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THE EFFECTS OF DISPARITY IN CLIENT AND THERAPIST PERSONAL
POWER ON SECURITY OPERATIONS IN BRIEF PSYCHOTHERAPY

By

Robert Neal Graham Jr.

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ABSTRACT

THE EFFECTS OF DISPARITY IN CLIENT AND THERAPIST PERSONAL POWER ON SECURITY OPERATIONS IN BRIEF PSYCHOTHERAPY

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In the traditions of psychoanalysis, the technique of interpretation has played a central role in the theory and practice of psychotherapy. The effect of interpretations on clients and, more importantly, the effect of clients' reactions on therapists, were systematically investigated. Specifically, this study examined client and therapist responses following therapist interpretation from an extended Sullivanian perspective which incorporated security operations and personal power functions. Data consisted of audio-cassettes and transcripts of 24 sixteenth session therapies conducted as a part of the Vanderbilt Psychotherapy Research Project II. Psychotherapists were eight clinical psychologists and seven psychiatrists from the Nashville area trained in Time-Limited Dynamic Psychotherapy. Clients were comparable to a general psychiatric outpatient population. Interpretations and depth of interpretation were operationalized with a new pantheoretical measure called the Interpretation Scoring Guide.

Client and therapist personal power were operationalized using the Personal Power Functions Profile. Client and therapist responses were scored using an extended version of the Security Operations Inventory. Although reliabilities

were modest, they entered into a variety of functional relationships in an orderly fashion consistent with theory. Prominent among these, clients frequently responded to therapist with security operations, especially following therapist interpretations; therapists had more personal power and used more mastery-dominant security operations than clients; therapists with more personal power tended to have more years of therapy experience.

As predicted, the mastery-dominance level of therapist security operation(s) following both interpretation and noninterpretation statements was found to be directly related to personal power, but the corresponding analysis for clients was not inversely related to personal power, as expected. Hypotheses relating depth of interpretation to disparity of personal power functions and security operations did not have an opportunity to demonstrate its scientific value. Neither did number of interpretations.

Overall, the findings converge on the conclusion that therapist's interpretations are apt to function as security operations.

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In the traditions of psychoanalysis, the technique of interpretation plays a central role in the theory and practice of psychotherapy. Numerous authors have presented guidelines to consider when utilizing interpretive techniques (e.g., Levy, 1984; Weiner, 1975; Hammer, 1968. See Appendix A for a review of the literature). Theoretical and technical approaches to interpretation abound yet the empirical evidence to support these claims is sparse. The effect of an interpretation on the client and, more important still, the effect of the client's reaction on the therapist, have yet to be systematically investigated. These interpersonal events constitute the psychoanalytic domain of the present study, as elucidated below.

Psychoanalytic theory

Interpretation and resistance. Whereas the analysis of resistance is the sine qua non of a successful analysis in classical psychoanalysis (e.g., Freud, 1904, 1913, 1923, 1937; and Reich, 1949), it is generally regarded as an obdurate and unwelcome problem in psychodynamically oriented psychotherapy. This dichotomy is not absolute because some analysts also regard it as an obstacle to progress, i.e., understanding the ego defenses and the defensive and regressive functions of values and ideals, rather than as a vehicle to a fundamental understanding of the ego or self. Whether there is such a thing as a productive interpretation is a moot question. Resistance, that is, all the forces

within the client which oppose the procedures and processes of psychoanalytic work, is ever present (Freud, 1913, 1937; Greenson, 1967).

A relationship between therapist interpretations and client resistance has been previously recognized in the literature. For example, Levy (1984) declared, "Interpretations stir up resistance, the intensity of which determine whether or not the interpretation will be accepted and expand the patient's self-knowledge" (p. 23). Some psychoanalysts believe that resistance arises from errors in technique or from issues of countertransference (Fenichel, 1945; Greenson, 1978; Hammer, 1968b; Langs, 1973, 1982, 1983; & Wolberg, 1977).

Spero (1977) noted, "In many cases, resistance emerges when anxiety-provoking material is touched by an interpretation. A more pervasive form of resistance is that based on interpretations perceived as a threat to self" (p. 75). Spero explained that interpretations that are perceived as a threat to the self mobilize strong resistance in many clients. If interpretations are perceived as threats to clients, then observation of threat reducing-behavior is likely. For instance, after a therapist makes an interpretation, the client provides the illusion of acceptance and then changes the topic (Reyher, 1989). This maneuver functions to protect the therapeutic relationship while moving away from something that imposes a threat, provokes anxiety, or invokes a loss of euphoria in the

client. Whatever the rationale, it has been observed that therapist interpretation is likely to meet with client resistance.

It has also been noted that all resistances have both an intrapersonal (intrapsychic) and an interpersonal component and function to avoid real or imagined pain (Milman & Goldman, 1987; Freud, 1923, 1937; Langs, 1987; Strupp & Binder, 1984).

How do therapists cope with outright rejection of an interpretation or, more commonly, a tentative or conditional acceptance? Poorly timed interpretations cue anxiety that typically cannot be mastered (Freud, 1900), consequently generating excessive resistances.

Relevant Sullivanian theory

Interpretation and resistance. Sullivanian theory is one way to make sense of client responses and reactions to proffered interpretations and a therapist's subsequent response to a client. The contention is made that resistance, even in its extremes of automatic compliance versus rejection or opposition, can be interpersonally conceptualized as security operations.

Sullivan (1954) defined resistance as, ". . . in general it has come to mean something that opposes what was presumed to be helpful" (p. 219). How therapists and analysts choose to address this resistance is directly influenced by their theoretical beliefs and corresponding treatment techniques or practices.

Security operations function to maintain self-esteem and thereby prevent anxiety (the lowering of euphoria¹) in interpersonal situations and increase interpersonal security. Sullivan (1954) argued that anxiety² is aroused in the client and "resistance" follows when something threatening to the client, e.g., a disturbing, anxiety-provoking topic or interpretation, is introduced. Clients will employ all kinds of devices to avoid the topic (resistance) while attempting to preserve the therapist's esteem of them (security operations). Therefore, security operations could be conceptualized as one component of resistance, functioning to maintain interpersonal security in the face of intrapsychic threat.

Self-system. The self-system or anti-anxiety system is "the system involved in the maintenance of felt interpersonal security . . ." (Sullivan, 1953, p. 109). The self-system provides more of an equilibrating influence by functioning to either avoid, conceal, or minimize anxiety to insure safety from dangerous situations. It develops from interpersonal experiences with anxiety beginning very early in life. Any lowering of self-esteem (lowering of euphoria) is experienced as anxiety (Sullivan, 1954). Within the self-system, security operations function as a protective measure against

1. Euphoria is a sense of well-being characterized by high self-esteem and minimal anxiety.
2. Anxiety is any drop in the sense of well-being or any lowering of self-esteem.

undue anxiety or the threat of anxiety arising from forbidding gestures (behavioral and expressive cues that lower euphoria) in interpersonal situations.

Therapy, although different from typical everyday interactions, is an interpersonal situation. It involves two participants seeking to communicate with each other while striving to remain secure from anxiety. When communications stir up anxiety in one or both parties, security operations are generated to protect against any drop in euphoria.

Security operations are generated by the self-system whenever it reacts to threat. As Sullivan (1954) stated, "In other words, all anti-anxiety operations are security operations; all efforts to protect one's self-esteem are security operations" (p. 97). They sustain a feeling of safety or measure of interpersonal security as well as relieve anxiety while protecting a person's self-esteem from additional threat.

Interpretation and security operations. Interpretations have the potential to produce anxiety and be perceived as threats. Assuming that the therapist is inferring something about a client they do not want to know, interpretation can be viewed as a stimulus for security operations. Interpretations stimulate a sequence of interpersonal interactions between client and therapist that are hypothetically characterized by security operations. This occurs because the clients perceive an interpretation as a threat (lowering of euphoria) yet want to preserve their

established esteem in the presence of the therapist. In fact, a pattern of client responses to interpretation has been identified as the application of security operations (Reyher, 1978).

Spence (1987) observed, ". . . minor misinterpretations by the analyst are frequently overlooked by the patient, and even significant mistakes may either be ignored or rationalized away" (p. 87). The client's strategy is to engage in security operations in the form of ignoring, rationalizing, or overlooking something that has been communicated, i.e., an interpretation. However, the client does not want to alienate the therapist by rejecting an interpretation outright (Reyher, 1989). This conflict causes undue anxiety and increases the possibility of eliciting forbidding gestures. If this were to happen, the self-system would work to minimize the anxiety and prevent a drop in self-esteem by using security operations.

Therapists, trained to interpret, have their esteem wrapped up in the interpretation that is proffered to the client and have a narcissistic investment in the outcome of their interventions. If the interpretation is rejected or ignored, therapists struggle to restore their own sense of security and esteem in the eyes of the client by engaging in security operations of their own. A therapist may even use an interpretation to attack or retaliate against a client for rejecting a previous interpretation. Hence, it follows that interpretations can generate security operations in both

client and therapist (Reyher, 1989).

Self-esteem has been implicated as an important variable in the outcome of an interpretation. Spiegel & Hill (1989) have hypothesized that self-esteem may function as a moderating variable affecting how receptive a client is to interpretation. Furthermore, Weiner (1975) asserted, "Hence even a mild interpretation challenges the patient's integrity and deflates his self-esteem, and it thereby constitutes an attack against which he may feel a need to defend himself" (p. 120).

I propose that security operations are employed to protect oneself against "attack" or any other perceived threats to one's self-esteem.

Client strivings and reactivity. Therapist and client are brought together into a relationship by the client's life problems. Even though clients come in with these problems, they attempt to create a favorable impression with the therapist to minimize their level of anxiety. Clients carefully watch the therapist, whom they typically hold in high esteem, for signs of approval to bolster their self-esteem or signs of disapproval (forbidding gestures) which can precipitate intense anxiety in the client (Sullivan, 1954). In response to perceived or anticipated forbidding gestures, the self-system activates security operations to avoid or minimize any drop in euphoria, often experienced as anxiety. In addition to decreasing clients' level of anxiety, client security operations help preserve therapist's

esteem and, thereby, maintain a feeling of safety in the therapy relationship. Clients use security operations to gain or maintain interpersonal safety.

Therapist strivings and reactivity. Therapists strive to generate respect, esteem, prestige, approval, etc. from clients, which can impede the work of therapy. They have an investment in what they communicate to the client and how the therapy session proceeds. Therapists are also concerned with the client's appraisal of their abilities and technical skills while attempting to sustain the "favored status" conferred by the therapist role. When they make an intervention, they leave themselves vulnerable to client communications (forbidding gestures) that pose a potential threat to their self-esteem, often signaled by an increase in anxiety. Any topics or experiences that lower euphoria and generate client' forbidding gestures will be experienced by therapists as a need for relief (Sullivan, 1953). Consequently, security operations become engaged to decrease their anxiety level as well as maintain their esteem and status in the eyes of the client.

Client-therapist collusion. Reyher (1989) has drawn attention to the articulation between client and therapist security operations. He explained that both therapist and client are pursuing security in the relationship by avoiding direct acknowledgement of forbidding gestures, rejection, or disapproval by the other. In addition, their self-systems are actively repairing any drop in self-esteem. A shared

avoidance of confrontation leads both parties to collude in two ways. One way is to ignore the injury to self-esteem that occurs. The other way is to repair the damage. This collusion, whether conscious or unconscious, allows the relationship to continue in a relatively safe environment with minimal threat to one's self-esteem.

Interpretation: theory and practice

Clients and therapists have certain expectations about what goes on in therapy and interpretive interventions are often central to those expectations as well as the therapeutic interaction itself. Clients expect to hear interpretations and some may even ask for them directly, but at the same time, clients appear to dread interpretations (J. Reyher, personal communication, May 20, 1990).

Interpretations often contain revelations about clients that they do not want to know about, e.g., reprehensible content that the client is not aware of. An interpretation may also threaten one's sense of interpersonal security within the therapist-client relationship, e.g., "How can you really value me while knowing that I harbor such infantile cravings."

Definitions of interpretation in the psychotherapy literature have been inconsistent at best (Spiegel and Hill, 1989). In the present study, interpretation is defined as, "any therapist statement in a session that infers something about the client that the client has not explicitly (i.e., verbally) expressed" (Graham and May, 1989, p. 56). This is

a broad conceptualization of interpretation and may include other types of interventions (e.g., confrontations, clarifications, etc.) that have been defined elsewhere (See Elliott, 1985; Hill, 1989; & Stiles, 1979). However, these distinctions deal with the intent (e.g., why therapists used a particular response) of an intervention as well as the content (e.g., what therapists actually said or did). This makes the various interventions difficult for impartial raters to differentiate and identify. Actual interpretations make up only a fraction of therapist inferences and therapists do not share with clients all the inferences they make during the course of therapy (Ramzy, 1974). The important factor for the present study is whether a therapist statement contains an inference about the client that the client is not explicitly and verbally acknowledging.

Favorable views. There is a dichotomy of opinion on the role of interpretation in therapy. Some theorists advocate strongly for interpretive techniques while others focus on the limits of interpretation and emphasize more of a noninterpretive approach (refer to review in Appendix A for additional theoretical perspectives).

Koss et al. (1986) pointed out that most therapists who practice brief psychotherapy believe that some form of interpretation is the key to behavioral change. They also suggested that the manner in which interpretive remarks by the therapist are received and processed by the client may be one way to gain a better understanding of the components of

the interpretive process.

There have been a number of theoretical arguments proffered to explain how interpretations bring about change in therapy. Most of these theoretical postulates have come from the psychoanalytic literature. Early on, Freud (1904) wrote that the therapist works to reveal repressed traumatic experiences and bring these hidden traumas into consciousness while encouraging the client to release the corresponding emotions in the safety of the therapy setting. Coltrera and Ross (1976) have outlined the function and rationale of interpretive interventions based on Freud's early writings on technique. They explained that when a therapist makes an interpretation, the client's attention is directed to preconscious material that is generated from the unconscious. The explanatory contents and form elements contained in an interpretation facilitate the recognition of unconscious derivatives by the conscious system. Wolberg (1977) believed that unconscious material must be related to what is happening in the present. He stated that all conscious and unconscious behavior is dynamically motivated, having a definite meaning and function that interpretation helps to uncover.

Other writers have focused more on structural theory in delineating how interpretations work. More specifically, the ego is viewed as the central structure involved in the process of change. Various perspectives include, bringing repressed material into awareness and placing it at the

control of the ego (Hammer, 1966); drawing the attention of the client's ego to 'preconscious derivatives' which become less distorted as the client observes himself and comprehends previously unknown motives for his own activity (Fenichel, 1941); employing ego capabilities to modify its' relationship with the id (Saul, 1958); decreasing the amount of energy built up in the id by increasing awareness of unconscious impulses (Strachey, 1934); and influencing the ego through the transference relationship to bring about change (Weiss, 1986).

The importance of patterns rather than of exact events when formulating and making interpretations has been noted (Loewenstein, 1957). Loewenstein argued that interpretation works on the psychological dynamics and conflicts within the client and its effectiveness is dependent on the client's reaction. Interpretations are often developed over a series of interventions and seek to provide new material for the client to consider along with the therapist (Glover, 1955; Langs, 1973; Loewenstein, 1957; and Zac, 1972).

Unfavorable views. Interpretations can generate both anxiety and defensiveness or resistance in the client (Weiner, 1975). Certain interpretations have actually been viewed as accusations, criticisms, or pejorative statements and tend to evoke negative responses in clients, like resistance or even rage (Wile, 1984). Wile believed that interpretations are made because they are theory-based and therapists subscribe to the philosophy that their clients

need to know the 'truth.'

Fine (1968) stated that few interpretations are heard by clients in the way that therapists intended them. The therapist needs to attend to how the client reacts and elaborates on an interpretation rather than focusing on the correctness of it. It is also crucial to monitor how the therapist responds to the reactions of the client.

It is not interpretation that cures the client and insight does not lead directly to beneficial structural transformations characteristic of a successful analysis (Kohut, 1977). Kohut maintained that clients are narcissistically vulnerable in the face of interpretations and may experience the intervention as a nonempathic response in the present that is "genetically connected" to traumatic events from the past. It is a narcissistic injury that threatens the cohesion of the self and narcissistic rage is really motivated by the wish to increase self-esteem (Kohut, 1977).

Rogers (1942, 1957) believed that interpretations have limited value in therapy. He stated that interpretations have no essential value to therapy other than to become a channel for communicating the essential conditions of unconditional positive regard, empathy, and genuineness of the therapist (Rogers, 1957). Furthermore, Rogers (1942) declared, "Interpretation has value only to extent that it is accepted and assimilated by the client" (p. 26). He thinks that the therapist needs to provide more than an intellectual

picture or explanation to change a client's behavior.

Summary. A dichotomy of opinion regarding the role of interpretation in therapy is evident. Some theorists or practitioners advocate strongly for an interpretive method while others relegate interpretation to a minor or even harmful role in therapy. This discrepancy highlights the complex characteristics and theoretical intricacies of interpretive techniques as well as the interpersonal nature of therapy.

Research on interpretation

There is a broad body of research on various aspects of interpretive interventions (refer to the review of the empirical literature on interpretation in Appendix A for detailed findings). The empirical outcomes have been mixed in terms of providing support for making interpretations in therapy. The erratic results are due in part to methodological problems and limitations in external validity. Renewed interest in psychotherapy process research and interpretation in particular has been observed (Kiesler, 1982).

In brief, results of empirical research on interpretation have been inconsistent at best. Numerous studies employing a verbal conditioning paradigm have consistently found a reinforcement effect (Adams, Butler, & Noblin, 1961; Adams, Noblin, Butler, & Timmons, 1962; Auerswald, 1974; Kanfer, Phillips, Matarazzo, & Saslow, 1960; Noblin, Timmons, & Reynard, 1963). However, they have

displayed a lack of external validity, limiting their usefulness. Other research that exhibited an increased methodological refinement did not investigate actual therapy sessions (Claiborn, 1979; Claiborn, Ward, & Strong, 1981; Cooke & Kipnis, 1986; Forsyth & Forsyth, 1982; Strong, Wambach, Lopez, & Cooper, 1979).

Naturalistic studies show promise but results have been varied and systematic investigation of the effects of interpretation have been limited in scope (Bergman, 1951; Brunink & Schroeder, 1979; Elliott, Barker, Caskey, & Pistrang, 1982; Elliott, Hill, Stiles, Friedlander, Mahrer, & Margison, 1987; Fiedler, 1951; Frank & Sweetland, 1962; Goodman & Dooley, 1976; Hawton, Reibstein, Fieldsend, & Whalley, 1982; Hill, 1978; Hill, Carter, & O'Farrell, 1983; Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988; Russell & Stiles, 1979; Snyder, 1945; Staples, Sloane, Whipple, Cristol, & Yorkson, 1975; Stiles, 1979; Stiles, Shapiro, & Firth-Cozens, 1988; Zimmer & Pepyne, 1971).

Studies exploring specific theoretical distinctions in interpretive interventions have found that: (a) *"moderately deep" interpretations* (Fisher, 1956; Garduk & Haggard, 1972; Gill & Hoffman, 1982; Grossman, 1952; Harway, Dittman, Raush, Bordin, & Rigler, 1955; Raush, Sperber, Rigler, Williams, Harway, Bordin, Dittmann, & Hays, 1956; Sklansky, Issacs, Levitov, & Haggard, 1966; Speisman, 1959), (b) *relevant transference interpretations* (Forman & Marmar, 1985; Frances & Perry, 1983; Luborsky, Bachrach, Graff, Pulver, & Cristoph,

1979; Marziali, 1984; Marziali & Sullivan, 1980; Silberschatz, Fretter, & Curtis, 1986; Weiss & Sampson, 1983), (c) *increased productivity with therapist skill* (Fiedler, 1951; Gomes-Schwartz, 1978; Gomes-Schwartz & Schwartz, 1978; Strupp, 1955, 1958; Strupp & Hadley, 1979), (d) *object focus* (Piper, Debbane, Bienvieu, Carufel, & Garant, 1986), and (e) *interpretation tense* (Abramowitz & Jackson, 1974) have all produced mixed findings. In addition, theory-based research has demonstrated that the suitability and accuracy of interpretations are more predictive of client response than type of interpretation (Crits-Cristoph, Cooper, & Luborsky, 1988; Malan, 1976; Marziali, 1984; Marziali & Sullivan, 1980; Silberschatz, Fretter, & Curtis, 1986; Weiss & Sampson, 1983, 1986).

Present research

Personal power functions (PPF) have been affiliated with security operations as a way to increase the ability to predict the type of security operations an individual will use (Reyher, 1979). Personal power is the constellation of resources, properties, attributes or characteristics of an individual which are all external in nature, can be determined through observation or biographical data, and tend to create positive conceptions in others (Gavrilides, 1980; Hamernik, 1987). A personal power functions profile (PPFP) was developed by Reyher (1979) that initially was based on Sullivanian theory but later (Reyher, 1992) came under the sway of Freudian and ethological perspectives. It consists

of sixteen different personal power functions that provide a measure of an individual's level of power¹ in a relationship. Although no longer an instrument hewing to Sullivanian theory, personal power has been shown to influence the selection and use of security operations (now called "security measures") in therapy. Personal power plays a central role in the dynamics of interpersonal interaction process.

Gavrilides (1980) demonstrated that the personal power functions of communication style, communications skills, and achievement status were significantly correlated with security operations while physical factors were not. In addition, high personal power persons were less anxious, interrupt more, and tend to use more aggressive or assertive security operations compared to low personal power persons. It was concluded that the aforementioned power functions influence interpersonal dynamics. Based on this finding, the differential status or disparity in power might help predict which security operations will be utilized by a particular individual.

Relative control in relational communications is another concept that has similarities to power from an ethological perspective. A coding system was developed and used with marital couples that focused on the control defining aspects of communication (Ericson, 1972; Ericson & Rogers, 1973;

1. Intimidation via threat of narcissistic injury or life and limb (Reyher, 1992).

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Mark, 1970). Sequences of messages are analyzed in relation to the control aspects of verbal exchanges that define an individual's role at a given moment in an interaction. Control can move toward dominance (one-up position), being controlled (one-down position), or neutralized (one-across position). In this scheme, a message is both a response to what precedes it and a stimulus for the message that follows. In therapy, if the therapist offers a message that is dominant, the client can respond with a dominant message (competitive response), a submissive message (complementary response), or a neutral message (leveling response, e.g., ignore the message). It therefore seems reasonable to assume that personal power and the control defining aspects of communication influence what type of security operations are selected by both therapists and clients during a therapy session.

Security operations involve observable interpersonal acts and can be mobilized in therapy when a topic generates anxiety in the client (Chapman, 1978). Chapman stated, "A healthy security operation usually increases a person's social effectiveness and emotional stability. In contrast, an *unhealthy* security operation diminishes anxiety at some cost to the person" (p. 58).

Gavrilides (1980) found a similar relationship indicating that high personal risk-takers possessing greater personal power will utilize more productive security operations resulting in less observed anxiety and greater

happiness compared to low personal risk-takers. The inverse relationship was also validated demonstrating that low personal risk-takers with low personal power utilize more nonproductive security operations resulting in more observed anxiety and less happiness compared to high personal risk-takers.

Interpersonal security operations have been operationally defined and elaborated on by Reyher (1978) in his development of the Security Operations Inventory and recent Security Operations Scale (Reyher, 1992; Tobias, 1993) wherein each security operation has an empirically derived value. The original inventory identified 38 separate security operations (Reyher, 1979). The most recent version of the inventory contains 61 different security operations that are combined to make up eight subheadings subsumed under five separate categories (Reyher, 1989). These five main categories can be divided into productive mastery-dominance security operations and nonproductive submissive-compliant security operations which are more self-protective in nature.

In his most recent communication, Reyher (1992) contended that Sullivanian theory does not include postulates or assertions regarding personal power and mastery-dominance. He pointed out that mastery-dominance is not a factor in Sullivan's interpersonal construal of the self-system. These matters are more in keeping with Freud's notion of "security measures" in the service of the ego-interests and narcissism. In addition, these ideas are also consistent with ethological

perspectives on dominance hierarchies, agonistic dominance in particular.

According to Sullivan, a power drive is compensatory, a failure in competence in integrating interpersonal situations. A well-oriented person resists momentary opportunities for satisfaction or to enhance one's prestige (Sullivan, 1953). Disparity in personal power in an interpersonal relationship has great consequences for clients who, in Sullivanian terms, are deemed to be ill-oriented. Thus the different sets of strivings that characterize these two divergent styles of interpersonal interaction result in distinct security operations that can be objectively observed and identified (Reyher, 1980; J. Reyher, personal communication, May 15, 1991).

Therefore, the mastery-dominant category of security operations in the revised Security Operation Scale (Reyher, 1989) is regarded by Sullivan as compensatory strivings in an ill-oriented person. Thus, these too are deemed as attempts to avoid anticipated loss of euphoria, i.e., they are driven by anxiety. As Reyher noted, "One who has insight into these processes to 'anxiety-free discharge' of needs (integrating tendencies) and resists momentary opportunities for satisfaction or to enhance one's prestige can be said to be well-oriented in living (Sullivan, 1953, p. 243)....More in keeping with Sullivanian (1956, p 70-71) parlance, the righting movement of the self-system is impaired in a person whose compensatory power drive is attempting to integrate the

interpersonal situation, but the other fellow is trying to do the same thing. In attempting to take charge (how the encounter is to be integrated), the user of this security operation runs great risk (an assessment made by the self-system) of generating forbidding gestures and anxiety (the lowering of euphoria) associated with the fogging of 'Good Me' and the 'Good Mother' personifications by the 'Bad Me' and the 'Bad Mother' personifications." (Reyher, 1992, pp. 6-7).

Gavrilides' findings (1980) demonstrated that persons with high personal power functions (PPF) tend to engage in mastery-dominant (M-D) SOs; however, by implication, as if there is a disparity in PPF, the disadvantaged member of the dyad is less apt to employ M-D SOs. As Reyher (1992) asserted, "The greater the disparity in perceived PPF by the person of lower PPF, the more likely he or she will expect retaliation in return for his or her attempt to take charge of the interaction (mastery-dominance)" (Reyher, 1992, p. 7).

Reyher (1992) noted, however, that the positive correlation between M-D SOs and well-being and a negative correlation with objective (behavioral) indices of anxiety (refer to Appendix C) strongly suggests that the interpersonal actualization of M-D striving is associated with a well-orientation, not a compensatory ill-orientation. Reyher went on to show that Gavrilides' findings fit well into Freudian and ethological perspectives.

Although the Sullivanian theory under test is not

supported by this outcome, this study will attempt to increase its empirical content by testing hypotheses that potentially can refute (discorroborate) this previous finding (See Weimer on Popper, 1979, p. 37). In other respects than its failure to accommodate the findings, that persons who engage in M-D SOs are well-oriented, additional failures further jeopardize its viability. In Lakatos' (1970) view, the Sullivanian research program would be considered degenerative rather than progressive.

Therefore, not in keeping with Sullivanian theory, productive security operations are utilized more often by individuals who are more concerned with strivings of mastery and autonomy rather than generalized approval seeking (Pottinger, 1982; Reyher, 1978). Hence they are less dependent on the approval of others and are typically perceived by others as successful, arrogant, and insensitive to the feelings of others (Reyher, 1978, 1980, 1989, 1992).

Conversely, and in keeping with Sullivanian theory, nonproductive security operations are more likely to be used by individuals who seek approval from others, anticipate rejection and signs of disapproval because of negative self-conceptions of personal insufficiency, or attempt to offset any loss of euphoria by actively avoiding or minimizing negative self-other conceptions (Pottinger, 1982; Reyher, 1980, 1989). They tend to be more submissive, conforming, placating, indirect, and self-effacing compared to the more mastery-dominant individuals.

I assume that most clients use the therapy relationship in order to gratify their own unidentified needs, whatever they might be. Clients dread experiencing a loss of euphoria. Therefore, they will engage in security operations in an attempt to maintain or repair the therapy relationship if they think they have diminished the therapist's esteem of them. Therapists perceiving a rejection by the client will also engage in security operations to salvage their own self-esteem. Therapists may consciously or unconsciously retaliate against the client because of the anger generated (Reyher, 1989). They punish the client for not accepting their interpretation, i.e., make a critical or negative remark, interrupt the client, their tone of voice changes, etc.

An interpretation can also be an uplifting, self-esteem enhancing (euphoria increasing) experience for the therapist who has a personal investment in the interpretation. In these terms, interpretations can be construed as security operations.

Clients tend to respond to interpretations in such a way as to reject them while giving the impression that they have accepted them or that they deserve consideration (Reyher, 1989). The client does this in an attempt to preserve the therapy relationship and modify or cover up their own real feelings (Silberschatz & Curtis, 1986). However, this type of rejection by the client is often experienced by therapists as a loss of euphoria (Sullivan, 1953). Clients will attempt

to cover up by making some ambiguous comment or remark, i.e., Uh huh; that's interesting; I was not aware of that; that makes sense; etc. and then either change the topic, go on with what they were saying before the interpretation, or wait for the therapist to continue on a different course (Reyher, 1989). If therapists remain uniform in following a particular method of interpretation, it is expected that clients would respond to interpretations in a characteristic fashion.

To facilitate the organization of all possible types of interpretation, the Interpretation Scoring Guide (ISG) was developed. The ISG allows researchers to operationalize interpretations along a number of qualities derived from an extensive review of the theoretical literature. In an initial study using the ISG, May and Graham (1990, unpublished raw data) compared two of Carl Roger's therapy sessions (Snyder, 1947) with two of Lewis Wolberg's therapy sessions (Wolberg, 1954). They found that Rogers made more inferential statements (interpretations) that focused on the client only, that were stated in the present tense, and that were based on material immediately preceding the inferential statement itself. They also discovered a degree of consistency between Roger's therapy sessions and Wolberg's therapy sessions which corresponds with their therapy method and technique of interpretation. These were short-term therapies in which interpretations were proffered to clients. This study also demonstrated that the ISG is a valuable tool

for operationalizing theoretical constructs of interpretation and delineating theory-based differences in interpretation use as it occurs in actual therapy sessions.

The present study seeks to determine if security operations indeed play a major role in client response to interpretation and subsequent therapist response to the client. The intent here is to gain a better understanding about the course or outcome of an interpretation from the cascade of interpersonal interactions between therapist and client that follow an interpretive intervention. An additional goal of this study is to extend and systematize Sullivanian (1953, 1954) theory as conceptualized by Reyher (1978, 1979, 1980, 1989) in terms of personal power functions and security operations.

Although the following experimental hypotheses were formulated before problematic aspects of Sullivanian theory -personal power, strivings to procure narcissistic uplifts, mastery-dominant security operations- were identified by Reyher, they, nevertheless, are consistent with both Freudian and ethological perspectives¹. Also therapists were not

1. The original idea for this study was developed prior to the discovery that mastery-dominance was more consistent with Freudian theory than Sullivanian theory. Through further work with Gavrilides (1980) data, Reyher found that security operations could be ranked on the basis of mastery-dominance scores. Reyher also reviewed the theoretical literature, discovering that Sullivan never adequately addressed the concept of mastery-dominance in his writings. However, Sullivan does account for approbation and submissive-compliant security operations. The experimental hypotheses in this study were formulated with Sullivanian theory in mind. The shortcomings of Sullivan's theoretical model in explaining the results are

presumed to be necessarily well-oriented and, accordingly, interpretations are most likely to be security operations. Finally, theory must accommodate relevant experimental findings. In this case, the critical significance of personal power in relation to type of security operation (SO).

Hypotheses¹:

Hypothesis I. (a) The mastery-dominance level in client SO(s) is inversely related to the discrepancy (differential power) between therapist and client personal power. The derivation from the theory under test is straightforward. For every client response in a therapy session, clients will use SOs that are based on the discrepancy in personal power between therapist and client. As the discrepancy between therapist and client personal power increases in favor of the therapist, clients experience greater *intimidation* and their SOs decrease in their relative level of mastery-dominance.

(b) The mastery-dominance level in client SO(s) following therapist interpretation is inversely related to the discrepancy (differential power) between therapist and client personal power. This is a variation of hypothesis Ia wherein only a portion of the same data is used. The predictions are the same.

...Continued...

acknowledged in light of this new data and information.

1. Bold, italicized text identifies those auxiliary hypotheses (constructs) that enable derivation to proceed.

Hypothesis II. (a) The mastery-dominance level in therapist SO(s) is directly related to the discrepancy between therapist and client personal power. This derivation is straightforward too. For every therapist response in a therapy session, therapists will select SOs that are based on the discrepancy in personal power between therapist and client. As the discrepancy between therapist and client personal power increases in favor of the therapist, therapists experience less *intimidation* and their SOs increase in their relative level of mastery-dominance.

(b) The mastery-dominance level of the therapist response (therapist SO) to client following an interpretation is directly related to the discrepancy (differential power) between therapist and client personal power. This is a variation of hypothesis IIa wherein only a portion of the same data is used. The predictions are the same.

Hypothesis III. The depth of therapist interpretation is (a) directly related to the discrepancy between therapist and client personal power, but (b) is inversely related to client mastery-dominance level (client SOs).

With respect to the particulars of the theory under test, derivation of the foregoing formalized propositions preceeded as follows: As the discrepancy between therapist and client personal power increases in favor of the therapist, the therapist, experiencing less *intimidation*, is more likely to go beyond client awareness and understanding when formulating and proffering interpretations. For this

hypothesis, another auxiliary hypothesis is needed, in addition to intimidation, to complete the derivation¹. In this case, *going beyond clients' awareness* is asserting greater mastery-dominance. So as therapist power increases, depth of interpretation increases. In turn, clients relatively low in personal power, and experiencing greater *intimidation*, will be more likely to use less mastery-dominant SOs in response to these "deep" interpretations than to the more "superficial" interpretations.

Hypothesis IV. The total number of interpretations proffered by a therapist is directly related to the discrepancy between therapist and client personal power. The derivation of this proposition requires that therapists who are relatively high in personal power are experiencing less *intimidation*. Consequently, they assert greater *dominance* and, thereby, experience an *increase in euphoria* by interpreting more of what clients say and try to get clients to agree with their interpretations (client submission and acceptance).

1. Unlike hypotheses I and II, an additional mediating auxiliary hypothesis is required to connect the central propositions relating to relative personal power and type of SOs.

Method

Participants

The participants were 24 psychotherapy clients seeking psychotherapy services in the greater Nashville area. They received brief, time-limited, dynamic psychotherapy as part of a research project conducted by the Vanderbilt University Psychotherapy research group. The entire data set, which consisted of 24 clients who completed all 25 therapy sessions, was used. They ranged in age from 24 to 64 years (mean 41.04). Seventy-nine percent were female, twenty-one percent were male. Seven were married, one widowed, eleven divorced, and five were single. Twenty-three of the clients were Caucasian (96%). Their level of education ranged from eleventh grade to graduate school with two thirds of them having at least two years of college. Approximately 69% had been involved in one prior therapy experience.

Participants presented with complaints of anxiety, depression, and interpersonal difficulties. They were given corresponding diagnoses on Axis I of DSM-III and 70% were also given a diagnosis of dependent personality, avoidant personality, or mixed personality on Axis II of the DSM-III. As indicated by intake scores in the Global Severity Index, these clients were comparable to a general psychiatric outpatient population (Henry, Schacht, & Strupp, 1990). In addition, scores on the SCL-90-R (Derogatis, 1977) were consistent with the mean of national samples.

Therapists

The psychotherapists were all practicing therapy in the Nashville community. There were seven psychiatrists and eight clinical psychologists with several years of postdoctoral experience (Range = 2 to 14 years). Nine were male, and six were female. Nine therapists completed two therapy cases. They all participated in the time-limited dynamic psychotherapy (TLDP) training program under the careful supervision of expert therapists in this method over a period of six months. They were also closely supervised on a training case during this time. The therapist's skills in TLDP were assessed toward the end of this experience and deemed acceptable. After the training, the therapists conducted the therapies included in this sample.

Therapy

Strupp and Binder (1984) advocate for a time-limited dynamic psychotherapy that has an empirical basis. Clients were paired randomly with therapists. Data from their files were used in the present study. Interpretation was defined as, "an intervention that enlarges the patient's awareness of his or her current psychological state by a communication that facilitates understanding of a current interpersonal experience and the factors complicating it" (Strupp and Binder, 1984, p. 165). Some of the principles therapists are taught include emphasizing the here and now in transactions between therapist and client, an interpersonal focus using low level inferences, and maintaining a specific theme to

focus on with the client.

Instruments

The Interpretation Scoring Guide (ISG). The Interpretation Scoring Guide was developed by Graham and May (1989) to measure objectively the parameters that make up an inference and to identify the different levels of interpretation that therapists use (see Appendix B for detailed instrument).

Interpretation is defined broadly in the ISG as, "any therapist statement in a session that infers something about the client that the client has not explicitly (i.e., verbally) expressed" (Graham & May, 1989, p. 56). The ISG is made up of parameters and corresponding dimensions were derived from an extensive review of the theoretical literature. Parameters are those determining factors or characteristics that are essential to the delineation of an interpretation. The ten ISG parameters include Inference Location, Causal Connection, Object, Content, Tense, Immediacy, Depth, Topic Reintroduction, Specificity, and Form of interpretation. Dimensions are subsets of the parameters and provide a definition of each category contained within each parameter e.g., for the parameter Content, the corresponding dimensions are affective, behavioral, and cognitive. In addition, the ISG identifies seven levels or specific types of interpretations (e.g., Resistance, Transference, Genetic, etc.) that have been both empirically demonstrated and theoretically postulated to be of some

importance in the process of psychotherapy. These levels were not used in this study. The ISG allows researchers to quantify and qualify therapist interpretations as broadly or as specifically as needed.

In the current study, the definition of interpretation as stated above was used to identify interpretations in the 24 sixteenth session therapies. The ISG parameter, Depth, was used to investigate the relationship between depth of interpretation and security operations. The other ISG parameters and the levels were not used.

The Depth parameter is defined as: The extent to which the therapist departed from what the client explicitly stated in an interpretation. This parameter consists of three mutually exclusive dimensions: Substitution, Extension, and Introduction. These dimensions are defined as follows:

1. Substitution: The therapist replaces the client's nondenotative word or phrase with a more specific one. The therapist substitutes a more narrowly defined word(s) for a client verbalization that has a broader meaning. This is similar to specifying a single object from a class of objects (e.g., the client says flower, the therapist says tulip). If it is unclear whether the therapist's statement is a subset of the client's verbalization, then substitution is not scored. The therapist's interpretation must refer to client material that is readily identifiable in the transcript. Importantly, synonyms are not included in this dimension because they are restatements and do not include an

inference.

2. Extension: The therapist's interpretation includes both reference to what the client has explicitly stated and additional material that has not been verbalized by the client. In an Extension, the therapist adds material that goes beyond but is related to what the client has previously expressed. The meaning of a client verbalization is either added to or modified in some manner.

3. Introduction (of a new idea): The therapist 's interpretation only contains ideas that the client has not explicitly verbalized. The introduction of the new idea(s) by the therapist must differ in meaning from what the client actually said in the session. The therapist may reintroduce an interpretation even though the client has not verbalized any of this material after the first time it was presented. These interpretations are still scored as introductions.

The Security Operations Inventory. Four investigations (Gavrilides, 1980; Pottinger, 1982; Reyher, 1980; and Tobias, 1990) have used the Security Operations Inventory developed by Reyher (1979). A subsequent extension of this inventory (Reyher, 1989) increased the number of security operations (SO) from 36 to 61, classified by category.

This most recent version of this instrument includes 34 of the items in the original inventory for which data were available on personal power, happiness, and manifest anxiety. Whereas mastery-dominant (M-D) SOs tended to load high in personal power, high in happiness, and low in manifest

anxiety, submissive-compliant (S-C) SOs tended not to load high in personal power and happiness and load high in manifest anxiety, the mirror opposite of mastery-dominance. Reyher (1992) then created a scale (see Appendix C) by ranking the constituent SOs in terms of their joint loading on the three differentiating variables (well-being, PPF, anxiety). Each SO now has a score (rank) with respect to its discrepancy from the mastery-dominant configuration on the three variables. An investigator has the option of using the inventory where each SO contributes a score of one or the scale which permits the use of rank order statistics.

A new version of the Security Operations Inventory called the Extended Security Operations Scale (ESOS) was used to test the experimental hypotheses. The ESOS (Appendix D) contains 40 SOs. Thirty of the SOs contained in the original inventory (Reyher, 1979) were used and can be scored based on audiotapes alone. Loewenstein (1951) noted, "The therapeutic effects of analytic interpretations are displayed not only in objective and subjective changes in the patient, but also in verbal manifestations . . ." (p. 12). Other investigators have had success reliably rating verbal material (Duncan, Rice, & Butler, 1968; Mahl, 1956; Rice & Gaylin, 1973; Rice & Wagstaff, 1967; Stiles, Shapiro, & Firth-Cozens, 1988, 1989; Wiseman & Rice, 1989). Thus the effects of interpretations can be recognized or perceived within the verbal context.

Some of the SOs from the original inventory could not be reliably scored from an audiotape since they require actual

observation of the people involved (e.g., Head nodding, Pasted on smile). These SOs were removed from the ESOS. Ten additional SOs of interest in the present investigation were taken from the most recent SO scale (Reyher, 1989). By consensus, Reyher and Graham inserted them into the ESOS on the basis of their similarity to one or more scaled SOs. The ten SOs were Taking Charge, Nonanswers to Questions, Skepticism, Facelessness, You Know, Self-effacement, Apologizing, Silence, Stalling, and Incomplete Sentences.

The Personal Power Functions Profile. The Personal Power Functions Profile (PPFP) was developed by Reyher in 1979 (see Appendix E) to complement the Security Operations Inventory . This instrument has been used effectively in previous studies (Gavrilides, 1980, Hamernik, 1987, and Tobias, 1993). The profile consists of sixteen different personal power functions that provide a measure of an individual's power in a relationship. The profile is further divided into four subcategories: personal characteristics, interpersonal skills, physical characteristics, and personal-social attributes. These functions are scored using a scale ranging from one (low power) to five (high power). The seven power functions used in this study were Knowledge/Ability/Talent Germane to Interaction, Savoir Faire, Voice, Speech, Expression of Ideas, Authority, and Education. Personal power scores can range from 7 to 35. The personal power functions of Physical Attractiveness, Height, Stature, Attire, Carriage, Socio-Economic Status,

Personal Fame, Family Fame, and Eye Contact were not used because the information was not available or it could not be determined based on audiotapes alone.

Procedure

The third and sixteenth therapy sessions, videotaped at Vanderbilt University, contributed videotapes, audiotapes, and written transcripts to the data set. All the other sessions were audio-taped and conducted at the therapists' private offices. Only the audiotapes and transcripts for sessions three and sixteen were made available for this study. Clients had to complete the entire 25 session therapies for inclusion in the study. The sixteenth therapy session was selected over the third because it was believed that a more representative sample of therapist interpretations would be present based on the time-limited dynamic psychotherapy model (Strupp & Binder, 1984).

Data set - preparation of verbatim therapy protocols

First two raters identified and scored the specific SOs, when present, for each client and therapist verbalization contained in each of the 24 therapy transcripts as described above. Both raters had to agree that there was an SO present for it to be scored on the ESOS. Thus, each therapist and client verbalization was scored for the presence or absence of SOs. It is noted that there may be more than one SO per verbalization. A client verbalization was combined with the next client verbalization when there was no intervening therapist verbalization listed on the transcript, i.e., a

blank line and nothing identifiable on the audiotape. The same procedure was done for therapist verbalizations. If there was intervening text, then verbalizations were combined based on grammatical, syntactic, and semantic considerations as well as structural discourse, i.e., turn of speech. For example, the therapist is talking, then pauses briefly before continuing and then both therapist and client begin talking at the same time (marked "simultaneous" on the transcript), the therapist's verbalization would be combined with his or her previous verbalization and the client's verbalization would be combined with his or her subsequent verbalization. Both verbalizations would retain their respective SO scores.

Points of interest. Five points of interest in the verbatim record were selected for analysis.

The first point of interest is the therapist's interpretation (TI) itself. There had to be 100% agreement among raters on the ISG for an interpretation to be included in the scoring procedure outlined above. Therefore, for each client-therapist pair ($n = 24$), there is 100% agreement for those interpretations that are identified. Each client-therapist pair generated a different number of interpretations per session. Also, interpretations can be proffered in response to any client statement or to follow-up a previous interpretation. Some TIs continued onto the next therapist verbalization, so they were included as part of the TI.

The second point of interest in the verbatim record is

the client response (CRI) following a TI. CRI will be used throughout the remainder of the text to represent client SOs following therapist interpretation only. CRI consisted of those client SOs immediately following TI. When the client response continued onto the next client verbalization, it was included as part of the CRI.

The third point of interest is the therapist's subsequent response (TRI) to CRI. This includes TIs that occur after the initial CRI. TRI will be used throughout the remainder of the text to represent therapist SOs in response to CRI. TRI consisted of those therapist SOs immediately following CRI. When the therapist response continued onto the next therapist verbalization, it was included as part of the TRI. Therefore, TI could also be considered a TRI.

The fourth point of interest is the therapist's SOs in response to client (TRC) following each client verbalization. TRC consisted of those therapist SOs immediately following CRT (see below) or CRI. When the therapist response continued onto the next therapist verbalization, it was included as part of the TRC.

The fifth point of interest is the client's SOs in response to therapist (CRT) following each therapist verbalization. CRT consisted of those client SOs immediately following TI, TRI and TRC. When the client response continued onto the next client verbalization, it was included as part of the CRT.

Data reduction

The verbatim data (transcripts) had to be prepared in a variety of ways to facilitate the use of the ISG and the ESOS. Additionally, the raters' ratings on the ISG and ESOS had to be processed in a variety of ways in preparation for statistical analyses. These changes in the data set are detailed below.

Interpretation Scoring Guide (ISG). Four advanced graduate students in clinical psychology at Michigan State University, who had at least one year of practicum experience, scored therapy transcripts using the ISG. They were extensively trained over the course of five months on sample material. The sample therapy sessions used for training were selected from published transcripts by Wolberg (1954) and Snyder (1963). Scoring interpretations with the ISG was a multi-step process described in a 34-page training manual (see Appendix B). This procedure is outlined below.

First, each rater carefully read written transcripts of the 24 psychotherapy sessions and identified all therapist verbalizations containing inferences about the clients. They then met as a group and reached a consensus on which therapist verbalizations were actually inferences. If the raters did not agree that there was an inference, the statement was discussed and both sides of the disagreement were processed with the principle investigators. If agreement could not be reached within a reasonable amount of time (approximately 10 minutes) or if the raters thought that

they could not reliably rate a given statement, then it was dropped from subsequent ratings. If agreement was reached, then the inferential statement was marked as an interpretation.

These interpretations were then numbered and divided into three basic units for scoring according to the ISG: clause, sentence, and segment. These were defined as follows: A clause (independent or dependent) is a group of words that have a subject and a predicate; a sentence contains one or more clauses and expresses a complete thought; and a segment is a group of sentences containing at least one inference. If a clause or sentence contained a pronoun, raters replaced the pronoun with actual text where it could be readily identified from the transcript and all raters agreed with the modification (e.g., 'it' is replaced with 'intellectualizing' because the therapist is referring to something the client just said). A pronoun was designated as general if the raters could not identify any actual text in the transcript to which the pronoun referred back to. Pronouns were modified so that the raters were scoring identical material.

Once modifications were completed, the transcripts were randomly distributed among the raters so that each of the four graduate students scored 18 of the 24 sessions. With this arrangement, each transcript was scored by three raters. The raters independently scored their 18 sessions on all of the 10 operationally defined parameters and dimensions. Once

this was completed, the raters categorized the interpretations on one or more of the seven interpretive levels from the ISG.

Raters were monitored on a regular basis in terms of the agreement and reliability of their ratings compared to expert ratings. This was to ensure a minimum of rater drift. Portions of a short-term therapy session that was not part of the data set were rated periodically throughout actual scoring with the ISG to check rater agreement. Supervision was provided when errors in procedure needed correcting or if there were questions about rating the material. Questions about the scoring system were answered based on the instructions. Discussion of any material not relevant to the scoring procedures was deferred until the ratings were completed.

Depth was the only parameter from the ISG used in this study. At least 2 out of 3 raters had to agree on a particular Depth dimension. Most of the ratings on Depth (96.3%) met this criterion. When this criterion was not met, e.g., each rater selected a different Depth dimension for the same interpretation, Extension was marked because it includes aspects of both Substitution and Introduction (see descriptions above) in addition to the fact that one rater did mark Extension.

The three ISG Depth dimensions were rank ordered based on how far removed the therapist's interpretation was from what the client said i.e., moving from being within the

client's awareness to outside of their awareness. The resulting rank order was Substitution = 1 (aware), Extension = 2 (partially aware), and Introduction = 3 (unaware). These rank ordered values were assigned to each interpretation, based on the ISG Depth ratings, and labelled Depth score. If a therapist interpretation contained more than one inference and the Depth score for each inference was different, then an average Depth score was calculated (e.g., Extension = 2 and Introduction = 3; so the Depth score would be 2.5). There was a Depth score for each interpretation.

Raters were blind to the hypotheses of this study.

Expanded Security Operations Scale (ESOS). Two undergraduate students were recruited to rate the therapy transcripts using the ESOS. They received both research credit (see Appendix F for consent form and Appendix G for the written debriefing summary) and money for their participation. Training consisted of studying the definitions and descriptions of the different SOs to ensure that the raters understood the meaning of each one; reviewing written examples of the SOs (see Appendix H for training materials); rating a partial transcript as a group and discussing the procedure; scoring complete sample sessions individually and meeting as a group to evaluate and discuss the ratings so that each rater was familiar with the rating system.

Sample therapy sessions selected from published transcripts by Snyder (1963) were used to rate SOs based on

the content of therapist and client verbalizations. A published transcript and the accompanying tape taken from Budman and Gurman (1988) were used for training the raters to discriminate SOs based on tone of voice, patterning of speech, etc.

Given that the raters engage in interpersonal interactions where SOs are likely to be employed, it is expected that they will be able to discriminate and identify SOs based on their own personal experiences. In addition, voice tone provides important information and is an ingrained part of the subculture, so the raters will know how to decode that piece of the data and apply it to the scoring of SOs.

Raters scored the actual therapy sessions for SOs while listening to an audiotape and following along with the session transcript. Client and therapist verbalizations were numbered sequentially on both the transcripts and the rating sheets used to record the ratings so that ratings matched up with the corresponding text in the transcripts. Ratings were completed on all verbalizations contained in the transcripts. Interpretations were not identified anywhere on the transcripts or rating sheets.

Raters were monitored on a regular basis in terms of the agreement and reliability of their ratings compared to independent ratings completed by the principal investigator. Half of a short-term therapy session that was not part of the data set was rated halfway through the rating process to check rater agreement on the ESOS and correct any rater

drift. Supervision was provided when errors in procedure needed correcting or if there were questions about rating the material.

Raters were blind to the hypotheses of this study.

Personal Power Functions Profile (PPFP). The principle investigator and another graduate student rated the therapy tapes using the PPFP. Both raters were already familiar with the instrument and needed only minimal training. Training consisted of studying the descriptions of the different PPFP variables to ensure that the raters understood the rating scale; reviewing examples of specific qualities to listen for while rating the audiotapes (see Appendix I for training materials); rating a partial transcript together and discussing the procedure; evaluating and discussing the practice ratings so that each rater was familiar with the rating system.

Portions of seven therapy sessions on a therapy tape taken from Budman and Gurman (1988) were used for training the raters to discriminate PPFP scores based on tone of voice, patterning of speech, content of verbalizations, etc. In addition, a sample therapy tape from the data set was used to complete training following the procedure below.

Raters scored the actual therapy sessions on five PPFP variables (Knowledge, Savoir Faire, Speech, Voice, and Expression) while listening to an audiotape of each therapy session. The PPFP variables of Education and Authority were obtained from demographic data that was available on both the

clients and therapists. Ratings began approximately five minutes into the sessions because it generally took a few minutes for clients and therapists to get situated in the room. Raters were able to complete their ratings using the next fifteen minutes of the audiotapes. They worked independently on their ratings while listening to the audiotapes together. Previous ratings were covered with a sheet of paper to minimize their effect on subsequent ratings. Ratings were set aside after they were completed for each therapy session.

Next, the raters worked together to arrive at a consensus PPF rating. They discussed the previous ratings and material from the audiotape until agreement was reached for the consensus rating. The audiotape was played again if the raters needed to listen to a particular passage to identify material in the session relevant to making a final rating. This served as a check on the procedures and provided a consensus score to compare the independent ratings against. The independent ratings were combined into an average PPF rating score. Then the average scores for each of the seven personal power functions were added together to make an overall PPF score. There was an overall average PPF score for each client ($n = 24$) and therapist ($n = 24$) in the data set. This score was used for statistical analysis.

Results

Reliability

Interrater agreement. Interrater agreement provided a measure of how well the scoring criteria were adhered to for the dependent measures. The greater the agreement, the more fairly the hypotheses can be tested. Interrater reliabilities for Personal Power Functions, Interpretation Depth, and Security Operations are presented below. The critical values for all the Spearman rank order correlations throughout were taken from E. G. Olds (1938).

Personal power functions. The average score of the two raters' ratings of personal power functions (PPF) was used. Average PPF scores derived from the original independent ratings of both raters were selected to represent client and therapist personal power. Rater reliabilities on these ratings were low but acceptable (Kraemer, 1981) for both client PPF, $r_s = .61$, $p < .005$, and therapist PPF, $r_s = .63$, $p < .001$. In comparison, Gavrilides (1980) obtained high interrater reliability ($r = .90$) on the full PPFP. The fact that the more objective personal power functions were not available and, therefore, not included, might account for the lower reliabilities in this study.

Comparing the average PPF intercorrelation coefficients (APIC) with the consensus PPF intercorrelation coefficients (CPIC), by inspection, they are very similar (see Table 1). For therapist PPF, the APIC are higher than the CPIC (8 out of 10). Education and Authority PPF scores, 3 and 4

respectively, were identical for the therapists. For client PPF, the APIC are higher than the CPIC (7 out of 10 and 1 tie). Education and Authority PPF scores favor APIC over CPIC (6 out of 11 and 2 ties) for the clients. In addition, the average PPF scores and the consensus PPF scores are essentially identical. Thus the rating methods are regarded as equivalent. Contrary to my expectations, the CPIC did not perform better than the APIC. In fact, the trend is that it performed worse.

Insert Table 1 about here

Comparing therapist APIC with client APIC, the correlations are all positive in the therapist matrix, suggesting coherence. The correlations in the client matrix are mixed with respect to sign of the correlations, suggesting incoherence. This difference could be attributed to the clients use of submissive-compliant SOs or the resulting narcissitic injury or decrease in euphoria by being placed in the client role is proportionate to the disparity in clients' authority and education.

Depth. From the Interpretation Scoring Guide (ISG), a criterion of at least 2 of 3 raters in agreement on the Depth rating was established. Such agreement occurred 96% of the time, but this is illusory because the agreement of all three raters was much less, 45%. Unlike the pilot study, interrater reliabilities were disappointing (see to Table 2).

Table 1

Comparison of Intercorrelation Coefficients Between Average PPF and Consensus PPF for Both Therapists and Clients

Entries in the body of the table are average PPF intercorrelation coefficients and entries in parentheses are consensus PPF intercorrelation coefficients.

Therapist PPF						
	KN	SF	SP	VO		
SF	.12 (.45)					
SP	.37 (.12)	.37 (.19)				
VO	.57 (.40)	.46 (.39)	.56 (.40)			
EX	.43 (.36)	.36 (.44)	.49 (.42)	.43 (.37)		
Client PPF						
	KN	SF	SP	VO	EX	ED
SF	.42(.48)					
SP	.22(.07)	-.22(-.22)				
VO	.32(.37)	-.40(-.27)	.57(.37)			
EX	.50(.38)	.30(.14)	.53(.31)	.40(.56)		
ED	.08(.06)	.28(.15)	-.02(-.26)	-.01(-.01)	.48(.40)	
AU	-.12(.03)	.33(.25)	-.36(-.50)	-.20(-.26)	.04(.04)	.43*

Note. PPF means personal power functions. KN = Knowledge germane to the interaction; SF = Savoir Faire; SP = Speech; VO = Voice; EX = Expression of ideas; ED = Education; AU = Authority.

*Average and consensus correlation coefficients were identical.

The defining criteria for Depth, based on the ISG, were inadequate and the lack of examples contributed to the lower reliabilities. In addition, the graduate students may have been biased by their own theoretical views in rating Depth and the 24 therapy transcripts were verbatim material whereas the training materials were edited and much easier to rate.

 Insert Table 2 about here

Security operations. The overall agreement for the presence of SOs was 93% (range of 79% to 100%). That is, raters agreed that an SO exists but they do not necessarily agree on which particular SO is present. For example, both raters agreed that there is an SO contained in a client verbalization, but one rater rated it as Take Charge and the other rated it as Turning the Tables. However, since both raters had to agree that there was an SO for it to be included and scored, SOs identified (presence of) by only one rater were not included.

Combining all twenty-four sessions, rater agreement for each of the forty SOs varied from -0.001 to 0.976 (Pearson product-moment correlations¹). The smaller correlation coefficients tended to result from a low frequency of SO scores for that particular SO. Most of the correlation

 1. Pearson product-moment correlations were calculated on the raw data to determine interrater reliabilities.

Table 2

Interrater Reliabilities for Depth of Interpretation

Raters	Raters		
	BC	TC	DF
TC	.18	.37	.72
DF		.36	.21
CM			.33

Note. BC = rater 1. TC = rater 2. DF = rater 3.
CM = rater 4.

coefficients are acceptable. For the others that are not at acceptable levels of agreement, the operational definitions and examples need to be improved or those particular SOs need to be dropped from the scale. Refer to Table 3 for a summary of Pearson correlations for each of the forty SOs.

 Insert Table 3 about here

It was necessary to account for multiple SO scores contained in some of the client and therapist responses. In addition, SO ratings needed to reflect only one score per response. Therefore, rater SO scale scores in the same response were combined into a mean SO score. This score was used in the data analysis and statistical calculations to test the hypotheses.

Conclusion. Rater agreement is low but at acceptable levels for PPF and Depth; however, it varied considerably for the particular type of SO (Table 3). Some of the SOs were scored infrequently, and the corresponding interrater reliabilities were very low. According to Kraemer (1981), most of these rater reliabilities would be regarded as acceptable but possibly improvable. Therefore, the hypotheses may not receive a fair test.

Preliminary analyses

These are routine exploratory comparisons which were not theory-driven; nevertheless, the outcomes are either consistent or inconsistent with the theoretical model under

Table 3

Interrater Reliabilities for each of the Security Operations

S.O.	Pearson r^a	S.O.	Pearson r
Interrupting	0.76	Obsequiousness	0.55
Take Charge	0.38	Char. Bld. I	0.37
Repartee	0.47	Questioning	0.73
Dramatization	0.74	Diffidence	0.31
Sentence Finishing	0.67	Qualifying	0.51
Teasing	0.48	Exemption	0.28
Turning The Tables	0.41	Facelessness	0.51
Humor	0.44	You Know	0.89
Arm Twisting	0.60	Char. Bld. II	0.61
Incessant Talking	0.30	Self-justify	0.52
Changing Topic	0.63	Self-efface	0.47
Annoyance	0.46	Apologizing	0.71
Security Blanket	0.43	Char. Bld. III	0.40
Connecting	0.68	Reassurance	0.30
Placation	0.56	Silence	0.96
Disparagement	0.13	Taciturn	0.33
Nonanswers to Questions	0.11	Stalling	0.76
Skepticism	0.31	Word Change	0.66
Side-stepping	0.16	Incom. Sentence	0.61
Dissembling	0.00	Automatic Laugh	0.98

Note. S.O. = security operation. Char. Bld. = Character Building. Incom. = Incomplete.

^aPearson product-moment correlations coefficients calculated on the raw data over all (n = 24) sessions. Used for convenience. Very similar to Spearman rank correlations calculated on a subset of these data.

test.

Personal Power Functions Profile

Personal power. A differential power score (Difpower) was calculated by subtracting the client personal power score from the therapist personal power score. Twenty-one of twenty-four client-therapist pairs favored the therapist in terms of personal power (PPF). Of the three remaining pairs, one pair was equal in PPF and the other two had power scores favoring the client over the therapist. Thus, consistent with therapists being more powerful and intimidating, they possessed greater overall personal power than clients. The medians for therapists and clients were 26 and 22 respectively. The former ranged between 20.5 and 29.0, and the latter ranged between 16.5 and 26.5. The Sign test was significant, $\chi = 2$ ($N = 23$), $p < .005$.

Examining the distributions of PPFP scores (refer to Figure J-1 in Appendix J), the histograms illustrate that therapist scores were approaching a normal distribution or were skewed to the left. Client scores were either bi-modal or skewed to the right, opposite that of the therapists. This suggests that there is an orderly, functional relationship.

Inconsistent with background theory (Sullivan, Freud, Ethology), therapist PPF scores and client PPF scores appeared to be functionally related, as revealed by a positive correlation between them, $r_s = .34$, $p < .06$, that approached significance. That is, therapist and client

personal power functions covary in the same direction. Unfortunately, there is no way of ascertaining what is happening to account for this: Does high therapist PPF elicit high client PPF? Perhaps the reverse is true and low client PPF elicits low therapist PPF.

Componential analysis of PPFP scale. The uniform disparity between client-therapist mean PPF scores (see Table 4) favoring therapists indicates that the latter were indeed more powerful and, therefore, intimidating.

 Insert Table 4 about here

Table 1 above shows the interrelations between the components of PPFP. Whereas the 10 coefficients in the therapists' matrix were all positive and often significant (9 out of 10), two in the clients' matrix were negative. Moreover, five of the correlations involving Authority and Education, which could not be done for therapists, were negative. Consistent with the theory under test, client intimidation (loss of euphoria) is proportionate to their own level of education and authority. If these results are taken at face value, then interpretive methods of psychotherapy appear to be counterproductive.

Security operations

Submissive-compliant security operations (SOs).

Consistent with the provisions of the theory under test, that clients would be more submissive-compliant in relation to

Table 4

Mean Power Scores for Therapist PPF and Client PPF
based on the Personal Power Functions Profile

Entries in the body of the table are mean PPF scores
 n = 24) and entries in parentheses are standard
 deviations.

Mean scores (SD)		
Power function	Therapist PPF	Client PPF
Knowledge	3.79 (0.72)	3.27 (0.71)
Savoir Faire	3.50 (0.49)	2.81 (0.51)
Speech	4.10 (0.42)	3.69 (0.36)
Voice	3.75 (0.77)	3.44 (0.65)
Expression	4.15 (0.56)	3.48 (0.54)
Authority	3.00 (0.00)	2.58 (0.97)
Education	4.00 (0.00)	3.29 (0.87)

Note. PPF means personal power functions.

therapists given therapists' role and "favored status" in therapy, clients used more submissive-compliant SOs than did therapists. The average median scale values for clients and therapists were 16.74 and 28.05 respectively. The former ranged between 6.64 and 25.94, and the latter ranged between 17.73 and 34.50. The Sign test was significant, $\chi = 0$ ($N = 24$), $p < .001$.

Client response following therapist interpretation (CRI). Consistent with the provisions of the theory under test, that interpretations decrease client euphoria, clients used a high percentage of SOs following an interpretation. Overall, clients used an SO after an interpretation 87% of the time. Within each therapy session, clients responded to interpretations with SOs anywhere from 67% to 100% of the time (Table 5). Once again, interpretive methods of psychotherapy appear to be counterproductive.

 Insert Table 5 about here

Therapist response following interpretation (TRI). Consistent with background knowledge on clients' typical limited acceptance or side-stepping SOs, therapists experience a decrease in euphoria and therefore typically employ SOs following a clients' response (usually an SO) to interpretations. Overall, therapists responded to a CRI with an SO 61% of the time. Within each therapy session, therapists responded to CRIs with SOs ranging from 22% to 92%

Table 5

**Percentage of Client and Therapist Security Operation
Responses Following Interpretations and Noninterpretation
Statements**

Entries in the body of the table are percentages.

Case	Interpretation response		Noninterpretation response	
	Client	Therapist	Client	Therapist
01	96	78	62	65
02	82	68	71	48
03	72	40	62	46
04	82	74	73	59
05	83	92	82	76
06	100	74	63	57
07	92	25	85	52
08	82	41	71	59
09	94	47	83	32
10	100	44	80	63
11	75	54	61	62
12	90	71	81	65
13	88	36	76	38
14	82	59	76	68
15	81	63	80	43
16	100	60	78	42
17	80	90	70	60
18	67	61	64	35
19	88	67	63	51
20	94	88	90	61
21	89	22	81	45
22	94	39	75	39
23	93	73	88	73
24	86	57	58	21

of the time (Table 5). This finding diminishes claims that therapists can be objective.

Therapist response following client verbalization (TRC).
In accord with Sullivan, SOs are ubiquitous. Therapists responded with an SO after client statements (noninterpretive event) 54% of the time, with a range of 21% to 76% (Table 5). Consistent with their intimidation by client nonacceptance of SOs, TRC (excluding TRI) was less than TRI (54% vs. 61%) (Wilcoxon, $T = -75.5$, $N = 22$, $z = -1.66$, $p < .05$). Again, the evidence favors the claim that therapists self-system is too involved for them to be objective.

Client response following therapist verbalization (CRT).
Once again documenting the ubiquity of SOs, overall, clients responded with an SO after TRC (excluding TRI) 73% of the time. For each therapy session, the range was 58% to 90% (Table 5). Consistent with the inherent intimidation of therapists' interpretations, CRT (excluding CRI) was less than CRI (73% vs. 87%) (Wilcoxon, $T = 0$, $N = 24$, $z = -4.29$, $p < .0001$).

Comparison of client and therapist security operations following both interpretation and noninterpretation statements. Consistent with their disadvantage in PPF, clients responded with an SO more often than therapists following an interpretation (87% vs. 61%) ($U = 522.5$, $N = 48$, $p < .0003$). Moreover, clients also responded with an SO more often than therapists following a noninterpretation statement (73% vs 54%) ($U = 519$, $n = 48$, $p < .0003$). Overall, clients

used SOs more often than therapists in the therapy sessions, revealing their greater intimidation.

Examining the distributions of SO scores (zero scores, representing no security operation scored, were taken out of the histograms, refer to Figure J-2 in Appendix J), the histograms illustrate that therapist scores were skewed to the left following both interpretations and noninterpretations while client scores were skewed to the right following both interpretations and noninterpretations. This suggests that there is an orderly, functional relationship in the way clients and therapists use security operations.

Clients did not use an SO following TI only 13% of the time. With regard to acceptance of interpretations, some portion of that 13% would possibly be included. Unfortunately, the question of TI acceptance by the client goes beyond the scope of this study but these findings do suggest that clients parry interpretations most of the time; that is, they are not accepted.

Therapist interpretation (TI). There were 24 client-therapist pairs with 464 interpretations made by the therapists collectively. The mean number of interpretations per session was 19.3, ranging from 5 to 34. The percentage of therapist utterances that were interpretations ranged from 5% to 38%. Therapists followed a client's response to an interpretation with another interpretation almost 30% of the time. Consistent with their intimidation by client

nonacceptance of interpretations, it is not surprising that they responded with another interpretation, when clients responded with an SO. This is not in accord with the therapeutic task of helping clients deal with the impact and aftermath of an interpretation.

When proffering an interpretation, therapists went beyond a client's awareness [introduction depth level: The therapist interpretation only contains ideas that the client has not explicitly verbalized (refer to ISG in Appendix B)] over 50% of the time. Consistent with both Sullivanian and Freudian theory, deep interpretations are more intimidating than shallow ones. When therapists' interpretations went beyond a client's awareness, it led to a high frequency of client SOs (74%). For Sullivan, this would imply disapprobation; for Freud, this would suggest that the client was unprepared for such "insight."

Therapist experience. In exploring the data further, therapists' years of therapy experience was significantly correlated with PPF, ($r_s = 0.48$), $t = 2.59$, $p < .02$. So as years of therapy experience increased, therapists tended to possess more personal power.

Conclusion. Although the foregoing contrasts are consistent, for the most part, with the theory under test, they were not formulated as hypotheses or predictions beforehand. Therefore, they have less confirmatory/corroborative impact, i.e., the theory did not "stick its neck out," compared to the experimental hypotheses

below (Popper, 1959).

The preliminary analysis attested to the apparent validity of the two research instruments (PPFP and ESOS); they behaved as they should, often significantly, in a variety of contrasts. Also the relationship between personal power (clients low, therapists high) and SOs (clients' median SO score lower than therapists' median SO score) is consistent with Gavrilides (1980) findings. This empirical appearance of validity ensured that the experimental hypotheses were provided a fair test in the present investigation. There is no question as to the ability of the designated instruments of mensuration to order data (observations) and to enter into significant and meaningful relationships with each other (Hilgard, 1969).

Implications. Even though uniformly consistent with the theory under test and background theory, the foregoing post hoc comparisons do not have empirical content (Popper, 1963). Only where theory "sticks its neck out" by making a prediction is there empirical content. Nonetheless, a theory is better off if there is consistency rather than inconsistency in post hoc findings (Popper, 1963), i.e., it accommodates experimental facts not associated with successful predictions. Post hoc and ad hoc claims of consistency are more apt to involve the stretching and twisting of theoretical propositions than does logically deriving hypotheses from them (J. Reyher, personal communication, September 24, 1995).

The negative light in which this particular interpretive method (Time-Limited Dynamic Psychotherapy) is cast is both surprising and discouraging.

Experimental hypotheses:

Hypothesis Ia. This hypothesis, which asserts that mastery-dominance level of client SOs, as measured by the ESOS, following each therapist verbalization is inversely related to the discrepancy (dif.PPF) between therapist and client personal power, was not corroborated, $r_s = -.21$, $p > .10$ (Table 6). Although this hypothesis did not achieve statistical significance, it was certainly in the predicted direction (negative). The low reliabilities in PPFP may have contributed to this. Perhaps this could have been remedied if the more objective dimensions of PPFP had been available on videotape or other sources.

 Insert Table 6 about here

Hypothesis Ib. This hypothesis, which asserts that mastery-dominance level of client SOs, as measured by the ESOS, following each therapist interpretation is inversely related to the discrepancy (dif.PPF) between therapist and client personal power, was not corroborated, $r_s = -.01$, $p > .10$ (Table 6). The obtained correlation is only trivially in the predicted direction (negative).

Table 6

Spearman Rank Order Correlation Coefficients Between Personal Power (PPF) and Median Security Operation (SO) Scores

Participants	Personal power		
	Differential PPF ^a	Client PPF	Therapist PPF
Client			
CRI ^b	-0.01	0.06	0.20
CRT ^c	-0.21	0.09	-0.03
Therapist			
TRI ^d	0.46*	-0.18	0.36**
TRC ^e	0.37**	-0.11	0.38**

Note. n = 24. Critical values for the Spearman's rank order correlation coefficients taken from E. G. Olds (1938). TI = therapist interpretation. CR = all client SOs & non SOs in response to all therapist verbalizations. TR = all therapist SOs & non SOs in response to all client verbalizations.

^aDifferential power obtained by subtracting client personal power (PPF) score from therapist personal power (PPF) score.

^bCRI = client SOs following TI only.

^cCRT = client SOs following both TI and TR.

^dTRI = therapist SOs following CRI only.

^eTRC = therapist SOs following both CRI and CR.

*p < .025. **p < .05.

Hypothesis IIa. This hypothesis, which proposed that the mastery-dominance level of therapist SOs, as measured by the ESOS, following each client verbalization is directly related to the discrepancy (dif.PPF) between therapist and client personal power, was corroborated, $r_s = .37$, $p < .05$ (Table 6).

Hypothesis IIb. This hypothesis, which proposed that the mastery-dominance level of therapist SOs, as measured by the ESOS, following each therapist interpretation (TI) is directly related to the discrepancy between therapist and client personal power (dif.PPF), was corroborated, $r_s = .46$, $p < .02$ (Table 6).

Hypothesis III. This hypothesis asserts that depth of therapist interpretation is (a) directly related to the discrepancy (differential power) between therapist and client personal power, but (b) is inversely related to client mastery-dominance level (client SOs as measured by ESOS).

a. Interpretation depth and dif.PPF were not related as predicted, $r_s = .12$, $p > .10$. Once again this failure to corroborate is mitigated by the obtained correlation being in the predicted direction and the relatively low reliability of the abbreviated PPFP.

b. Client mastery-dominance level and depth of therapist interpretation were not related as predicted, $r_s = -.06$, $p > .10$.

Both part a and b of this hypothesis were not corroborated. The minimally acceptable interrater

reliabilities associated with Depth have contributed to these disappointing findings. As discussed later, the levels of depth were insufficiently delineated and were not clearly defined.

Hypothesis IV. This hypothesis, which proposed that total number of interpretations proffered by therapists is directly related to the discrepancy (dif.PPF) between therapist and client personal power, was not corroborated, $r_s = -.29$, $p < .09$. Moreover, the obtained correlation (-0.29) was negative and approached significance ($r_s, .05 = -0.34$).

Discussion

Evaluating the impact of interpretations in therapy based on extended Sullivanian theory was the main purpose of this study. Overall, the findings are mixed regarding the hypothesized relationships between personal power and security operations. The success of only one of the four experimental hypotheses reveals some of the limitations of the theory under test, despite its consistency with the preliminary analyses. One limitation was the low rater reliabilities on PPFP and Depth. Another limitation was the varied reliabilites on ESOS. Nevertheless, PPFP and ESOS entered into a variety of orderly relationships based on results from the preliminary analyses. Depth did not have the same opportunity to demonstrate its scientific value.

Only the magnitude in differential PPF in relation to therapist's SOs (hypothesis II) survived falsification. Fortunately, this hypotheses happens to be derived directly from the most central conceptual region of the theory without the need of auxiliary hypotheses other than those relating to the instruments used (PPFP and ESOS); namely, the relation between relative personal power and type of security operations.

In contrast, the corresponding derivation for clients was not corroborated (hypothesis I). Even though clients used more security operations in the therapy sessions than therapists, they did not display a behavior pattern of submissive-compliance hypothesized to be consistent with low

PPF.

The relation between type of SO and Depth of interpretation (hypothesis III) is complicated by the inclusion of additional auxiliary hypotheses relating Depth to the personal power of the therapist, thereby increasing the separation between the theoretical core and dependent variables. There is a thicker "protective belt" of auxiliary hypotheses (Lakatos, 1979). This hypothesis as stated was not corroborated.

Hypothesis IV also requires additional auxiliary hypotheses to relate frequency of interpretation to personal power. Despite disconfirmation, the results do suggest the possibility of interpretations functioning as intimidating SOs when the therapist's self-system perceives a threat or anticipates a lowering of euphoria. Proffering an interpretation may momentarily increase experienced power of the therapist's self-system but decrease experienced power of the other participant in the interaction.

Why the difference between therapists and clients? Perhaps being in the disadvantaged side of the dyad, clients are continually striving (a dynamism) to "right themselves", in Sullivanian theory, that is, to integrate the relationship with the therapist wherein they can obtain deference in the integration. This dynamism is presumed to be intensified as differential in personal power increases. This righting dynamism, analogous to the righting reflex, generates verbal attempts to assert mastery-dominance which therapists are

likely to construe as resistance against emerging dissociated material (i.e., lust dynamism, "bad" personifications). This is not to say that this reaction accounts for all resistance. In one context Sullivan (1953) relates this to an attempt, in some relationships, for the participants to extract deference from each other in their pursuit of security. This ad hoc explanation requires installing righting behavior as a central theoretical construct in the conceptualization of the self-system. In a Popperian perspective, this would only add empirical content to the theory if it provided a falsifiable prediction. Accordingly, one testable prediction is that the righting reaction of a person with low relative personal power in a dyad would be displayed in projective stimuli (e.g., TAT) as "turning the tables" and becoming dominant, whereas enjoying mastery-dominance would be displayed for the member of the dyad enjoying high relative personal power. However, this remedial tactic also requires that personal power be installed as a central construct in the self-system, that is, in addition to only being attentive to forbidding gestures, the self-system would equally be alert to extracting deference from others.

Such massive theoretical surgery is not required in Reyher's (1992) extension of Freud's conceptualization of the ego interests; namely, the ego's attempt to extract an advantage from any interpersonal situation and thereby experience satisfaction. As previously noted, the extended Sullivanian theory under examination already includes

ethological components; namely personal power, dominance hierarchy, and implicit agonistic dominance.

In regard to Depth (Hypothesis III), only some types of interpretations would cue a righting reaction. Interpretation pertaining to content, resistance, and transference, particularly, the latter two, should reliably produce it, whereas stitching together recollections interpretively to construct a coherent life story (hermeneutic perspective) should not be as reliably causal. The same should be true for nondirective (Rogerian) reflections.

Frequency of interpretation (Hypothesis IV) ignores type of interpretation and requires the same auxiliary hypotheses as does Depth. It also assumes a nontonic, linear relationship between rate of interpretations and lowering of euphoria. One "ugly" ad hoc explanation (ad hoc₃, [Lakatos, 1979]) is that there might be a point where selective inattention (Sullivan) intervenes - clients no longer pay attention but give the appearance of listening. However, this is not a mere auxiliary hypothesis. This turn off point, if it indeed exists, is both idiosyncratic and variable and must be determined empirically as it happens (e.g., failure to maintain eye contact, cessation of eye blinks) but is likely to be undetectable.

Summary. The intent of this study was to examine an extended Sullivanian theory by assessing the effects of personal power on the selection and use of security

operations by both clients and therapists following therapist interpretations in brief time-limited dynamic psychotherapy. The preliminary findings revealed that clients were more likely to respond with a security operation than therapists, especially following therapist interpretations. Therapists, as a group, had more personal power in the therapy situation and used more dominant security operations when compared to clients. In addition, the therapists with more personal power tended to have more years of therapy experience.

Overall, the hypotheses under test were tested fairly except for those two that included Depth. The orderly relationships in which PFP and ESOS entered, as demonstrated by the consistency of the preliminary results, attests to their validity with respect to background theory. The hypothesis on mastery-dominance level of therapist security operation(s) following both interpretation and noninterpretation statements was directly related to personal power, but the corresponding analysis for clients was not inversely related to personal power as expected.

Perhaps the hypotheses regarding depth of interpretation were not corroborated because low interrater reliabilities did not provide a fair test of this hypothesis. A reexamination of the different levels of Depth revealed that they may have been insufficiently defined and illustrated to enable raters to decipher and rate the therapy sessions with any consistency.

Even though the total number of interpretations

proffered by therapists was not directly related to the discrepancy between therapist and client personal power as predicted, the outcome suggests that interpretations may indeed function as security operations. That is, therapists' threat (anticipation of lowered euphoria) increases as they experience less power vis-a-vis clients. If this finding holds up in future investigations, then it is legitimate to infer that objectively manifested greater personal power in an interpersonal encounter is not experienced as such by the self-system, which always perceives opportunities for loss in the neighboring future (J. Reyher, personal communication, August 4, 1995).

Overall, both clients and therapists respond with security operations in therapy. Interpretations seem to cue anxiety (a lowering of euphoria) that typically cannot be mastered, consequently generating security operations in response. These security operations function to maintain interpersonal security in the face of no threat. They serve as a protective measure against undue anxiety or the threat of anxiety arising from forbidding gestures (behavioral and expressive cues that lower euphoria) in interpersonal situations.

Implications

Treatment and interpretation. Therapists need to reexamine why they proffer interpretations to clients in therapy. Is it because they were trained to interpret and they feel obligated to provide these "gifts" to their clients

or do they anticipate that their competence and skill as a therapist will be questioned if they do not interpret? Therapists in this study were using more dominant SOs when responding to clients and the more powerful therapists seemed to be interpreting less. It could be that the therapists were anticipating a lowering of euphoria because these sessions were being videotaped and audiotaped. If therapists are not responding objectively to clients then that leads one to question this particular method of interpretive therapy. Maybe they need to take more care in timing interpretations.

On the other hand, maybe all SOs are not necessarily bad, i.e., some SOs may provide an opportunity for clients to explore their own social effectiveness as well as learn about alternative SOs by observing and interacting with the therapist. Therapists might interpret less and help clients decrease their anxiety to a level where they are able to attend to what is happening in the therapy sessions. This may free up therapists so that they are not feeling pressured to interpret, thereby decreasing their anxiety level and circumventing an anticipated drop in euphoria by the self-system.

What about when therapists or clients do not use SOs? One possibility is the therapist proffered a "good" interpretation. Alternatively, clients might be so overwhelmed by a previous interpretation, that the self-system has not had enough time to respond with another SO or either party may employ "selective inattention" to avoid

further taxing the self-system.

Limitations. As stated previously, low interrater reliabilities on the measures used in this study did not allow for a fair test of extended Sullivanian theory regarding Depth. This investigation included only the sixteenth session therapies out of 25 total sessions and therapy outcome was not examined. Also Sullivanian theory itself cannot accommodate client "righting" behavior without major additions to its core assumptions.

Future research. Even though evaluation of extended Sullivanian theory was not given a fair test based on these findings, an alternative theory, i.e., Freudian theory, was found to be better matched to the constructs. That is, mastery-dominance and personal power are not a central constructs of Sullivanian theory, but more in keeping with Freudian and ethological perspectives. Future investigations developed from these models could provide a better test of mastery-dominance and personal power constructs in a therapy setting.

Other possible studies that are suggested by the above findings include: 1) using undergraduate students, in fields other than psychology, to rate interpretations using the ISG to determine if theoretical bias influenced the Depth ratings; 2) editing the therapy transcripts to resemble the training materials, being careful not to distort the data contained in the transcripts, and compare that to ratings of the 'raw' data; or 3) given that there was a qualitative

difference between therapists (PPF influenced therapist SOs in direction of mastery-dominance) and clients (the same relationship was negative but not statistically significant), this has implications regarding both participants' state of mind during therapy. One would need to conceptualize what that state of mind might be and attempt to corroborate their conceptualization or theory.

REFERENCES

References

- Abramowitz, S. & Jackson, C. (1974). Comparative effectiveness of there-and-then versus here-and-now therapist interpretations in group psychotherapy. Journal of Counseling Psychology, 21, 288-293.
- Adams, H., Butler, J., & Noblin, C. (1961). Effects of psychoanalytically-derived interpretations: A verbal conditioning paradigm? Psychological Reports, 10, 691-694.
- Adams, H., Noblin, C., Butler, J., & Timmons, E. (1962). Differential effect of psychoanalytically-derived interpretations and verbal conditioning in schizophrenics. Psychological Reports, 11, 195-198.
- Auerswald, M. (1974). Differential reinforcing power of restatement and interpretation on client production of affect. Journal of Counseling Psychology, 21, 9-14.
- Bergman, D. (1951). Counseling method and client responses. Journal of Consulting Psychology, 15, 216-224.
- Brunink, S. & Schroeder, H. (1979). Verbal therapeutic behavior of expert psychoanalytically oriented, gestalt, and behavior therapists. Journal of Consulting and Clinical Psychology, 47, 567-574.
- Budman, S. & Gurman, A. (1988). Theory and practice of brief therapy. New York: The Guilford Press.
- Chapman, A. (1978). The treatment techniques of Harry Stack Sullivan. New York: Brunner/Mazel, Publishers.
- Claiborn, C. (1979). Counselor verbal intervention, nonverbal behavior, and social power. Journal of Counseling Psychology, 26, 378-383.
- Claiborn, C., Ward, S., & Strong, S. (1981). Effects of congruence between counselor interpretations and client beliefs. Journal of Counseling Psychology, 28, 101-109.
- Coltrera, J. & Ross, N. (1976). Freud's psychoanalytic technique from the beginnings to 1923. In B. Wolman (Ed.), Psychoanalytic techniques: A handbook for the practicing psychoanalyst. New York: Basic Books, Inc.
- Cooke, M. & Kipnis, D. (1986). Influence tactics in psychotherapy. Journal of Consulting and Clinical Psychology, 54, 22-26.

- Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. Journal of Consulting and Clinical Psychology, 56, 490-495.
- Derogatis, L. (1977). SCL-90 manual I: Administration, scoring, and procedures for the revised version. Baltimore: Clinical Psychometrics Unit, Johns Hopkins University School of Medicine.
- Duncan, S., Rice, L., & Butler, J. (1968). Therapists' paralinguistic in peak and poor psychotherapy hours. Journal of Abnormal Psychology, 73, 566-570.
- Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. Journal of Counseling Psychology, 32, 307-322.
- Elliott, R., Barker, C., Caskey, N. & Pistrang, N. (1982). Differential helpfulness of counselor response modes. Journal of Counseling Psychology, 29, 354-361.
- Elliott, R., Hill, C., Stiles, W., Friedlander, M., Mahrer, A., & Margison, F. (1987). Primary therapist response modes: Comparison of six rating systems. Journal of Consulting and Clinical Psychology, 55, 218-223.
- Ericson, P. (1972). Relational communication: complementarity and symmetry and their relation to dominance-submission. Unpublished doctoral dissertation, Michigan State University, East Lansing.
- Ericson, P. & Rogers, L. E. (1973). New procedures for analyzing relational communication. Family Process, 12, 245-267.
- Fenichel, O. (1941). Problems of psychoanalytic technique. New York: The Psychoanalytic Quarterly, Inc.
- Fenichel, O. (1945). The psychoanalytic theory of neurosis. London: Routledge & Kegan Paul Ltd.
- Fiedler, F. (1951). Factor analysis of psychoanalytic, nondirective, and Adlerian therapeutic relationships. Journal of Consulting Psychology, 15, 32-38.
- Fine, R. (1968). Interpretation: The patient's response. In E. Hammer (Ed.), Use of interpretation in treatment: technique and art. New York: Grune & Stratton.
- Fisher, S. (1956). Plausibility and depth of interpretation. Journal of Consulting Psychology, 20, 249-256.

- Foreman, S. & Marmar, C. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. American Journal of Psychiatry, 142, 922-926.
- Forsyth, N. & Forsyth, D. (1982). Internality, controllability, and the effectiveness of attributional interpretations in counseling. Journal of Counseling Psychology, 29, 140-150.
- Frances, A. & Perry, S. (1983). Transference interpretations in focal therapy. American Journal of Psychiatry, 140, 405-409.
- Frank, G. & Sweetland, A. (1962). A study of the process of psychotherapy: The verbal interaction. Journal of Consulting Psychology, 26, 135-138.
- Freud, S. (1900). The interpretation of dreams. S.E., (Vols. 4 & 5).
- Freud, S. (1904). Freud's psychoanalytic procedure. S.E., (Vol. 7, pp. 249-256).
- Freud, S. (1913). On beginning treatment, further recommendations on the technique of psychoanalysis. S.E., (Vol. 12, pp. 122-179).
- Freud, S. (1923). Psycho-analysis. S.E., Vol. 18, pp. 234-254).
- Freud, S. (1937). Analysis terminable and interminable. S.E., (Vol. 23, pp. 323-374).
- Freud, S. (1937). Constructions in analysis. In L. Paul (Ed.), Psychoanalytic clinical interpretation, (pp. 65-78). London: Collier-Macmillan Ltd.
- Freud, S. (1958). Papers on Technique. In J. Strachey (Ed. & trans), The Standard Edition of the Complete Psychological Works of Sigmund Freud, 12, 85-171. London: Hogarth Press.
- Freud, S. (1963). Three case histories. [P. Rieff (Ed.)]. New York: Collier Books, Macmillan Publishing Company.
- Garduk, E. & Haggard, E. (1972). Immediate effects on patients of psychoanalytic interpretations. Psychological Issues, 7(4), Monograph 28, 3-82.
- Gavrilides, G. (1980). The relationship of personal power functions to general happiness, interpersonal risk, interpersonally induced anxiety, and security operations. Unpublished dissertation, Michigan State University.

- Gill, M. & Hoffman, I. (1982). A method for studying the analysis of aspects of the patient's experience of the relationship in psychoanalysis and psychotherapy. Journal of the American Psychoanalytic Association, 30, 137-168.
- Glover, E. (1955). The technique of psycho-analysis. New York: International University Press, Inc.
- Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. Journal of Consulting and Clinical Psychology, 46, 1023-1035.
- Gomes-Schwartz, B. & Schwartz, J. (1978). Psychotherapy process variables distinguishing the "inherently helpful" person from the professional psychotherapist. Journal of Consulting and Clinical Psychology, 46, 196-197.
- Goodman, G. & Dooley, D. (1976). A framework for help intended communication. Psychotherapy: Theory, Research, and Practice, 13, 106-117.
- Graham, R. & May, B. A. (1989). The Interpretation Scoring Guide. Unpublished manuscript. Michigan State Univ.
- Greenson, R. (1967). The technique and practice of psychoanalysis: Vol. I. New York: International University Press, Inc.
- Greenson, R. (1978). Explorations in psychoanalysis. New York: International University Press, Inc.
- Grossman, D. (1952). An experimental investigation of a psychotherapeutic technique. Journal of Consulting Psychology, 16, 325-331.
- Hamernik, K. (1987). Experimental personal power and monitoring effects on figure drawing tasks. Unpublished dissertation, Michigan State University.
- Hammer, E. (1966). Interpretations in treatment: Their place, role, timing, and art. Psychoanalytic Review, 53, 463-468.
- Hammer, E. (1968a). Interpretation: What is it? In E. Hammer (Ed.), Use of interpretation in treatment: technique and art. New York: Grune & Stratton.
- Hammer, E. (1968b). Interpretive technique: A Primer. In E. Hammer (Ed.), Use of interpretation in treatment: technique and art. New York: Grune & Stratton.

- Harway, N., Dittmann, A., Raush, H., Bordin, E., & Rigler, D. (1955). The measurement of depth of interpretation. Journal of Consulting Psychology, 19, 247-253.
- Hawton, K., Reibstein, J., Fieldsend, R. & Whalley, M. (1982). Content analysis of brief psychotherapy sessions. British Journal of Medical Psychology, 55, 167-176.
- Henry, W., Schacht, T., & Strupp, H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapy outcome. Journal of Consulting and Clinical Psychology, 58, 768-774.
- Hilgard, J. (1969). Pain as a puzzle for psychology and physiology. American Psychologist, 24, 103-113.
- Hill, C. (1978). Development of a counselor verbal response category system. Journal of Counseling Psychology, 25, 461-468.
- Hill, C. (1989). Therapist techniques and client outcomes. Newbury Park: Sage Publications, Inc.
- Hill, C., Carter, J. & O'Farrell, M. (1983). A case study of the process and outcome of time-limited counseling. Journal of Counseling Psychology, 30, 3-18.
- Hill, C., Helms, J., Tichenor, V., Spiegel, S., O'Grady, K., & Perry, E. (1988). Effects of therapist response modes in brief psychotherapy. Journal of Counseling Psychology, 35, 222-233.
- Kanfer, F., Phillips, J., Matarazzo, J., & Saslow, G. (1960). Experimental modification of interviewer content in standardized interviews. Journal of Counseling Psychology, 24(6), 528-536.
- Kiesler, D. (1982). Reaction: The comeback trail for process analysis. The Counseling Psychologist, 10, 21-22.
- Kohut, H. (1977). Restoration of the self. New York: International University Press.
- Koss, M., Butcher, J., & Strupp, H. (1986). Brief psychotherapy methods in clinical research. Journal of Consulting and Clinical Psychology, 54, 60-67.
- Lakatos, I. (1970). Falsification and the methodology of scientific research programmes. In I. Lakatos & A. Musgrave (Eds.), Criticism and growth of knowledge. Cambridge: Cambridge University Press.

- Langs, R. (1973). The technique of psychoanalytic psychotherapy, vol. I. New York: Jason Aronson, Inc.
- Langs, R. (1982). Psychotherapy: A basic text. New York: Jason Aronson, Inc.
- Langs, R. (1983). The technique of psychoanalytic psychotherapy, vol. II. New York: Jason Aronson, Inc.
- Levy, S. (1984). Principles of interpretation. New York: Jason Aronson, Inc.
- Loewenstein, R. (1951). The problem of interpretation. Psychoanalytic Quarterly, 20, 1-14.
- Loewenstein, R. (1957). Some thoughts on interpretation in the theory and practice of psychoanalysis. In L. Paul (Ed., 1963), Psychoanalytic clinical interpretation, (pp. 162-188). London: Collier-Macmillan Ltd.
- Luborsky, L., Bachrach, H., Graff, H., Pulver, S. & Christoph, P. (1979). Preconditions and consequences of transference interpretations: A clinical-quantitative investigation. The Journal of Nervous and Mental Disease, 167, 391-401.
- Mahl, G. (1956). Disturbances and silences in the patient's speech in psychotherapy. Journal of Abnormal and Social Psychology, 53, 1-15.
- Malan, D. (1976). Toward the validation of dynamic psychotherapy: A replication. New York: Plenum Medical Books Co.
- Mark, R. (1970). Parameters of normal family communication in the dyad. Unpublished doctoral dissertation, Michigan State University, East Lansing.
- Marziali, E. (1984). Prediction of outcome of brief psychotherapy from therapist interpretive interventions. Archives of General Psychiatry, 41, 301-304.
- Marziali, E. & Sullivan, J. (1980). Methodological issues in the content analysis of brief psychotherapy. British Journal of Medical Psychology, 53, 19-27.
- May, B., Graham, R., Cefai, T., Clark, B., Finke, D., & Miller, C. (1990). Does theory permeate practice? Comparing two theoretically diverse therapists with the Interpretation Scoring Guide. Unpublished manuscript, Michigan State University.
- Milman, D. & Goldman, G. (1987). Techniques of working with resistance. New Jersey: Jason Aronson.

- Noblin, C., Timmons, E., & Reynard, M. (1963). Psychoanalytic interpretations as verbal reinforcers: Importance of interpretation content. Journal of Clinical Psychology, 19, 479-481.
- Olds, E. G. (1938). Distribution of sums of squares of rank differences for small numbers of individuals. Annals of Mathematical Statistics, 9.
- Piper, W., Debbane, E., Bienvenu, J., Carufel, F., & Garant, J. (1986). Relationships between the object focus of therapist interpretations and outcome in short-term individual psychotherapy. British Journal of Medical Psychology, 59, 1-11.
- Popper, K. (1959). The logic of scientific discovery. New York: Harper Row.
- Popper, K. (1963). Conjectures and refutations. New York: Harper Row.
- Pottinger, J. (1982). The effect of posthypnotic suggestion on dream recall. Unpublished doctoral dissertation, Michigan State University.
- Ramzy, I. (1974). How the mind of the psychoanalyst works: An essay on psychoanalytic inference. International Journal of Psycho-Analysis, 55, 543-550.
- Raush, H., Sperber, Z., Rigler, D., Williams, J., Harway, N., Bordin, E., Dittmann, A., & Hays, W. (1956). A dimensional analysis of depth of interpretation. Journal of Consulting Psychology, 20, 43-48.
- Reich, W. (1949). Character analysis. New York: Orgone Institute Press, Inc.
- Reyher, J. (1978). Emergent uncovering psychotherapy: The use of imagoic and linguistic vehicles in objectifying psychodynamic processes. In J. Singer & K. Pope (Eds.), The power of human imagination. New York: Plenum Press.
- Reyher, J. (1979). Personal Power Functions Profile. (Unpublished manuscript). Michigan State University, Psychology Department, East Lansing.
- Reyher, J. (1979). Security Operations Inventory. (Unpublished manuscript). Michigan State University, Psychology Department, East Lansing.

- Reyher, J. (1980). Treatment outcome in relation to visual imagery, suggestibility, transference, and creativity. In J. Shorr, G. Sobel, P. Robbin, & J. Connella (Eds.), Imagery: Its many dimensions and applications. New York: Plenum Press.
- Reyher, J. (1988). Transforming manifest content into latent content. (Unpublished manuscript). Michigan State University, Psychology Dept., East Lansing.
- Reyher, J. (1989). Freud's models of the psyche. (Unpublished manuscript). Michigan State University, Psychology Dept., East Lansing.
- Reyher, J. (1989). Security Operations Scale. (Unpublished manuscript). Michigan State University, Psychology Dept., East Lansing.
- Reyher, J. (1992). The fate of narcissistic strivings in human encounters: Vicissitudes of the primordial ego. (Unpublished manuscript). Michigan State University, Psychology Dept., East Lansing.
- Rice, L. & Gaylin, N. (1973). Personality processes reflected in client vocal style and rorschach performance. Journal of Consulting and Clinical Psychology, 40, 133-138.
- Rice, L. & Wagstaff, A. (1967). Client voice quality and expressive style as indexes of productive psychotherapy. Journal of Consulting Psychology, 31, 557-563.
- Rogers, C. (1942). Counseling and psychotherapy: Newer concepts in practice. Boston: Houghton Mifflin.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, 95-103.
- Russell, R. & Stiles, W. (1979). Categories for classifying language in psychotherapy. Psychological Bulletin, 86, 404-419.
- Saul, L. (1958). Making Interpretations. In L. Paul (Ed., 1963), Psychoanalytic clinical interpretation, (pp. 228-248). London: Collier-Macmillan Ltd.
- Siegel, S. (1956). Nonparametric statistics for the behavioral sciences. New York: McGraw-Hill.
- Silberschatz, G. & Curtis, J. (1986). Clinical implications of research on brief dynamic psychotherapy: II. How the therapist helps or hinders therapeutic progress. Psychoanalytic psychology, 3, 27-37.

- Silberschatz, G., Fretter, P., & Curtis, J. (1986). How do interpretations influence the process of psychotherapy? Journal of Consulting and Clinical Psychology, 54, 646-652.
- Sklansky, M., Isaacs, K., Levitov, E., & Haggard, E. (1966). Verbal interaction and levels of meaning in psychotherapy. Archives of General Psychiatry, 14, 158-170.
- Snyder, W. (1945). An investigation of the nature of non-directive psychotherapy. The Journal of General Psychology, 33, 193-223.
- Snyder, W. (1947). The casebook of non-directive counseling. New York: Houghton Mifflin Co.
- Snyder, W. (1963). Dependency in psychotherapy: A casebook. New York: The Macmillan Co.
- Speisman, J. (1959). Depth of interpretation and verbal resistance in psychotherapy. Journal of Consulting Psychology, 23, 93-99.
- Spence, D. (1987). The Freudian metaphor. New York: W. W. Norton & Co., Inc.
- Spero, M. (1977). Interpretations and ego readiness: A psychodynamic approach. Psychotherapy: Theory, Research and Practice, 14, 74-78.
- Spiegel, S. & Hill, C. (1989). Guidelines for research on therapist interpretation: Toward greater methodological rigor and relevance to practice. Journal of Counseling Psychology, 36, 121-129.
- Staples, F., Sloane, R., Whipple, K., Cristol, A., & Yorkson, N. (1975). Differences between behavior therapists and psychotherapists. Archives of General Psychiatry, 32, 1517-1522.
- Stiles, W. (1979). Verbal response modes and psychotherapeutic technique. Psychiatry, 42, 49-62.
- Stiles, W., Shapiro, D., & Firth-Cozens, J. (1988). Verbal response mode use in contrasting psychotherapies: A within-subjects comparison. Journal of Consulting and Clinical Psychology, 56, 727-723.
- Stiles, W., Shapiro, D., & Firth-Cozens, J. (1989). Therapist differences in the use of verbal response mode forms and intents. Psychotherapy, 26, 314-322.

- Strachey, J. (1934). The nature of the therapeutic action of psycho-analysis. International Journal of Psycho-Analysis, 15, 127-159.
- Strong, S., Wambach, C., Lopez, F., & Cooper, R. (1979). Motivational and equipping functions of interpretation in counseling. Journal of Counseling Psychology, 26, 98-107.
- Strupp, H. (1955). An objective comparison of Rogerian and psychoanalytic techniques. Journal of Consulting Psychology, 19, 1-7.
- Strupp, H. (1958). The performance of psychoanalytic and client-centered therapists in an initial interview. Journal of Consulting Psychology, 22, 265-274.
- Strupp, H. & Binder, J. (1984). Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy. New York: Basic Books, Inc., Publishers.
- Strupp, H. & Hadley, S. (1979). Specific vs nonspecific factors in psychotherapy. Archives of General Psychiatry, 36, 1125-1136.
- Sullivan, H. (1953). The interpersonal theory of psychiatry. New York: W. W. Norton & Co.
- Sullivan, H. S. (1954). The psychiatric interview. New York: W. W. Norton & Co.
- Sullivan, H. S. (1956). Clinical studies in psychiatry. New York: W. W. Norton & Co.
- Tobias, R. (1993). Ego-Ideal and superego differences among males and females. Unpublished doctoral dissertation, Michigan State University, East Lansing.
- Weimer, W. (1979). Notes on the methodology of scientific research. New Jersey: Lawrence Erlbaum Assoc.
- Weiner, I. (1975). Principles of psychotherapy. New York: John Wiley & Sons.
- Weiss, J., Sampson, H., & The Mount Zion Psychotherapy Research Group (1986). The psychoanalytic process: Theory, clinical observation, and empirical research. New York: Guilford Press.
- Weiss, J. & Sampson, H. (1983). Testing alternative psychoanalytic explanations of the therapeutic process. In J. Masling (Ed.), Empirical studies of psychoanalytic theories (pp. 1-27). New Jersey: Lawrence Erlbaum.

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- Wile, D. (1984). Kohut, Kernberg, and accusatory interpretations. Psychotherapy, 21, 353-362.
- Wiseman, H. & Rice, L. (1989). Sequential analysis of therapist-client interaction during change events: A task-focused approach. Journal of Consulting and Clinical Psychology, 57, 281-286.
- Wolberg, L. (1954). The technique of psychotherapy. New York: Grune and Stratton, Inc.
- Wolberg, L. (1977). The technique of psychotherapy: Part I. New York: Grune and Stratton, Inc.
- Zac, J. (1972). An investigation on how interpretations arise in the analyst. International Journal of Psycho-Analysis, 53, 315-320.
- Zimmer, J. & Pepyne, E. (1971). A descriptive and comparative study of dimensions of counselor response. Journal of Counseling Psychology, 18, 441-447.

APPENDICES

APPENDIX A

**Theory and Research on Therapist Interpretation:
A Literature Review**

By

**Brett A. May Robert N. Graham, Jr.
Michigan State University**

Abstract

Interpretation has been hailed by many influential theorists as the specific factor in psychotherapy. Yet research in this area has been repeatedly criticized for a simplistic treatment of the construct and for the failure to consistently show therapeutic effectiveness. This paper presents a review of the literature on the use of interpretation in psychoanalysis and psychotherapy. The role of interpretation in theory is reviewed, followed by an investigation of the empirical literature. Criticisms of past research are examined, variations in methodological approach are considered, and recent works are presented that redress prior shortcomings. Finally, recommendations for future research are given.

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"How, for instance, can we expect to agree upon the vexed question of whether and when we should give a 'deep interpretation,' while we have no clear idea of what we mean by a 'deep interpretation,' while, indeed, we have no exact formulated view of the concept of 'interpretation' itself, no precise knowledge of what 'interpretation' is and what effect it has upon our patients."

James Strachey, 1934

Introduction

Clinical interpretation has been hailed by many influential theorists as the specific factor in psychoanalysis and psychodynamic psychotherapy (e.g., Fenichel, 1935; Freud, 1900, 1904, 1923; Glover, 1931; Strachey, 1934). Yet research conducted over the past 50 years has largely failed to corroborate the premier status ascribed to its use, particularly within the psychodynamic domain. It seems that many would still consider Strachey's statement valid today. Research on the interpretive process in psychotherapy has been repeatedly criticized for its incomplete operationalization (Garduk & Haggard, 1972; Spiegel & Hill, 1989), shallow theoretical base (Claiborn, 1982; Garduk & Haggard, 1972; Gomes-Schwartz & Schwartz, 1978), methodological limitations (Gomes-Schwartz, 1978; Spiegel & Hill, 1989; Windholz & Silberschatz, 1988), and lack of relation to practice (Garduk & Haggard, 1972; Kiesler, 1979; Strupp, 1989).

In contrast, even a casual perusal of the theoretical literature on the use of interpretation reveals that treatment of the construct, especially post-1950, is widely varied in both proposed application and underlying orientation. The theoretical literature reveals an overabundance of prescriptive texts that differ on why, when, and how to make interpretations--if at all. This paper presents a review of the literature on the use of interpretation in psychoanalysis and psychotherapy. A brief historical review of the theoretical role of interpretation is offered, followed by a more thorough investigation of the empirical literature in this domain. Criticisms of past empirical work are examined, some variations in methodological approach are reviewed, and more recent research is presented. Finally, recommendations for future work in this area are given.

Interpretation in Theory

One primary criticism of past empirical work on

interpretation has been the lack of grounding in theory. Although a comprehensive treatment of interpretive theory is beyond the scope of this review, a partial review of this literature, with a focus on the historical origins of interpretation, is warranted.

The origins of interpretation

Modern day interpretation developed from the pioneering work of Sigmund Freud. Unfortunately, Freud never addressed the construct of interpretation in a comprehensive manner, despite two series of papers (Coltrera & Ross, 1976) that speak fairly directly to his therapeutic technique. In his chapter from Lowenfeld's book, Freud (1904/1963) wrote, "The details of this technique of interpretation or translation have not yet been published by Freud. According to the hints he has given, they comprise a number of rules, reached empirically, of how the unconscious material may be reconstructed from the associations, directions of how to interpret the fact when the patient's ideas cease to flow, and experience concerning the most important typical resistances that arise in the course of such a treatment" (pp. 58-59). This hinted at book of rules was ultimately abandoned and replaced by the six essays which comprise the bulk of his second series on technique (Coltrera and Ross, 1976; Gay, 1988). In these essays, Freud outlined only the most general of principles pertaining specifically to interpretation.

Exploring the underpinnings of what Freud did write about interpretive technique, Coltrera and Ross (1976) reported that the theoretical intent of interpretation varied between Freud's earlier topographic perspective and his later structural view (also see Arlow & Brenner, 1964). Viewed from the topographic perspective, the patient's attention becomes fixed by a 'widening of attention' attained through free association on derivative formations that have reached the preconscious through their cathexis with neutral material. They stated that, according to Freud,

interpretation "discharges a very necessary hypercathetic function by providing the additional quantum of attention cathexes above and incidental to the attention-directing function of a semantic explanatory proposition whose content is one of elucidation and synthesis" (pp. 20-21). In other words, interpretation allows the synthetic and integrative functions of the ego access to the interpretive content that previously existed in preconscious derivative form (Fenichel, 1941). Through the therapist's translation of the preconscious derivative, it becomes hypercathetized, or conscious. Thus, Freud (1904) stated that the role of the analyst is to demonstrate to the patient through interpretation that which is hidden, or unconscious (i.e., in the form of preconscious derivatives). Prior to about 1905, Freud thought that this demonstration or translation was optimally achieved through the interpretation of dreams, although slips of the tongue, free associations, and other phenomena could also provide insight into these derivative formations (Freud, 1904).

Coltrera and Ross (1976) reported that Freud's later structural perspective emphasized the importance of transference and resistance elements in the treatment situation as both facilitating and blocking changes in personality. They stated that by 1920, Freud "had arrived at the realization that a recapitulation of the personal history of his patients could be achieved only through the instrumentality of the transference by means of the resolution of resistances" (p. 703). This resolution was achieved through interpretation. Freud realized through his working with patients that genetic reconstruction (via topographic theory) alone was insufficient to bring about change. The ultimate goal of interpretation and treatment remained basically the same, "bringing to the knowledge of the patient the unconscious, repressed impulses existing in his mind" (Freud, 1919/1963, p. 181). However, this was now

thought best achieved through "exploiting the patient's transference to the person of the physician, so as to induce him to adopt our conviction of the inexpediency of the repressive processes established in childhood and of the impossibility of conducting life on the pleasure-principle" (Ibid, p. 182).

Later perspectives on interpretation

Freud's lack of specificity regarding the development of guiding principles of interpretive technique has contributed to the proliferation of later attempts to define the construct and develop rules for therapists to follow. Importantly, almost all later constructions follow from Freud's structural theory, rather than from his topographic perspective. This literature varies considerably. Even in clinical discussions about interpretation (Scientific Proceedings, 1983, 1984) there is little consensus on how interpretations work or what is the most important aspect of interpreting. Hammer (1966) summarized this rather nicely: "Interpretation is perhaps the most widely used therapeutic tactic and is one aimed directly at the promotion of self-understanding. The fact is that the vast majority of therapists employ interpretations in varying degrees and style, yet surprisingly little agreement has been reached with respect to their place, role and timing, much less the art of their delivery" (p. 140). To provide a sample of this variation, some definitions and guidelines for interpreting will be reviewed. When possible, similarities among perspectives will be highlighted.

The problem of definition. To begin with, authors have had difficulty defining the construct of interpretation. Definitions range in complexity from "the verbal expression of what is understood about the patient and his problems" (Levy, 1984, p. 4), to "an attempt to describe by means of verbal symbols an emotional reaction or a behavior pattern exhibited by the patient in relation to the therapist, of whose interpersonal or dynamic significance the patient is

unaware" (Strupp, 1973, p. 49). Strachey (1934) has even devoted an entire manuscript to the problem.

 Insert Table A-1 about here

Among the definitions given in Table A-1, one commonality is evident. They refer to a process whereby the therapist makes an inference about the client that the client has not explicitly stated prior to the interpretation. The client either exhibits a lack of awareness or is unconscious of the interpreted material.

Perspectives on effectiveness

Writers have also offered differing theoretical views regarding how an interpretation works. As noted previously, most of these elaborations begin from some aspect of Freud's structural theory, even though viewpoints vary considerably within this framework. For example, Hammer (1966) stated that interpretations help connect dissociated actions which have become automatic. The interpretation brings the dissociated material into awareness and places it at the control of the ego. Interpretations attempt to make sense out of an irrational world by giving control back to the ego. Saul (1958) wrote, "The analyst allies with the ego, not threatening it with the id, but working through the ego to help the patient understand, accept and learn to deal with the id. Interpretation theoretically employs the ego capabilities in an effort to modify its relationship with the id" (p. 240). Strachey (1934) furnished this description, "In the classical model of an interpretation, the patient will first be made aware of a state of tension in his ego, will next be made aware that there is a repressive factor at work (that his super-ego is threatening him with punishment), and will only then be made aware of the id-impulse which has stirred up the protests of his super-ego and so given rise to the anxiety in his ego" (p. 147). He further conceptualized

Table A-1

Definitions of interpretation
in psychotherapy and psychoanalysis.

<u>Author</u>	<u>Definition</u>
Fenichel (1945)	"Helping something unconscious to become conscious by naming it just at the moment it is striving to break through" (p. 322).
Freud (1913) (1923) (1937a)	"The interpretation of a dream falls into two phases: the phase in which it is translated and the phase in which it is judged or has its values assessed (1923)." "Even in the later stages of the analysis one must be careful not to communicate the meaning of a symptom or the interpretation of a wish until the patient is already close upon it, so that he has only a short step to take in order to grasp it himself (1913)." "Our therapeutic work swings to and fro like a pendulum, analyzing now a fragment of the id and now a fragment of the ego. In one case our aim is to bring a part of the id into consciousness and in the other to correct something in the ego (1937a)."
Greenson (1967)	"To interpret means to make an unconscious phenomenon conscious. More precisely, it means to make conscious the unconscious meaning, source, history, mode, or cause of a given psychic event. This usually requires more than a single intervention" (p. 39).
Grotstein (1984)	"An interpretation that...goes further than the patient's experience--that is, further than the manifest content of the experience--may undermine the vouchsafement or notarization of the experience and suggest that the analyst knows more about what goes on inside the patient than the patient does, thereby leading to a situation rife with intimidation and consequent envy."
Hill (1989)	An interpretation, "Goes beyond what the client has overtly recognized and provides reasons, alternative meanings, or new frameworks for feelings, behaviors, or personality. It may establish connections between seemingly isolated statements or events; interpret defenses, feelings, resistance, or transference; or indicate themes, patterns, or causal relationships in behavior or personality, related present events to past events" (p. 15).

table continues

- Korchin
(1976)** "Classically the effort [of interpretation] was directed at divining ultimate causes of the patient's symptoms in terms of their originating experiences. Interpretation is now made of defensive strategies, resistance, and transference reactions in therapy, and of current fantasies, impulses, and behavior, not only to discover their origins but to understand their dynamics in contemporary functioning" (p. 315).
- Langs
(1973)** "There is a brief and deceptively simple definition of interpretations: That they are verbal interventions through which the therapist makes material previously unconscious in the patient, conscious for him in a meaningful and affective way" (p. 451).
- L. Levy
(1963)** "To sum up, psychological interpretation, viewed as a behavior, is engaged in whenever a state exists that seems refractory to other efforts at mitigation or understanding. In essence it consists of bringing an alternative frame of reference, or language system, to bear upon a set of observations or behaviors, with the end in view of making them more amenable to manipulation."
- S. Levy
(1984)** "Interpretation, defined more narrowly, is the verbal expression of what is understood about the patient and his problems" (p. 4).
- Pope
(1977)** "Thus in making an interpretation about the behavior of the patient, the therapist goes beyond the personal information communicated to him; he makes a causal inference about this information. The analyst would not object to the designation of inference as an attribute of interpretation. But he would hasten to add that the inferences made pertain to motives, experiences, images, and thoughts beyond the patient's awareness. Thus, the therapist as interpreter amplifies and translates the signals from the patient's unconscious" (p. 368).
- Strupp
(1973)** "An interpretation, then, is an attempt to describe by means of verbal symbols an emotional reaction or a behavior pattern exhibited by the patient in relation to the therapist, of whose interpersonal or dynamic significance the patient is unaware or insufficiently aware" (p. 49).

each interpretation as involving the release of a certain quantity of id-energy. He added the super-ego and the concept of energy to his explanation. From his viewpoint, interpretations decrease the amount of energy built up in the id by increasing awareness of unconscious impulses.

Along the same lines, Bergler (1946) conceptualized the therapist's goal as wanting to, "change the inner, unconscious part of the personality. Conscious belief inevitably follows" (p. 420). He reasoned that initially the patient fights the analyst's interpretations, then gradually accepts them consciously, followed by a working through of the resistances to understand what the meaning of various symptoms are. Loewenstein (1957) highlighted the importance of interpreting patterns rather than exact events. He explained that, "Interpretations aim at reflecting the work not only of the id, but also of the superego and the ego. While interpretations decisively influence the process of analysis and while, to be effective, they have to be timed and worded in certain ways, they are continuously influenced in their turn by the psychological processes taking place in the patient" (p. 182). Therefore, the interpretation works on the psychological dynamics and conflicts within the patient and effectiveness is dependent on the patient's reaction. Taking this idea further, Wolberg (1977) wrote that the patient has to be capable of understanding the meaning of the analyst's interpretations and be able to integrate them within himself in the form of insight. In addition, he said that it is always essential to get the patient to realize that current problems cannot be solved merely by revealing unconscious material. This material must be related to what is happening in the present.

In contrast to the structurally-based perspectives described above, Wolman (1965) divided interpretation into topographic and economic elements. "Repressed material is, topographically speaking, unconscious, but at the same time

it carries an emotional load of libido or destructive energy. Interpretation by means of verbal symbols may modify the direction of cathexes and neutralize impulses. The ego operates with symbols, and it is capable of binding and neutralizing great amounts of hitherto blind, id-seated energy. To talk about impulses and to understand them are great steps toward their neutralization and control" (p. 123). Insight into unconscious impulses and conflicts by way of interpretation help the patient to negate the energy contained in the id and give the ego some measure of control.

Authors from other perspectives have also referred to interpretation in their writings. Staines (1969) offered the following comparison between analytic and client-centered approaches, "The counselor (therapist) via his empathic responses (interpretations) brings to awareness (makes conscious) the feelings (strivings) of the experiencing organism (unconscious)" (p. 406). This comparison underscores the change in focus and language between these two theories as well as their similarities. Rogers (1957) indicated that interpretation may be one way of communicating the 'essential conditions' of therapy, but cautioned that interpretation can also function to signal the therapist's 'conditional regard.' It has also been pointed out that gestalt therapists make interpretations through structural vehicles (e.g. empty-chair technique) even though they may deny it (Nielsen, 1980). Additionally, experiential therapists have commented on interpretive interventions. The basic principle of the experiential method in terms of interpretive technique is that the analyst can say any hunch or idea in an asking way, sometimes adding another possibility, to insure that the patient knows it's not a conclusion but an invitation for him to explore the interpretation further (Gendlin, 1974). The interpretation is made experiential by not including any of the inferential and thinking steps the therapist makes and by the therapist asking himself what the patient would concretely feel or find

within himself if the therapist is right. Rice (1974) presented an alternative to interpretation that is called 'evocative reflection.' The aim of this intervention is to help the client get in touch with their experience and provide a process where the client can form their own more accurate constructions of their experience. Yet another conceptualization of interpretation is that the therapist provides a new way of construing events or an alternate frame of reference to consider a problem from that is cognitively discrepant from the patient's own view (Claiborn, 1982; Levy, 1963).

Rules of interpretation

Numerous authors have presented informal 'rules' or basic 'principles' that provide pointers on interpretive technique and offer some general guidelines about the process of making interpretations. Some of these principles are described below. Importantly, many authors have cautioned or qualified the development of interpretive guidelines. One qualification was aptly stated by Glover (1955) when he noted that, "Rules in therapy never have more than a relative validity." Eissler (1958) observed that analysts and theorists seem more prepared to demonstrate errors and mistakes in analytic technique than to formulate a general code to follow. Even if rules were developed, errors in technique would probably be given primary emphasis. Blomfield (1982) has stated that it is best to avoid leading students to believe that there is a complete set of rules to interpreting that they will know in time. He said that interpretation arises from the analyst's internal understanding of the development of a patient's thoughts, the patient's effect on the analyst, and the effect of the patient's thoughts on their own behavior. In addition, Reich (1949) warned that it is an error to interpret just because the material presents itself rather than considering the different levels of material and the structure of the

neurosis. Finally, Saul (1958) reminds us, "There are always exceptions. We have guiding principles, not inexorable rules" (p. 232).

Depth of interpretation. Depth is most commonly thought of as pertaining to the degree of inference in an interpretation. Depth is determined by "the extent to which the therapist includes what the client explicitly stated in an interpretation" (Graham & May, 1989, p. 11). The greater the degree of inference on the therapist's part from what the client has actually said, the greater the depth of the interpretation. While not all theorists refer to the distinctions they create as variations in the "depth" of interpretation, many systems of interpretation seem adequately organized by this heuristic.

For instance, Collier (1953) has proposed that a continuum exists in the realm of interpretation. He maintained that restatements and reflections of feeling actually call the patient's attention to what the therapist thinks is significant or reveals previously unrecognized material. Others echo this sentiment that reflections of feelings and restatements are really mild or conservative interpretations (Giovacchini, 1969; Korchin, 1976).

Paul (1963) differentiated between two types of interpretation. He presented the following distinction, "Type I interpretation points to and describes and names what and who and where and when of the most pre-eminent presenting preconscious behavior; Type II interpretation adds the why, or how come" (p. 252-253). The Type I interpretations bring prominent derivative material to the patient's awareness and Type II provides a causal explanation.

Other analysts approach interpretation using a hierarchy model. The first 'rule' in most analyst's hierarchy is that therapists or analysts should deal with patient resistances first. It follows that if the therapist interprets material other than resistance, the resistance will interfere with exploring the material presented and inhibit the progress of

therapy. Reich (1949) strongly advocated interpreting resistance before content. He added that not making a resistance interpretation in favor of another interpretation can complicate the transference situation as well as miss the opportunity to give the interpretation when the material is immediate and the patient can make the best use of it. Strupp (1971) noted that after the resistances are overcome, the therapist will move to interpreting underlying conflicts. Kapelovitz (1987) said that the main motives behind resistance are the avoidance of pain and the evasion of change. These phenomena make the analysis of resistances before other material an imperative for psychotherapy to be effective.

It was Strachey's (1934) opinion that an interpretation of a resistance will almost invariably be a transference interpretation. Hammer (1968b) agreed and advocated that when the patient's resistance or manner of deflecting the therapist's interpretations is active, this needs to be dealt with before content can be considered. He recommended that when the resistances intensify, it is time to interpret within the frame of the transference. Both of these theorists identified the transference relationship as the arena where resistance should be resolved.

The therapist should deal with present conflicts before exploring earlier material (Bergler, 1946). This idea is consistent with the onion metaphor where the surface layers are explored before other 'deeper' layers are uncovered. Presumably, only 'deeper' layers are the dynamically effective ones. In line with this, process should be addressed before content. It is important not to dampen or short-circuit the patient's emotional experiences (Nydes, 1966). This will inhibit the patient's ability to fully integrate what is being interpreted and result in an intellectual exercise with limited success. One of French's (1958) 'rules' is to interpret at the level of the focal

conflict because it is easier for the patient to understand and assimilate the interpretation as well as easier for the analyst to predict its effect. Both participants are more likely to end up working on the same material and not be dealing with deeper, genetic conflicts that are better left alone until the patient is ready to make the connection between past and present.

Working with active conflict. Another 'rule' of interpretation is to work with what the patient is presenting at the moment. Loewenstein (1957) noted that when interpretations deal with the conflict that is active at the moment, they also implicitly encompass and indirectly affect other conflicts in the patient. It is also recommended by Gendlin (1974) that the therapist deal with what is concretely there rather than with inferential concepts. Thus, focusing on currently active material that is readily apparent to the patient enhances the impact of interpretation. Hammer (1968b) added that an interpretation is more useful and better able to access feelings if it is directed toward emotionally relevant aspects of the patient's experience. This view emphasizes the notion that affect is primary in interpreting material and the patient needs to be close to their affect for maximum effectiveness.

Dosage of interpretation. Taking into consideration the amount of the material that is interpreted to the patient has also been addressed in the literature. This has been referred to as the dosage or economics of an interpretation, though clearly it is also related to depth. Tarachow (1962) declared that interpretations should seldom go as far as possible, preferably falling short of their intended goal. This allows the patient to become more involved in the process of therapy by providing an opportunity for the patient to expand on an interpretation. Fialkow and Muslin (1987) stated that more than one interpretation is often needed to extend patient self-knowledge and insight. Patient resistance to changing their attitudes and behavior is one

reason why a single interpretation is ineffective. They also reported that the influence of the immediate transference and the multiply determined nature of conflict prevents a single interpretation from resolving a conflict. Another aspect of dosage arises when considering that a given conflict may be active in a number of various situations. A single interpretation cannot account for all the situations that arouse conflict (Fenichel, 1945). This further conveys the implicit message that one interpretation does not make or break an analysis or therapy. As Colby (1958) stated, an analysis does not stand or fall with the response to a single interpretation.

Strachey (1934) recommended that the patient be given minimal doses of interpretation so that the patient's ego functions can continue to cope with reality. Moving beyond the patient's ability to cope would be counterproductive. Freud himself pointed out that a single interpretation is more likely to be 'accepted' than a construction (Freud, 1937), as the dosage of a construction is more than an interpretation and therefore may be more difficult to integrate.

Proffering interpretations. Langs (1973) stated that, after a formulation is made, attention should be given to expressing the interpretation in terms of language that is relatively simple and similar to the patient's own way of communicating. They should be precise, succinct, and straightforward to increase the possibility of integration. He further said that it is preferred if interpretations are balanced with respect to other interventions, presented systematically rather than at random, and are few in number. Strupp (1989) agreed that communication with the patient should be free of jargon, be based on a minimum of inference, and meaningful. He added that talking to the patient in a way that they can easily understand will greatly assist in the progress of therapy. Hammer (1968b) maintained that

phrasing an interpretation using the patient's vernacular places the therapist closer to the patient and translates meanings back into the patient's specific experience.

Some theorists have divided language into an unconscious, primary process, infantile level; and a reality based, conscious, secondary process level (Blomfield, 1982, Major, 1974). Major (1974), for instance, views language as the primary path to consciousness and stated that interpretation should exploit this. He noted that interpretations can act on both the unconscious and conscious levels of a patient's experience.

Tact of interpretation. The issue of offering an interpretation with tact is independent of any thoughts of offending or needing to please the therapist. Saul (1958) wrote that interpretations should not be made in a dogmatic way since they are much more effective if elicited directly from the patient, especially when a patient is not ready for an insight. Greenson (1960) presented two attributes of tact, the intonation with which the analyst speaks and the language the therapist uses. The therapist can present an interpretation in either a tentative or an authoritative manner to the patient. Sometimes tentative interpretations are made on the basis of a hunch by the therapist or when the therapy seems to be stuck. The therapist then waits for further material to develop to verify the accuracy of their hunch. Burton (1972) said, "A good rule of thumb is that no therapist has a right to make an interpretation he would be unprepared to receive about himself were he the client" (p. 91). Burton also advocated that interpretations be made tentatively. This allows the patient to feel less coerced into accepting an interpretation by the therapist. Bauer and Mills (1989) said that a posture of 'certainty' on the part of the therapist may interfere with the patient's ability to work in therapy. Additionally, Nydes (1966) alleged that a direct interpretation will almost invariably be construed as a personal accusation that may confirm any feelings of morbid

guilt or stir up a defensive response despite careful wording. Along the same lines, Colby (1958) recommended offering an interpretation to a patient in the form of hypotheses-provisional statements to be confirmed or disconfirmed on the basis of observable evidence. He reasoned that by maintaining a provisional atmosphere, an interpretation does not have a closure effect and allows the patient to explore it further.

Timing. Timing is often considered another vital factor in formulating and proffering interpretations. Devereux (1951) recommended that the analyst interpret only material that the analysand is psychologically ready to consider and utilize immediately. He said that the interpretation will have a higher likelihood of being considered by the patient if it follows clearly and is sufficiently developed from the patient's material. When evidence is readily identifiable from the session, the patient is more likely to accept and confirm the interpretation with additional material. This process usually takes more than one session and at times requires a series of partial interpretations rather than comprehensive ones that can overwhelm the patient. Olinick et al., (1973) noted that these partial interpretations or statements are often aimed at working through as well as toward developing more complete interpretations. Sandler, Dare, and Holder (1971) alleged that, "It is fairly generally accepted in the psychoanalytic literature that no interpretation can ever be complete and perhaps the most practical use of the concept would be to include within it all comments and other verbal interventions which have the aim of making the patient aware of some aspect of his psychological functioning of which he was not previously conscious" (p. 56). They used the term 'preparation for interpretation' to describe other verbal interventions that are made to set up an interpretation. Again, single interpretations cannot incorporate all the complexities of a

patient's psychological functioning. Change occurs over time.

Timing is considered best when either the behavior that is interpreted is occurring immediately within the session or when minimal fear or anxiety will be aroused by the interpretation if the patient is unlikely to see the point on their own (Dollard & Miller, 1950). If anxiety or fear are likely responses, the interpretation should be made in a tentative manner. Thus the plausibility of the interpretation helps to determine whether it is proffered to the patient. If the patient seems less inclined to accept an interpretation, withholding it is usually recommended. As Wolberg (1977) put it, "To advance an opinion in a hit or miss manner, hoping that it will touch something off in the patient, is worse than useless" (p. 445). This can lead to 'wild-analysis' which is more harmful to the patient than helpful. The patient should not be taken too much by surprise when an interpretation is proffered. In contrast, Binstock (1974) suggested that the therapist can influence a patient to think new thoughts and respond in new ways by presenting an interpretation which surprises the patient.

Saul (1958) wrote that it is rarely a mistake to wait until near the end of the session to deliver an interpretation. The guiding principle that he used in timing interpretations is that of 'readiness' or 'ripeness.' These terms refer to how close derivative formations are to consciousness. He also advocated allowing time near the end of the session for the patient to react to the interpretation. Spero (1977) combined a psychodynamic and learning theory orientation to present a guide for timing interpretation. He emphasized gauging the patient's ego readiness to receive an interpretation. That is, the extent that the ego can visibly reinforce and enlarge on the new adaptive model suggested by an interpretation should be estimated before a given interpretation is proffered.

Interpretation in Empirical Research

Empirical studies on interpretation as a specific factor in psychotherapy can be differentiated into naturalistic and experimental works. Experimental studies can be further divided into early research based on a reinforcement paradigm and later works conducted from the social influence perspective. Within the naturalistic studies, interpretation has been empirically investigated in three primary ways; as one aspect of a larger verbal response mode system, in works where single qualities of interpretation are examined, and as part of a theory-based system of intervention.

Experimental studies

Interpretation as reinforcement. Early experimental works have viewed the use of interpretation from within a verbal conditioning paradigm (Adams, Butler, & Noblin, 1961; Adams, Noblin, Butler, & Timmons, 1962; Auerswald, 1974; Kanfer Phillips, Matarazzo, & Saslow, 1960; Noblin, Timmons, & Reynard, 1963). These studies purported to demonstrate that 'psychoanalytic-type' interpretations were simply a method whereby therapists differentially reinforced particular client responses (e.g., Adams, Butler, & Noblin, 1961). Unfortunately, as Spiegel and Hill (1989) noted, the context for these findings deviate quite drastically from the natural circumstances of therapy. Most of these studies utilized undergraduate volunteers who received only one or two 30-minute sessions of "therapy" (Auerswald, 1974; Kanfer et al., 1960). In some studies, interpretations were read from a set randomly mixed index cards (Adams, Butler, & Noblin, 1961; Noblin, Timmons, & Reynard, 1963). Additionally, while these studies have consistently found a reinforcement effect, this might be said of any therapist verbalization. Korchin (1976) noted that even a simple "tell me more" carries the meaning that an issue is important and more information is desired. In general, the limitations of these early studies restrict their external validity and subsequent usefulness.

Social influence studies. More recently, experimental works have investigated clinical interpretation both as an influence process (Claiborn, 1979; Cooke & Kipnis, 1986), and as depending on the patient's potential control over what is interpreted (Claiborn, Ward, & Strong, 1981; Forsyth & Forsyth, 1982; Strong, Wambach, Lopez, & Cooper, 1979). While these efforts evidence greater methodological sophistication, problems with artificiality persist. With one notable exception (Cooke & Kipnis, 1986), these studies have continued to use extremely time-limited formats with individuals who are not seeking treatment. Overall, these recent studies have found that: (a) use of interpretation is perceived as more expert by outside observers (Claiborn, 1979), (b) therapists use more direct forms of influence with female clients and explain their actions more with male clients (Cooke & Kipnis, 1986), and (c) interpretations identifying causal factors that clients can directly control are responded to more productively (Claiborn, Ward, & Strong, 1981; Forsyth & Forsyth, 1982; Strong et al., 1979) particularly if the client has an internal locus of control (Forsyth & Forsyth, 1982).

Naturalistic studies

Verbal response mode systems. Verbal response mode systems (VRM) attempt to divide therapist and client verbalizations into a comprehensive set of categories. These systems typically include interpretation as one type of therapist response. Early works tended to vary widely depending on the theoretical perspective of the author (Goodman & Dooley, 1976; Russell & Stiles, 1979), and relatively little attention was paid to statistical composition (Spiegel & Hill, 1989). More recent VRM systems have shown an increased awareness of both linguistics and statistical design, resulting in systems that are more similar than different. In a comparison of six popular rating systems (Elliott et al., 1987), "moderate to strong convergence" was found for six of the modes represented in

all of the systems, which included interpretation.

In these VRM systems, interpretations are simply identified and tallied. No effort is made to investigate similarities or differences among interpretations. As might be expected, the specificity and complexity of information provided by these studies as they apply to interpretation has been limited in scope. When investigations have examined VRM in connection with client response, comments regarding the effects of interpretation are typically limited to a brief paragraph. Definitions of interpretation have varied among VRM systems as well, likely contributing to the largely mixed findings (Spiegel & Hill, 1989). Furthermore, interpretation has been found to be related to other response modes in the same system. For example, Hill (1978) noted that confrontation, interpretation, reflection, and restatement were all highly correlated in her system. Overall, the primary results of the VRM line of inquiry are: (a) interpretation is consistently related to rejecting or unproductive client responses (Bergman, 1951; Snyder, 1945), (b) interpretation is consistently related to productive client response (Elliott, Barker, Caskey, & Pistrang, 1982; Frank & Sweetland, 1962; Hill, Carter, O'Farrell, 1983; Hill et al., 1988), (c) interpretation is used with similar frequency by different types of therapists (Brunink & Schroeder, 1979; Fiedler, 1951; Stapes, Sloane, Whipple, Cristol, & Yorkston, 1975; Stiles, 1979), (d) interpretation is used with differing frequencies by different types of therapists (Stiles, 1979; Stiles, Shapiro, Firth-Cozens, 1988; Zimmer & Pepyne, 1971), and (e) interpretation use increases as therapy progresses (Hawton, Reibstein, Fieldsend, & Whalley, 1982; Hill, 1978; Hill, Carter, O'Farrell, 1983).

Restricted focus studies. Another area of research has focused on a limited set of theoretically important distinctions within the construct of interpretation. In this

regard, *depth* has been studied most often (Fisher, 1956; Garduk & Haggard, 1972; Gill & Hoffman, 1982; Grossman, 1952; Harway, Dittmann, Raush, Bordin, & Rigler, 1955; Raush et al., 1956; Sklansky, Isaacs, Levitov, & Haggard, 1966; Speisman, 1959). *Transference* (Forman & Marmar, 1985; Frances & Perry, 1983; Luborsky, Bachrach, Graff, Pulver, & Cristoph, 1979; Marziali, 1984; Marziali & Sullivan, 1980; Silberschatz, Fretter, & Curtis, 1986; Weiss & Sampson, 1983), *object focus* (Piper, Debbane, Bienview, Carufel, & Garant, 1986), *skill* (Fiedler, 1951; Gomes-Schwartz, 1978; Gomes-Schwartz & Schwartz, 1978; Strupp, 1955, 1958; Strupp & Hadley, 1979), and *tense* (Abramowitz & Jackson, 1974) have been investigated as well. Although studies on depth of interpretation have typically used different measures of the construct, they have fairly consistently concluded that "moderately deep" interpretations are responded to productively (Grossman, 1952; Sklansky et al., 1966; Spiesman, 1959). In addition, some of these works have noted that "deep" interpretations are followed by a less productive response (Garduk & Haggard, 1972; Sklansky et al., 1966).

Research on transference interpretation is more recent and tends to be more theory-based. Two works have investigated interpretation in connection with therapeutic alliance (Forman & Marmar, 1985; Frances & Perry, 1983). Both studies found that transference interpretations improved productivity in cases with extremely poor alliances when they addressed the client's current transference experience. Luborsky and colleagues (1979) found that in three of four cases transference interpretations were responded to productively. In contrast to the two studies just mentioned, they found that transference interpretations were responded to negatively in the one case where the therapeutic alliance was poor. Other investigations of transference have reported significant correlations with positive outcome (Malan, 1976; Marziali, 1984; Marziali & Sullivan, 1980).

The research findings on therapist skill, object focus,

and tense have been mixed. Examining therapist skill, researchers have shown no differences in outcome between professionals and "inherently helpful" nonprofessionals (Gomes-Schwartz & Schwartz, 1978; Strupp & Hadley, 1979). Other investigators have concluded that "nonspecific" factors in general are more important than specific technical skills (e.g., Anderson, 1968; Strupp, 1958). Piper et al. (1986) found "little evidence" that therapist-parent links in object focus led to better client outcome. Finally, Abramowitz & Jackson (1974) found that in therapy groups a combination of here-and-now and there-and-then interpretations were more productive than either type alone.

Theory-based studies. Two related lines of investigation have focused on the role of theory as it pertains to interpretation in psychotherapy. One of these addresses psychoanalytic psychotherapy (Crits-Cristoph, Cooper, & Luborsky, 1988; Silberschatz, Fretter, & Curtis, 1986; Weiss & Sampson, 1983; Weiss & Sampson, 1986), while the other stems from Malan's time-limited dynamic perspective (Malan, 1977; Marziali & Sullivan, 1980; Marziali, 1984). Although these studies are the most theoretically sophisticated of those reviewed, they also restrict their definition of interpretation to a greater extent than in other works, thus reducing overall generalizability.

The Mount Zion Group (e.g., Silberschatz, Fretter, & Curtis, 1986; Weiss & Sampson, 1983) conducted research utilizing the identification of patient themes in determining interpretation accuracy. They found that suitability rather than type of interpretation was most predictive of productive patient response (Silberschatz, Fretter, & Curtis, 1986). Their work also supported a definition of suitability based on Freud's later structural model as compared to his earlier topographic conceptualization (Weiss & Sampson, 1983). Crits-Cristoph, Cooper, & Luborsky (1988) identified interpretation adequacy in accordance with the Core

Conflictual Relationship Theme (CCRT), which "establishes guidelines for clinical judgments about the content of patients' central relationship patterns" (p. 491). In this study, the authors found "a significant and moderately strong" (p. 492) relationship between interpretation accuracy and positive outcome. They further noted that their findings corroborated the results of the Silberschatz et al. (1986) study.

Another line of study heavily influenced by theory is based on the writings of David Malan. His original work (Malan, 1976) was criticized for its reliance on therapy process notes rather than on audiotapes or session transcripts. However, Marziali has replicated and extended his findings in two separate investigations (Marziali & Sullivan, 1980; Marziali, 1984). She supported Malan's view that interpretations are related to favorable outcome when they focus on the patient's experience with parental figures as it is emotionally re-experienced in the current transference relationship.

Summary of prior works

Marziali (1984) complained that process research has focused too heavily on ratings of global therapeutic actions such as "therapist directiveness," and "number of interpretations" (p. 301). This empirical review supports her argument. Over the past 50 years, research has discovered (somewhat equivocally) that interpretations probably are more helpful than harmful, and that this state of affairs is most likely influenced by some aspects of interpretive quality such as depth or transference. In contrast, most theorists considered the overall usefulness of interpretation in psychotherapy to be a given. These clinicians seemed more concerned with the stylistic issues of interpretive technique, such as timing, tact, and dosage, method of approach. Evidently, many clinicians continue to regard interpretation as an important tool in therapy despite the relative lack of consistent and detailed empirical

support for its use. It seems that this area has reached a point in development not unlike that said of therapy process research in general since the classic Smith, Glass, & Miller (1981) meta-analysis: Now that we know that it usually works, lets find out why.

Overall, it seems to us that prior empirical work on interpretation in psychotherapy can be viewed in a similar, but slightly different manner. That is, the use of interpretation appears to result in productive patient responses in many circumstances, and unproductive responses in others. Certainly the use of interpretation has some impact on the patient, since very few studies have found no effect. Therefore, the question remains, what are the 'active ingredients' of interpretation? As Spiegel and Hill (1989) recently stated, "Although interpretation is a theoretically important and frequently used technique in brief and time-limited individual therapy, the contribution of the research has been limited because of several methodological problems in the areas of (a) definitions, (b) designs, (c) the search for a single underlying mechanism, (e) measurement of the impact, (f) type, (g) the role of the therapeutic relationship, and (h) timing" (p. 121).

Current Directions

Research on the effects of interpretation in psychotherapy and psychoanalysis will progress as researchers take into greater consideration the theoretical, operational, and methodological complexities of interpretive technique. In this sense, the search for the 'active ingredients' of interpretation has already begun.

Theory-based empirical testing

The Mount Zion research group has based their empirical investigations on a well thought out theoretical rationale. They have studied interpretation and other psychotherapy process variables by contrasting Freud's early topographic model and his later structural model. One aspect of their

research is to test the validity of each theoretical model. According to Joseph Weiss of the Mount Zion group, pathogenic beliefs play an important part in the development and maintenance of repressions, inhibitions, and symptoms. They are a part of the unconscious mind which is consistent with Freud's ego psychology or structural theory (the higher mental functioning hypothesis). It is hypothesized that these beliefs need to be altered in order for change to occur. Weiss compared this conceptualization with Freud's topographic theory (the automatic functioning hypothesis) where there are no unconscious beliefs of any kind. In testing these two models, the research group assumed that the nongratification of patient neurotic needs in the transference of therapy will either produce frustration, tension, and conflict (automatic functioning) or anxiety and tension (higher mental functioning). With regard to interpretation, Weiss et al. (1986) wrote, "The defenses are weakened (undermined) by the analyst's interpretations. The resolution of a transference, however, is conceptualized as taking place by quite a different process. In this process the ego is helped by analytic interpretations to gain insight into the transference. The ego, as a consequence of such insight, recognizes the transference as an irrational repetition of childhood experiences and abolishes it" (p. 327). The empirical findings suggest that structural theory is the more consistent model to explain what happens in therapy and that interpretations influence the ego to bring about change.

Other researchers connected with the group have expanded on these theoretical ideas and tested them empirically (Silberschatz et al., 1986; Silberschatz & Curtis, 1986; Weiss et al., 1986; Weiss & Sampson, 1983; Curtis et al., 1988; and Silberschatz et al., 1989). Pathogenic beliefs and the patient's plan for therapy are two interesting constructs that have been developed. Pathogenic beliefs are unconscious, irrational, painful ideas that cause, and help

to maintain, psychological disturbance (Weiss, 1990; Weiss et al., 1986). In psychotherapy, the patient attempts to disprove these beliefs by unconsciously testing them out with the therapist. The patient is thought to have a particular unconscious plan for therapy, determined by these beliefs and corresponding testing behavior. This plan, once it is understood by the therapist, guides the therapist in making interpretations that are helpful to the patient. Empirical support for this viewpoint further strengthens the Mt. Zion Groups' argument that the structural theory approach to interpretation is more valid than the topographic perspective.

Parameters of interpretation

Another potentially fruitful avenue of investigation is to more fully explore the meaningful aspects of therapist interpretation. One approach that appears promising is represented by our Interpretation Scoring Guide (ISG: Graham & May, 1989). The ISG is a pantheoretical instrument that operationalizes interpretations along ten parameters and one or more of seven levels. The parameters of the ISG are thought to comprehensively define the meaningful categorical boundaries of an interpretation as defined by theory and prior research. Seven of the ten parameters also contain dimensions which further specify the qualities of an interpretation. The parameters and corresponding dimensions of the ISG include: Inference Location, Causal Connection, Object (client only, therapist-client, parent-client, other-client), Content (affective, behavioral, cognitive), Tense (past, present, future), Immediacy (preceding segment, same session, unscorable), Depth (substitution, extension, introduction), Topic Reintroduction, Specificity (specific, general), and Form (tentative question, firm question, tentative statement, firm statement). The ISG levels operationalize the intent of an interpretation as defined by psychoanalytic theory. ISG levels include: Resistance,

Defense, Transference, Character, Adaptive Context, Genetic, and Other interpretations.

The ISG has been designed to be a comprehensive, flexible, and pantheoretical research instrument. Theory-based hypotheses can be investigated by selectively choosing a subset of ISG parameters and levels. Several studies are currently under investigation and initial rater reliabilities are promising.

New methodologies

In the past five to seven years a number of psychotherapy process studies have been published that utilize newer, more sophisticated methodologies. These studies often use multiple predictors and dependent measures and base their predictions on more well-defined theory, thus redressing many prior complaints regarding process research (Greenberg, 1986; Schaffer, 1982; 1983). Two promising approaches are the detailed investigation of critical episodes in therapy (e.g., Elliott, 1983; Elliott, James, Reimschuessel, Cislo, & Sack, 1985) and the use of sequential analyses (e.g., Wampold & Kim, 1989; Wiseman & Rice, 1989). Elliott (1983) cited several researchers and theorists who advocate for the detailed investigation of critical episodes or significant events in psychotherapy. A common thread of their complaints about current process research is that there is an over-reliance on 'frequency' methods of research, where occurrences of something are tallied and correlated with a single outcome measure (Russell & Trull, 1986; Schaffer, 1982). Researchers (Elliott, 1983; Elliott, et al., 1985) have identified single episodes and employed a variety of process measures ranging from global 'experiencing' to literal speech disturbances. Other investigators have applied sequential analyses to change events in psychotherapy, "for studying therapist-client interactions in the context of clinical microtheories of change events" (Wiseman & Rice, 1989, p. 281). Wiseman & Rice (1989) productively used this strategy to track a therapist's

response to a client's "problematic reaction point." While these newer methodologies have not focused specifically on the issue of therapist interpretation in psychotherapy, this approach appears promising and complementary to past frequency paradigms.

Conclusion

A gaping chasm currently exists between the development of theory pertaining to the use of therapist interpretation and the empirical investigation of this construct. Theorists have relied on 'evidence' from their own idiosyncratic experiences and the 'by fiat' authority of past analysts to develop guidelines that vary widely. These guidelines reach well beyond the available evidence obtained thus far by psychotherapy process investigators.

In spite of this, recent research on interpretation appears to be on the "comeback trail" (Kiesler, 1982) along with the rest of psychotherapy process research. One encouraging sign is the existence of research programs that compare and contrast theoretical approaches in increasingly sophisticated ways. In addition, new methodologies are maturing and new comprehensive measures are being developed. The empirical literature indicates that interpretation is probably influenced by a number of factors and researchers appear to be readying to meet this challenge. This new wave of research is promising. Hopefully clinicians will find these new investigations applicable to the actual practice of psychotherapy.

References

- Abramowitz, S. I., & Jackson, C. (1974). Comparative effectiveness of there-and-then versus here-and-now therapist interpretations in group psychotherapy. Journal of Counseling Psychology, 21(4), 288-293.
- Adams, H. E., Butler, J. R., & Noblin, C. D. (1961). Effects of psychoanalytically-derived interpretations: A verbal conditioning paradigm? Psychological Reports, 10, 691-694.
- Adams, H. E., Noblin, C. D., Butler, J. R., & Timmons, E. O. (1962). Differential effect of psychoanalytically-derived interpretations and verbal conditioning in schizophrenics. Psychological Reports, 11, 195-198.
- Anderson, S. C. (1968). Effects of confrontation by high- and low-functioning therapists. Journal of Counseling Psychology, 15(5), 411-416.
- Arlow, J. A., & Brenner, C. (1964). Psychoanalytic concepts and the structural theory. New York: International Universities Press, Inc.
- Auerswald, M. C. (1974). Differential reinforcing power of restatement and interpretation of client production of affect. Journal of Counseling Psychology, 21(1), 9-14.
- Bauer, G. & Mills, J. (1989). Use of transference in the here and now: Patient and therapist resistance. Psychotherapy, 26, 112-119.
- Bergler, E. (1946). Use and misuse of analytic interpretations by the patient. Psychoanalytic Review, 33, 416-441.
- Bergman, D. (1951). Counseling method and client responses. Journal of Consulting Psychology, 15, 216-224.
- Binstock, W. (1974). Psychoanalysis, psychotherapy and surprise: The impact of words. International Review of Psycho-Analysis, 1, 363-371.
- Blomfield, O. (1982). Interpretation: Some general aspects. International Review of Psycho-Analysis, 9, 287-301.
- Brunink, S. A., & Schroeder, H. E. (1979). Verbal therapeutic behavior of expert psychoanalytically oriented, gestalt, and behavior therapists. Journal of Consulting and Clinical Psychology, 47(3), 567-574.
- Burton, A. (1972). Interpersonal Psychotherapy. New Jersey: Prentice Hall, Inc.
- Claiborn, C. D. (1979). Counselor verbal intervention, nonverbal behavior, and social power. Journal of Counseling Psychology, 26(5), 378-383.
- (1982). Interpretation and client change in counseling. Journal of Counseling Psychology, 29(5), 439-453.
- Claiborn, C. D., Ward, S. R., & Strong, S. R. (1981). Effects of congruence between counselor interpretations and client beliefs. Journal of Counseling Psychology, 28(2), 101-109.

- Colby, K. (1958). Causal correlations in clinical interpretation. In L. Paul (Ed., 1963) Psychoanalytic Clinical Interpretation, pp. 189-199. London: Collier-Macmillan Ltd.
- Collier, R. (1953). A scale for rating the responses of the psychotherapist. Journal of Consulting Psychology, 17, 321-326.
- Coltrera, J. & Ross, N. (1976). Freud's psychoanalytic technique from the beginnings to 1923. In B. Wolman (Ed.) Psychoanalytic Techniques: A Handbook for the Practicing Psychoanalyst. New York: Basic Books, Inc., Publishers.
- Cooke, M., & Kipnis, D. (1986). Influence tactics in psychotherapy. Journal of Consulting and Clinical Psychology, 54(1), 22-26.
- Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. Journal of Consulting and Clinical Psychology, 56(4), 490-495.
- Curtis, J., Silberschatz, G., Weiss, J., Sampson, H., & Rosenberg, S. (1988). Developing reliable psychodynamic case formulations: An illustration of the plan diagnosis method. Psychotherapy, 25, 256-265.
- Devereux, G. (1951). Some criteria for the timing of confrontations and interpretations. In L. Paul (Ed., 1963) Psychoanalytic Clinical Interpretation, pp. 79-92. London: Collier-Macmillan Ltd.
- Dollard, J. & Miller, N. (1950). Personality and Psychotherapy. New York: McGraw-Hill Book Co. Inc.
- Eissler, K. (1958). Remarks on some variations in psychoanalytic technique. International Journal of Psychoanalysis, 39, 222-229.
- Elliott, R. (1983). That's in your hands: A comprehensive process analysis of a significant event in psychotherapy. Psychiatry, 46, 113-129.
- Elliott, R., Barker, C., Caskey, N., & Pistrang, N. (1982). Differential helpfulness of counselor verbal response modes. Journal of Counseling Psychology, 29, 354-361.
- Elliott, R., Hill, C. E., Stiles, W. B., Friedlander, M. L., Mahrer, A. R., & Margison, F. R. (1987). Primary therapist response modes: Comparison of six rating systems. Journal of Consulting and Clinical Psychology, 55(2), 218-223.
- Elliott, R., James, E., Reimschuessel, C., Cislo, D., & Sack, N. (1985). Significant events and the analysis of immediate therapeutic impacts. Psychotherapy, 22, 620-630.
- Fenichel, O. (1935). Concerning the theory of psychoanalytic technique. In L. Paul (Ed.), Psychoanalytic Clinical Interpretation (pp. 42-65). London: Collier-Macmillan Ltd.
- (1941). Problems of Psychoanalytic Technique. New York: The Psychoanalytic Quarterly, Inc.
- (1945). The Psychoanalytic Theory of Neurosis. London: Routledge & Kegan Paul Ltd.
- Fialkow, N. & Muslin, H. (1987). Working through: A cornerstone of psychotherapy. American Journal of Psychotherapy, 41(3), 443-452.

- Fiedler, F. E. (1951). Factor analyses of psychoanalytic, nondirective, and Adlerian therapeutic relationships. Journal of Consulting Psychology, 15, 32-38.
- Fisher, S. (1956). Plausibility and depth of interpretation. Journal of Counseling Psychology, 20(4), 249-256.
- Foreman, S. A., & Marmar, C. R. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. American Journal of Psychiatry, 142(8), 922-926.
- Forsyth, N. L., & Forsyth, D. R. (1982). Internality, controllability, and the effectiveness of attributional interpretations in counseling. Journal of Counseling Psychology, 29(2), 140-150.
- Frances, A., & Perry, S. (1983). Transference interpretations in focal therapy. American Journal of Psychiatry, 140(4), 405-409.
- Frank, G. H., & Sweetland, A. (1962). A study of the process of psychotherapy: The verbal interaction. Journal of Consulting Psychology, 26(2), 135-138.
- French, T. (1958). Art and science in psychoanalysis. In L. Paul (Ed., 1963) Psychoanalytic Clinical Interpretation, pp. 200-219. London: Collier-Macmillan
- Freud, S. (1900). The interpretation of dreams. S.E., (Vols 4-5).
- (1904). Freud's Psychoanalytic Procedure. S.E., (Vol. 7, 249-256).
- (1913). On beginning the treatment, further recommendations on the technique of psychoanalysis. S.E., (Vol. 12, 122-179).
- (1919). Turnings in the ways of psychoanalytic therapy. S.E., (Vol. 17, 157-168).
- (1923). Psycho-analysis. S.E., (Vol 19, 235-254).
- (1937a). Analysis terminable and interminable. S.E., (Vol 23, 234-254).
- (1937b). Constructions in analysis. S.E., (Vol 23, 255-270).
- Garduk, E. L., & Haggard, E. A. (1972). Immediate effects on patients of psychoanalytic interpretations. Psychological Issues, 7 monograph 28, 1-83.
- Gay, P. (1988). Freud: A life for our time. New York: Norton & Co.
- Gendlin, E. (1974). Client-centered and experiential psychotherapy. In D. Wexler & L. Rice (Eds.), Innovations in Client-Centered Therapy. New York: John Wiley & Sons.
- Gill, M. M., & Hoffman, I. Z. (1982). A method for studying the analysis of aspects of the patient's experience of the relationship in psychoanalysis and psychotherapy. Journal of the American Psychoanalytic Association, 30, 137-168.
- Giovacchini, P. (1969). The influence of interpretation upon schizophrenic patients. International Journal of Psycho-Analysis, 50, 179-186.

- Glover, E. (1931). The therapeutic effect of inexact interpretation: A contribution to the theory of suggestion. The International Journal of Psycho-Analysis, 12(4), 397-411.
- (1955). The Technique of Psycho-Analysis. New York: International University Press, Inc.
- Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. Journal of Consulting and Clinical Psychology, 46(5), 1023-1035.
- Gomes-Schwartz, B., & Schwartz, J. M. (1978). Psychotherapy process variables distinguishing the "inherently helpful" person from the professional psychotherapist. Journal of Consulting and Clinical Psychology, 46(1), 196-197.
- Goodman, G., & Dooley, D. (1976). A framework for help-intended communication. Psychotherapy: Theory, Research, and Practice, 13(2), 106-117.
- Graham, R. & May, B. A. (1989). The Interpretation Scoring Guide. Unpublished manuscript. Michigan State University.
- Greenberg, L. S. (1986). Change process research. Journal of Consulting and Clinical Psychology, 54(1), 4-9.
- Greenson, R. (1960). Scientific meetings: Problems of dosage, timing, and tact in interpretation. Bulletin of the Philadelphia Association for Psychoanalysis, 10, 23-24.
- Greenson, R. (1967). The technique and practice of psychoanalysis: Vol. I. New York: International Universities Press, Inc.
- Grossman, D. (1952). An experimental investigation of a psychotherapeutic technique. Journal of Consulting Psychology, 16, 325-331.
- Grotstein, J. S. (1984). The higher implications of Lang's contributions. In J. Raney (Ed.), Listening and interpreting: The challenge of the work of Robert Langs (pp. 3-20). New York: Jason Aronson, Inc.
- Hammer, E. (1966). Interpretations in treatment: Their place, role, timing, and art. Psychoanalytic Review, 53, 463-468.
- Hammer, E. (Ed., 1968). Use of Interpretation in Treatment: Technique and Art. New York: Grune & Stratton.
- Hammer, E. (1968b). Interpretive technique: A Primer. In E. Hammer (Ed., 1968). Use of Interpretation in Treatment: Technique and Art. New York: Grune & Stratton.
- Harway, N., Dittmann, A., Raush, H., Bordin, E., & Rigler, D. (1955). The measurement of depth of interpretation. Journal of Consulting Psychology, 19(4), 247-253.
- Hawton, K., Riebstien, J., Fieldsend, R., & Whalley, M. (1982). Content analysis of brief psychotherapy sessions. British Journal of Medical Psychology, 55, 167-176.
- Hill, C. E. (1978). Development of a counselor verbal response category system. Journal of Counseling Psychology, 5(5), 461-468.

- Hill, C. E. (1989). Therapist techniques and client outcomes. Newbury Park: Sage Publications, Inc.
- Hill, C., Carter, J., & O'Farrell, M. (1983). A case study of the process and outcome of time-limited counseling. Journal of Counseling Psychology, 30(1), 3-18.
- Hill, C. E., Helms, J., Tichenor, V., Spiegel, S., O'Grady, K., & Perry, E. (1988). Effects of therapist response modes in brief psychotherapy. Journal of Counseling Psychology, 35, 222-233.
- Kanfer, F., Phillips, J., Matarazzo, J., & Saslow, G. (1960). Experimental modification of interviewer content in standardized interviews. Journal of Consulting Psychology, 24(6), 528-536.
- Kapelowitz, L. (1987). To Love and To Work. New Jersey: Jason Aronson, Inc.
- Kiesler, D. (1979). An interpersonal communication analysis of relationship in psychotherapy. Psychiatry, 42, 299-311.
- (1982). Reaction: The comeback trail for process analysis. The Counseling Psychologist, 10, 21-22.
- Korchin, S. J. (1976). Modern clinical psychology. New York: Basic Books.
- Langs, R. (1973). The Technique of Psychoanalytic Psychotherapy, Vol. I. New York: Jason Aronson, Inc.
- Levy, L. (1963). Psychological Interpretation. New York: Holt, Rinehart, & Winston, Inc.
- Levy, S. (1984). Principles of interpretation. New York: Jason Aronson, Inc.
- Loewenstein, R. (1957). Some thoughts on interpretation in the theory and practice of psychoanalysis. In L. Paul (Ed., 1963) Psychoanalytic Clinical Interpretation, pp. 162-188. London: Collier-Macmillan Ltd.
- Luborsky, L., Bachrach, H., Graff, H., Pulver, S., & Christoph, P. (1979). Preconditions and consequences of transference interpretations: A clinical-quantitative investigation. The Journal of Nervous and Mental Disease, 167(7), 391-401.
- Major, R. (1974). The language of interpretation. International Review of Psycho-Analysis, 1, 425-435.
- Malan, D. H. (1976). Toward a validation of dynamic psychotherapy: A replication. New York: Plenum Press.
- Marziali, E. A. (1984). Prediction of outcome of brief psychotherapy from therapist interpretive interventions. Archives of General Psychiatry, 41, 301-304.
- Marziali, E. A., & Sullivan, J. M. (1980). Methodological issues in the content analysis of brief psychotherapy. British Journal of Medical Psychology, 53, 19-27.
- Nielsen, A. (1980). Gestalt and psychoanalytic therapies: structural analysis and rapprochement. American Journal of Psychotherapy, 34, 534-544.

- Noblin, C. D., Timmons, E. O., & Reynard, M. C. (1963). Psychoanalytic interpretations as verbal reinforcers: Importance of interpretation content. Journal of Clinical Psychology, 19, 479-481.
- Nydes, J. (1966). Interpretation and the therapeutic act. Psychoanalytic Review, 53, 469-481.
- Olinick, S., Poland, W., Grigg, K., & Granatir, W. (1973). The psychoanalytic work ego: Process and interpretation. International Journal of Psycho-Analysis, 54, 143-151.
- Paul, L. (1963). The logic of psychoanalytic interpretation. In L. Paul (Ed., 1963) Psychoanalytic Clinical Interpretation, pp. 189-199. London: Collier-Macmillan Ltd.
- Piper, W., Debbane, E., Bienview, J., Carufel, F., & Garant, J. (1986). Relationships between the object focus of therapist interpretations and outcome in short-term individual psychotherapy. British Journal of Medical Psychology, 59, 1-11.
- Pope, B. (1977). Research on therapeutic style. In A. Gurman & A. Razin (Eds.), Effective psychotherapy: A handbook of research (pp. 356-394). New York: Pergamon.
- Raush, H. L., Sperber, Z., Rigler, D., Williams, J., Harway, N., Bordin, E., Dittmann, A., & Hays, W. (1956). A dimensional analysis of depth of interpretation. Journal of Consulting Psychology, 20, 43-48.
- Reich, W. (1949). Character Analysis. New York: Orgone Institute Press, Inc.
- Rice, L. (1974). The evocative function of the therapist. In D. Wexler & L. Rice (Eds.), Innovations in Client-Centered therapy. New York: John Wiley & Sons.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, 95-103.
- Russell, R. L., & Stiles, W. B. (1979). Categories for classifying language in psychotherapy. Psychological Bulletin, 86(2), 404-419.
- Russell, R. & Trull, T. (1986). Sequential analyses of language variables in psychotherapy process research. Journal of Consulting and Clinical Psychology, 54, 16-21.
- Sandler, J., Dare, C., & Holder, A. (1971). Basic psychoanalytic concepts: X. Interpretations and other interventions. British Journal of Psychiatry, 118, 53-59.
- Saul, L. (1958). Making Interpretations. In L. Paul (Ed., 1963). Psychoanalytic Clinical Interpretation, pp. 228-248. London: Collier-Macmillan Ltd.
- Schaffer, N. (1982). Multidimensional measures of therapist behavior as predictors of outcome. Psychological Bulletin, 92(3), 670-681.
- Schaffer, N. (1983). Methodological issues of measuring the skillfulness of therapeutic techniques. Psychotherapy: Theory, Research, and Practice, 20, 486-493.
- Scientific Proceedings-Panel Reports. (1983). Interpretation: Toward a contemporary understanding of the term. Journal of the American Psychoanalytic Association, 31, 237-245.

- Scientific Proceedings-Panel Reports. (1984). The value of extratransference interpretation. Journal of the American Psychoanalytic Association, 32, 137-146.
- Silberschatz, G. & Curtis, J. (1986). Clinical implications of research on brief dynamic psychotherapy: II. How the therapist helps or hinders therapeutic progress. Psychoanalytic psychology, 3, 27-37.
- Silberschatz, G., Curtis, J., & Nathans, S. (1989). Using the patient's plan to assess progress in psychotherapy. Psychotherapy, 26, 40-46.
- Silberschatz, G., Fretter, P. B., & Curtis, J. T. (1986). How do interpretations influence the process of psychotherapy? Journal of Consulting and Clinical Psychology, 54(5), 646-652.
- Sklansky, M. A., Isaacs, K. S., Levitov, E. S., & Haggard, E. A. (1966). Verbal interaction and levels of meaning in psychotherapy. Archives of General Psychiatry, 14, 158-170.
- Smith, M., Glass, G., & Miller, T. (1981). The benefits of psychotherapy. Baltimore: John Hopkins University Press.
- Speisman, J. C. (1959). Depth of interpretation and verbal resistance in psychotherapy. Journal of Consulting Psychology, 23(2), 93-99.
- Spero, M. (1977). Interpretations and ego readiness: A psychodynamic approach. Psychotherapy: Theory, Research and Practice, 14, 74-78.
- Spiegel, S. B., & Hill, C. E. (1989). Guidelines for research on therapist interpretation: Toward greater methodological rigor and relevance to practice. Journal of Counseling Psychology, 36(1), 121-129.
- Staines, G. L. (1969). A comparison of approaches to therapeutic communication. Journal of Counseling Psychology, 16(5), 405-414.
- Staples, F. R., Sloane, B., Whipple, K., Cristol, A. H., & Yorkston, N. J. (1975). Differences between behavior therapists and psychotherapists. Archives of General Psychiatry, 32, 1517-1522.
- Stiles, W. B. (1979). Verbal response modes and psychotherapeutic technique. Psychiatry, 42, 49-62.
- Stiles, W. B., Shapiro, D. A., & Firth-Cozens, J. A. (1988). Verbal response mode use in contrasting psychotherapies: A within subjects comparison. Journal of Consulting and Clinical Psychology, 56(5), 727-733.
- Strachey, J. (1934). The nature of the therapeutic action of psychoanalysis. International Journal of Psycho-Analysis 50, 275-292.
- Strong, S., Wambach, C., Lopez, F., & Cooper, R. (1979). Motivational and equipping functions of interpretation in counseling. Journal of Counseling Psychology, 26, 98-107.
- Strupp, H. H. (1955). An objective comparison of Rogerian and psychoanalytic techniques. Journal of Consulting Psychology, 19(1), 1-7.

- . (1958). The performance of psychoanalytic and client-centered therapists in an initial interview. Journal of Consulting Psychology, 22(4), 265-274.
- . (1971). Psychotherapy and the Modification of Abnormal Behavior. New York: McGraw-Hill Book Co.
- . (1973). Psychotherapy: Clinical, research, and theoretical issues. New York: Jason Aronson, Inc.
- . (1989). Psychotherapy: Can the practitioner learn from the researcher? American Psychologist, 44(4), 717-724.
- Strupp, H. H., & Hadley, S. W. (1979). Specific versus nonspecific factors in psychotherapy. Archives of General Psychiatry, 36, 1125-1136.
- Tarachow, S. (1962). Interpretation and reality in psychotherapy. The International Journal of Psycho-Analysis, 43(6), 377-387.
- Wampold, B. & Kim, K. (1989). Sequential analysis applied to counseling process and outcome: A case study revisited. Journal of Counseling Psychology, 36, 357-364.
- Weiss, J. (1990). Unconscious mental functioning. Scientific American, March, 103-109.
- Weiss, J., & Sampson, H. (1983). Testing alternative psychoanalytic explanations of the therapeutic process. In J. Masling (Ed.), Empirical Studies of Psychoanalytic Theories (pp. 1-27). New Jersey: Lawrence Erlbaum Assoc.
- . (1986). The psychoanalytic process: Theory, clinical observations, and empirical research. New York: The Guilford Press.
- Windholz, M. J., & Silberschatz, G. (1988). Vanderbilt Psychotherapy Process Scale: A replication with adult outpatients. Journal of Consulting and Clinical Psychology, 56(1), 56-60.
- Wiseman, H. & Rice, L. (1989). Sequential analysis of therapist-client interaction during change events: A task-focused approach. Journal of Consulting and Clinical Psychology, 57, 281-286.
- Wolberg, L. (1977). The technique of psychotherapy: Part I. New York: Grune and Stratton, Inc.
- Wolman, B. (1965). Handbook of Clinical Psychology. New York: McGraw-Hill.
- Zimmer, J. M., & Pepyne, E. W. (1971). A descriptive and comparative study of dimensions of counselor response. Journal of Counseling Psychology, 18(5), 441-447.

APPENDIX B

THE INTERPRETATION SCORING GUIDE

A manual for operationalizing interpretations



By

Robert Graham and Brett May
Michigan State University

Author Notes

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THE INTERPRETATION SCORING GUIDE

This guide contains a pantheoretical system for operationalizing interpretations. An attempt is made to minimize theoretical bias by defining all interpretations according to their parameters. Parameters are those determining factors or characteristics that are essential to the delineation of an interpretation. The more traditional approach of using levels (or types) of interpretation is included as well. The ISG utilizes a hierarchical approach where interpretations are initially identified and defined in the broadest sense of the term. Next, they are scored along ten operationally defined parameters, then categorized on one (or more) of seven interpretive levels. This approach to defining interpretations has the advantage of minimizing ambiguity and bias because it identifies those factors within an interpretation that are thought to be important (e.g., depth, object focus) and classifies the level of interpretation (e.g., transference, resistance, genetic). It also results in a more useful and flexible instrument because potentially important theoretical distinctions can be represented, thus increasing scientific knowledge and enhancing the prospect of successful replication. The more traditional levels of interpretation serve as an additional verification of parameter utility. The parameters encompassed by this scoring guide include: Inference Location, Causal Connection, Object, Content, Tense, Immediacy, Depth, Topic Reintroduction, Specificity, and Form of interpretation.

The levels of interpretation represented in the ISG include: Resistance, Defense, Transference, Character, Adaptive Context, Genetic, and Other Interpretations. These levels correspond to those aspects of interpretation that have been both empirically and theoretically postulated to be of some importance in the process of psychotherapy. The term level (as opposed to type) is used in the ISG to recognize that these different aspects of interpretations tend to be interrelated, rather than mutually exclusive. The level Other Interpretation is an exploratory category. The purpose of this category is to identify other interpretive levels not presently included in our scoring system that regularly occur within the therapeutic context.

The Initial Definition

An interpretation is defined *as any therapist statement in a session that infers something about the client that the client has not explicitly (i.e., verbally) expressed*. This is a broad conceptualization, encompassing very simple forms of interpretation as well as more

commonly considered complex ones. At the very simplest level any therapist comment might be construed as an interpretation, as therapist comments in general are selective. This selectivity in and of itself indirectly focuses the attention of the client to what the therapist comments on. Korchin (1976) notes that even a simple "Tell me more" carries the meaning that an issue is important and that more information and exploration is desirable. If every therapist comment is defined this way, however, the term "interpretation" loses its meaning (and therapist verbal behavior might better be studied). Thus, while this definition is expansive it is important to note that it is not all inclusive. It does not, for example, include behavioral observation. It does encompass all therapist statements where a direct inference is made about the meaning of the client's behavior, verbal or nonverbal. This includes but is not limited to: substitution of nondenotative words or statements with explicit ones; the connection of ideas that the client has stated but not explicitly linked together; and any kind of behavioral, cognitive, or affective assumption by the therapist that the client may have implied but did not explicitly convey. So if, for example, the therapist states, "When you said that you were upset, your voice was shaking.", it is not an interpretation but rather an observation of the client's behavior. If that same therapist were to state, "Your voice was shaking when you said that. You must have been angry.", then the latter statement, "You must have been angry.", would be scored as an interpretation due to the affective inference made. We think that the critical distinction between any therapist statement and an interpretation is that in an interpretation the therapist assumes knowledge of unstated meaning and provides it for the client. There may be cases where the client interrupts the therapist, if an inference is included in the therapist's partial statement, then it is regarded as an interpretation. In a noninferential therapist statement, attention may be focused selectively, but it is still the client who explores and uncovers the meaning of, say, a shaking voice. As you may note, this approach to definition is much broader than those commonly found in dynamically oriented works that may focus interpretations exclusively on resistance, transference, genetic, structural, or other unconscious processes (e.g., Malan, 1976). What all areas of interpretation have in common, however, is that they all require the therapist to infer or deduce something that the client is not explicitly and verbally acknowledging.

Units of Scoring

After an interpretation has been identified, it must be operationalized. To adequately capture the complexity and richness of interpretive statements, basic units of

meaning are delineated. These basic units are then combined into larger units. The ISG separates units of meaning into clauses, sentences, and segments.⁸

The clause is considered here to be the fundamental unit of meaning. It is defined as a group of words that has a subject and a predicate. There are two types of clauses, independent and dependent. An independent clause can stand alone grammatically as a sentence. In contrast, a dependent clause cannot stand alone as a sentence. Dependent clauses are always preceded or followed by independent clauses, and are utilized in conjunction with an independent clause to express a related idea.

A sentence may consist of a single clause or several clauses. A sentence expresses a complete thought and consists of a subject and a predicate. (If either the subject or predicate is not expressed, it must be readily understood from sentences that precede or follow). In more complex sentences, it is not unusual to find a number of clauses containing several inferences.

In some instances a therapist may verbalize several sentences containing inferences before a client responds. In this case, sentences are combined to form what are referred to as segments. Segments are sentences containing at least one inference that fall between two client verbalizations. This is a higher level unit of meaning representing all of the therapist's inferences verbalized before a client responds. Operationalization at this level can become very complex. For example, a single therapist segment may consist of several sentences containing interpretations that are proffered to the client. Each sentence will contain one or more clauses that may include separate inferences. Additional inferences about the client may exist in the form of causal connections between clauses within a sentence and causal connections between sentences. Furthermore, these inferences often vary in Depth, Object, Tense, Immediacy, etc. Each sentence may be representative of a different level of interpretation as well. This is only one example of several possible therapist segments within a single therapy session.

Interpretive Parameters

Interpretive parameters define the meaningful boundaries of an interpretation. Within every interpretation there are a number of potential parameters that may be identified. In addition, there are a number of dimensions within each parameter. The

⁸We do not address quantification issues in this guide. How the ISG parameters and levels are valued depends on both the theoretical focus and the hypotheses included in a particular study. (for a review of the grammatical rules, see Shertzer , 1986).

following eight parameters have been selected on the basis of a review of the theoretical and empirical literature. An interpretation is scored by clause or by sentence on the dimensions within each of the ten parameters⁹. More than one dimension may be scored for some parameters. Examples are provided when relevant. Note that some examples contain dimensions defined by other parameters. This approach allows for a greater degree of operational specificity regarding what was actually said by the therapist to the client as compared to previous works which have focused on interpretation as one aspect of therapist verbal behavior (Hill, 1978; Stiles, 1979). Other studies have restricted their investigation to one or two parameters such as Object (Piper et al., 1986) or Depth (Speisman, 1959).

Two general rules, the pronoun rule and the relationship rule, are often helpful in determining how parameters are scored. Pronouns are often encountered (e.g., that) in the therapist's interpretations. When the material the pronoun refers to is *readily identifiable* in the transcript, replace the pronoun with the material it represents¹⁰. Next score the interpretation based on the *revised* sentence. The relationship rule is applied in a similar manner. When a nonspecific reference is made to a relationship that is readily identifiable in the transcript from previous verbalizations, then score the interpretation using the specific reference. When the client interrupts the therapist's interpretive statement and the interpretation is completed in the next therapist verbalization, then the two statements are considered one sentence.

Operational definitions for the ten parameters are provided below.

I. Inference Location: This parameter denotes the presence or absence of an inference for each clause in an interpretive sentence. When an interpretive sentence contains a single clause, it is automatically scored. If an interpretive sentence consists of multiple clauses, score only those clauses that contain inferences about the client. Do not use specific pronoun or relationship replacements for this parameter.

II. Causal Connection: The therapist's interpretation introduces a connection(s) between two or more ideas¹¹ about the client. The therapist makes a causal inference in the form of

⁹The parameters Inference Location, Object, Content, Tense, and Immediacy are scored by clause; whereas Depth, Topic Relatedness, Specificity, and Form are scored by sentence. Causal Connections can be scored both between clauses and between sentences.

¹⁰An exception to this rule is when the therapist uses a pronoun in an interpretive sentence with the intent of seeking agreement from the client about another part of the interpretation (e.g., is that it?, don't you?, etc.).

¹¹An idea is defined in the ISG as a single unit of meaning. This is represented by an independent or dependent clause (see Units of Scoring).

a linkage between these ideas. This parameter emphasizes the idea of causality. Generally, but not always, this is represented in a "Given this, then this" form, where one idea follows *causally* from another¹². The ideas may have been expressed by the client, but the causal connection has not been specifically verbalized prior to the interpretation. Connections can be made between clauses or between sentences. If the therapist's interpretation contains no causal connection¹³, this parameter is not scored.

T: The trouble you have described in relating to women stems from the competition with your father you mentioned earlier.

T: You didn't actually say it, but your feelings of affection for your father are threatening *because of your mother's response*.

T: You loved your father but felt a need to compete with your mother for his affection, *so you* still compete with other women at work and in social situations, especially when there is a man involved.

III. **Object:** Object is identified in two ways. The first is when the client is the only individual about whom the therapist makes an inference. The second is when the therapist also includes a reference to another person(s). In the first instance, the object dimension, Client Only, would be scored. If no individuals are specified in an interpretation, then the Client-Only dimension is still scored, because interpretations, by definition, involve an inference about the client. In the second case, object dimensions are scored as Therapist-Client, Parent-Client, or Other-Client; depending on who the therapist is referring to. If more than one person-client reference is verbalized by the therapist, then more than one dimension is scored. In the case where a general reference is made about 'relationships' or 'people,' then Client-Only is scored. In contrast, when a reference is made to *a specific and readily identifiable relationship* or person then one of the other dimensions is scored.

A. Client Only: the client is the only individual mentioned in the therapist's interpretation. If no individuals are specified, then the Client-Only dimension is still scored.

T: Emotional commitments still frighten *you*.

T: *You* used to have to prove that you weren't castrated.

¹²We have noticed a tendency to change words in sentences that strongly *imply* a causal connection but lacks an overt causal inference. Use the interpretive sentence as it stands *without* restructuring it to score Causal Connection.

¹³Interpretations often contain connections that do not specify a causal relationship. These connections are syntactic and most often a conjunction between the clauses of a sentence is present.

B. Therapist-Client: the therapist's interpretation includes a reference to the therapist or the therapeutic relationship. The therapist *must* be presented as part of the interpretation for the client to consider. If the therapist is only mentioned as part of a verbal convenience (e.g., I think that . . ., I mean . . .), then Therapist-Client is not scored.

T: *You* may also have experienced some anger towards *me* in here.

T: *You* look anxious now just talking about it with *me*.

C. Parent-Client: the therapist includes something about the client's relationship with the parent(s) in the interpretation. References to either parent, step-parents, or 'parents' are acceptable. This *does not* include general references about family or other relatives. In these instances, score Other-Client Relationship.

T: *You* took responsibility for your *mother's* behavior.

T: It sounds like *you* fear your *parents* reaction to your decision.

D. Other-Client: the therapist includes something about the client's relationship with someone other than a parent or the therapist.

T: *You* are concerned about what *others* think of you.

T: Social interactions with women make *you* nervous because they remind you of your *sister*.

IV. CONTENT: This parameter refers to the readily apparent subject domains of the therapist's interpretation (i.e., what dimension of the client's experience the therapist is addressing). Three content dimensions are defined below. Score the *primary* dimension that the therapist is emphasizing in a given clause.¹⁴ This parameter determines whether the therapist is interpreting material based on the client's affect, behavior, or cognitions. Content is scored for each clause in an interpretive sentence. If more than one Content dimension is present in a clause, score *only the main focus of the clause*. The content dimensions are:

¹⁴Because an interpretation by definition infers meaning, many affective and behavioral inferences will also contain a cognitive component. Cognition is not scored in these cases. Cognition is scored only when it is the primary focus of the clause.

A. Affective: the therapist refers primarily to the affective state of the client.¹⁵ The particular affect is *not* labeled by the client prior to the therapist's interpretation. When the word 'feeling' is contained in an interpretation, this does not automatically insure inclusion in this dimension¹⁶.

T: You *seem* to be *angry*.

T: You may also have experienced *fear*.

B. Behavioral: the therapist's interpretation refers to the client's overt physical behavior. Figurative behavior are scored in the cognitive dimension (e.g., "I noticed that you *pushed away* your feelings just now.>").

T: No matter *what you did and gave*, it ended as if you had nothing to give.

T: I think your *silence* has some significance.

C. Cognitive: the therapist's interpretation addresses the client's thoughts, attitudes, beliefs, or perceptions.

T: You *thought* you would die.

T: You *believed* your wish to sexually possess your mother was wrong and you feared possible retaliation from your father.

V. TENSE: This refers to the verb form of the therapist's interpretation. If a clause contains more than one verb tense, score *only* the tense that is most closely related to the subject of the clause. In the case where tense cannot be determined from the therapist's statement, use a zero to denote that the parameter is unscorable. Tense can be:

A. Present Tense.

T: Emotional commitments *still frighten* you.

T: *You're* afraid that might happen again.

¹⁵A general guideline for deciding whether a word is a feeling or a cognition is to determine if the feeling can be expressed facially. For example, resentment quickly brings to mind the specific facial characteristics of frowning or grimacing. Resistance, on the other hand, does not bring specific facial features to mind.

¹⁶Sometimes therapists state thoughts in terms of feelings. For example, a therapist might say, "I *feel* that this is a very important issue for you." As a general rule, if you can replace feel or felt with think or thought without losing meaning, the sentence contains a cognition and not a feeling (e.g., "I *think* that this is a very important issue for you.>"). At other times the therapist will preface interpretations with a phrase that is misleading in terms of the content contained in the actual inference (e.g., "I would think that you would feel angry in that situation.>"). In this example, the interpretation would be scored for affective content (...you would feel angry...) whereas the cognition (I would think...) does not contain an inference about the client.

B. Past Tense.¹⁷

T: You *used to* have to prove that you weren't castrated.

T: You *took* responsibility for your mother's behavior.

C. Future Tense.¹⁸

T: So you *will be* confused if she says yes.

T: The upcoming reunion *will* increase your level of anxiety.

VI. IMMEDIACY: This parameter refers to the temporal proximity of the content dimension(s) contained in the therapist's interpretation to when the client last mentioned them. The therapist is responding to something the client actually said (i.e., an object or content dimension that can be *specifically located* in the transcript) at some point in the course of therapy. If both Preceding Statement and Same Session can be scored, then score Preceding Statement only. If it is not clear that the therapist's interpretation is addressing readily identifiable client verbalizations from the transcript, then use the dimension, Unscorable .

A. Preceding Statement: the therapist's interpretation refers to specific object or content dimensions contained in client verbalizations immediately before the interpretation was given. These verbalizations are located between this interpretation and the preceding therapist statement.

B. Same Session: the therapist's interpretation refers to specific object or content dimensions contained within the same session that the interpretation was given.

C. Unscorable: the therapist's interpretation refers to material that cannot be identified in prior client verbalizations.

¹⁷There are instances where an interpretation will be prefaced by a phrase in the present tense, followed by a statement in the past or future tense (e.g., I think that you used to...; I wonder if you would feel that way next time your...). These types of statements are scored according to the tense most closely related to the subject of the clause in question.

¹⁸Some interpretations contain key words like again that would indicate future tense.

VII. DEPTH: The extent to which the therapist includes what the client explicitly stated in an interpretation. This parameter consists of three mutually exclusive dimensions: Substitution, Extension, and Introduction. There may be instances where Depth is unscorable. Denote these with a zero.

A. Substitution: the therapist replaces the client's nondenotative word or phrase with a more specific one. The therapist substitutes a more narrowly defined word(s) for a client verbalization that has a broader meaning. This is similar to specifying a single object from a class of objects (e.g., the client says flower, the therapist says tulip). If it is unclear whether the therapist's statement is a subset of the client's verbalization, then substitution is not scored. The therapist's interpretation must refer to client material that is *readily identifiable* in the transcript. Importantly, synonyms are *not* included in this dimension because they are restatements and do not include an inference.

T: In other words, you want people to *understand* you.

T: You *say* you feel bothered, but you seem *angry* to me.

C. Extension: the therapist's interpretation includes both reference to what the client has explicitly stated and additional material that has not been verbalized by the client. In an Extension, the therapist adds material that goes beyond but is related to what the client has previously expressed. The meaning of a client verbalization is either added to or modified in some manner.

D. Introduction: the therapist's interpretation only contains ideas that the client has not explicitly verbalized. The introduction of the new idea(s) by the therapist must differ in meaning from what the client actually said in the session. The therapist may reintroduce an interpretation even though the client has not verbalized any of this material after the first time it was presented. These interpretations are still scored as introductions.

VIII. SPECIFICITY: An interpretation is Specific when it contains references to behavior or events that are distinct or idiosyncratic to the client. This dimension also includes client relationships that refer to people who are specific and readily identifiable. A general interpretation is scored if the therapist makes an inference that is devoid of references that could distinguish one client from another. In the case where a reference is

made about nonspecific relationships, General is also scored. Specificity is dichotomous, both dimensions cannot be scored for a single interpretive statement.

A. *Specific:* an interpretation includes *explicit* references to specific behavior (including verbatim client verbalization), history, events, or readily identifiable relationships that are attributed to the client¹⁹.

T: You feel you end up with men like Rod by chance when, in fact, you choose them because they feel safe to you.

T: The common theme here seems to be your fear at succeeding at both your job and at school.

B. *General:* an interpretation that is applicable to other clients due to its nonspecific nature. For example, the therapist's interpretation may refer to 'relationships', but does not refer to a distinct or particular relationship. General interpretations, *when read in isolation*, lack a link to the client identified in the transcript.

T: You are concerned about what others think of you.

T: You feel angry.

IX. TOPIC REINTRODUCTION: This parameter operationalizes the therapist's *repeated introduction* of a specific topic or theme. It is scored when an interpretive statement contains a reintroduction of material that has been previously introduced or interpreted by the therapist. The second interpretive statement *reiterates the primary theme* of the therapist's previous interpretation. These statements must be separated by at least one client verbalization. The specific topic or basic theme may continue to be presented by the therapist in subsequent interpretations, and Topic Reintroduction is scored each time. The interpretation may be worded differently each subsequent time, but the *same basic topical meaning* (within a similar context) *must be readily identifiable* from the earlier therapist statement.

X. FORM: Form describes the sentence type of a therapist's interpretation. Interpretations have two dimensions and two manners of presentation. The dimensions are question and statement. The therapist presents an interpretive question or statement in either a tentative or firm manner.

A. *Question:* the interpretation is in the form of a question.

¹⁹When pronouns are encountered (e.g., that) in the therapist's interpretation, Specific is scored if the material the pronoun refers to is *readily identifiable* in the transcript. If not, General is scored.

B. *Statement:* the interpretation is in the form of a statement.

1. ***Tentative:*** the interpretation is in the form of a question or declarative statement, but includes introductory phrases (e.g., It would seem to me that ...; I think that ...; You feel that ...; etc.) or modifier words.(e.g., might, may, could be, possibly, wonder if, etc.)²⁰.

T: I wonder if you feel fearful at those times?

T: I would think that you might feel fearful about that.

2. ***Firm:*** the interpretation is in the form of a direct question or statement.

T: Do emotional commitments frighten you?

T: You think that all women are punishing, just like your mother was when you were growing up.

Levels of Interpretation

The literature on psychoanalysis and psychotherapy defines a number of different levels of interpretation that therapists proffer to their clients. These levels of interpretation do not seem to be mutually exclusive as there is some overlap between the various categories. For example, the constructs of transference and resistance as they appear in the course of the therapy session can be combined by the therapist to make up a transference-resistance interpretation. This section of the guide presents an operational definition of selected levels of psychodynamic interpretations followed by examples.²¹ Material from different theorists are then presented that illustrate the wide variation in how interpretive levels have been defined. It is acknowledged that other theoretical perspectives exist and that there are other levels of interpretation that may not be included in the ISG at this time. We chose to start operationalizing levels of interpretation from the psychodynamic perspective because this is where the therapeutic technique of interpretation first originated. An exploratory level, Other Interpretations, is included in this section to identify interpretive levels that are not presently included in the ISG, but

²⁰Sometimes it is unclear whether words or phrases modify a sentence. If the suspected words can be left out of the sentence without changing the meaning of that sentence, then the question or statement is scored as tentative.

²¹Examples in this section are from Levy's (1984), *Principles of Interpretation*, and Kapelovitz's (1987), *To Love and to Work*. We acknowledge that these examples are independent of the therapeutic context and may be less meaningful.

are regularly utilized by therapists. The intent of this category is to specify those levels of interpretation that occur with a relatively high frequency in psychotherapy.

Interpretations are scored on one or more of the six psychodynamic levels. If an interpretation cannot be scored on one of these levels, Other Interpretations is scored. When identifying interpretations by level, raters should guard against inferring what the therapist only implies. Operational definitions for the interpretive levels are provided below.

I. RESISTANCE INTERPRETATION: The therapist's interpretation points out some aspect of the client's behavior that is interfering with the process of therapy. The behavior the therapist interprets as impeding the client's self-understanding varies in blatancy from very overt behavior (e.g. missing sessions, saying that a topic is not important, etc.) to subtle behavior (e.g. superficial content, changing topics, etc.). In a resistance interpretation, the interpreted behavior itself is not significant. It is the inference that the behavior interferes with the therapy process that is relevant.

T: (Overt) From your observation that you don't always listen, we can surmise that you keep us from both thinking about the same thing, from working together on a problem (p. 64).

T: (Subtle) By directing your attention to my interest in your sexual life, you avoid recognizing or acknowledging your own sexual impulses yet engage me in a highly charged exchange in which sex is at the center of things (p. 161).

Theoretical Background:

- The manifestation of a defense mechanism, in therapy, that most commonly occurs when therapist is making conscious, via an interpretation, an impulse, idea, or affect which the defense mechanism was keeping unconscious (Kapelovitz, 1987).
- That aspect of all behavior during treatment that stands in opposition to the therapeutic process. An interpretation will show ways that the patient protects or defends the self. A way of conceptualizing those aspects of the patient's activity, conscious and unconscious; which are used to counteract or interfere with therapeutic progress. Useful to include the notion that the resistance is directed against therapeutic activities of the therapist (Levy, 1984).
- The tendency to oppose change, even when seeking it, and to maintain the neurotic status quo. The defensive maneuvers which avert self-knowledge. Eg. blocks, periods of silence, dwelling on trivia, avoidance of topics, and similar behavior (Korchin, 1976).
- Resistance impedes the progress of treatment (Reich, 1949).
- Patient resistance to divulging the motives behind his/her feelings (Wolberg, 1977).

- Patient is defensive or oppositional. Among many forms, he may express denial, repudiation, exaggerated doubt, or hostility to the therapist as manifestations of resistance. He may try to distort, evade, or change the subject (Luborsky et al., 1979).
- Resistance is defense expressed in the transference (Gill, 1981).
- Everything that prevents the patient from producing material derived from the unconscious is resistance (Fenichel, 1945).
- Any impediment within the patient to the work of therapy or analysis (Langs, 1982).
- Well, the resistance is the surest sign to us of a conflict. There must be a force here which is seeking to express something and another which is striving to prevent its expression (Freud, 1933).
- Resistances of this kind [transference] should not be one-sidedly condemned. They include so much of the most important material from the patient's past and bring it back in so convincing a fashion that they become some of the best supports of the analysis if a skillful technique knows how to give them the right turn. Nevertheless, it remains a remarkable fact that this material is always in the service of the resistance to begin with and brings to the fore a *facade* that is hostile to the treatment. Nor must you get an impression that we regard the appearance of these resistances as an unforeseen risk to the analytic influence. No, we are aware that these resistances are bound to come to light; in fact we are dissatisfied if we cannot provoke them clearly enough and are unable to demonstrate them to the patient. Indeed we come finally to understand that the overcoming of these resistances is the essential function of analysis and is the only part of our work which gives us an assurance that we have achieved something with the patient (Freud, 1916).
- Resistances (secondary defense) guard against the established ego defense, character defensive trait, and neurosis (primary defense). Preserves self-defeating but desperately clung to, symptom defenses. Often the more handicapping, the more isolated, and the more prominent the symptom, the more grim and vigorous its (secondary) defense [i.e., resistance strength]. (Laughlin, 1983).

II. DEFENSE INTERPRETATION: The therapist interprets some aspect of the client's thoughts or behavior that operate to exclude from the client's awareness distressing affect (e.g. shame, guilt, disgust, fear, etc.); or unacceptable thoughts, wishes, or impulses.

T: Do you think you have an impulse to do things that serves a purpose of some kind? (p. 719)

T: So, by overeating, you could, at least in one area, defeat her control over you, while protecting yourself from being accused of being sexually provocative (p. 154).

Theoretical Background:

- A defense mechanism prevents the recognition of painful affects (Korchin, 1976, p. 324).
- The therapist interprets the nature, purpose, manifestation, and origin of a defense mechanism (Wolberg, 1977).
- A defense connotes something intrapsychic whereas a resistance connotes something interpersonal (Gill, 1982).
- An interpretation of a defense mechanism that is keeping an impulse, idea, or affect unconscious (Kapelovitz, 1987).
- Defensively-intended intrapsychic dynamisms. A mental mechanism, dynamism, or ego defense is a specific defensive process, operating outside of and beyond conscious awareness. It is automatically and unconsciously employed in the endeavor to secure resolution of emotional conflict, relief from emotional tension, and to avert or allay anxiety. A given dynamism is evoked by the ego as an attempted means of coping with an otherwise consciously intolerable situation (Laughlin, 1983).
- All psychological efforts, conscious and unconscious, by an individual that are designed to protect him or her from danger situations, anxiety and other unpleasant affects, unbearable conflict, disruptive introjects, and disturbing conscious realizations. Defenses therefore constitute intrapsychically founded, protective psychological mechanisms utilized by the ego in an effort to cope with disturbing external and internal realities, and conscious and unconscious fantasy and perception constellations that pose any degree of threat. Defenses may be pathological or nonpathological depending on their adaptive aspects and the extent to which they disturb the functioning of the user (Langs, 1982, p. 724).
- Defenses are related to security needs and the more pathological aspects of behavior. They include repression, isolation, reaction formation, projection, introjection, rationalization, regression, and other particular ways in which we avert painful anxiety (Langs, 1973, p. 73).
- Systems of defence [sic] are in use against the possible generation of anxiety (Freud, 1916).
- The psychical mechanism of defence as being 'unconscious' (Freud, 1923).
- The hypothesis of repression (or, more generally, of defence) as a mental function.... (Freud, 1923).

III. TRANSFERENCE INTERPRETATION: The therapist infers that the client's current manner of relating to the therapist is a re-enactment of past relationships with significant others.

T: Each time I begin to say something to you, you wince as though you expect me to say something to hurt you just the way you always expected your father would (p. 97).

T: Sometimes you struggle with me because you feel that otherwise, you will not continue to feel involved with me, which is how you have described feeling during periods when your mother seemed depressed and uninterested in you (p. 104).

Theoretical Background:

- The inappropriate repetition in the present of a relationship that was important in a person's childhood. The distortion is in terms of time, person, and situation and the displacement is repetitive (Kapelovitz, 1987).
- Transference is the manifestation, within the psychotherapeutic relationship, of the ubiquitous distorting influence of the past relationships on current ones, intensified by the regressive forces inherent in the treatment situation and clarified by the therapist's neutrality, relative anonymity, and objectivity in the face of the patient's distorted view of him. A means of knowing the past by re-experiencing it in relation to the therapist (Levy, p. 94).
- Positive or negative feelings not generated in the present (therapy), but rather are brought forward (transferred) from childhood experiences with key persons, especially parents (Korchin, 1976, p. 328).
- The degree to which the patient is dealing with material that is related either overtly or covertly to the analyst. This material should be a manifestation or a displacement from an early important object relationship. The previous object, however, does not have to be mentioned; it may be inferred by the analyst because of the presence of distortion, strong affect, inappropriateness, etc (Luborsky et al. 1979).
- The repetition of previously acquired attitudes toward the analyst. The patient misunderstands the present in terms of the past; and then instead of remembering the past, he strives, without recognizing the nature of his action, to relive the past and to live it more satisfactorily than he did in childhood. He "transfers" past attitudes to the present. (the patient defends by reliving infantile conflicts rather than remembering them. Transference also offers an opportunity to observe patient's past and understand conflicts) (Fenichel, 1945, p. 29).
- In all, transferences are repetitions of the past as it really happened, or was imagined or idealized (Langs, 1983, p. 159).

- Based on pathological unconscious fantasies, memories and introjects, transference includes all distorted and inappropriate responses to and perceptions of the therapist derived from these disruptive inner mental contents and the related mechanisms and defenses. These distortions may be based on displacements from past genetic figures, as well as on pathological interactional mechanisms (Langs, 1982, p. 746)
- A transference of feelings on to the person of the physician, because we do not believe that the situation in the treatment can account for the origin of such feelings. [*Transfer repetition into recollection*]. (Freud, 1912).
- The process of 'transferring' on to a contemporary object feelings which originally applied, and still unconsciously apply, to an infantile object (Freud, 1905).
- Thus, in subtle, disguised, and convoluted ways, the patient relates to the therapist as a personification from the past . In turn, this has the effect of evoking certain affective reactions that "pull for" particular responses from the therapist (Strupp, 1989).
- An emotional feeling is transferred, deflected, and redirected from its internal object to a substitute one. The emotional feeling is thus displaced to a new person, situation, or object (Laughlin, 1983).
- It refers to an infantile relationship with a significant person such as a parent or a sibling as being similar to the patient's relationship with the analyst (Giovacchini, 1987).

IV. CHARACTER INTERPRETATION: The therapist makes the client aware of well- established, ingrained, habitual modes of experiencing or responding. The therapist interprets regular patterns about how the client makes sense of the world.

T: You feel you end up with such men by chance when, in fact, you choose them because they feel safe to you (p. 193).

T: That's (I can't always let myself do what I want to do) a big part of your psychic structure (p. 217).

Theoretical Background:

- The totality of the relatively stable personality traits and the usual mode of response of the individual (Kapelovitz, 1987).
- A person's typical ways of resolving tensions among conflicting mental trends. The character structure is determined by various identifications, especially parental objects (Levy, 1984).
- The emphasis of characteristic behavior, stereotyped beliefs, repetitive acts, and other aspects of the functional personality as manifested in the life situation (Korchin, 1976).

- Character types = 1) Basic function is an armoring against the stimuli of the outer world and against the repressed inner impulses. 2) The external form of the armoring has its specific historical determination (development or determinants) (Reich, 1949).
- Character resistance such as affectless intellectualization (Luborsky et al. 1979). Some enduring personality trait or disposition in the client that is manifested interpersonally.
- Definition of character: The individual's usual, repetitive, largely ego-syntonic, characteristic way of reacting, behaving, defending and gratifying himself (Langs, 1983).
- The delineation of constellations of consistent (persistent, characteristic) human behavior over time and situation. The stable ways in which the ego reconciles the inevitable conflicts among the internal psychic structures and between those structures and the demands of the environment. [Long-standing, somewhat successful behavior patterns]. (Johnson, 1985).
- Character structure attitudes and patterns are molded out of specific conditioning in early interpersonal relationships (Wolberg, 1977).
- The concept of character evidently has a broader scope than "modes of defense anchored in character." The ego not only protects the organism from external and internal stimuli by blocking its reactions. It also reacts. It sifts and organizes stimuli and impulses; it permits some of them to find expression directly, others in a somewhat altered form. The dynamic and economic organization of its positive actions and the ways in which the ego combines its various tasks in order to find a satisfactory solution, all of this goes to make up "character." Character as a habitual mode of bringing into harmony the tasks presented by internal demands and by the external world, is necessarily a function of the constant, organized, and integrating part of the personality which is the ego (Fenichel, 1945, p. 466-7).
- It may also be said that what is being mobilized for fighting against the alterations we are striving for are character-traits, attitudes of the ego. In this connection we discover that these character-traits were formed in relation to determinants of the neurosis and in reaction against its demands, and we come upon traits which cannot normally emerge, or not to the same extent, and which may be described as latent (Freud, 1916).
- Idea that identification is an important factor in the formation of character (Freud, 1933).
- The individual's usual, repetitive, largely ego-syntonic, characteristic way of reacting, behaving, defending, and gratifying himself. It develops out of innate givens and their specific unfolding under the influence of, and in interaction with, his environment. Pathological character formations are repetitive, maladaptive, ego-syntonic patterns (Langs, 1973, p. 245).

- Character reflects the ego's habitual modes of adjusting to the id, superego, and the external world, and as constituting the individual's enduring mode of relating and adapting to others (Langs, 1982, p. 9).

V. ADAPTIVE CONTEXT INTERPRETATION: The therapist interprets the client's strivings, wishes, or needs as they are facilitated or frustrated by real life situations.

T: What you are really saying is that you are angry at me for not being here next week because you feel you have nothing to say about it (my leaving) (p. 41).

T: What prevents you from expressing your opinions directly in business meetings in a way that gets you the respect you desire is the fear that your boss won't take you seriously.

Theoretical Background:

- To interpret the patient's strivings as related to something that is happening to him in the present helps provide him with a picture of his interpersonal attitudes in operation (Wolberg, 1977).
- The therapist believes that the more the patient accurately knows about himself, past and present, the better are his chances for fashioning compromises among the many conflicting forces within himself and in his environment that will improve his life. Adaptation is a word sometimes used here (Levy, 1984).
- The aim is to make the patient realize some of the ideas he has and the conflicts between them that he did not know he possessed (Wisdom, 1963).
- The way in which a psychic phenomenon relates to the environment (Kapelovitz, 1987).
- Adaption in a dynamic sense means finding common solutions for the tasks represented by inner impulses and outer (inhibiting and threatening) stimuli (Fenichel, 1945).
- Adaptive context is the specific reality that evokes an intrapsychic response (Langs, 1982).

VI. GENETIC INTERPRETATION: The therapist interprets early life motives or strivings as they continue to influence present life experiences.

T: Although you feel like a victim in such situations, we have seen how you often provoke these tirades by your husband, and then elect to suffer silently through them in order to feel mistreated in a manner similar to the way your mother felt mistreated by your father (p. 193).

T: At work, you've become like your father, doing to your employees what he did to you.

Theoretical Background:

- Refers to the constitutional factors and early life experiences which contribute to the development of the phenomenon in question (Garduk & Haggard, 1972).
- The infantile and childhood developmental experiences from which adult behavior, personality, and psychic structure are derived (Kapelovitz, 1987).
- A genetic interpretation explains a current reaction or feeling as the outcome of a past relationship (Giovacchini, 1987).
- Genetic interpretations aim at the establishment of a reciprocal relationship between the present and the past (Loewenstein, 1957).
- Linking the meaning of present behavior to affectively significant events in the patient's past (Basch, 1980).

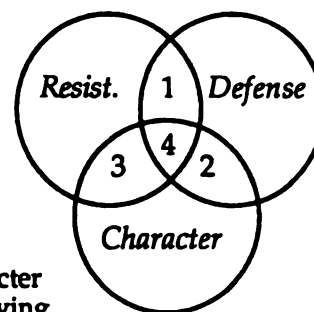
VII. OTHER INTERPRETATIONS: This is an exploratory category for developing levels of interpretation not included in the traditional levels operationalized above. The intent of this category is to generate new levels of interpretation by asking raters to answer the question, "What is the therapist inferring about the client?"

Comparison of Interpretive Levels

The levels of interpretation are not necessarily mutually exclusive. Given the natural overlap between different aspects of the levels, they are at times difficult to distinguish. For example, a client's defense may also function to inhibit the process of therapy. This would be scored as both a defense and a resistance interpretation. Four sets of interpretive levels that display common features are Resistance, Defense, and Character; Transference and Genetic; Transference and Resistance; and Defense, Character, and Adaptive Context. One exception to multiple scoring is the Other category, which is rated separately. The purpose of this section is to help raters distinguish between related interpretive levels with a higher degree of confidence.

Figure 1

Similarities & Differences Between Resistance, Defense, & Character Interpretations



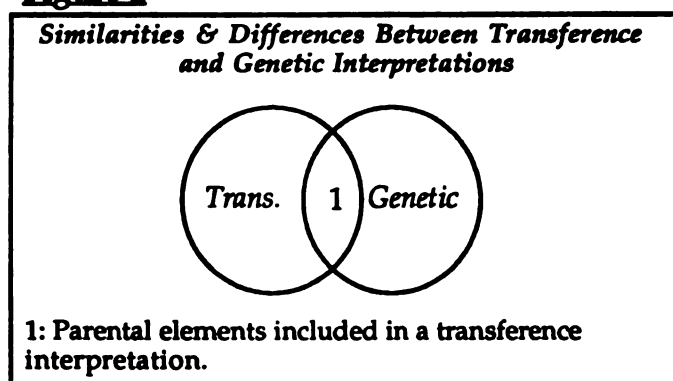
- 1: Defense serving as a resistance.
- 2: Character defense.
- 3: Long-standing character trait (not a defense) serving resistance.
- 4: Character defense serving as a resistance to the therapy process.

Resistance operates in the here-and-now to impede the progress of therapy. Defenses exclude from the client's awareness distressing thoughts, wishes, or impulses. A defense can serve as a resistance. When this is the case, the act of excluding material from awareness is interpreted to the client as inhibiting the therapy process. Character refers to ingrained habitual modes of experiencing the world. A defense can be a part of the client's character. A Character-Defense interpretation occurs when defenses are interpreted as having become so ingrained in the personality that they are habitually relied upon. Other aspects of character may be interpreted as interfering with the therapy process. These would be Character-Resistance interpretations. On rare occasions all three levels may be combined into one interpretation. In these instances, a character-defense is interpreted as serving the resistance. Figure 1 illustrates the possible interactions between Resistance, Defense, and Character interpretations.

A Genetic interpretation refers to early life motives or strivings and connects them

with the present. Genetic interpretations can also be reversed and take something that influences the client's present life experience and connect it to the past. This type of interpretation usually includes references to significant people in the client's past (e.g., a parent), without any reference to the client's relationship with the therapist.

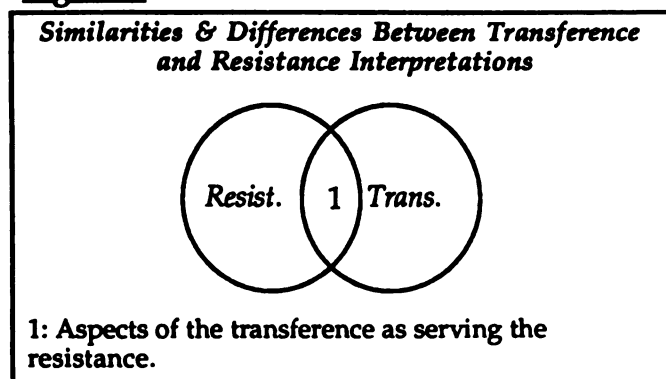
Figure 2



Transference interpretations do include a reference to the therapist. The material is interpreted as a replay of past conflicts once again in the present. These two levels are similar in that they both connect present material with past material. The major difference is that the therapist is not included in a genetic interpretation (see Figure 2).

The client can resist exploring the transference relationship. The client can also utilize the transference relationship as a way to resist exploration or uncovering when conflicts are re-enacted rather than worked through. The therapist

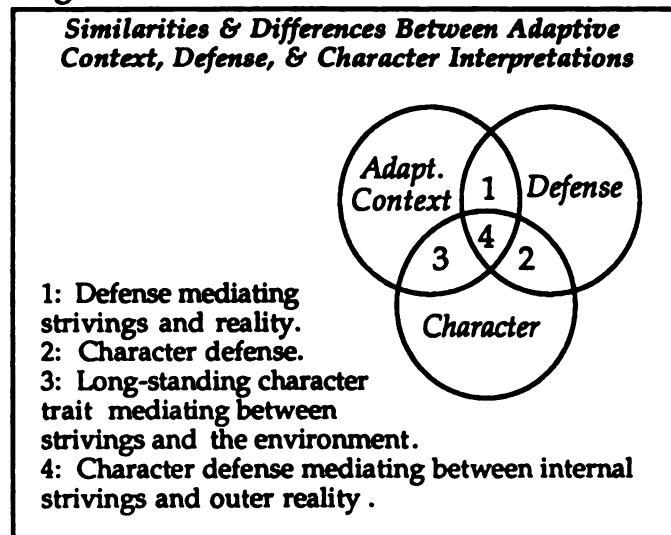
Figure 3



may interpret the resistance alone. A Transference-Resistance interpretation occurs when the therapist interprets transference manifestations as impeding progress in therapy (see Figure 3). Differences between transference and resistance interpretations include the focus on the relationship with the therapist in the transference and the client's behavior that impedes therapeutic progress in the resistance. Transference is directed toward the therapist, whereas resistance is directed toward the therapy itself.

Adaptive Context interpretations infer a relationship between the client's inner needs, wishes, and strivings and a specific external environmental reality. A Character-Adaptive Context interpretation occurs when the therapist's inference refers to ingrained habitual ways of mediating between inner strivings, wishes, or needs and the outside world. At times, a defense may be interpreted as performing these same mediating functions. When this is the case, both Defense and Adaptive Context are scored. A rare but possible interpretation may also occur where a character-defense is interpreted as mediating between strivings and a specific environmental condition. In this instance, Adaptive Context, Defense, and Character would be scored (see Figure 4).

Figure 4



Importantly, multiple scoring situations *occur only when all of the definitions for each individual interpretive level are fully satisfied*. The most common occurrence is when only one of the levels are scored for an interpretive sentence. Level combinations are relatively rare, and combinations other than those described may occur. Avoid the inevitable temptation of inferring what the therapist only implies.

Scoring the ISG

To identify and score interpretations with the ISG, a transcript of the therapy sessions from which the interpretations will be drawn is required. Initially, raters read through the transcript and examine each therapist statement for the presence of an inference²². Raters will sometimes encounter client verbalizations like “uh-huh” or “yeah” that suggest acceptance of the therapist’s interpretation. These minimal client statements do not constitute explicit agreement with the interpretation. Later therapist statements inferring similar material should be scored as inferences, even if there is prior minimal agreement. After all inferences have been denoted, brackets are placed around each interpretive sentence. These are referred to as “bracketed sentences.” Each bracketed sentence will contain at least one clause and in many instances, more than one clause. The clause is the basic unit of scoring for six of the parameters contained in this guide.²³ For the interpretive levels and the other three parameters, one bracketed sentence equals one scoring unit. All scoring units between two client verbalizations are referred to in the ISG as a “therapist segment.” Each rater denotes with a “√” in the margin where therapist segments occur in the transcript. Next, rater transcripts are compared and those segments containing bracketed sentences on which all raters agree are numbered sequentially for an entire series of therapy sessions²⁴. Throughout the scoring process, raters will note on a separate sheet of paper any technical or procedural difficulties encountered while using the ISG.

After interpretations have been identified at the sentence level, each sentence is further divided into clauses. Raters meet as a group and divide bracketed sentences into clauses by enclosing them in parentheses “().” Discrepancies are resolved by discussion and by referring to the grammatical rules in Appendix A. At this point, the raters also identify the specific referents of pronouns that occur in the therapist’s *and* the client’s verbalizations. In those cases where specific referents can be identified, the raters write these above the pronouns in the transcript and the specific text is used in scoring rather than

²²When the client interrupts the therapist’s interpretive statement and the interpretation is completed in the next therapist verbalization, then the two statements are considered one sentence.

²³The parameters are Inference Location, Causal Connection, Object, Content, Tense, and Immediacy. Causal Connection is also scored at the sentence level.

²⁴We think 100% agreement is necessary for defining basic interpretive statements because each rater has to score each bracketed sentence on a number of different parameters and levels of interpretation. If raters cannot agree on basic interpretive statements, we see little reason to expect them to agree on the properties of those statements.

the pronoun. If specific referents cannot be identified, a "G" is placed next to the pronoun to signify that a specific referent could not be identified. Inference Location is an exception to this rule. It is scored using the sentence as it is stated by the therapist. Figure 5 illustrates this method of delineation.

Figure 5

An example delineating basic units of inference²⁵

P: Perhaps I think about that, you know. Sometimes I say, what happens if, OK, I just said, "that's (g) it, I'll just commit myself to Lisa. Right, I'll go the full route and I'll just be really open with her and spend as much time with her as I can." Um, I guess what I'm thinking is that once I do that, then it's all over. You know, that means marriage. But I guess what I was thinking about . . .

T: [(I think to you it means possible loss).] [(It means getting involved with somebody, loving that person, caring about that person, feeling committed,)(and then in one way or another you get shafted at the end of the story).] With Linda, she left in, you know, sort of a hostile and malicious way. With Kate, she left through dying. [(But nonetheless the consequences are the same:)(You're left).] [(You're looking pretty sad).] What are you feeling?

The next step is to represent the therapist's interpretations on the ISG Scoring Sheet. The Scoring Sheet is comprised of a Parameter Grid and a Level Grid. First, therapy transcripts are quantified by session, segment, sentence, and clause. This is represented on the Scoring Sheet in a 1.2.3.4 format. This denotes (following from right to left) the fourth clause, in the third sentence, in the second segment, of the first session of a therapy transcript. Session, segment, sentence, and clause numbers are recorded on the Parameter Grid on the top four rows of the form. On the Level Grid, information at the clause level is omitted and only the session, segment, and sentence information are recorded. Within each bracketed sentence, all clauses are represented on the Parameter Grid.²⁶ Sentences that do not contain inferences about the client are not quantified. Figure

²⁵Text excerpted from Budman & Gurmans' (1988), *Theory and Practice of Brief Therapy*.

²⁶Every clause within a bracketed sentence is scored on the Parameter Grid even though some clauses may not contain an inference. Additionally, the parameters Depth, Topic Relatedness, Specificity, and Form are quantified at the sentence level only.

4 provides an illustration of this method of denotation as it would be entered on the Parameter Grid, using the sample transcript shown in Figure 5. Thus the therapist statement, "You're looking pretty sad" is represented as 2.14.4.1, that is, the first clause of the fourth sentence in the 14th segment of the second session.

Figure 6
Recording Information on the ISG Parameter Grid

		Session # 2				3			
Unit of Inference	Segment	14						1	
	Sentence	1	2		3		4	1	
	Clause	1	1	2	1	2	1	1	
Inference	Location	√	√	√	√	√	√	√	
Connection	Causal			C1					
Object	Client Only	√	√	√	√	√	√	√	
	Therapist - Client								
	Parent - Client								
	Other - Client								
Content	Affective		√				√		
	Behavioral								
	Cognitive	√		√	√	√		√	

After interpretations have been represented on the ISG Scoring Sheets, they are operationalized by parameter.

Parameters are scored independently for each session. Raters score all bracketed sentences within a session on each separate

parameter before moving on to the next one. For the parameters Inference Location, Object, Content, Tense, Immediacy, Depth, and Specificity, dimensions are denoted with a "√." Always score parameters in the order in which they occur on the ISG Parameter Grid. For example, all clauses within a session should be examined for the presence of an inference before the next parameter, Causal Connection is scored (see Figure 5). Likewise, all Causal Connections are scored for that session before Object is quantified. Each parameter should be fully operationalized for a given session before moving on to the next parameter. Additionally, all interpretations in a given session should be quantified on all parameters before interpretive level is scored. Note that Inference Location, Causal Connection, Object, Content, Tense, and Immediacy are scored at the clause level and the parameters Depth, Causal Connection, Topic Reintroduction, Specificity and Form are evaluated at the sentence level.

Causal Connection deserves special mention as the possibility of connections must be investigated between clauses within sentences, and between sentences within a segment. For the Causal Connection parameter, connections are first operationalized by clause before sentences are evaluated. Only the clauses within each bracketed sentence are exam-

ined for the presence of causal connections. Similarly, only sentences within a given segment are scored on the Causal Connection parameter. Additionally, connections between clauses and between sentences are denoted differently on the ISG Parameter Grid. Connections between clauses are denoted with a "C" and a subscript indicating the clauses to which they are causally connected. Sentence connections are denoted with an "S," with the subscript representing the sentence that it is connected to (see Figure 5). Remember that all connections must be causal inferences to be scored.

Scoring procedures for the parameters Topic Reintroduction and Form are also different from the other parameters. Topic Reintroduction between segments is denoted numerically. Topic Reintroduction is scored by numbering each reintroduction of a theme with the sentence and segment number of that theme's first introduction by the therapist. The first introduction of a theme is not scored. For example, a rater identifies a theme that has been reintroduced in the first sentence of the sixth segment of a session. The original introduction was in the second segment's first sentence. The denotation at the point of reintroduction would then read, "2.1," meaning that the theme was first verbalized in the first sentence of the second segment. The first time a theme is reintroduced, raters summarize the theme and write it on the back of the Scoring Sheet. When encountering subsequent reintroductions, refer to the written theme for scoring Topic Reintroduction. Form is evaluated first on the dimensions question and statement. After these dimensions have been determined, raters use a "T" or an "F" to denote Form, depending on whether the question or sentence is phrased in a tentative or firm manner.

After all clauses, sentences, and segments have been scored on all of the parameters for a given session, the rater proceeds to code levels of interpretation. As previously stated, coding of levels of interpretation is done by sentence. First, the rater returns to the beginning of the session and scores levels of interpretation on the ISG Level Grid, independent of the previously coded dimensions and parameters. Occasionally, sentences may be scored on more than one interpretive level. For this reason, raters should examine a bracketed sentence for the presence of each of the first six interpretive levels before scoring the next sentence. When identifying interpretations by level, raters should guard against inferring what the therapist only implies. In general, if raters find themselves spending too much time trying to decide if an interpretation belongs to a given level, it probably does not. If an interpretation cannot be scored on any of the first six operationally defined interpretive levels, then the exploratory level, Other Interpretation, is scored. After raters mark Other Interpretation on the ISG Level Grid, they write out their response to the question, "What is the therapist's interpretation inferring about the client?" Responses to this questions are recorded in the area below the Level Grid. The interpretation's segment

and sentence numbers are denoted, followed by the response to the question. The rater may use as much space as necessary to answer the question and begins the next occurrence of Other Interpretation on the line below.

Appendix A

Basic Rules of Grammar

In this appendix, we include those rules of grammar that are necessary to divide therapy transcripts up into segments, sentences, and clauses as defined in the body of this guide. These rules are a composite taken directly from three books on grammar: *Index to English* (Ebbitt & Ebbitt, 1977); *The Elements of Grammar* (Shertzer, 1986); and *Elements of Style* (Strunk & White, 1979). Raters should refer to these books to resolve any conflicts regarding the proper way to unitize a transcript when the appendix is unclear.

We offer some guidelines for raters use when delineating clauses within sentences:

1. *Punctuation marks like commas, semi-colons, and colons as markers of a separation between clauses.*
2. *Conjunctions such as: for, as, and, but, or, so that, etc. (refer to list below) that join words, phrases, or clauses.*
3. *Clauses contained in a sentence can stand alone, i.e., it is an independent clauses, then parentheses are places around the clause. By reading sentences and looking for independent clauses, the task of identifying clauses in a transcript is made easier.*
4. *All sentences will have at least one independent clause.*
5. *Nonrestrictive dependent clauses are considered part of the independent clause for unitizing.*
6. *Be aware that therapy transcripts may not follow the appropriate rules of grammar or style due to improper use of the English language when speaking.*

It is assumed that raters will know the definitions of the basic elements in written language (i.e., a noun, verb, etc.). The following definitions are thought to be particularly relevant and therefore are included in the appendix.

A sentence expresses a complete thought and consists of a subject and a predicate. If either the subject or predicate is not expressed, it must be readily understood from sentences that precede or follow. The subject of a sentence is the person, object, or idea being described. The predicate is the explanation of the action, condition, or effect of the subject. So, the predicate of a sentence or clause is the verb with its modifiers and objects or complements. Two verbs depending on one subject are known as a compound predicate.

A phrase is a group of words that are closely related but have no subject or predicate. A phrase may be used as a noun, verb, adjective, or adverb. A phrase that is

essential to the meaning of the sentence is called restrictive. A phrase which is actually a parenthetical comment is called nonrestrictive and is usually set off by commas.

A clause is a group of words which has a subject and a predicate. A main (or independent) clause can stand alone as a sentence. A subordinate (or dependent) clause is incomplete and is used with a main clause to express a related idea.

Conjunctions are words that may signal a break between a dependent clause and an independent clause. They are: after, although, and, as, as . . . as (e.g., as well as), as if, as though, because, before, but, but that, ever since, even if, except that, for, how, if, if only, in addition to, inasmuch as, in case, in order that, just as, more than, nor, now that, once, or, provided, rather than, since, so that, so . . . as, such . . . that, than, though, till, together with, unless, until, when, whenever, where, wherever, whereupon, whether, while, why, yet; and the relative pronouns: who, which, that, what.

Nonrestrictive clauses do not limit or define, they merely add something. A sentence containing a nonrestrictive clause can be split into two independent statements. Restrictive clauses, by contrast, are not parenthetical and are not set off by commas. A sentence containing a restrictive clause cannot be split into two independent statements. So, in a clause that modifies the meaning of a sentence, does the clause add something that the sentence requires for its basic meaning (restrictive), or does it offer information—no matter how important—that could be omitted from that sentence without detracting from its central message (nonrestrictive). Nonrestrictive clauses are included with the restrictive clause when marking the units for scoring on the ISG. Dependent and independent clauses are separated out.

Appendix B

Quick Reference Sheet for ISG Levels

This reference sheet is intended for use during the scoring of interpretive levels. It is not meant as a substitute for the ISG. The purpose of this sheet is to simplify the scoring process by allowing raters to easily compare the levels for each interpretive sentence. Questions or conflicts should be resolved by referring to main body of the guide.

I. RESISTANCE INTERPRETATION: The therapist's interpretation points out some aspect of the client's behavior that is interfering with the process of therapy. The behavior the therapist interprets as impeding the client's self-understanding varies in blatancy from very overt behavior (e.g. missing sessions, saying that a topic is not important, etc.) to subtle behavior (e.g. superficial content, changing topics, etc.). In a resistance interpretation, the interpreted behavior itself is not significant. It is the inference that the behavior interferes with the therapy process that is relevant.

II. DEFENSE INTERPRETATION: The therapist interprets some aspect of the client's thoughts or behavior that operate to exclude from the client's awareness distressing affect (e.g. shame, guilt, disgust, fear, etc.); or unacceptable thoughts, wishes, or impulses.

III. TRANSFERENCE INTERPRETATION: The therapist infers that the client's current manner of relating to the therapist is a re-enactment of past relationships with significant others.

IV. CHARACTER INTERPRETATION: The therapist makes the client aware of well- established, ingrained, habitual modes of experiencing or responding. The therapist interprets regular patterns about how the client makes sense of the world.

V. ADAPTIVE CONTEXT INTERPRETATION: The therapist interprets the client's strivings, wishes, or needs as they are facilitated or frustrated by real life situations.

VI. GENETIC INTERPRETATION: The therapist interprets early life motives or strivings as they continue to influence present life experiences.

VII. OTHER INTERPRETATIONS: This is an exploratory category for developing levels of interpretation not included in the traditional levels operationalized above. The intent of this category is to generate new levels of interpretation by asking raters to answer the question, "What is the therapist inferring about the client?"

Notes

Rater Notes on Scoring the ISG

References

- Basch, M. F. (1980). Doing Psychotherapy. New York: Basic Books, Inc.
- Budman, S. H. & Gurman, A. S. (1988). Theory and practice of brief therapy. New York: Guilford Press.
- Ebbitt, W., & Ebbitt, D. (1977). Index to English. Glenview, Il: Scott Foresman & Co.
- Fenichel, O. (1945). The Psychoanalytic Theory of Neurosis. London: Routledge & Kegan Paul Ltd.
- Freud, S. (1905). On psychotherapy. S.E. (Vol. 7, 256-281).
- . (1912). The dynamics of the transference. S.E. (Vol. 12, pp. 98-228).
- . (1916). Introductory lectures on psychoanalysis. S.E. (Vols. 15-16).
- . (1923). The ego and the id. S.E. (Vol. 19, pp. 3-107).
- . (1933). New introductory lectures on psychoanalysis. S.E. (Vol. 22, pp. 3-198).
- Garduk, E. L., & Haggard, E. A. (1972). Immediate effects on patients of psychoanalytic interpretations. Psychological Issues, 7 monograph 28, 1-83.
- Gill, M. (1982). Analysis of transference, volume I: Theory and technique. New York: International Universities Press, Inc.
- Giovacchini, P. (1987). A narrative textbook of psychoanalysis. New Jersey: Jason Aronson.
- Hill, C. E. (1978). Development of a counselor verbal response category system. Journal of Counseling Psychology, 25(5), 461-468.
- Johnson, S. (1985). Characterological transformation: The hard work miracle. New York: W. W. Norton Co.
- Kaplovitz, L. (1987). To Love and To Work. New Jersey: Jason Aronson, Inc.
- Korchin, S. J. (1976). Modern clinical psychology. New York: Basic Books.
- Langs, R. (1983). The technique of psychoanalytic psychotherapy (Vol. II). New York: Jason Aronson, Inc.
- Langs, R. (1982). Psychotherapy: A basic text. New York: Jason Aronson, Inc.
- Langs, R. (1973). The Technique of Psychoanalytic Psychotherapy (Vol. I). New York: Jason Aronson, Inc.
- Laughlin, H. (1983). The ego and its defenses. New Jersey: Jason Aronson, Inc.
- Levy, S. (1984). Principles of interpretation. New York: Jason Aronson, Inc.
- Loewenstein, R. (1957). Some thoughts on interpretation in the theory and practice of psychoanalysis. In L. Paul (Ed., 1963) Psychoanalytic Clinical Interpretation (pp. 162-188). London: Collier-Macmillan Ltd.

- Luborsky, L., Bachrach, H., Graff, H., Pulver, S., & Christoph, P. (1979). Preconditions and consequences of transference interpretations: A clinical-quantitative investigation. The Journal of Nervous and Mental Disease, 167, 391-401.
- Malan, D. H. (1976). Toward a validation of dynamic psychotherapy: A replication. New York: Plenum Press.
- Piper, W. F., Debbane, E. G., Bienvieu, J.-P., Carufel, F., & Garant, J. (1986). Relationships between the object focus of therapist interpretations and outcome in short-term individual psychotherapy. British Journal of Medical Psychology, 59, 1-11.
- Reich, W. (1949). Character Analysis. New York: Orgone Institute Press, Inc.
- Shertzer, M. (1986). The elements of grammar. New York: Macmillan Publishing Co.
- Speisman, J. C. (1959). Depth of interpretation and verbal resistance in psychotherapy. Journal of Consulting Psychology, 23, 93-99.
- Stiles, W. B. (1979). Verbal response modes and psychotherapeutic technique. Psychiatry, 42, 49-62.
- Strunk, W., & White, E. B. (1979). The elements of style (3rd ed.). New York: Macmillan Publishing Co.
- Strupp, H. H.. (1989). Psychotherapy: Can the practitioner learn from the researcher? American Psychologist, 44, 717-724.
- Wisdom, J. (1963). Psycho-analytic technology (1956). In L. Paul (Ed.), Psychoanalytic clinical interpretation (pp. 143-161). London: Collier-Macmillan Ltd.
- Wolberg, L. (1977). The technique of psychotherapy: Part I. New York: Grune and Stratton, Inc.

APPENDIX C

Ranked Scale of Constituent Security Operations

On either Sullivan's or Freud's views the items in Table 1 are not homogeneous: Each item represents a distinct behavior with unique underlying determinants. In fact, the scale might be the ordering of three homogeneous scales that might aptly be called Narcissistic Satisfaction (1-11), Frustrated Narcissistic Strivings (12-18), and Narcissistic Retreat (19-34). On the views of both Sullivan and Freud, each of the items (behaviors) represents a distinctive dynamic process that is the outcome of the self-system/ego. In contrast, the ethological view simply pits an aggressive behavior against fear of superior retaliation. Then again, the behaviors might simply be regarded as mediating degree of well-being.

The items permit rank ordering on the basis of the degree to which the configuration of coefficients for each item departs from the mastery-dominance criterion (the coherent pattern of PPFP, HQ, and ASRS). Each of the component correlations (variance accounted for) was squared, and those which were discrepant were subtracted from those that were not discrepant. For example, the PPFP, HQ, and ASRS coefficients for Interrupting are .33, .35, and .24, respectively, and since all conform to the mastery-dominance criterion, the summed squares equals 2890. In contrast, all three coefficients for Automatic Laughter, -.38, -.27, and 0.41 are discrepant, and the sum of their squares is 3854×10^{-4} . Items from 21 to 34 turned out to be discrepant for all three correlations: PPFP and HQ decrease while ASRS increases. In regard to Changing Topic (11), note that only

HQ is discrepant from the mastery dominance criterion; thus, its squared coefficient (121×10^{-4}) is subtracted from the sum of the remaining two: $121 \times 10^{-4} + 169 \times 10^{-4} - 121 \times 10^{-4} = 169 \times 10^{-4}$.

Table 1
Interpersonal Behaviors Depicting the Fate of
Narcissistic Strivings

Ranking of spontaneous behaviors (items) with respect to departure from the Mastery-Dominance criterion: increasing personal power (PPFF), increasing happiness (HQ), and decreasing anxiety (ASRS).

Entries in the body of the table are point biserial coefficients of correlation (users versus nonusers of each item).

	r ² (diff)	<u>r</u>		
		PPFF	HQ	ASRS
1 Interrupting	2890	.33	.35*	-.24
2 Repartee	1941	.21	.27	-.26
3 Dramatization	1902	.10	.29	-.31*
4 Sentence finishing	1706	.13	.31*	-.24
5 Teasing	1223	-.03	.39*	.17
6 Turning tables	906	-.01	.28	.11
7 Humor	853	.23	-.10	-.18
8 Arm twisting	784	.09	.24	-.13
9 Pasted on smile	302	.05	.14	-.09
10 Incessant talking	204	.02	.10	-.10
11 Changing topic	169	.11	-.11	-.14

	r2 (diff)	<u>r</u>		
		PPFP	HQ	ASRS
12 Flashlight smile	125	.03	.04	.10
13 Annoyance	102	.02	-.07	-.07
14 Security blanket	101	.02	.04	.10
15 Connecting	000	-.02	.07	.07
16 Placation	- 63	.18	.13	.12
17 Headnod	- 81	-.02	.12	.15
18 Disparagement	-109	-.13	-.14	-.14
19 Side-stepping	-195	-.13	-.01	.05
20 Headnod I	-225	-.12	.12	.15
21 Dissembling	-499	-.15	-.07	.15
22 Obsequiousness	-763	-.03	-.15	.23
23 Character bldg I	-765	-.02	.19	.20
24 Questioning	-949	-.02	.09	.31*
25 Diffidence	-1409	-.24	-.28	.07
26 Qualifying	-1441	-.27	-.17	.24
27 Exemption	-1701	-.36*	-.09	.18
28 Character bldg II	-1746	-.08	-.01	.41*
29 Self-justification	-2010	-.32*	-.19	.25
30 Character bldg III	-2200	-.30*	-.30*	.20
31 Reassurance	-2214	-.07	-.22	.41*
32 Taciturn	-2334	-.41*	-.13	.22
33 Word substitution	-3324	-.39*	-.17	.21
34 Automatic laughter	-3854	-.38*	-.27	.41*

*p < .05

APPENDIX D

Extended Security Operations Scale

1. Humor: Speaker saying anything designed to elicit laughter; allusions, jokes, puns, goofs and gaffes (speaker usually laughs or smiles).
2. Repartee: Saying anything to elaborate on what speaker says and prompts speaker to reply in kind, particularly wit and put down. Listener usually laughs or smiles.
3. Teasing: Speaker says something designed to put person listening in bad light, ostensibly harmless form. Or speaker tempting a listener without providing gratification (speaker usually laughs or smiles).
- 4a. Turning the Tables: Listener reversing role of listener and questioner or persecutor and defendant or active and passive.
- 4b. Knowing: Listener or speaker provides answer or insight as being right - speaker or listener is proven right or comment is considered to be right or correct.
5. Disparagement: Speaker saying anything to reduce the esteem in which the listener may hold someone or something. Create a bad impression.
6. Taciturn/Reticence: Neither initiating new topics or elaborating on topics or questions introduced by speaker.
7. Dissembling ("I'm alright"): Speaker or listener saying anything to present oneself as being "cool," "together," "on top of things," when confronting or having confronted a dystonia inducing or possible dystonia inducing event or circumstance. Not feeling dystonia when he/she ought to.
8. Incessant Talking: Speaker continues to talk thus preventing listener from saying something. Speaker will not assume role of listener.
9. Interrupting: Something said by listener before speaker finishes sentence or makes point.
10. Connecting (personal, yea-saying): Listener saying something to place self on good side of speaker. "I agree," "I approve," or "me too." Listener Saying something to formally impress speaker when comment is misdirected; "I know him" or "I've been there."
11. Exemption: Speaker or listener saying anything to exclude self from evaluation.
12. N'est-ce pas/Arm Twisting: Speaker forcing opinion or statement on listener, e.g. "O.K."; "You Know?"; "Isn't that right?, Isn't it?" Usually in the form of a question following an assertion.

13. Self-Justification: Speaker saying anything to prevent self from being criticized or creating a bad impression in listener. E.g. rationalization, excuses.
14. Qualifying: Speaker qualifies own statement. Listener qualifies statements of others.
- 15a. Word Substitution: Speaker replaces or rephrases own/others words.
- 15b. Stalling: Use of non-words like "uh" or "um" to fill in space or delay so speaker can consider their next comment or response.
16. "I'm from Missouri (skepticism)": Listener not accepting statement of speaker at face value.
17. Having no opinions or values (facelessness): Speaker does not identify self with a position on topic, particularly when asked.
18. Changing the Topic: Listener introduces new topic before completion of current topic.
19. Security blanket: Bootstrapping comment by speaker (1) name dropping, (2) prestige association (clubs, cars, boats), (3) calls attention to apparel and possessions, (4) bragging: calling attention to self in a favorable way.
20. Indifference: Speaker casts lack of involvement in a favorable light.
21. Dramatization: Inspire interest by colorful description. Speaker's use of colorful language builds up events by "putting you there."
22. Side-Stepping: Listener does not answer question by talking about something relevant but off the point.
23. Annoyance/Impatience: Speaker acts displeased, expresses annoyance or impatience. Modulated expression of anger.
24. Questioning/Confronting: Speaker asks questions which require listener to justify what he/she is saying. Meet the person head on, "explain yourself." Confront others.
25. Placation/Flattery/Ingratiation: Unsolicited comments by either party designed to enhance other's self-esteem.
26. Self-Effacement: Speaker devalues self in relation to listener. Speaker makes invidious comparisons in favor of listener.
27. Automatic Laughter: Inappropriate laughter, nothing funny happened.
28. Character Building I: Speaker describes dystonia-inducing past events (mishaps, misfortunes), inspires admiration.

29. Character Building II: (1) Make a good impression/good works- SO insight: Comments which specify behavior that denotes a striving to make a good impression. (2) Avoid bad impression- SO insight: Comment which specify behavior denotes a conscious striving to avoid making a bad impression.
30. Character Building III: Self-abnegation; speaker devalues self to listener.
31. Diffidence: When listener responds to speaker by placing speaker's needs, comfort, convenience first, with or without justification. Defer to other.
32. Obsequiousness: When listener initiates comments or activity (e.g., getting chair, ashtray) in absence of request or obvious cue (unsolicited) to provide physical comfort (with or without justification). Includes wanting to do favors.
33. Sentence Finishing: Listener finishes sentence when he/she has not been asked or pressured to finish sentence or have his/her opinion asked.
34. Reassurance: Speaker asked questions directly soliciting reassurance from listener, e.g., "Am I doing all right?" "Is this OK?"
- 35a. Taking Charge: Initiate problem solving.
- 35b. Giving Instructions: Speaker tells listener how to do something.
- 35c. Remonstrate: A rational, logical way to oppose someone; use of argument to reason someone into change.
- 35d. Offering Suggestions: Speaker gives listener suggestions about how to do or think about something.
36. Nonanswers to Questions: Listener does not respond to questions asked by speaker.
37. Incomplete Sentences: Speaker does not complete sentences or finish thought/idea.
38. Apologizing: A formal justification, defense, excuse.
39. "You Know!"/"O.K.!": Not a question. Attempt to put off disagreement or a questioning response from listener.
40. Silence: Listener does not respond to speaker.

APPENDIX E

Personal Power Functions Profile

1. Physical Attractiveness

- ☐ 1. ugly
- ☐ 2.
- ☐ 3. plain
- ☐ 4.
- ☐ 5. beautiful/
very handsome

2. Height

- ☐ 1. 5'0"
- ☐ 2. 5'5"
- ☐ 3. 5'10"
- ☐ 4. 6'3"
- ☐ 5. 6'8"

3. Stature

- ☐ 1. frail
- ☐ 2.
- ☐ 3. medium build
- ☐ 4.
- ☐ 5. very well built

4. Knowledge/Ability/Talent Germane to Interaction

- ☐ 1. novice
- ☐ 2.
- ☐ 3. muddles through
- ☐ 4.
- ☐ 5. expert

5. Savoir-Faire

- ☐ 1. social dunce
- ☐ 2.
- ☐ 3. rough at the edges
- ☐ 4.
- ☐ 5. charmingly adroit

6. Socio-Economic Status

- ☐ 1. lower class
- ☐ 2.
- ☐ 3. middle class
- ☐ 4.
- ☐ 5. upper class

7. Authority (occupation)

- ___1. bus boy
- ___2. waitress, clerk
- ___3. teacher
- ___4. policeman
- ___5. chairman of board,
president

8. Education

- ___1. grade school
- ___2. high school
- ___3. technical
certificate
- ___4. ordinary
college
- ___5. prestige
college

9. Attire

- ___1. street person
- ___2. discount store
- ___3. department store
- ___4. specialty store
- ___5. high fashion
shop; luxurious

10. Personal Fame
(reputation)

- ___1. nobody
- ___2. school
- ___3. local community
- ___4. regional
- ___5. national

11. Family Fame (reputation,
social, position)

- ___1. nobody
- ___2. school
- ___3. local community
- ___4. regional
- ___5. national

12. Speech

- ___1. stutter
- ___2. stammer
- ___3. halting, hesitant
- ___4. fluid
- ___5. eloquent

13. Eye Contact

- ___1. 0%
- ___2. 25%
- ___3. 50%
- ___4. 75%
- ___5. 100%

14. Voice

- ___1. high-diminutive
- ___2.
- ___3. moderate
- ___4.
- ___5. full, overtones,
color

15. Carriage

- ___1. slumped, head
bowed
- ___2. head bowed
- ___3. slouches somewhat,
eyes downcast
- ___4. erect body but head
not high
- ___5. body erect and head
high (poised)

16. Expression of Ideas

- ___1. uninformed and
illogical
presentation
- ___2.
- ___3. moderate
- ___4.
- ___5. highly informed
and logical
presentation

APPENDIX F

CONSENT FORM

Security Operations In The Therapy Interaction

You are invited to participate in a research study examining the interpersonal interactions between therapists and clients in actual short-term therapy sessions. You were selected to rate the therapy sessions because you expressed interest in the study. Robert Graham of Michigan State University is conducting this study. Please read this entire form and ask any questions you may have before agreeing to be a rater in this study.

The purpose of this investigation is to explore the dynamics of interpersonal communication between two people in an established relationship. The therapy relationship was chosen because there is a relationship already established between the two individuals involved and there is a similar pattern of communication in each of the client-therapist pairs. This study also seeks to better understand the interaction effects of verbal communications as well as their self-protective or self-enhancing nature.

If you agree to be in this study, you would be asked to rate the verbal communications in 24 therapy sessions on a "security operations" scale that contains both self-protective and self-enhancing mechanisms used in everyday interpersonal communications. Tapes of therapy sessions along with the corresponding transcripts will be used to make the ratings. There will be an initial training period where you will be taught to recognize and rate "security operations." The training period and rating of the 24 therapy sessions will take approximately sixty-five hours to complete.

You will not know what the hypotheses (predictions) are at the beginning of this study. Hypotheses will be revealed only after completion of the ratings.

You will benefit by receiving training to use a theory-based rating scale to rate interpersonal interactions, gain a better understanding of short-term dynamic therapy, and acquire some research experience making ratings. The intent is to provide you with an opportunity to learn more about conducting research.

You will receive payment for your participation. \$25 will be paid after training is completed and the remaining \$75 will be paid after all the ratings are finished. You must complete all the ratings to be eligible for the \$75.

The data and records of this study will be kept private. All identifying information will be removed so that the students cannot be directly tied to their ratings. In any sort of report we might publish, we will not include any information that will make it possible to identify a participant. Only the researchers will have access to the records. You will also be asked to make a confidentiality vow to keep all therapy tapes and materials you come in contact with confidential and not reveal any information related to this project to anyone outside the research group.

Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota or Michigan State University. If you decide to participate, you are free to withdraw anytime without affecting those relationships.

You may ask any questions you have of the principle investigator, Robert Graham, now. If you have questions or concerns later, you may contact Robert at (612)-894-4788 or his major advisor, Joseph Reyher of Michigan State University, at (517)-355-0186.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received satisfactory answers. I consent to participate in the study.

Student _____ Date _____

Investigator _____ Date _____

Vow of Confidentiality

You will be listening to actual therapy sessions on audiotapes. Because of the sensitive nature of this material, you are asked to keep all the information you see or hear about clients and therapists confidential.

We, the undersigned, agree to maintain the confidentiality of those participants who were involved in the psychotherapy research project. We will not talk about the therapy sessions or participants with anyone outside the research group.

APPENDIX G

Educational Debriefing Form

The purpose of the present study was to explore the dynamics of interpersonal communication within the therapy situation. Given that everyone uses security operations as defined in this study (Sullivan, 1953, 1954), it was thought that certain interventions (i.e. interpretations) would elicit security operations from both clients and therapists in the therapy situation. Personal power and perceived roles in interpersonal relationships has been shown to influence the type of security operations used (Gavrilides, 1980). The greater personal power an individual has, the more likely they are to use a dominance-mastery type of security operation. It was expected that therapist and client would use security operations that were complementary in order to preserve the relationship and maintain some level of self-esteem. This pattern of relating was viewed as extending beyond just the therapy context to other interpersonal interactions.

References

- Chapman, A. H. (1978). *The Treatment Techniques of Henry Stack Sullivan*. New York: Brunner/Mazel, Publishers.
- Gavrilides, G. (1980). The relationship of personal power functions to general happiness, interpersonal risk, interpersonally induced anxiety, and security operations. Unpublished dissertation.
- Sullivan, H. S. (1953). The Interpersonal Theory of Psychiatry. New York: W. W. Norton & Co.
- Sullivan, H. S. (1954). The Psychiatric Interview. New York: W. W. Norton & Co.

APPENDIX H

Examples of Security Operations (Therapy situations)

1. Humor

Client or therapist will tell a joke, use a pun or allusion, etc. to make light of a serious situation or possibly distract the other person from some issue. Client may imitate something someone (friend, relative) does or says. Therapist could joke with client about a situation that happened in a previous therapy session, e.g. client maintains a rigid view about something.

2. Repartee

Usually a light sparring with words between parties in response to each other. Therapist will add a clever phrase or word to elaborate of what client is saying and client continues with a clever phrase of their own on the same theme or topic.

3. Teasing

Therapist teases client about a habit they have (or vice versa), i.e. client is always late to sessions, therapist has a favorite chair, office is small, new hair style, etc.

4. Turning the tables (knowing)

Therapist asks client a direct question or is pursuing a topic and client asks a (related) question of the therapist in response or takes the topic up and turns it back on the therapist. Therapist can also turn topic back on client when it gets diverted. (Knowing)-Client or therapist presents opinion or view as correct or right and beyond question.

5. Disparagement

Therapist or client will talk negatively about someone or something in a way that reduces the value or esteem of that object for the listener.

6. Taciturn-reticence

More likely to be used by client. Client gives brief responses to questions with no elaboration.

7. "I'm alright" (dissembling)

Client saying, "My relationship is going to work itself out and I'll be o.k." (when relationship is breaking up); My father's death didn't affect me that much, I'm still functioning.

8. Incessant talking

Therapist or client will usually try to get a word in while the other is speaking but attempts are unsuccessful (may hear filler words like ah or um or person begins sentence unsuccessfully).

9. Interrupting

Therapist interrupts the client before the client has completed their sentence or makes their point. They might say something like "Let me stop you there."; ask a question; or just say what they want regardless of whether the client is speaking or not. Clients will also interrupt the therapist but may use different words or phrases, e.g. "No, that's not the case." (before therapist completes entire thought); "That is very true for me." (Therapist still has more to say and client continues speaking after interrupting therapist).

10. Connecting (yea-saying)

May be as simple as Uh-huh (listen to voice tone, volume, etc.)

Agreeing with speaker and not being confronting, oppositional.

11. "I'm just a housewife" (exemption)

"That's just the way I am."; "That doesn't apply to me."

12. N'est pas or arm twisting with ratification expected

Usually in the form of a question (Don't you agree form). May repeat same question or comment stated previously.

13. Self-justifying

"I have always done things this way."; "It wasn't my fault because..."; "You told me to do it that way." Not taking responsibility for own actions.

14. Qualifying

"I'm not an expert in this area but..."; "I'm not sure about what this means but..."; "I realize that you are making an educated guess when you say that." "Well you just had that one experience."

15. Word substitution (rephrasing)/(stalling)

"I mean..."; "You mean..."; "What I (you) am really saying is..."; "Um, I am ah...."

16. "I'm from Missouri" (skepticism)

"I'm don't see it that way."; "There's more to that."; "Show me what you mean by that."; (convince me attitude)

17. Having no opinions or values (facelessness)

Client may play out both sides of an issue without taking a firm stance or making a choice about something. May use examples to support both sides of an argument but doesn't own either side as their personal position.

18. Changing topic

Therapist or client change topic of discussion when anxiety is generated. For example, when client is experiencing some emotion while discussing an issue, therapist will redirect client and move away from dealing with the emotion.; or Therapist will begin talking about the client's relationship with mother and the client will say something like "Well that reminds of an incident with my aunt where . . ."; or Either party says something totally out of the blue or unrelated to previous topic of discussion.

19. Security Blanket

"So and so did this too."; "I worked with ..."; "I belong to..."; "I led all employees in production this month."; "My house is..."

20. Indifference

"Being active in politics doesn't get you anywhere."; "That relationship is destructive anyway." (May not acknowledge their part in relationship problems); "I can take it or leave it..."

21. Dramatization

Very descriptive in presentation, client may tell stories, therapist uses dramatic anecdotes to illustrate a point.

22. Side-stepping

Client goes off on a tangent; therapist digresses. One way to avoid an issue. E.g. Client questions the therapist about a termination date; client talks about mother's cooking rather than their conflict at Thanksgiving.

23. Annoyance (impatience)

Listen to voice characteristics in addition to content.

24. Questioning (confronting)

"Why do you say that about your parents?"; "That doesn't make sense to me."; "Weren't you quoted in the paper last week?"

25. Placating (flattery)

"You look nice today."; "You always make me feel good when I leave these sessions."; "That was very insightful."

26. Self-effacement

"I'll never be able to see things as clearly as you do."; "You are more ... than I am."; "I wish I could ... like you do."

27. Automatic laughter

May be a nervous laughter. Laughing to ease the tension. Ask yourself if client or therapist said anything funny.

28. Character Building I

"I helped this client even though I was ..."; "I was in this one relationship where ... and I survived it."

29. Character Building II

"I always treat people at work with respect."; "I wasn't trying to..."

30. Character Building III

"I'm just not thinking clearly today."; "I always have trouble doing that."; "I never follow-through."

31. Diffidence

"Why don't you take my chair."; "No, you go first."; "You seem uncomfortable. Why don't you ..."

32. Obsequiousness

"Let me get another chair for you."; "Let me get that for you."; "I will bring that in next week for you to see." (Not asked to).

33. Sentence finishing

Therapist or client completes sentence for other;

34. Reassurance

Therapist-"Is the therapy progressing the way you wanted?"

Client-"Am I doing this the right way?"

35. Taking charge (giving instruction/remonstrate/offering suggestions)

"Let's talk about your problems at home and what you have tried to do about them."; "You just tell your roommate no!"; "You need to tell him you are angry because when you don't, you end up feeling depressed and anxious."; "You could try to get to work earlier." "Consider her motives before you take action."

36. Nonanswers to questions

Therapist: "Was that fun?" Client: "I saw my sister."

37. Incomplete sentences

"I think ah."; "I mean I."; "When he said."

38. Apologizing

"I am so sorry...."; "I can't help myself, I am always like that, please forgive me."; "I'll make it up to you."

39. You know (O.K.!)

"You know how it is."; "It was scary, you know."; "She was there, OK, and I ignored her the whole night, OK!"

40. Silence

There is a pause in speech (5 seconds or more)

APPENDIX I

Additional training material for scoring personal power functions

Knowledge/Ability/Talent germane to interaction:

For therapist:

- a. Training- All trained in same method.
- b. Review Strupp and Binder (1984).
- c. Education- 8 clinical psychologist vs 7 psychiatrists
- d. Experience- 2-14 yrs.
- e. Talent- Natural or innate capacity.

For client:

- a. Previous therapy.
- b. Exploring issues

Savoir-Faire:

Tact, Cleverness, Wits. Knowing how to do.
Capacity for appropriate action, esp. a polished sureness in social behavior; poise; A keen sense of what to do or say in order to maintain good relations; skill and grace in dealing with others. Social dunce, socially clumsy.

Speech:

Manner of speaking:

- a. Stutter- to speak with involuntary disruption or blocking of speech.
- b. Stammer- to make involuntary stops and repetitions in speaking. To utter stumblingly.
- c. Halting/Hesitant-Pause, delay, hold back in doubt or indecision, waver, falter, stop.
- d. Fluid- a smooth easy style, flowing, moves easily
- e. Eloquent- discourse marked by force and persuasiveness, forceful and fluent expression, vividly or movingly expressive or revealing.

Voice:

- a. Range
- b. Quality how does the voice sound? Tone quality.
- c. Pitch- high; low; mid; low-rising; falling.
- d. Vibration- Full of life, pulsating, responsive, sensitive, resonant (richness, varied) vs diminutive, flat.
- e. Expressive Inflection- warm and expressive vs cold and unfeeling.
- f. Volume- soft to loud.
- g. Vibration- diminutive to full.

Expression of Ideas:

- a. Difficult to understand.
- b. Unclear, disjointed.
- c. Can piece it together to make sense.
- d. Clear, able to follow, makes sense for the most part.
- e. Very easy to understand, clear and concise, knows of what they are talking about.

APPENDIX J

Figure J-1

Histograms of average personal power scores for client and therapist.

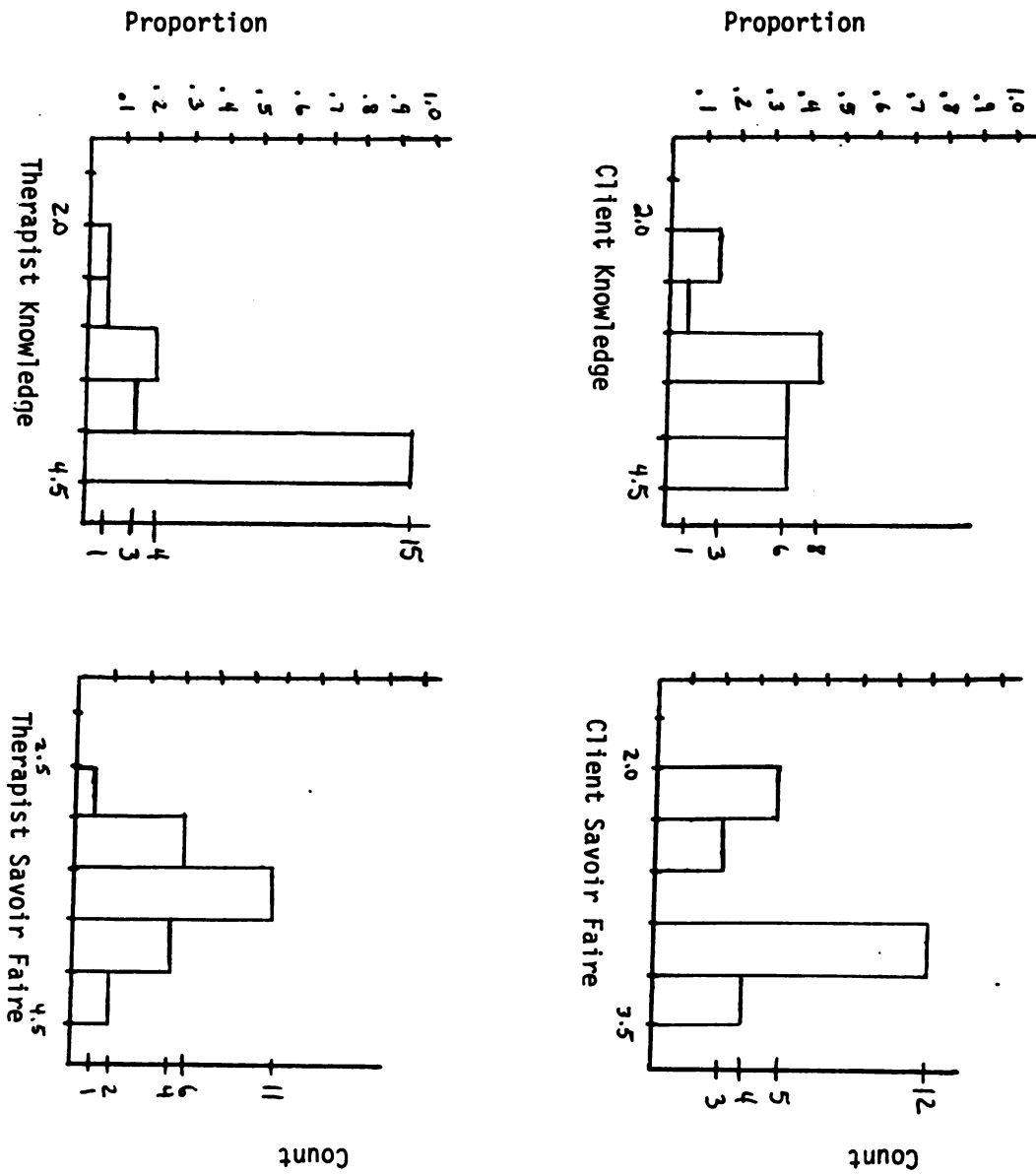


Figure J-1 Continued.

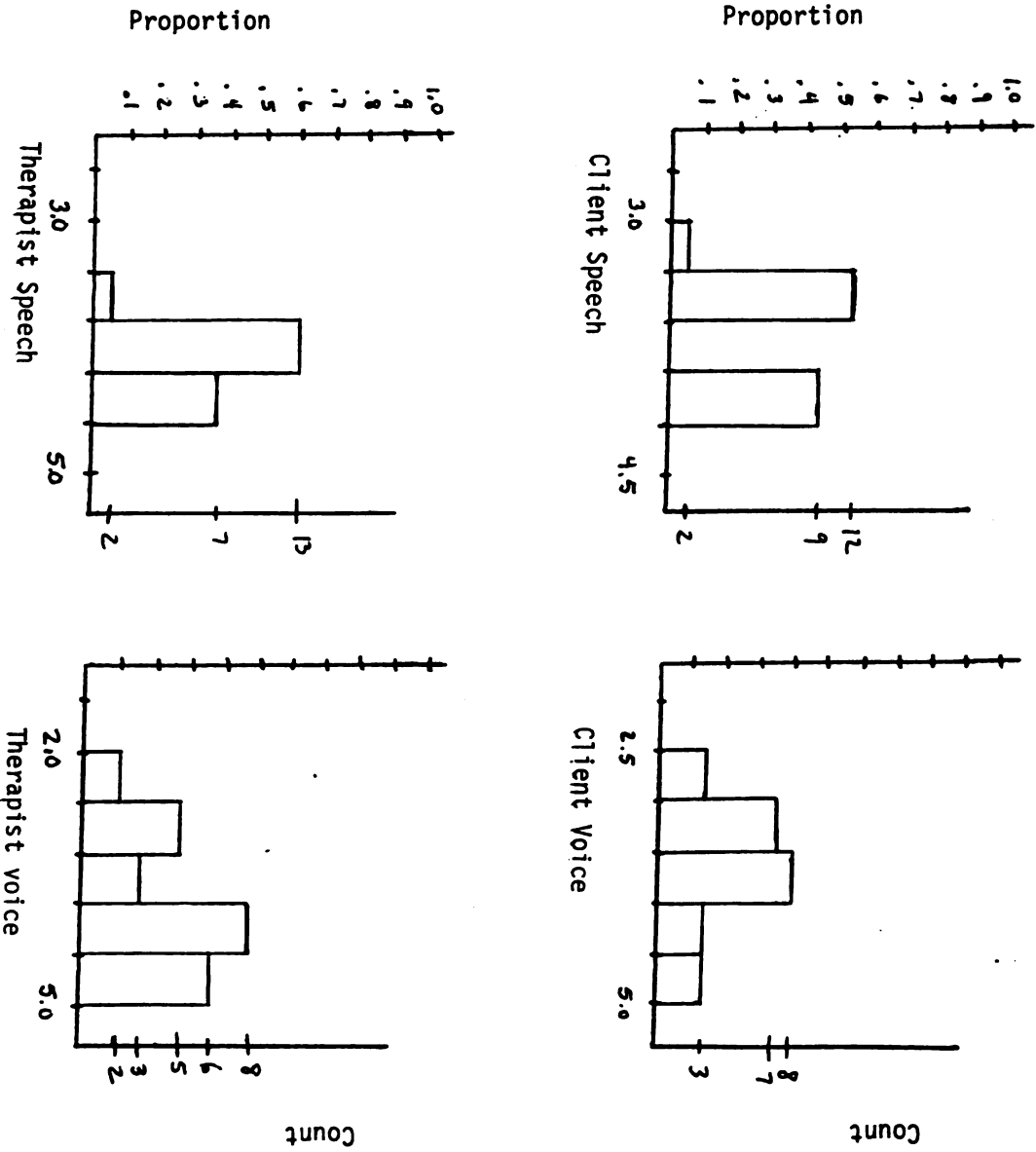


Figure J-1 Continued.

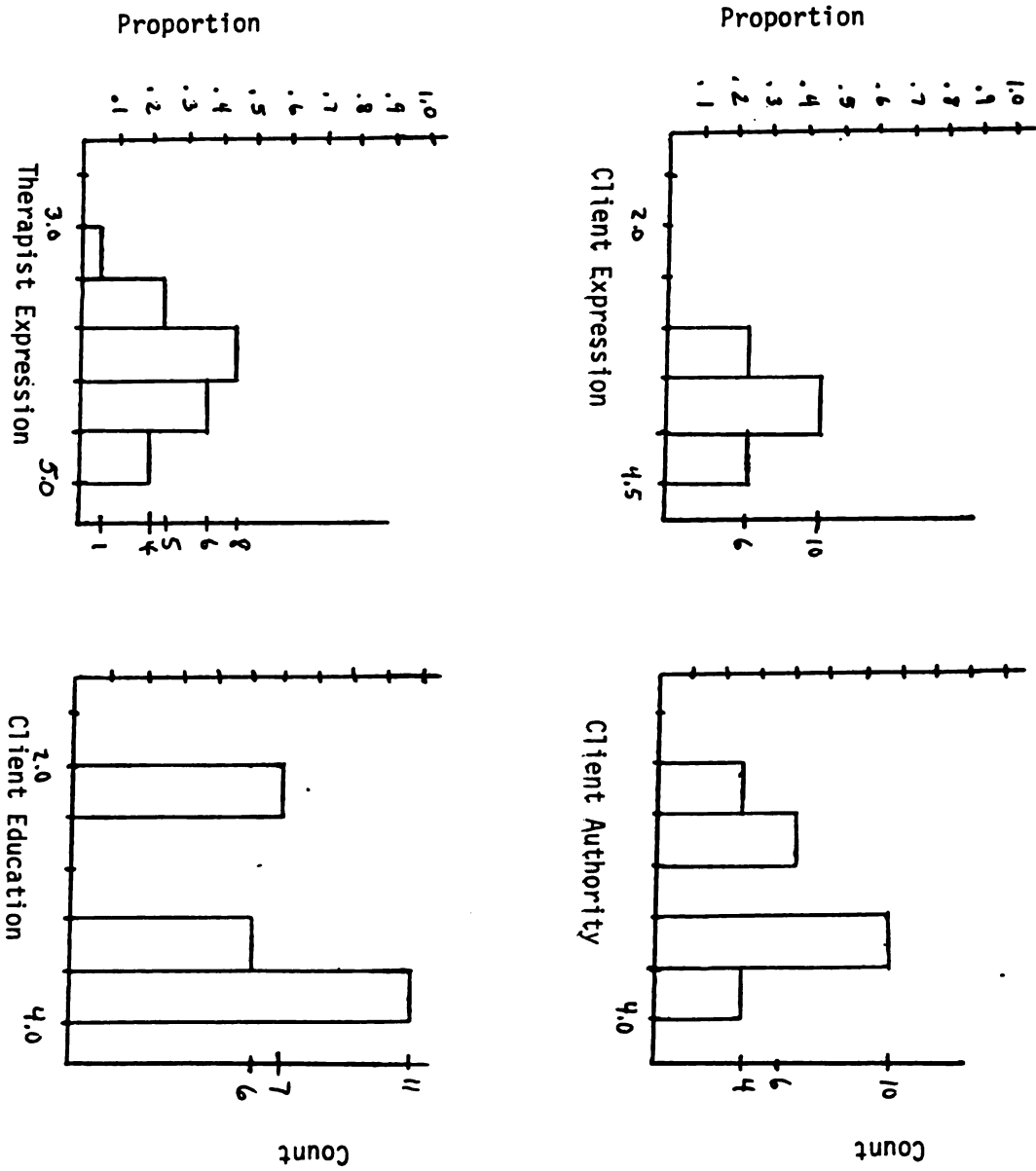


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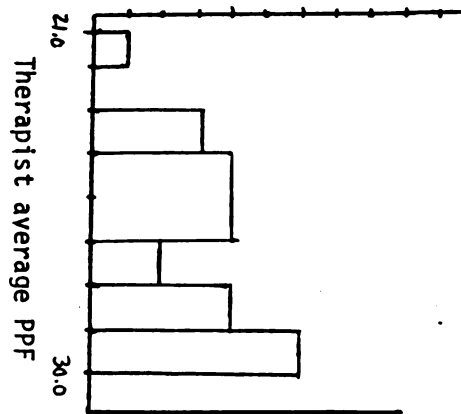
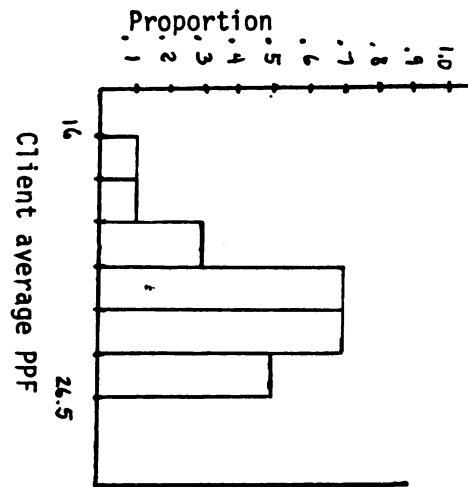
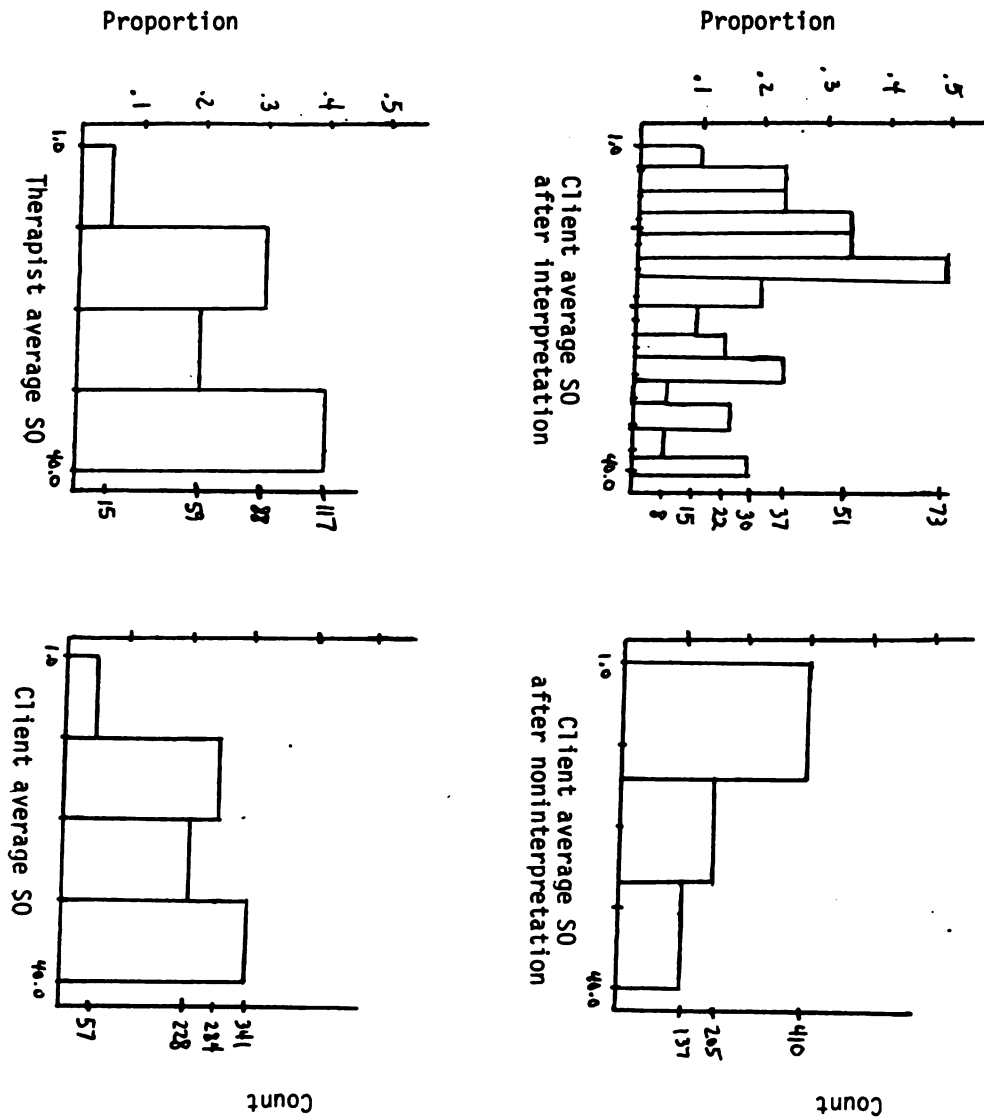


Figure J-2

Histograms of average security operations scores for client and therapist.



APPENDIX K

General References

- Abraham, G. (1984). The definition of the analytic field: Container and content. Analytic Psychotherapy & Psychopathology, 1, 131-141.
- Alexander, F. & French, T. (1946). Psychoanalytic Therapy: Principles and Applications. New York: Ronald Press Co.
- Altshuler, K. (1989). Will the psychotherapies yield differential results?: A look at assumptions in therapy trials. American Journal of Psychotherapy, 43, 310-320.
- Anderson, S. (1968). Effects of confrontation by high- and low-functioning therapists. Journal of Counseling Psychology, 15, 411-416.
- Anderson, S. (1969). Effects of confrontation by high- and low-functioning therapists on high- and low-functioning clients. Journal of Counseling Psychology, 16, 299-302.
- Ashby, J., Ford, D., Guernsey, B. & Guernsey, L. (1957). Effects of a reflective and a leading type of psychotherapy. Psychological Monographs, 71, 3-24.
- Auerbach, A. (1963). An application of Strupp's method of content analysis to psychotherapy. Psychiatry, 26, 137-148.
- Auld, Jr., F. & Murray, E. (1955). Content-analysis studies of psychotherapy. Psychological Bulletin, 52, 377-395.
- Auld, Jr., F. & White, A. (1956). Rules for dividing interviews into sentences. Journal of Psychology, 42, 273-281.
- Auld, Jr., F. & White, A. (1959). Sequential dependencies in psychotherapy. Journal of Abnormal and Social Psychology, 58, 100-104.
- Bachrach, H., Curtis, H., Escoll, P., Graff, H., Huxster, H., Ottenberg, P., & Pulver, S. (1981). Units of observation and perspectives on the psychoanalytic process. British Journal of Medical Psychology, 54, 25-53.
- Bales, R. (1970). Personality and Interpersonal Behavior. Cambridge Mass.: Addison-Wesley Press.
- Barkham, M. & Shapiro, D. (1986). Counselor verbal response modes and experienced empathy. Journal of Counseling Psychology, 33, 3-10.

- Barnabei, F., Cormier, W., & Nye, L. (1974). Determining the effects of three counselor verbal response on client verbal behavior. Journal of Counseling Psychology, 21, 355-359.
- Beutler, L., Pollack, S., & Jobe, A. (1978). "Acceptance," values, and therapeutic change. Journal of Consulting and Clinical Psychology, 46, 198-199.
- Blum, G. (1953). Psychoanalytic Theories of Personality. New York: McGraw-Hill Book Company, Inc.
- Bordin, E., Cutler, R., Dittmann, A., Harway, N., Raush, H., & Rigler, D. (1954). Measurement problems in process research on psychotherapy. Journal of Consulting Psychology, 18, 79-82.
- Bozarth, J. & Krauft, C. (1968). Accurate empathy ratings: Some methodological considerations. Journal of Clinical Psychology, 28, 408-410.
- Claiborn, C. & Dowd, E. (1985). Attributional interpretations in counseling: Content versus discrepancy. Journal of Counseling Psychology, 32, 188-196.
- Cohler, B. (1981). Adult developmental psychology and reconstruction in psychoanalysis. In S. Greenspan & G. Pollack (Eds.), The course of Life, Vol. III: Adulthood and the Aging Process (pp. 149-199). U.S. Dept. of Health & Human Services.
- Cook, M. (1969). Anxiety, speech disturbances and speech rate. British Journal of Social and Clinical Psychology, 8, 13-21.
- Cummings, A. (1989). Relationship of client problem type to novice counselor response modes. Journal of Counseling Psychology, 36, 331-335.
- Davies, G. & O'Farrell, V. (1976). The logic of transference interpretation. International Review of Psycho-Analysis, 3, 55-64.
- De Racker, G. (1961). On the formulation of the interpretation. International Journal of Psycho-Analysis, 42, 49-54.
- Dittmann, A. (1952). The interpersonal process in psychotherapy: Development of a research method. Journal of Abnormal and Social Psychology, 47, 236-244.

- Dowd, E. & Boroto, D. (1982). Differential effects of counselor self-disclosure, self-involving statements, and interpretation. Journal of Counseling Psychology, 29, 8-13.
- Eagle, M. (1984). Recent Developments in Psychoanalysis: A Critical Evaluation. New York: McGraw-Hill.
- Edelson, M. (1975). Language and Interpretation in Psychoanalysis. New Haven: Yale University Press.
- Elliott, R. (1979). How Clients perceive helper behaviors. Journal of Counseling Psychology, 26, 285-294.
- Elliott, R. & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. Clinical Psychology Review, 9, 443-467.
- Ezriel, H. (1956). Experimentation within the psychoanalytic session. In L. Paul (Ed., 1963), Psychoanalytic Clinical Interpretation, (pp. 112-142). London: Collier-Macmillan Ltd.
- Fenichel, H. & Rapaport, D. (Eds., 1954), The Collected Papers of Otto Fenichel. London: Routledge & Kegan Paul.
- Fiedler, F. (1950). A comparison of therapeutic relationships in psychoanalytic, nondirective and Adlerian therapy. Journal of Consulting Psychology, 14, 436-445.
- Fiedler, F. (1971). A note on Zimmer and Pepyne's study comparing counselor response. Journal of Counseling Psychology, 18, 448-449.
- Finell, J. (1987). A challenge to psychoanalysis: A review of the negative therapeutic reaction. Psychoanalytic Review, 74, 487-515.
- Frank, J. (1971). Therapeutic factors in psychotherapy. American Journal of Psychotherapy, 25, 350-361.
- Frank, J. (1973). Persuasion and healing. Baltimore: Johns Hopkins University Press.
- French, T. (1970). Psychoanalytic Interpretation: The Selected Papers of Thomas M. French. Chicago: Quadrangle Books.
- Friedlander, M. (1982). Counseling discourse as a speech event: Revision and extension of the Hill counselor verbal response category system. Journal of Counseling Psychology, 29, 425-429.

- Friedlander, M., Ellis, M., Siegel, S., Raymond, L., Hasse, R. & Highlen, P. (1988). Generalizing from segments to sessions: Should it be done? Journal of Counseling Psychology, 35, 243-250.
- Fuller, F. & Hill, C. (1985). Counselor and helpee perceptions of counselor intentions in relation to outcome in a single counseling session. Journal of Counseling Psychology, 32, 329-338.
- Garfield, S. (1968). Interpretation and the interpersonal interaction in psychotherapy. In E. Hammer (Ed., 1968), Use of Interpretation in Treatment: Technique and Art. New York: Grune & Stratton.
- Gendlin, E. (1974). Client-centered and experiential psychotherapy. In D. Wexler & L. Rice (Eds.), Innovations in Client-Centered Therapy. New York: John Wiley & Sons.
- Gill, M. (1984). Analysis of Transference, Volume I: Theory and Technique. New York: International Universities Press, Inc.
- Goffman, E. (1967). Interaction Ritual. Chicago: Aldine Pub. Co.
- Goldstein, A. & Dean, S. (1966). The Investigation of Psychotherapy: Commentaries and Readings. New York: Wiley & Sons, Inc.
- Graff, H. & Luborsky, L. (1977). Long-term trends in transference and resistance: A report on a quantitative-analytic method applied to four psychoanalyses. Journal of the American Psychoanalytic Association, 25, 471-489.
- Greenberg, L. & Pinsof, W. (1986). The psychotherapeutic Process: A Research Handbook. New York: Guilford Press.
- Greenson, R. (1972). Beyond transference and interpretation. International Journal of Psycho-Analysis, 53, 213-217.
- Grunbaum, A. (1984). The Foundations of Psychoanalysis: A Philosophical Critique. Berkeley: University of California Press.
- Grunbaum, A. (1986). Precis of The Foundations of Psychoanalysis: A philosophical critique. The Behavioral and Brain Sciences, 9, 217-284.

- Gurman, A. (1973). Instability of therapeutic conditions in psychotherapy. Journal of Counseling Psychology, 20, 16-24.
- Heatherington, L. (1989). Toward more meaningful clinical research: Taking context into account in coding psychotherapy interaction. Psychotherapy, 26, 436-447.
- Helner, P. & Jessell, J. (1974). Effects of interpretation as a counseling technique. Journal of Counseling Psychology, 21, 475-481.
- Highlen, P. & Baccus, G. (1977). Effect of reflection of feeling and probe on client self-referenced affect. Journal of Counseling Psychology, 24, 440-443.
- Hill, C., Helms, J., Spiegel, S., & Tichenor, V. (1988). Development of a system for categorizing client reactions to therapist interventions. Journal of Counseling Psychology, 35, 27-36.
- Hill, C. & O'Grady, K. (1985). List of therapist intentions illustrated in a case study and with therapists of varying theoretical orientations. Journal of Counseling Psychology, 32, 3-22.
- Hill, C., Thames, T., & Rardin, D. (1979). Comparison of Rogers, Perls, and Ellis on the Hill counselor verbal response category system. Journal of Counseling Psychology, 26, 198-203.
- Hoffer, W. (1954). Defensive process and defensive organization: Their place in psychoanalytic technique. International Journal of Psycho-Analysis, 35, 194-198.
- Horowitz, L., Sampson, H., Siegalman, E., Wolfson, A., & Weiss, J. (1975). On the identification of warded-off mental contents: An empirical and methodological considerations. Journal of Abnormal and Social Psychology, 84, 545-558.
- Horowitz, M. (1989). Nuances of Technique in Dynamic Psychotherapy. New Jersey: Jason Aronson, Inc.
- Horowitz, M., Rosenbaum, R., & Wilner, N. (1988). Role relationship dilemmas: A potential new process variable. Psychotherapy, 25, 241-248.
- Houts, P., MacIntosh, S., & Moos, R. (1969). Patient-therapist interdependence: Cognitive and behavioral. Journal of Consulting and Clinical Psychology, 33, 40-45.
- Howard, K. & Orlinsky, D. (1972). Psychotherapeutic processes. Annual Review of Psychology, 23, 615-668.

- Howard, K., Orlinsky, D., & Hill, J. (1969). The therapist's feelings in the therapeutic process. Journal of Clinical Psychology, 25, 83-93.
- Howard, K., Orlinsky, D., & Perilstein, J. (1976). Contributions of therapists to patient's experiences in psychotherapy: A components of variance model for analyzing process data. Journal of Consulting And Clinical Psychology, 44, 520-526.
- Howe, E. & Pope, B. (1961). The dimensionality of ratings of therapist verbal responses. Journal of Consulting Psychology, 25, 296-303.
- Howe, E. & Pope, B. (1962). Therapist verbal activity level and diagnostic utility of patient verbal responses. Journal of Consulting Psychology, 26, 149-155.
- Hoyt, M., Marmar, C., Horowitz, M. & Alvarez, W. (1981). The therapist action scale and the patient action scale: Instruments for the assessment of activities during dynamic psychotherapy. Psychotherapy: Theory, Research, and Practice, 18, 109-116.
- Hoyt, M., Xenakis, S., Marmar, C., & Horowitz, M. (1983). Therapists' actions that influence their perceptions of "good" psychotherapy sessions. The Journal of Nervous and Mental Disease, 171, 400-404.
- Hsu, L. (1989). Random sampling, randomization, and equivalence of contrasted groups in psychotherapy outcome research. Journal of Consulting and Clinical Psychology, 57, 131-137.
- Isaacs, S. (1939). Criteria for interpretation. International Journal of Psychoanalysis, 20, 148-160.
- Jones, A. & Gelso, C. (1988). Differential effects of style of interpretation: Another look. Journal of Counseling Psychology, 35, 363-369.
- Jones, E., Cumming, J., & Horowitz, M. (1988). Another look at the nonspecific hypothesis of therapeutic effectiveness. Journal of Consulting and Clinical Psychology, 56, 48-55.
- Karl, N. & Abeles, N. (1969). Psychotherapy process as a function of the time segment sampled. Journal of Consulting and Clinical Psychology, 33, 207-212.
- Karpf, R. (1980). Nonverbal components of the interpretive process in psychoanalytic psychotherapy. American Journal of Psychotherapy, 34, 477-486.

- Kazdin, A. (1980). Research Design in Clinical Psychology. New York: Harper & Row, Publishers.
- Kazdin, A. (1986). Comparative outcome studies of psychotherapy: Methodological issues and strategies. Journal of Consulting and Clinical Psychology, 54, 95-105.
- Kazdin, A. & Bass, D. (1989). Power to detect differences between alternative treatments in comparative psychotherapy outcome research. Journal of Consulting and Clinical Psychology, 57, 138-147.
- Kell, B. & Mueller, W. (1966). Impact and Change: A Study of Counseling Relationships. New York: Appleton-Century-Crofts.
- Kiesler, D. (1966). Basic methodologic issues implicit in psychotherapy process research. American Journal of Psychotherapy, 20, 135-155.
- Kiesler, D. (1973). The Process of Psychotherapy: Empirical Foundations and Systems of Analysis. Chicago: Aldine.
- Klauber, J. (1972). On the relationship of transference and interpretation in psychoanalytic therapy. International Journal of Psycho-Analysis, 53, 385-391.
- Knapp, P. (1974). Segmentation and structure in psychoanalysis. Journal of the American Psychoanalytic Association, 22, 14-36.
- Kraemer, H. (1981). Coping strategies in psychiatric clinical research. Journal of Consulting and Clinical Psychology, 49, 309-319.
- Kris, E. (1951). Ego psychology and interpretation in psychoanalytic therapy. Psychoanalytic Quarterly, 20, 15-30.
- Kubie, L. (1952). problems and techniques of psychoanalytic validation and progress. In E. Pumpian-Mindlin (Ed.), Psychoanalysis as Science, (pp. 46-124). Stanford: Stanford University Press.
- Lafferty, P., Beutler, L., & Crago, M. (1989). Differences between more and less effective psychotherapists: A study of select therapist variables. Journal of Consulting and Clinical Psychology, 57, 76-80.

- Lakatos, I. (1979). Falsification and the methodology of scientific research programs. In J. Worrall & G. Currie (Eds.), The methodology of scientific research programmes: Lakatos philosophical papers, (Vol. 1, pp. 8-101). Cambridge, England: Cambridge University Press.
- Lambert, M. (1989). The individual therapist's contribution to psychotherapy process and outcome. Clinical Psychology Review, 9, 469-485.
- Langs, R. (1980). On the properties of an interpretation. Contemporary Psychoanalysis, 16, 460-478.
- Langs, R. (1985). The communicative approach and the future of psychoanalysis. Contemporary Psychoanalysis, 21, 403-423.
- Le Guen, C. (1982). The trauma of interpretation as history repeating itself. International Journal of Psycho-Analysis, 63, 321-330.
- Lipton, S. (1976). Later developments in Freud's technique (1920-1939). In B. Wolman (Ed.), Psychoanalytic Techniques: A Handbook for the Practicing Psychoanalyst. New York: Basic Books, Inc., Publishers.
- Luborsky, L. (1984). Principles of Psychoanalytic Psychotherapy. New York: Basic Books, Inc.
- Luborsky, L. & Auerbach, A. (1985). The therapeutic relationship in psychodynamic psychotherapy: The research evidence and its meaning for practice. Psychiatry Update: American Psychological Association Annual Review, Vol. 4 (Chapter 28).
- Luborsky, L., Woody, G., McLellan, A., O'Brien, C., & Rosenzweig, J. (1982). Can independent judges recognize different psychotherapies? An experience with manual-guided therapies. Journal of Consulting and Clinical Psychology, 50, 49-62.
- Masling, J. (Ed., 1986), Empirical Studies of Psychoanalytic Theories, Vol. 2. New Jersey: Lawrence Erlbaum Assoc.
- Meltzoff, J. & Kornreich, M. (1970). Research in Psychotherapy. New York: Atherton Press, Inc.
- Menninger, K. (1958). Theory of Psychoanalytic Technique. New York: Basic Books.
- Milne, C. & Dowd, E. (1983). Effect of interpretation style on counselor social influence. Journal of Counseling Psychology, 30, 603-606.

- Mintz, J. & Luborsky, L. (1971). Segments versus whole sessions: Which is the better unit for psychotherapy process research? Journal of Abnormal Psychology, 78, 180-191.
- Mitchell, K., Bozarth, J., & Krauft, C. (1977). A reappraisal of the therapeutic effectiveness of accurate empathy, nonpossessive warmth, and genuineness. In A. Gurman & A. Razin (Eds.), Effective Psychotherapy: A Handbook of Research (pp. 482-502). New York: Pergamon Press.
- Moos, R. & MacIntosh, S. (1970). Multivariate study of the patient-therapist system. Journal of Consulting and Clinical Psychology, 35, 298-307.
- Morran, D., Kurpius, D., & Brack, G. (1989). Empirical investigation of counselor self-talk categories. Journal of Counseling Psychology, 36, 505-510.
- Nichols, M. & Paolino, T. (1986). Basic techniques of psychodynamic psychotherapy. New York: Gardner Press.
- Olinick, S. (1984). Psychoanalysis and language. Journal of the American Psychoanalytic Association, 32, 617-653.
- Olinick, S. (1985). The primary data of psychoanalysis. Contemporary Psychoanalysis, 21, 492-500.
- Olson, D. & Claiborn, C. (1990). Interpretation and arousal in the counseling process. Journal of Counseling Psychology, 37, 131-137.
- O'Malley, S., Suh, C., & Strupp, H. (1983). The Vanderbilt psychotherapy process scale: A report on the scale development and a process-outcome study. Journal of Consulting and Clinical Psychology, 51, 581-586.
- Orlinsky, D. (1989). Researchers' images of psychotherapy: Their origins and influence on research. Clinical Psychology Review, 9, 413-441.
- Orlinsky, D. & Howard, K. (1977). The therapist's experience of psychotherapy. In A. Gurman & A. Razin (Eds.), Effective Psychotherapy: A Handbook of Research, (pp. 566-589). New York: Pergamon Press.
- Paolino Jr., T. J. (1981). Psychoanalytic Psychotherapy: Theory, Technique, Therapeutic Relationship and Treatability. New York: Brunner/Mazel, Inc.
- Pierce, R. & Drasgow, J. (1969). Nondirective reflection vs. conflict attention: an empirical evaluation. Journal of Clinical Psychology, 25, 341-342.

- Pollens, B. (1966). The analyst's role, to interpret or to react? Psychoanalytic Review, 53, 482-489.
- Racker, H. (1958). Counterresistance and interpretation. In L. Paul (Ed., 1963), Psychoanalytic Clinical Interpretation, (pp. 220-227). London: Collier-Macmillan.
- Rapaport, D. (1954). On the psychoanalytic theory of thinking. In R. Knight & C. Friedman (Eds.), Psychoanalytic Psychiatry and Psychology: Clinical and Theoretical Papers, Vol. I, (pp. 259-273). New York: International University Press, Inc.
- Rapaport, D. (1954). The conceptual model of psychoanalysis. In R. Knight & C. Friedman (Eds.), Psychoanalytic Psychiatry and Psychology: Clinical and Theoretical Papers, Vol. I, (pp. 221-247). New York: International University Press, Inc.
- Reid, J., & Finesinger, J. (1951). Inference testing in psychotherapy. American Journal of Psychiatry, 107, 894-900.
- Reyher, J. (1977). Spontaneous visual imagery: Implications for psychoanalysis, psychopathology, and psychotherapy. Journal of Mental Imagery, 2, 253-274.
- Rice, L. (1973). Client behavior as a function of therapist style and client resources. Journal of Counseling Psychology, 20, 306-311.
- Rice, L. & Greenberg, L. (1984). Patterns of Change: Intensive Analysis of Psychotherapy Process. New York: The Guilford Press.
- Richfield, J. (1954). An analysis of the concept of insight. In L. Paul (Ed., 1963), Psychoanalytic Clinical Interpretation, (pp. 93-111). London: Collier-Macmillan.
- Rosen, V. (1974). The nature of verbal interventions in psycho-analysis. In L. Goldberger & V. Rosen (Eds.), Psychoanalysis and Contemporary Science, Vol. III, (pp. 190-209).
- Rosenfeld, H. (1958). Contribution to the discussion on variations in classical technique. International Journal of Psycho-Analysis, 39, 238-239.
- Russell, R. (1989). Language and psychotherapy. Clinical Psychology Review, 9, 505-519.

- Russell, R. (1988). A new classification scheme for studies of verbal behavior in psychotherapy. Psychotherapy, 25, 51-58.
- Russell, R. & Staszewski, C. (1988). The unit problem: Some systematic distinctions and critical dilemmas for psychotherapy process research. Psychotherapy, 25, 191-200.
- Schafer, R. (1983). The analytic attitude. London: Hogarth Press.
- Schauble, P. & Pierce, R. (1974). Client in-therapy behavior: A therapist guide to progress. Psychotherapy: Theory, Research, and Practice, 11, 229-234.
- Schindler, L., Hohenberger-Sieber, E., & Hahlweg, K. (1989). Observing client-therapist interaction in behaviour therapy: Development and first application of an observational system. British Journal of Clinical Psychology, 28, 213-226.
- Schmidl, F. (1955). The problem of scientific validation in psycho-analytic interpretation. International Journal of Psycho-Analysis, 36, 105-113.
- Schonbar, R. (1968). Interpretation and insight in psychotherapy. In E. Hammer (Ed., 1968), Use of Interpretation in Treatment: Technique and Art. New York: Grune & Stratton.
- Shapiro, T. (1970). Interpretation and naming. Journal of the American Psychoanalytic Association, 18, 399-421.
- Sloane, B., Staples, F., Cristol, A., Yorkston, N., Whipple, K. (1975). Short-term analytically oriented psychotherapy versus behavior therapy. American Journal of Psychiatry, 132, 373-377.
- Sloane, B., Staples, F., Whipple, K., & Cristol, A. (1977). Patients' attitudes toward behavior therapy and psychotherapy. American Journal of Psychiatry, 134, 134-137.
- Snyder, W. (1968). Interpretation in relationship therapy. In E. Hammer (Ed., 1968), Use of Interpretation in Treatment: Technique and Art. New York: Grune & Stratton.
- Snyder, W. (1961). The Psychotherapy Relationship. New York: The Macmillan Co.
- Snyder, W. (1963). Dependency in Psychotherapy: A Casebook. New York: The Macmillan Co.

- Spotnitz, H. (1966). The maturational interpretation. Psychoanalytic Review, 53, 490-493.
- Staples, F., Sloane, R., Whipple, K., Cristol, A., & Yorkson, N. (1976). Process and outcome in psychotherapy and behavior therapy. Journal of Consulting and Clinical Psychology, 44, 340-350.
- Stiles, W. (1978). Verbal response modes and dimensions of interpersonal roles: A method of discourse analysis. Journal of Personality and Social Psychology, 36, 693-703.
- Stiles, W. (1986). Levels of intended meaning of utterances. British Journal of Clinical Psychology, 25, 213-222.
- Stiles, W. (1987). Comment: Some intentions are observable. Journal of Counseling Psychology, 34, 236-239.
- Stiles, W. (1988). Psychotherapy process-outcome correlations may be misleading. Psychotherapy, 25, 27-35.
- Stiles, W. & Sultan, F. (1979). Verbal response mode use by clients in psychotherapy. Journal of Consulting and Clinical Psychology, 47, 611-613.
- Strupp, H. (1957). A multidimensional system for analyzing psychotherapeutic techniques. Psychiatry, 20, 293-307.
- Strupp, H. (1958). The psychotherapist's contribution to the treatment process. Behavioral Science, 3, 34-67.
- Sullivan, H. (1949). The theory of anxiety and the nature of psychotherapy. Psychiatry, 12, 3-12.
- Sullivan, H. (1953). Conceptions of Modern Psychiatry. New York: W. W. Norton & Co.
- Sundland, D. & Barker, E. (1962). The orientations of psycho-therapists. Journal of Consulting Psychology, 26, 201-212.
- Talley, P., Strupp, H., & Morey, L. (1990). Matchmaking in psychotherapy: Patient-therapist dimensions and their impact on outcome. Journal of Consulting and Clinical Psychology, 58, 182-188.
- Tarachow, S. (1963). An Introduction to Psychotherapy. New York: International University Press, Inc.

- Truax, C. (1966). Influence of patient statements on judgements of therapist statements during psychotherapy. Journal of Clinical Psychology, 22, 335-337.
- Van der Veen, F. (1965). Effects of the therapist and the patient on each other's therapeutic behavior. Journal of Consulting Psychology, 29, 19-26.
- Wallach, M. & Strupp, H. (1964). Dimensions of psychotherapists' activity. Journal of Consulting Psychology, 28, 120-125.
- Wallerstein, R. (1989). The psychotherapy research project of the Menninger Foundation: An overview. Journal of Consulting and Clinical Psychology, 57, 195-205.
- Weiss, D., Marmar, C., & Horowitz, M. (1988). Do the ways in which psychotherapy process ratings are made make a difference? The effects of mode of presentation, segment, and rating format on interrater reliability. Psychotherapy, 25, 44-50.
- Weiss, J. (1990). Unconscious mental functioning. Scientific American, March, 103-109.
- Wexler, D. (1976). A scale for the measurement of client and therapist expressiveness. Journal of Clinical Psychology, 31, 486-489.
- White, A., Fichtenbaum, L., & Dollard, J. (1966). Measuring change: A verbal and nonverbal content analysis method. Psychotherapy: Theory, Research, and Practice, 3, 107-113.
- Yulis, S. & Kiesler, D. (1968). Countertransference response as a function of therapist anxiety and content of patient talk. Journal of Consulting and Clinical Psychology, 32, 413-419.
- Zetzel, E. (1956). Current concepts of transference. International Journal of Psycho-Analysis, 37, 369-376.

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