the comparison group. QOR and treatment group were uncorrelated ($r = -.03$). WAI and treatment group were uncorrelated ($r = .05$), and QOR and WAI were also uncorrelated ($r = -.12$). Within the transference group ($n = 51$), we could not detect any associations between the amount of transference work in early, middle, or late sessions, and WAI in Session 7. The correlations were .02, .08, and .07, respectively. This indicates that the level of WAI was not influenced by the amount of transference work, or vice versa, that WAI did not influence the amount of transference work over treatment.

B_2 (Time × Treatment), the treatment effect for the typical patient in the sample, was not significant ($B_5 = .47$), $F(1, 81) = 0.7$, $p = .40$. The effect size was .20 (small). The moderator term B_5 (Time × Treatment × QOR) indicated that the differences in slopes for treatment and control group (the treatment effect) for patients with typical WAI increased with lower levels of the QOR Scale ($B_5 = -1.9$), $F(1, 81) = 5.8$, $p = .02$. The effect size of this term was .54 (moderate). B_8 (Time × Treatment × WAI) indicated that the treatment effect for patients with typical QOR changed in a negative direction as a function of higher WAI scores, but not to a significant degree ($B_8 = -1.3$), $F(1, 81) = 2.7$, $p = .10$. The effect size was, however, not negligible: .37 (small to moderate). The interaction term B_9 (Time × Treatment × QOR × WAI) indicates how nonadditive the effects B_5 and B_8 are. The association between WAI and the effects of transference work varied significantly, depending on level of QOR ($B_9 = -1.7$), $F(1,$

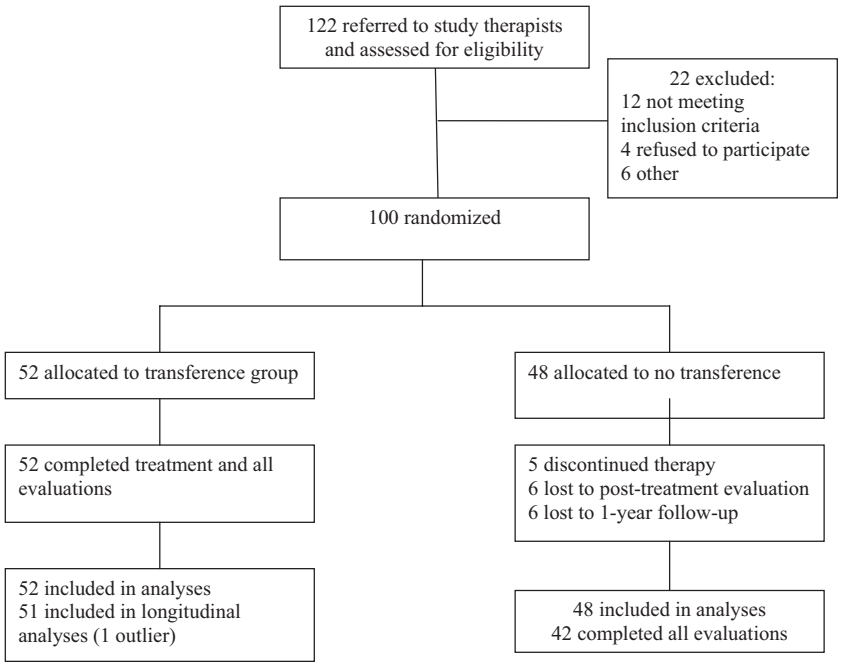

Figure 1. Patient flow in the randomized clinical trial.

81) = 4.8, $p = .03$. The effect size for this interaction term was .49 (moderate).

The term B_7 (Time × WAI) was significant ($B_7 = 1.7$), $F(1, 97) = 8.3$, $p = .005$. This reflects that WAI predicts overall outcome (across treatment groups), as generally reported in the literature. Overall outcome is not the specific effect of transference work.

To assess the potential effect of dropouts in the comparison group, we included treatment completion status by time in the statistical model. This did not change the results.

In order to illustrate our findings, especially what the three-way interaction (B_9) means, we computed the specific treatment effect: B2 + B5QOR + B8WAI + B9QOR × WAI, for patients with different pairs of values on QOR and WAI. The treatment effects computed are estimated unstandardized mean differences in slopes between the two treatment groups for hypothetical patients with the same pair of values on QOR and WAI, for various values of QOR and WAI. Figure 2 shows that the association between WAI and the specific treatment effect changes in a negative direction as a function of higher QOR Scale scores. For patients with a typical (median) WAI score (WAI = 5.1), the treatment effect is positive for patients with QOR Scale scores below median (QOR = 5.2). For patients with typical QOR Scale scores, the association between WAI and the treatment effect is negative.

Discussion

Contrary to our hypothesis and common clinical wisdom, transference work had the strongest specific effect for patients with low QOR Scale scores within the context of weaker alliance (low WAI). For patients with a high alliance score and high QOR Scale scores, the specific effect of transference work was negative. Unexpectedly, patients with more mature relationships and the ability to form a favorable alliance with the therapist did relatively better in the treatment that had no transference interpretations compared with the treatment that had transference interpretations. The conventional clinical wisdom in predicting psychotherapy outcome has been that patients with greater psychological resources and more mature relationships will benefit from transference interpretation (Gabbard, 2006; Sifneos, 1992). However, this study indicates that transference work is crucial when treating patients with more severe and chronic difficulties in establishing stable and fulfilling relationships outside therapy and also difficulties in establishing a favorable alliance within therapy. Transference work may be helpful to the more disturbed patients' understanding of the distortions they bring to the transference, such as fear of rejection, avoidance, dependency, need for overcontrol, and devaluation/idealization (Gabbard, 2006). If the therapist does not address this, the patient may easily feel less understood and less contained by the therapy, leading to deterioration in an already weak alliance (Safran & Muran, 2000).

Although contrary to clinical wisdom, at least within the psychodynamic tradition, our findings are consistent with experimental clinical research in medicine and psychiatry. From as early as 1950, researchers conducting randomized clinical trials for a wide range of medical and psychiatric conditions have observed that patients with more serious disturbances showed greater specific effects from active treatments (Elkin et al., 1989; Fisher, Lipman, Uhlenhuth, Rickels, & Park, 1965; Fournier et al., 2010).

We used an experimental dismantling design in our study. The association between transference work and outcome can therefore be interpreted as a causal relation. However, the level of alliance cannot be experimentally manipulated. Alliance might be dependent on technique, or techniques might be adjusted in response to the level of alliance. However, we found that the average level of

Table 1
Pretreatment Characteristics of 100 Patients Receiving 1 Year of Dynamic Psychotherapy With or Without Transference Interpretation

Characteristic	Transference (n = 52)	Comparison (n = 48)	Total (N = 100)
	M (*SD*)	*M* (*SD*)	*M* (*SD*)
Age	37.8 (8.7)	35.9 (9.9)	36.9 (9.3)
Education (years)[a]	15.0 (2.4)	15.0 (2.5)	15.0 (2.5)
Expectancy[b]	8.2 (2.2)	8.4 (2.4)	8.3 (2.3)
Motivation[c]	5.4 (0.6)	5.4 (0.6)	5.4 (0.6)
QOR[d]	5.1 (0.8)	5.1 (0.8)	5.1 (0.8)
PFS[e]	63.0 (4.6)	63.3 (5.2)	63.2 (4.8)
	n (%)	*n* (%)	*N*
Female sex	26 (50)	30 (63)	56
Single marital status	20 (38)	26 (54)	46
Employed	42 (81)	35 (73)	77
Axis I diagnosis			
Depressive disorders	29 (56)	29 (60)	58
Anxiety disorders	19 (37)	15 (31)	34
Adjustment reaction	2 (4)	3 (6)	5
Other	7 (13)	7 (15)	14
No Axis I diagnosis	9 (17)	9 (19)	18
Axis II diagnosis			
General criteria PD[f]	23 (44)	23 (48)	46
Avoidant	6 (12)	5 (10)	11
Dependent	1 (2)	1 (2)	2
Obsessive compulsive	5 (10)	5 (10)	10
Passive aggressive	2 (4)	1 (2)	3
Paranoid	3 (6)	0 (0)	3
Histrionic	1 (2)	1 (2)	2
Narcissistic	2 (4)	1 (2)	3
Borderline	1 (2)	2 (4)	3
Personality disorder not otherwise specified	8 (15)	10 (21)	18
Depressive	3 (6)	5 (10)	8
Antisocial	1 (2)	0 (0)	1
More than one PD	10 (19)	9 (19)	19
Axis III diagnosis (somatic disorders)	6 (12)	5 (10)	11

Note. QOR = Quality of Object Relations; PFS = Psychodynamic Functioning Scale; PD = personality disorder.
[a] Formal education. [b] Target Expectancy (1–12). [c] Motivation for active change and self-understanding. [d] Quality of Object Relations—life-long pattern. [e] Psychodynamic Functioning Scales. [f] General criteria for any personality disorder.

transference work in early, middle, and late sessions was not associated with alliance. The correlations were very small or zero. The alliance might also be a function of early improvement in therapy. More frequently, measurement of psychodynamic outcomes would be needed to unravel the causal connections between clinical improvement, alliance, and outcomes at posttherapy and follow-up.

The relative advantage of dynamic psychotherapy without transference interpretations, compared with that with transference interpretations, for patients with greater capacity for mature relationships and a high alliance with the therapist is surprising. However, a long-standing admonition that stems from Freud's work is that one should not interpret transference until it becomes a resistance (Gabbard, 2010). When a high alliance exists, there may be minimal resistance. Hence, a therapist who is overly zealous in interpreting transference may appear to the patient to be narcissistically and needlessly focusing the patient's attention on the therapist. Resourceful patients with a positive alliance may feel that they have only minimal problems with the therapist so that the interpretation of transference is experienced as jarring or strange. One may also speculate that patients who habitually establish mutual relationships with others present more subtle transference cues, thus leading therapists to base transference interpretation more on inference than on sufficient evidence. Such interventions in the absence of concrete evidence may result in increased resistance. On the other hand, the "spontaneous" transferences of patients with low QORs may take on a "dependent " or "pathological" form that is more suitable for transference work. It should be noted, however, that patients in the transference interpretation treatment with high QOR and high alliance improved considerably on psychodynamic functioning from baseline to posttherapy and follow-up. Thus, it is not the case that these patients who receive transference interpretation do poorly in psychodynamic therapy. The data here, however, suggest that such patients have particularly good outcomes in the context of a treatment without transference work.

Regardless of the explanation for our results, the findings presented here indicate that the relationships between therapist technique (transference work), patient characteristics (QOR), therapy process (alliance), and outcome are complex. Examination of any one of these variables in isolation from the others may provide a misleading understanding of their role in relation to outcome. The

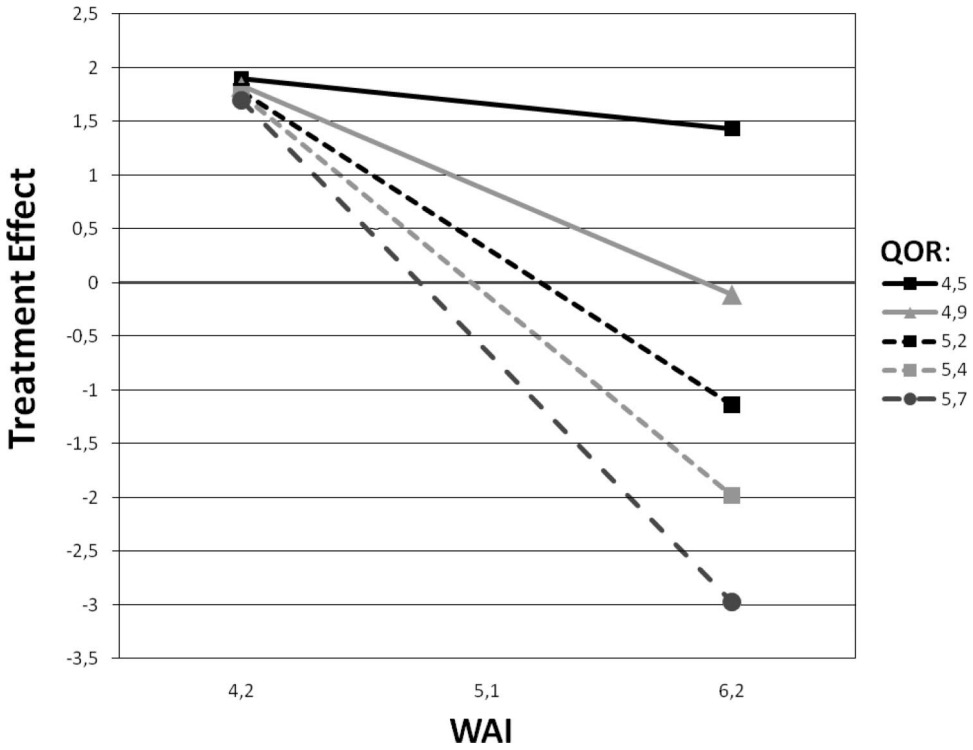

Figure 2. The association between WAI (Working Alliance Inventory) and the specific effects of transference work for patients with different QOR (Quality of Object Relations) Scale scores. The treatment effects are estimated unstandardized mean differences in slopes between the two treatment groups for hypothetical patients with the same pair of values on QOR and WAI, for different values of QOR and WAI. WAI on the *x*-axis between 10th and 90th percentiles. Selected values of QOR for the lines in the figure are the 20th, 40th, 50th, 60th, and 80th percentiles.

presence of a three-way interaction between technique, alliance, and a patient characteristic may explain why some previous studies that have attempted to examine only two of these factors failed to find two-way interactions (e.g., Crits-Christoph et al., 1988; Svartberg & Stiles, 1994). Lack of statistical power to detect interactions may also have hampered previous studies. Findings from the present study indicate that larger sample sizes than typically used in many psychotherapy process-outcome studies may be needed to adequately test the complex interacting relationships among key clinical concepts.

Several limitations of this research are important to note. Because our aim was not to study treatment of specific disorders, the extent to which the findings of the study are relatively specific to certain disorders and not others is not known. However, the treatments studied do not target specific psychiatric disorders. The wide variety of diagnoses in this sample may in fact increase generalizability to patients seeking outpatient psychotherapy. A second limitation is that the alliance was only measured at a single session.

For high-QOR patients, therapists were clearly in favor of using transference work with 65% of the patients. For low-QOR patients, the proportion was 50%. The therapists were specifically trained over a long period of time to be able to perform both treatments equally well. Therapist allegiance effects can hardly explain our findings.

The alpha level was liberal in this study, which may have increased the risk of Type I errors. Three-way interactions may be unreliable in moderately large patient samples. This study was not large enough to provide accurate estimates of effect sizes. The population estimates may range from small to large. Furthermore, our analyses were exploratory in nature. Until the findings are replicated in future studies with larger samples, they must be considered preliminary. Finally, there are likely other technique variables (e.g., timing of interventions), patient variables (e.g., chronicity of problems), and process variables (e.g., achievement of key insights) beyond the ones measured here that are important to treatment outcome and may moderate the impact of transference interpretations, QOR, and alliance. Despite these limitations, the present study adds to an evolving literature that suggests that patient characteristics, technique variables, and so-called common factors process variables are all important, and interact in complex ways, to determine psychotherapy outcome (cf. Castonguay & Beutler, 2005).

In this study, those patients who need to improve the most benefit the most from explicit analysis of the patient–therapist interaction. One may speculate that such work for the more disturbed patients may have the potential to improve patient–therapist collaboration and outcome in other types of treatment as well.

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