THE CLIENT-SOCIAL WORKER RELATIONSHIP: TRANSFERENCE BEHAVIOR AND INTERPRETATION

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ABSTRACT

THE CLIENT-SOCIAL WORKER RELATIONSHIP:
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By

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An inevitable occurrence within the client-social worker relationship is the phenomenon of transference. Clients transfer onto the social worker feelings and behaviors once directed toward parents, siblings, and significant others. The transference within the relationship can be manipulated by interpretations resulting in changes for the client.

The focus of this study is the exploration of the transference phenomenon within the context of the client-social worker relationship. Specifically, the study explores the association between the client's transference behavior and the social worker's interpretations to the client of the transference for the following consequences: 1) The effect of interpretations and non-interpretations on the existence of the transference behavior; 2) The client continuance; and 3) The client's affective and behavioral changes.

Hypotheses regarding the association between the client's transference behavior and the social worker's interpretations to the client of that behavior are: Hypothesis I - During the early sessions (five through eight) of social work treatment, the frequency of the client's transference behavior will be greater when the social worker interprets to the client the client's transference behavior than when the social worker

does not interpret the transference behavior. Hypothesis II - During the later sessions (seventeen through twenty) of social work treatment, the client's transference behavior will be less frequent when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior. Hypothesis III - The client's transference behavior will exhibit more reduction between the early and later phases of treatment when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior.

The hypothesis regarding client continuance states: Hypothesis IV - Clients will continue in treatment for a longer period of time when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior.

The hypothesis regarding client changes states: Hypothesis V - The client's affective and behavioral symptoms will be alleviated to a greater degree when the social worker interprets to the client the client's transference behavior from the early through the later phases of treatment than when the social worker does not interpret the transference behavior.

Thirty-nine clients and seventeen social workers drawn from Family Service of Detroit and Wayne County and Family Services of Greater Toledo participate in this study. The clients and social workers are randomly assigned to the Interpretive group and the Non-Interpretive group based on

the social workers' management of transference. The Interpretive group consists of nineteen clients and eight social workers. The Non-Interpretive group has twenty clients and nine social workers. Three raters are used to determine the existence of the clients' transference behavior and the social workers' interpretations to the client of the behavior. The raters judge the same treatment sessions used for analysis. The raters' inter-reliability is statistically significant for the clients' transference behaviors and the social workers' interpretations of the transference. There also is a high percentage of agreement between the raters as to the affective and behavioral changes of the clients.

Treatment sessions selected for analysis are randomly chosen from the early and later phases of treatment. Two sessions from each phase are randomly selected for analysis. A fifteen-minute segment commencing ten minutes after the session begins is analyzed and is assumed for the purpose of this study to be representative of that session. Thus, a total of 94 treatment sessions, 58 sessions in the early phase and 36 sessions in the later phase, are used for analysis.

Hypotheses (I, II and III) concerning the association between the client's transference behaviors and the social worker's interpretations to the client of the transference are not supported by the data to a statistically significant degree. The frequency of the client's transference behaviors is less in the early phase of treatment and slightly greater in the later phase when the social

worker interprets to the client the transference. However, between the early and later phases of treatment, there is a greater reduction of client's transference behaviors when the social worker does not interpret the transference behaviors. These results are discussed primarily in terms of a need for a larger population to determine statistical significance with greater reliability and validity.

The client continuance hypothesis deals with the prediction that clients will stay in treatment over a longer period of time if their transference behavior is interpreted. The results of this hypothesis are in the direction predicted and are statistically significant at the .20 level.

To test whether or not the social workers' interpretations of the clients' transference behavior result in affective and behavioral changes, the social worker prepares clinical descriptive data which are then judged by the raters. The results indicate that the clients' affective and behavioral changes are in the direction predicted and statistically significant at the .01 level.

Thus, this study demonstrates that the clients seen by social workers for treatment transfer feelings and behaviors they once directed onto their parents, siblings, and significant others onto the social worker. The clients' transference behaviors are slightly more frequent over the course of treatment when the transference is interpreted to the client by the social worker. However, this result is not statistically significant, so the hypothesis cannot be said to be

supported by these data. These results do not conform to psychoanalytic theory and previous research regarding diminution of transference behavior. The clients tend to stay in treatment over a longer period of time, avoiding premature termination, when their transference behaviors are interpreted to them by the social worker. This result is statistically significant. Most important, the transference behaviors can be manipulated by interpretations to promote positive affective and behavioral changes within the client. This result is also statistically significant. These latter two results conform to psychoanalytic theory and previous research on the subject.

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By

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DEDICATION

TO JUDY AND DEBORAH

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A. Introduction

During the past two decades, the practice of social work has been undergoing innumerable profound changes, as have the other helping professions. The difficulties in the assimilation of new social, cultural, and psychological theoretical material emphasizing the present and the environmental approaches to treatment, along with the disagreement about the focus and direction of social work, have led to the devaluation of the relationship between client and social worker, especially with regard to its irrational and repetitious elements. Yet social workers should not, in the long run, rid themselves of the valuables in its tradition. The author views the concept of transference, as defined by Freud (1905 - [1901]-), as one of the most valuable concepts underlying the client-social worker relationship and must have a high priority in social work treatment.

In the past twenty years, there has been little interest in the transference phenomenon within the client-social worker relationship as indicated by the paucity of social work literature regarding the subject. Yet, in the relationship with the social worker, clients do display behavior which was once directed toward familial and extra-familial relationships (Garrett, 1941, 1949a; Lyndon, 1948). Garrett (1941) states that the transference of behavior is a frequent

occurrence in social work treatment. Theoreticians have noted that transference phenomena can be manipulated to promote change within the client, and add that the resolution or dissipation of the transference behavior indicates the 'cure' of the client (Freud, 1905 - [1901]-; Garrett, 1941; Lyndon, 1948; Rogers, 1951). The client's transference behavior is also a source of information which enables the social worker to understand the client's underlying dynamics (Fenichel, 1945; Lyndon, 1948; Garrett, 1949; Colby, 1951; Greenson, 1967). Alexander and French (1946) state, and Reid and Shyne (1969) imply, that the inadequate handling of the transference accounts for many failures and difficulties in treatment. The distortion of the client's current interpersonal relationships have caused, in part, his emotional difficulties. It is, therefore, important to help some clients understand how their emotional attitudes toward the social worker have departed from reality and how "these distortions stem from earlier difficulties in childhood (Fromm-Reichmann, 1950, p.98)."

If transference phenomena are important, why has there been a lack of social work literature on the subject: Actually, the relative difficulty in the understanding and use of the transference within the client-social worker relationship has confronted the social worker since the profession began. Garrett, writing in the early forties, expresses the difficulty this way:

> The word transference has long stirred in the caseworker mixed feelings of confusion and anxiety.

> By some it has been avoided as connoting areas into which the social worker should not trespass. However, the phenomenon of transference has continued to confront us in all aspects of casework, and some, unable to deny its repeated occurrence, have attempted to exorcize it by baptizing it with some new phrase. This attitude has been due partly to the anxiety that the phenomenon arouses in us and partly to our fear that in dealing with transference we are usurping the role of the analyst (1941, p.42).

This writer views the client's use of transference behavior as his attempt to correct in action traumatic situations which cannot be recalled. It is the client's attempt to keep things as they presently exist for him. The behavior is intended to help the client cope in the present interpersonal relationship. It is always characterized by its inappropriateness in the here-and-now current relationship with the social worker. The writer also believes that transference behavior exists in all human relationships, although it may not be acknowledged as such, and there is certainly wide disagreement among social workers with regard to its management in the client-social worker relationship.

The client unconsciously transfers feelings which were once directed toward a parent, a sibling, or other significant person in his life onto the social worker (Garrett, 1941; Katz, 1948; Lyndon, 1948). The question as to whether the social worker should deal with the client's unconscious processes, with transference being one of the manifestations of the client's unconscious processes, has been widely debated. This issue of if and how the social worker should deal with the client's transference behavior is related

to the broader question, still unresolved, of whether the social worker should deal in any of the client's unconscious processes. The current social work literature indicates a more direct method of treatment. Garrett saw this approach developing in the late thirties and early forties. She writes:

> There has been a shift from the earlier stream of conscious 'tell me anything that's on your mind -- just talk about anything -- it's all grist for my mill' to a more conscious direction of treatment. This previous stage has led to the release of so much dependency and often so much hostility from the client that both the caseworker and the client were frightened. Because of this some caseworkers withdrew and denied the validity of working with unconscious material. A few, however, have been challenged by this problem. They go on the assumption that unconscious factors are present whether we recognize them or not, and, therefore, the way out is not through a denial of their existence or importance but through a more thorough understanding of them. . . . . (1941, p.45).

The above mentioned theoreticians imply that the failure to recognize and deal with the transference behavior within the client-social worker relationship has led many social workers to fail to make use of one of the strongest treatment techniques in their armament. Levey adds in much stronger terms that social workers "have floundered and been blocked in their potential development of a creative scientific treatment method because of their confused understanding, fear, avoidance, or mishandling of transference (Garrett, 1941, p.43)."

The use of experimental approaches, involving clinical data regarding research on aspects of the therapeutic relationship, appear to be on the rise in psychology and

psychiatry but not in social work. The present study was conceived to examine one aspect of the therapeutic relationship--the transference phenomena--in social work treatment. This study deals with the impact of the social worker's interpretations to the client of the client's transference behaviors on the existence of that behavior and the results of the interpretations regarding client continuance and affective and behavioral changes.

B. The Literature

1. Social Work and Transference

a. History

Annette Garrett stated that the concept of transference was incorporated in the social worker's overall concept of relationship. This overall concept also included countertransference and a conscious reality relationship (Garrett, 1949, p.244). However, the relationship between the client and the social worker has received attention since the beginning of the development of the social work profession.

Mary Richmond, a pioneer in the social work profession, recognized the importance of the relationship between the friendly visitor and the family in her book Friendly Visiting Among the Poor in 1899 (Robinson, 1930, p.8). As early as 1905 Jackson emphasized the professional personal service within the relationship of the client and the social worker. In 1909 Simkhovitch stated that the client should be a part of the social worker's investigation--a kind of "co-operator in a common work (p.143)."

With the publication of Richmond's Social Diagnosis

(1917), social work began to emerge as a profession, the primary interest of which were the social difficulties of human beings. Lucia Clow (1925) emphasized that the success or failure of a professional therapeutic situation rests on the interplay in the relationship between the client and the social worker (p.272). Three years later the importance of the relationship was again stressed in the Report of the Milford Conference in 1928. The report states that the individual is helped to "achieve the fullest possible development of her personality" by the dynamic relationship between the client and the social worker (American Association of Social Workers, 1928, p.29).

During these early years of social work, Freud was also developing psychoanalysis as a therapeutic treatment and as a psychology of human growth and development. Social work gained new knowledge from Freud's contributions and subsequently the therapeutic use of the relationship between the client and the social worker gained new status. Freud defined transference in his case of Dora (Freud, 1905 - [1901]-). However, it was not until 1924, nineteen years later, that Jessie Taft introduced the concept of the "transfer" within the relationship between client and social worker (Taft, 1924).

Little was mentioned in the literature about the implication of the concept of transference in social work until the late thirties and early forties. The concept received more attention when the principles of psychoanalysis became

integrated into social work.

Lyndon (1948) stated that transference "has come to be a familiar term in the caseworker's vocabulary (p.17.)" Speaking of the forties, Lyndon adds.

> Today there is evidence in the literature that examination of its nature and therapeutic use is being further stimulated. There are probably a number of reasons for this: increased use of psychiatric and psychoanalytic consultation in agencies, greater understanding of the dynamics of behavior on the part of the caseworker, a more critical evaluation of the job being done (why we succeed or fail), greater professional security, and a wider acceptance of the idea of seeking professional help with personal problems (p.17).

What was true of the late thirties and forties was no longer true of the late fifties and sixties. Biestek (1957), Perlman (1957) and Hollis (1969) focus their attention on the client-social worker relationship, but little is said about transference. There is a paucity of articles on transference in the Social Work Journal and the Journal of Social Casework. There are a number of probable reasons for this lack. Robinson (1930) stated that the word transference "is too directly borrowed from psychiatric terminology and leaves the caseworker again with a dependence upon another profession and a confused sense of likeness at this point instead of forcing her to analyze her own process in the unique difference from every other professional venture (p.114)." Robinson's statement in 1930 is still significant in 1974.

Another reason for the lack of literature about transference may be due to the recent focus on environmental manipulation, social ills, and social reform. Some social workers, such as Borenzweig (1971) and Thurz (1971), as well as others,

state that social workers should focus their attention on the current problems facing society. By doing this, they believed that man's individual problems will be alleviated. Their emphasis on social action has led them to a de-emphasis if not outright disinterest and concern for the client-social worker relationship with perhaps a greater disinterest with its irrational components. However, there are those social workers, such as Perlman (1971), who feel that no matter how we change the environment, people will still have difficulties and will need professional treatment, the center of which is the client-social worker relationship.

b. Relationship and Transference.

In 1935 Young stated her ideas of the relationship between the client and the social worker. She writes:

> In the process of both diagnosis and treatment the interview is in reality an interplay of dynamic personalities which constantly act and re-act to each other's questions and answers, to each other's gestures, facial expressions, manners, and even dress (p.2).

> Whether this process is designated as friendliness, rapport, identification, transfer, relation, sympathetic insight, or empathy, it aims to establish a bridge across which an interviewer and interviewee can convey a sense of their mental and emotional natures to each other, whereby they can become "we" in another form, winning across the void which separates man from man and gaining a feeling of kinship (p.353).

Six years later, in 1941, Aptekar stated that the relationship "is the dynamic interaction which takes place between personalities, or better, between personality trends or drives (p.48)." Austin (1948) states: "The relationship is the medium through which the client is enabled to state his problem (p.205)." Biestek (1957) states: "The casework relationship is the dynamic interaction of attitudes and emotions

between the caseworker and the client . . . (p.12)." None of these writers explicitly include transference in the concept of relationship, yet all imply that transference may be a part of that relationship.

Hamilton (1940), Lyndon (1948), Garrett (1949), and Hollis (1969) view transference as one aspect of the client-social worker relationship. Lyndon sums up what these theoreticians are attempting to say. He defines relationship as:

> The relationship is the sum total of all that happens between the participants -- all the words exchanged, the feelings, attitudes, actions, and thoughts expressed; everything, in fact, that the client and worker do whether open and overt or devious and hidden (p.16).

Both verbal and non-verbal interaction takes place between the client and the social worker. These two forms of interaction, "emotional exchange," have two different aspects; a reality aspect and a non-reality aspect (Lyndon, p.16). The reality aspect of the interaction is "the area in which feelings related to the current situation are felt, expressed and reacted to by both parties (p.16)." The other aspect of the relationship "is that on which emotions are expressed whose source is not in the present relationship but is traceable to the past experiences of the client and worker . . . it is the client's transferring onto the worker feelings related to some important person in the client's past which is known as <u>transference</u> (p.16)."

Garrett (1941) states, as did Freud (1905) earlier, that transference is inherent in any human relationship. She writes, "There is little question but that varying degrees of transference and countertransference exist in all casework situations, and that these are the dynamic vehicles through which

the treatment we are so eager to offer our clients operates (p.42)." The reason the client transfers onto the social worker was later spelled out by Garrett (1949).

> The need to ask for help recreates to some extent in anyone a dependency situation analogous to one's infancy and thus tends to reactivate the characteristic way of handling problems which was developed at the time . . . . It is impossible for a person to place himself for long in such a dependency situation without a transference to this new situation of his infantile attitudes (p.225).

c. Treatment and Transference

Social work theoreticians have approached the use of transference in the treatment with the client on two different levels. One group, including Biestek (1957), Perlman (1957), and Austin (1957), believes that the social worker should understand the concept of transference and attempt to develop a positive transference on the part of the client. Another group of theoreticians, including Lyndon (1948), Katz (1948), Garrett (1941, 1949), and Hollis (1969), believes not only in the importance of understanding transference phenomena, but also in the interpretation to the client of transference reactions.

Garrett (1949) states that the client who seeks help from the social worker because of emotional difficulties tends to develop transference rapidly (p.225). Clients transfer both positive and negative feelings which they once had toward a parent, a sibling, a friend, or other person in authority such as a teacher, a doctor, or an employer (p.225). The transferred feelings might be the feelings that the client has at the present time toward another person (p.225). Thus, two levels of transference occur in the client-social worker relationship, 1) a primary transference reaction, and 2) a secondary transference

reaction.

As was mentioned earlier, transference is inherent in the client-social worker relationship. The social worker can promote the transference reaction by playing a passive role, setting up two or three appointments a week, and by asking the client to relate his feelings and thoughts.

Now we ask a most pertinent question. Why should the social worker interpret to the client the client's transference reactions? We get many responses to this question.

Hamilton (1940) responds by saying that the interpretation of transference "is designed to free the patient sufficiently so that he may think and feel more realistically about his behavior and relationships . . . (p.257)." Lyndon (1948) adds:

> In the treatment situation, as it becomes clear that certain feelings the client has toward the worker are related to his past, the worker uses this knowledge as the focus for interpretation of the out-of-time feelings. He points out that these feelings, which are irrelevant in the present, belong to the past. With this insight the client may begin to see that such feelings are inappropriate not only toward the caseworker but also toward a husband, a wife, a friend, a teacher, or an employer. The client comes to understand his relationship better and to see that he is acting out childhood patterns. In the end, symptoms may decrease or even disappear as the caseworker helps the client to recognize the inconsistency and futility of being controlled today by events of long ago (pp. 23-24).

Garrett (1949) implies that some transference reactions should be interpreted to help the client see the social worker in a realistic view. Hollis (1969) shares Garrett's views. All four of these theoreticians imply that the resolution of the transference is indicative of the cure of the client, and that the "interpretation of the transference feelings themselves can help in reducing transference (Garrett, 1949, p.238)."

Heiman (1969) summarizes three stages in the social worker's attempt to deal with transference manifestations: 1) understanding the transference, 2) utilizing the transference, and 3) interpreting the transference.

> Understanding of the transference will permit the worker to understand the behavior of the individual and to recognize its significance in terms of his developmental experience and his present unconscious needs. It gives to the worker added data that permit the fuller integration of other factors--the present behavior and problem, the environmental forces, the past experiences and earlier object relationships.
>
> The utilization of the transference is a technique available to the caseworker, the value of which will depend on his understanding of the phenomenon. It explains many "cures" of emotional disturbances by life situations, by fortunate relationships, with other persons, by faddists and cultists. A good friend who intuitively reassures an unhappy man may help to lift a depression without any awareness on his part of what he's doing. The professionally trained person who utilizes the transferences should, however, do so with an awareness of the dynamics involved. The recognition of a transference-need permits the establishment of a relationship between a caseworker and a client which allows for the utilization of such techniques as suggestions, advice, counseling, and education. Transference is the basis of, but not identical with, rapport. The development of a negative transference, that is, the expression of hostile, infantile, unconscious impulses introduces great difficulties in dealing with a client, and it's therefore preferable to avoid the provocation of such a reaction except in intensive therapy, where it does appear it requires skillful handling.
>
> The interpretation of the transference, that is confronting the individual with the awareness that his behavior is the repetition of a specific unconscious infantile constellation, is definitely part of a psychoanalytical therapy and requires the preparation of the individual by the careful analysis of his unconscious defenses. Otherwise one would be dealing here with the too frequent experience of "wild analysis." In some instances the transference manifestations are so obvious that their "interpretation" requires no preparation, but this is not usually the case. The premature interpretation of a transference phenomenon will in fortunate circumstances produce no effect whatever because of the individual's defenses; in less fortunate instances it may produce severe manifestations of anxiety and guilt (pp.72-74).

d. Clinical Studies

The importance of transference phenomena in social work has not been reflected in the social work research. This is also true in psychology and psychoanalysis (Crowder, 1970; Greenson, 1967). There are numerous theoretical papers published in the psychological and psychoanalytic journals as compared to the social work journals; however, research on the phenomena is limited in psychology and psychoanalysis and is almost nil in social work.

McCormick, Mueller, and Rich (1946) focused their attention on transference of clients in a Child Guidance Clinic. By direct observation of clients' verbal and non-verbal responses, they found that social work clients do, indeed, transfer feelings onto the social worker. These feelings were once directed toward a parent, sibling, or significant other. Interpretation of transference reactions and the resolution of the transference were not explored.

Reid and Shyne (1969) in their book on brief and extended treatment based on a project dealing with direct treatment of clients state the following:

> Up to a point the theory of transference offers a reasonable explanation of our findings relating to the client's reactions to the caseworker: PSTS (short term treatment) ended during the initial period of positive transference, "the honeymoon period," with which a treatment relationship normally begins. One would expect more negative feelings in CS (continuous treatment) as transference reactions begin to develop. But we would also expect these reactions to be worked through or resolved by the end of treatment. It is at this point that the treatment model and the project data take different turns. In a sizeable number of CS cases, caseworkers were not able to reverse a downward tendency in the client's feelings toward them. In some of these cases, it may have been negative transference reactions that precipitated termination (p.165).

Reid and Shyne do not spell out the reasons for the social worker's inability to resolve the transference, but they do state that short term treatment is just as good as, if not better than, long term treatment. Questions regarding their conclusions can be raised. Why was the negative transference not resolved? Was the countertransference a hindrance in the dissipation of the negative transference? What could have been done to correct the situation?

Gay (1954) comments on her work with a colleague in treating a husband and wife with emotional difficulties. Not only was transference recognized by each social worker with regard to the role they were assigned by their own client, but was recognized also "in a peripheral sense" toward the other social worker (p.225). Odmark (1946) also wrote about her work with a female client and demonstrated how her knowledge and use of transference enabled the client to grow up emotionally.

These studies involved the direct observation of clinical material. The transference was not manipulated to achieve resolution although these writers recognized the importance of the resolution of the transference with regard to the cure of the client. Freud's theoretical work was also based on his observations of his patients. The social worker's concept of transference as illustrated by Lyndon (1948), Garrett (1941, 1949), and Hollis (1969) is taken from psychoanalytic theory based on Freud's writings. What follows, therefore, is a review of Freud's writings regarding transference.

2. Freud's Contribution

Sigmund Freud was the first to fully understand and describe

the psychotherapeutic relationship between patient and therapist in terms of transference. He also explored theoretical and technical problems concerning the transference phenomena. Most psychoanalysts and psychoanalytically oriented therapists -- psychiatrists, psychologists, and social workers -- realize the significance of Freud's discovery and focus attention on the fluctuating interplay between patient and therapist. These therapists also recognize the importance of the personal relationship between patient and therapist in the process of cure, and they point out that this relationship goes beyond the realistic behavior pattern between themselves and their patients.

a. Origin of Transference

Freud along with Breuer, first discussed the transference phenomena in the publication of Studies on Hysteria (1893-95). The publication was mainly based on Breuer's treatment of Fraulein Anna O, his patient from December 1880, until the early part of June 1882, when she abruptly terminated therapy. The occurrence which marked the termination of Anno O's treatment was described by Breuer as an untoward event. Freud described the situation in greater detail, ". . . when the treatment had apparently reached a successful end, the patient suddenly made manifest to Breuer the presence of a strong unanalysed positive transference of an unmistakably sexual nature (p.41)."

Anna O's feelings toward Breuer, and Freud's recognition that his patients also had feelings toward him, led Freud to conclude that patients who undertake therapy become dependent on the therapist. He states, "I say, it is almost inevitable

that their personal relation to him will force itself, for a time at least, unduly into the foreground (p.266)." Freud stated that some patients feel neglected and rejected, while others fear becoming dependent. He described one patient with whom he attempted to apply the pressure technique which he felt was more appropriate to get at the repressed material than his first technique of hypnosis. The patient was unable to free associate. Later, during treatment, she told Freud that she was unable to associate because of her wish to have him kiss her. In her associations following this statement, the patient recalled having the wish earlier in relationship to a man with whom she was talking.

Freud recognized that the personal influence of the therapist by itself can help remove resistances; he also believed that the transference was another obstacle in the analyst's path (p.301).

Regarding transference as an obstacle for the therapist, Freud stated,

> I have already (p.266) indicated the important part played by the figure of the physician in creating motives to defeat the physical force of resistance. In not a few cases, expecially with women and where it is a question of elucidating erotic trains of thought, the patient's co-operation becomes a personal sacrifice, which must be compensated by some substitute for love. The trouble taken by the physician and his friendliness have to suffice for such a substitute. If, now, this relation of the patient to the physician is disturbed, her cooperativeness fails, too; when the physician tries to investigate the next pathological idea, the patient is held up by an intervening consciousness of the complaints against the physician that have been accumulating in her. In my experience this obstacle arises in three principal cases.
>
> (1) If there is a personal estrangement -- if, for instance, the patient feels she has been neglected, has been too little appreciated or has been insulted, or if she has heard unfavorable comments on the physician or the method

> of treatment. This is the least serious case. The obstacle can easily be overcome by discussion and explanation, even though the sensitiveness and suspiciousness of hysterical patients may occasionally attain surprising dimensions.
>
> (2) If the patient is seized by a dread of becoming too much accustomed to the physician personally, of losing her independence in relation to him, and even of perhaps becoming sexually dependent on him. This is a more important case, because the determinants are less individual. The cause of this obstacle lies in the special solicitude inherent in the treatment. The patient then has a new motive for resistance, which is manifested not only in relation to some particular reminiscence but at every attempt at treatment. It is quite common for the patient to complain of a headache when we start on the pressure procedure, for her new motive for resistance remains as a rule unconscious and is expressed by the production of a new hysterical symptom. The headache indicates her dislike of allowing herself to be influenced.
>
> (3) If the patient is frightened at finding that she is transferring onto the figure of the physician the distressing ideas which arise from the content of the analysis. This is frequent, and indeed in some analyses a regular occurrence. Transference onto the physician takes place through a <u>false connection</u> (p.301-302).

This is the first time Freud used the word "transference" in the psychoanalytic sense, and in his later writings he broadens this narrow concept. However, even in this early phase of Freud's publication, we see the importance he attributes to the patient-doctor relationship.

b. Definition of Transference

The Dora Case was an important contribution to psychotherapeutic techniques for it was here that Freud defined transference.

> What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment (Freud, 1905 - [1901]-, p.116).

In this paper Freud described how he learned about the importance of transference by his failure to recognize and handle it with Dora. This failure led to Dora's premature termination of the treatment. Freud put it this way:

> I have been obliged to speak of transference, for it is only by means of this factor that I can elucidate the peculiarities of Dora's analysis. Its great merit, namely, the unusual clarity which makes it seem so suitable as a first introductory publication is closely bound up with its great defect, which led to its being broken off prematurely. I did not succeed in mastering the transference in good time. Owing to the readiness with which Dora put one apart of the pathogenic material at my disposal during the treatment, I neglected the precaution of looking out for the first sign of transference, which was being prepared in connection with another part of the same material -- a part of which I was in ignorance. At the beginning it was clear that I was replacing her father in her imagination, which was not unlikely, in view of the difference between our ages. She was even constantly comparing me with him consciously and kept anxiously trying to make sure whether I was being quite straightforward with her, for her father 'always preferred secrecy and roundabout ways.' But when the first dream came in which she gave herself the warning that she had better leave my treatment just as she had formerly left Herr K's house, I ought to have listened to the warning myself. 'Now,' I ought to have said to her, 'it is from Herr K that you have made a transference on to me. Have you noticed anything that leads you to suspect me of evil intentions similar (whether openly or in some sublimated form) to Herr K's? Or have you been struck by anything about me or got to know anything about me which has caught your fancy, as happened previously with Herr K?' Her attention would then have been turned to some detail in our relations, or in my person or circumstances, behind which there lay concealed something analogous but immeasurably more important concerning Herr K. And when this transference had been cleared up, the analysis would have obtained access to new memories, dealing, probably, with actual events. But I was deaf to this first note of warning, thinking I had ample time before me, since no further stages of transference developed and the material for the analysis had not yet run dry. In this way the transference took me unawares, and, because of the unknown quality in me which reminded Dora of Herr K, she took her revenge on me as she wanted to take revenge on him,

> and deserted me as she believed herself to have been deceived and deserted by him. Thus she acted out an essential part of her recollections and phantasies instead of reproducing it in the treatment. What this unknown quality was I naturally cannot tell. I suspect that it had to do with money, or with jealousy of another patient who had kept up relations with my family after her recovery. When it is possible to work transference into the analysis at an early stage, the course of the analysis is retarded and obscured, but its existence is better guaranteed against sudden and overwhelming resistances (Freud, 1905 - [1901]-, pp.118-119).

This lengthy passage points out the importance of several issues pertinent to this study. Freud believed that interpretation of transference would have enabled the patient to bring forth new realistic material, and that the interpretation should be offered as soon as transference manifestations appear. He also pointed out that not only attitudes toward parents, but also attitudes toward significant others are transferred on to the therapist. Age, a sociological variable, is also mentioned in terms of the type of transference. Later (Freud, 1916-17 - [1915-17]-), he made explicit his thinking that a behavior labelled as transference must be inappropriate behavior in the present context. The behavior actually existed in a prior relationship and is inappropriate in the present relationship.

The reasons people tend to transfer feelings and attitudes from one person to another is alluded to throughout Freud's publications, and explicitly stated in a few. The central theme pervading all of Freud's works is stated by Singer. He writes that Freud believed "matter has a basic tendency to return to previous states of organization and that man exhibits this tendency to return to past states in

both physical and behavioral terms, that man tends to repeat previous acts over and over again (Singer, 1965, p.250)." Freud's concept of the repetition compulsion hinges on this homeostatic tendency. Freud thought of the transference as being an instance of the repetition compulsion. In the New Introductory Lectures on Psycho-Analysis Freud (1932-36) states:

> We may suppose that from the moment of which a state of things that has once been attained is upset, an instinct arises to create it afresh and brings about the phenomena which we can describe as a 'compulsion to repeat.' . . . We have been struck by the fact that the forgotten and repressed experiences of childhood are reproduced during the work of analysis in dreams and reactions, particularly in those occurring in the transference . . . (p.106).

Freud mentions earlier:

> What interests us most of all is naturally the relation of this compulsion to repeat to the transference . . . We soon perceive that the transference is itself only a piece of repetition, and that the repetition is a transference of the forgotten past not only on to the doctor but also on to all the other aspects of the current situation. We must be prepared to find, therefore, that the patient yields to the compulsion to repeat, which now replaces the impulsion to remember, not only in his personal attitude to his doctor but also in every other activity and relationship which may occupy his life at the time (Freud, 1914, p.151).

Freud cited numerous examples of this repeating and substituting behavior not only with his patients, but also in the general literature. Since Freud's contribution there have been numerous authors who have substantiated Freud's repeating and substituting concepts (Orr, 1954; Greenson, 1967; Wolstein, 1954, 1960).

The Dynamics of Transference (1912, pp.97-108) and Introductory Lectures on Psycho-Analysis (1916 - [1915-17]-)

clarified the relationship between Freud's concept of transference and his libido theory. Throughout his publications, Freud demonstrated the relationship between the concepts which he developed.

Freud recognized the pscyhotherapeutic aspect of treatment residing in the patient-therapist relationship; however, he theorized this process in terms of his libido theory.

> If someone's need for love is not entirely satisfied by reality, he is bound to approach every new person whom he meets with libidinal anticipatory ideas; and it is highly probable that both portions of his libido, the portion that is capable of becoming conscious as well as the unconscious one, have a share in forming that attitude.
>
> Thus, it is perfectly normal and intelligible that the libidinal cathexis of someone who is partly unsatisfied, a cathexis which held ready in anticipation should be directed as well to the figure of the doctor (Freud, 1912, p.100).

The transference reactions are, thus, indications of the regression of the libido (p.102). The patients' complexes, neuroses, must then be fought out in the transference situation (p.104).

In Introductory Lectures on Psycho-Analysis (Freud, 1916-17, [1915-17]-) Freud pointed out that the cure of the patient resides in the resolution of the ego-libido conflict. This resolution is obtained when the transference is resolved. First Freud states:

> He would become healthy if the conflict between his ego and his libido came to an end and if his ego had his libido at its disposal. The therapeutic task consists, therefore, in freeing the libido from its present attachments, which are withdrawn from the ego, and in making it once more serviceable to the ego (p.454).

He then adds:

> It will not be out of place to give a warning that we can draw no direct conclusion from the distribution of the libido during and resulting from the treatment as to how it was distributed during the illness. Suppose we succeeded in bringing a case to a favorable conclusion by setting up and then resolving a strong father transference to the doctor. It would not be correct to conclude that the patient had suffered previously from a similar unconscious attachment of his libido to his father. His father-transference was merely the battlefield on which we gained control of his libido; the patient's libido was directed to it from other positions . . . Not until after the transference has once more been resolved can we reconstruct in our thoughts the distribution of libido which had prevailed during the illness (pp.455-456).

Thus, the libido is concentrated and also mobilized in the transference situation. The resolution of the transference enables the libido to be in the service of the ego. Freud continues:

> . . . the struggle is waged around this new objective and the libido is liberated from it. The change which is decisive for a favourable outcome is the elimination of repression in the renewed conflict, so that the libido cannot withdraw once more from the ego by a flight into unconscious (p.455).

Freud believed that the neurotic, emotionally disturbed person, has his libido fixated at an earlier developmental phase of life, the Oedipal period. The neurotic, while in treatment, transfers this libido onto the therapist because of his dissatisfactions and anticipatory ideas. As the transference is resolved, the patient has more psychic energy at his disposal. Thus, Freud interrelated his definitions of transference, repetition compulsion, and libido theory. These theoretical concepts were mainly based on Freud's observations of his patients and contributed significantly to all further psychotherapeutic endeavors.

c. Clinical Usage

Freud sought out the relationship between his theoretical concepts and his practice in most of his publications. From his earlier views on transference and his definition of this phenomenon, he derived three aspects of transference which were pertinent in the clinical treatment of his patients.

These three aspects are:

1) transference neurosis;

2) positive transference; and

3) negative transference.

(Positive and negative transference behavior will be explored together.)

1) Transference Neurosis

The first mention of transference neurosis can be found in Freud's paper "Remembering, Repeating and Working-through" (1914, p.154). Freud states that through the 'transference-neurosis' the therapist can alter the patient's compulsion to repeat. He states it in this way:

> The main instrument, however, for curbing the patient's compulsion to repeat and for turning it into a motive for remembering lies in the handling of the transference. We render the compulsion harmless, and indeed useful, by giving it the right to assert itself in a definite field. We admit it into the transference as a playground in which it is allowed to expand in almost complete freedom and in which it is expected to display to us everything in the way of pathogenic instincts that is hidden in the patient's mind. Provided only that the patient shows compliance enough to respect the necessary conditions of the analysis, we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his ordinary neurosis by a 'transference neurosis' of which he can be cured by the therapeutic work. The

> transference thus creates an intermediate region between illness and real life through which the transition from the one to the other is made. The new condition has taken over all the features of the illness, but it represents an artificial illness which is at every point accessible to our intervention (1941, p.154).

Freud thus offers the psychotherapist a method of enabling the patient to transfer his neurosis onto the therapist who is then able to intervene. The feelings and thoughts that the patient has toward parents, siblings, and significant others are displaced onto the therapist. The difficulties cannot be worked out with the original parties in the conflict. They can, however, be worked out in the 'transference neurosis' with the therapist. Freud did not believe, though, that all patients were able to form a 'transference neurosis.' The hysterics, phobics, and obsessive compulsives were classified as being able to establish a 'transference neurosis,' having an ability to form and maintain transference reactions (1916-17, -[1915-17]-). On the other hand were those patients who were not able to maintain transference reactions. These patients were able to establish, once in a while, fragmentary transference reaction. Freud grouped these patients under the label of 'narcissistic neurosis,' the psychosis (1916-17, -[1915-17]-). These patients were not thought to be treatable by psychoanalysis. At times, however, Freud stated that all patients to one degree or another experience a 'transference neurosis' while in analysis (1914, pp.145-156; 1916-17, -[1915-17]-, Ch.27).

Since Freud's publications concerning the 'transference neurosis' and 'narcissistic neurosis,' there have been a number of contributions indicating that modified forms of psychoanalysis can be helpful to the psychotic patient. Notable among these contributors are Sullivan (1953) and Fromm-Reichmann (1950).

2) Positive and 3) Negative Transference

In a paper titled "The Dynamics of the Transference" (Freud, 1912, pp.97-108), Freud explored the concepts of positive and negative transference especially in connection with transference and resistance. The positive transference, such as warm and affectionate feelings, were contrasted with the negative transference, the hostile and angry feelings. These two types of transference must be dealt with separately for the therapist to understand the patient's use of transference as a resistance (p.105). Freud states:

> Positive transference is then further divisible into transference of friendly or affectionate feelings which are admissible to consciousness and transference of prolongations of these feelings onto the unconscious. As regards the latter, analysis shows that they invariably go back to erotic sources. And we are thus led to the discovery that all the emotional relations of sympathy, friendship, trust, and the like, which can be turned to good account in our lives, are genetically linked with sexuality and have developed from purely sexual desires through softening of their sexual aim, however pure and unsensual they may appear to our conscious selfperception. Originally we knew early sexual objects, and psychoanalysis shows us that people who in our real life are merely admired or respected may still be sexual objects for our unconscious (p.105).

Freud thus felt "that transference to the doctor is suitable for resistance to the treatment only insofar as it is a

negative transference or a positive transference of repressed erotic impulses (p.105)." The relationship between the patient and the analyst labelled by Freud as "rapport" is the nonsexual positive transference reactions (p.106).

Freud (1912), Greenson (1967), Stone (1961), Singer (1965), and many other therapists state that the transference per se is an inappropriate reaction toward the therapist. Singer argues that because transference is inappropriate, all transference reactions are negative. Freud felt that the act of transferring feelings onto the therapist and thus not perceiving the therapist in a realistic manner is inappropriate. However, the feelings being transferred, those originally felt by the patient when he was a child, could be positive as well as negative feelings.

d. Implication for Social Work Treatment

Freud illustrated as did others that transference exists in all human relationships. Every person, to one degree or another, transfers feelings which existed in past interpersonal relationships. These feelings may be manifested in present relationships.

Thus, some clients who seek treatment from a social worker, transfer feelings which were once directed toward parents, siblings, and/or significant others. The social worker should be aware of the transference and help those clients he thinks should become aware of the phenomenon so that they can accurately perceive the social worker in a more realistic sense. It is the "here-and-now" interpersonal

relationship between the client and social worker where the client's neurosis manifests itself so that the social worker can intervene.

The relationship between client and social worker is, therefore, the place of therapeutic change. Freud offers the social worker the fact that the exploration of the client's resistance to change in terms of understanding the transference reactions is an appropriate and effective way of overcoming the resistance and of moving forward in the treatment. The social worker does this by helping the client become consciously aware of the transference reaction. Although the timing of the interpretation has been limited to the onset of the resistance, Freud has not schematically dealt with the issue of timing. The client-social worker relationship does foster the mobilization of transference phenomena and it is the function of the social worker to recognize and appropriately handle the transference manifestations. The way the social worker responds to the client should influence the course of the relationship and of the treatment.

Freud stated that the resolution of the transference meant the 'cure' of the client; however, he did not define 'cure' in terms of behavioral changes, but rather in terms of structural changes (Freud, 1912, pp.97-108).

Since Freud's contribution, other theoreticians have developed new points of view on the concept of transference. Some of the theoreticians have explored variations of Freud's concept of transference, while others have abandoned Freud's definitions and have introduced their own.

3. Other Theoreticians

Although Greenson (1967) and Orr (1954) stated that the majority of psychoanalysts and psychoanalytically oriented therapists view transference as did Freud, there are a number of new developments and other points of view concerning the transference phenomenon. I have selected what appear to be the most important current deviations among therapists.

a. Klein and Alexander

Greenson (1967) summarizes the schools of Melanie Klein and Franz Alexander. He states:

> The followers of the Kleinian school consider the interpretation of the unconscious meaning of transference phenomena to be the crux of the therapeutic process. However, they believe that the patient's relationship to his analyst is almost entirely one of unconscious fantasy (Isaacs, 1948, p.79). Transference phenomena are regarded essentially as projections and introjections of the most infantile good and bad objects. Although these early introjections arise in a preverbial phase, the Kleinians expect their patients to comprehend the meaning of these primitive goings-on from the beginning of the analysis (Klein, 1961; Segal, 1964). They do not analyze resistance as such, but instead make interpretations about the complex, hostile and idealized projections and introjections of the patient in regard to the analyst. It seems as though they expect to influence the internal good and bad objects in the patient's ego by interpreting what they sense is going on. They do not communicate with a cohesive, integrated ego; they do not attempt to establish a working alliance, but seem instead to establish direct contact with the various introjects (Heimann, 1956).
>
> Kleinians hold the view that only transference interpretations are effective. No other interpretations are considered important (pp.169-170).

Alexander and French (1946) challenge the basic premise of the need for analyzing and interpreting transference manifestations. Greenson (1967) summarizes Alexander and French:

> On the contrary, they advocate that the transference should be regulated, controlled, and manipulated. It should not be allowed to flower in accordance with the patient's neurotic needs. One should not permit the patient to get into deep regressions since these regressions will lead to dependent transference reactions which are essentially resistances and not productive. It is best to avoid the patient's distrust and antipathy; a hostile and aggressive transference is a needless complication. Analysts may avoid all mention of the infantile conflicts and avoid thereby the dependent transference reactions. A transference neurosis of moderate intensity is permissible, but intense transference neuroses are to be avoided. One ought to focus much more on the present and less on the past (p.170).

Although the Kleinians maintain a psychoanalytic approach similar to Freud as to the necessity of interpreting the transference, they omit everything else and in this manner depart from Freud. Alexander and his followers, on the other hand, depart from Freud in a crucial area. They choose to avoid the interpretation of the transference. Their approach is similar to the "here-and-now" theoreticians.

b. Kaiser

Hellmuth Kaiser, a lesser known psychoanalyst, also departed from Freud and psychoanalytic terminology. Enelow and Adler in their forward of "Effective Psychotherapy" edited by Fierman(1965) summarizes Kaiser's views concerning psychotherapy. Kaiser introduced two concepts in a paper he wrote in 1955 titled, "The Problem of Responsibility in Psychotherapy." These concepts relate to transference phenomena. The first concept was the <u>delusion of fusion</u> in which the neurotic "wants either to incorporate himself into the other person and lose his own personality, or to incorporate the

other person and destroy the other person's personality (Fierman, 1965, XVII)." The second concept was the universal symptom which stems from the patient's efforts to achieve the delusion of fusion. He states, "what the patient says is not quite representative of him, his own self, but something which the hearer experiences as distant, indirect, an artifact, not a straightforward self-expression (Fierman, 1965, XVII)."

These two concepts were described by Kaiser as "transference attitude." Sullivan, an interpersonal theorist, also dealt with the phenomenon which Kaiser labelled the universal symptom and viewed at first as ungenuineness and later as duplicity. Sullivan labelled the phenomenon as parataxic distortion, an incongruity between non-verbal and verbal communication.

Kaiser, like Sullivan, wanted to find the reason behind the phenomenon. "Kaiser's original idea was his conception of the universal conflict. In his view, man is essentially separate and alone. No matter how close he may get to someone else, he cannot fuse with him (Fierman, 1965, XVIII)." Faced with this conflict, the patient "attemps to create an illusion of fusion through duplicitous communication (Fierman, 1965, XVIII)." Nunberg (1955) clarifies the phenomenon in similar terms when he described the reaction of the patient "is facilitated by the fact that every human being feels the need for a companion (p.339)."

c. Sullivan and Fromm-Reichmann

Sullivan (1953), as Kaiser, also attempted to explore the reasons why people duplicated in later life patterns learned as a child. He stated that anxiety produced by disapproval of others is the most upsetting and unbearable human feeling. People develop methods to avoid anxiety producing situations when they are very small children. This point of view led Sullivan to expect that when the adult encounters experiences which reactivate the old anxieties, he will reemploy the patterns of anxiety avoidance which he found useful. These patterns Sullivan labelled security operations, and he assumed that they take on a variety of forms learned as a child. Sullivan (1953) referred to this form of experiencing as the parataxic mode. Mullahy states what Sullivan meant:

> As the infant develops and maturation proceeds, the original, undifferentiated wholeness of experience is broken. However, the "parts," the diverse aspects, the various kinds of experience are not related or connected in a logical fashion. They "just happen" together, or they do not, depending on circumstances. In other words, various experiences are felt as concomitant, not recognized as connected in an orderly way. The child cannot yet relate them to one another or make logical distinctions among them. What is experienced is assumed to be the "natural" way of such occurrences, without reflection or comparison. Since no connection or relations are established, there is no logical movement of "thought" from one idea to the next. The parataxic mode is not a step by step process; experience is undergone as momentary, unconnected states of being (1948, pp.287-288).

Sullivan, however, felt that even though the young child may assume that events "just happen" together, he tries to recognize patterns and to generalize on the basis of his

observation. Sullivan stated it this way:

> The identifying of differences can make very useful contributions to behavior in the satisfaction of needs; and the generalizing of experience so that the significant common factors mixed in with the differences are identified or connected with one recurrent pattern of experience . . . elevates the complexity of elaboration of experiencing from the prototaxic to the parataxic mode of experience (1953, p.84).

The generalizations Sullivan speaks of developed through parataxic experiences giving rise to "parataxic processes," a term he used synonymously with "dynamisms of difficulty." Sullivan states:

> In further commenting on the critical opposition of anxiety and the self system to favorable growth in late adolescence, I would like to call attention to the parataxic processes in avoiding or minimizing anxiety. These processes extend from selective inattention -- which to a certain extent covers the world like a tent -- through all the other classical dynamisms of difficulty, to the gravest dissociation of one or more of the vitally essential human dynamisms. And incidentally while I once liked the rubric, dynamism of difficulty, it has lost its charm over my years of attempting to teach psychiatry, because the conviction grew among some of the people who encountered this usage that these dynamisms represented peculiarities shown by the morbid. On the contrary, I believe that there are only differences in degree -- that is, in intensity and timing -- of that which is shown by everyone. Thus whenever I speak of dynamisms, I am discussing universal human equipment, sometimes represented almost entirely in dreadful disformed misfortunes in development, restrictions of opportunity, and the like. Thus the interventions of the self system which are striking in the late adolescent phase -- that is, in chronological maturity -- cover the whole field of what we like to talk about as being psychiatric entities -- mental disorders, if you please (1953, pp.304-305).

Sullivan (1953) concluded that people in their adult life reacted to others on the basis of parataxic patterns of generalizing developed when they were small children. He labelled the phenomena of duplication and repetition as

"parataxic distortions."

Freda Fromm-Reichmann was also an interpersonal theorist and her views of transference were similar to Sullivan. She emphasized the importance of the patient-therapist relationship:

> Transference in its special application to the therapeutic process naturally means transferring to the therapist, as a present-day partner, early experiences in interpersonal relatedness. Such significant carryovers from people's early relationship with the parents of their childhood, of course, will also affect their later relationships with their family doctor, dentist, minister, etc. Even the mere anticipation of consulting any kind of qualified helper, including the future psychiatrist, may pave the way for the development of transference reactions (1950, p.57).

Although Fromm-Reichmann used the word transference in the above quote, it is evident that she meant parataxic distortion as was previously defined by Sullivan.

Fromm-Reichmann's (1950) main concern was in the therapeutic process and she emphasized the patient's reactions to therapist. She clarifies her concept when she states:

> Frequently the reports of patients about their early attachments to their parents may lend themselves to sexual misinterpretation. However, in evaluating these data, the psychiatrist should keep in mind the possibility of patient's difficulty of expressing feelings of friendliness towards the doctor and his own problem of accepting them. People in Western culture do not seem to find it too difficult to talk about sexual attachments, falling in love, etc., but . . . . . many of us are reluctant, if not afraid, to speak about the friendly, tender, asexual loving aspects of our interpersonal relationships. This holds true not only for adult relationships, but also for feelings of attachment to the parents of one's childhood as viewed and reported by adult patients. Moreover, the psychiatrist's own fear of a friendly give-and-take, if not recognized, may encourage these misconceptions (p.99).

In relating the phenomena to psychotherapy, Fromm-Reichmann (1950) states, "distortions of people and relationships

are responsible, of course, for part of the patient's emotional difficulties in living. The central part of all intensive psychotherapy is, therefore, the interpretive clarification of the connection between a patient's early patterns of interpersonal relationships and his present experiences (p.98)."

Sullivan's and Fromm-Reichmann's views of parataxic distortion are similar but not synonymous with Freud's concept of transference. Singer (1965) clarifies the essential similarities and differences between the concept of transference and that of parataxic distortions. He states:

> In both concepts, reactions and attitudes harbored toward significant individuals of one's past are seen as reactivated in the person's dealings with others. But Freud by and large reserved the term transference for such a reactivation in the analytic relationship. Sullivan was convinced that these distortions, such as recasting of one's contemporaries in the image of people in one's past, appear in all interpersonal contexts. Furthermore, transference specifically denotes a re-experiencing of the therapist within the framework of the Oedipal conflict; but the process of parataxic distortion implies no such restrictions, essentially because Sullivan did not consider the Oedipal conflict central to neurosis. Perhaps most important, both theorists believed that the processes they described were reactions to anxiety and to those threats which caused anxiety.
>
> Freud and Sullivan both saw the origins of anxiety and consequently understood reactions to anxiety in totally different terms. Transference behavior revealed to Freud Oedipal tendencies, reactions to them and anxiety associated with them; to Sullivan parataxic distortions revealed the patient's sense that loss of self-esteem was around the corner and methods of preventing this threat from materializing. Freud saw in the transference reactions how the individual went about trying to maintain his regressive and hostile Oedipal impulses without bearing dreaded consequences. Sullivan saw in the parataxic distortions learned behavior which the individual assumes will help him survive. Freud saw the potential for engaging in transference behavior in

> what he thought was the essentially regressive characteristic of nature basically expressed in the repetition compulsion; Sullivan saw the potential for parataxic distortions in the organism's constant tendency to maintain himself necessitating a reduction of anxiety (pp.261-262).

d. Rogers

Rogers (1951) presented a polarization point of view concerning transference. Freud, Sullivan, Fromm-Reichmann, and others believe that the transference is dissipated only after constant interpretation of the phenomenon. Rogers believed that the transference attitude of the patient will dissipate when the patient recognizes that the therapist is not judging or evaluating him, but is genuinely accepting him.

Actually, Rogers believed that transference manifestations are only observable when the patient feels threatened and his anxiety is provoked. Rogers states the following regarding his concept of the origin of transference:

> When the client is evaluated and comes to realize clearly in his own experience that this evaluation is more accurate than any he has made himself, then self-confidence crumbles and a dependent relationship is built up. When the therapist is experienced as "knowing more about me than I know myself," then there appears to the client to be nothing to do but to hand over the reins of his life into these more competent hands. This is likely to be accompanied by comfortable feelings of relief and liking, but also at times by hatred for the person who has thus become so all important (pp.215-216).

Rogers believed that when the client recognized the accepting attitude of the therapist, he "must" see that the attitudes he thinks the therapist has are really his own. This projection will then be given up and the client will view the therapist in a more realistic manner. Rogers puts it this way:

> Why is this accomplished so quickly and so readily? It would appear that one reason is that the therapist has so completely put aside the self of ordinary interaction that there is no shred of evidence upon which to base the projection. For four interviews this woman has experienced understanding and acceptance -- and nothing else. There has been no evidence that the therapist is trying to "size her up," diagnose her, evaluate her scientifically, judge her morally. There is no evidence that he approves or disapproves of anything she does -- of her behavior, present or past, of the topics she chooses to discuss, of the way she presents them, of her silences, of the interpretating she gives to her own behavior. Consequently when she feels that the therapist is passing a moral judgment upon her, and when this feeling too is accepted, there is nothing upon which this projection can hang. It must be recognized as coming from herself, since every evidence of her senses makes it plain that it does not come from the therapist, and the complete lack of immediate threat in the situation makes it unnecessary to insist upon the feeling in defiance of the evidence of her senses (1951, p.203).

Rogers does not deal with such concepts as Oedipal, repetition compulsion and inherent regressive tendencies. He believes that the client's transference reactions, which he called life-saving techniques, are manifested only when the client feels threatened. Other theorists would disagree with Rogers' reason for this phenomenon -- the client's threatened disrespect -- but would agree that the transference manifestation reflects the client's need for self-preservation.

4. Research on Transference

To this writer's knowledge, quantitative research in social work regarding patients' transference reactions toward the therapist, as well as the handling of these reactions by the therapist, is nonexistent. However, there are a few well documented scientific studies dealing with phenomena in other disciplines.

Alexander and French (1946) examined 292 patients seen at

the Chicago Psychoanalytic Institute and an equal number of patients seen in private practice in the Chicago area, a total of about 580 patients. The research project lasted seven years. The study involved (a) short-term and long-term treatment cases; (b) male and female patients; (c) male and female therapists; (d) clinic as well as private patients; and (e) fully trained and partially trained psychotherapists. The authors were concerned with therapeutic processes and outcomes. Judgments were based on written evaluations of the patients by their therapists at the beginning, during, and at termination of treatment. Raters, trained therapists, were also used to evaluate the cases. All therapists believed that the resolution of the transference indicated the "cure." Cure was operationally defined as the disappearance of behavioral symptoms (p.71). Some therapists believed that the interpretation of the transference was needed to resolve the transference, while other therapists believed that there was no need to interpret. Transference was operationally defined as the patient's reactions toward the therapist as though the therapist was not himself but some person in the patient's past (p.71). The authors concluded that the transference is "the most powerful instrument yet found for overcoming the patient's resistance to facing disturbing emotional experiences (p.71)." The patients who were able to come to terms with their transference reactions were able to "deal with conflictual psychological situations (p.18)." The resolution of the transference either by interpretations -- Freud's

approach -- or by understanding and acceptance -- Rogers' approach -- led to the disappearance and alleviation of behavioral symptoms.

The research of Rogers and Dymond (1954) and their coworkers Grummon and John (1954) and Seeman (1954) dealt with processes and outcomes of client-centered psychotherapy cases at the Counseling Center, University of Chicago. Rogers and Dymond (1954) concluded, as did Rogers (1951), that the client's attitude toward the therapist must be realistic if the client is to change his behavior. The research of Grummon and John (1954) dealt with the client's attitude toward his mother, father, siblings, mates, offspring, as well as toward people in authority, such as supervisors. The experimental group consisted of twenty-three clients and the control group consisted of sixteen clients. The control group did not receive any treatment. The authors found that patients' attitudes changed in the experimental group significantly between pre and post therapy whereas the attitudes in the control group did not change significantly. Seeman (1954) added that as the patient's attitude toward the therapist changed in a realistic manner, the therapeutic outcome was significantly more positive (p.107).

Rawn (1958) successfully identified quantitatively transference and resistance phenomena in therapy. He used the Stephenson Q technique and raters to judge four tape sessions of one patient seen in therapy over a one year period. He operationally defined transference as the "unconscious

polarized emotional set representing a repetition in the present of past emotional states (p.419)." Rawn concluded that three out of four sessions consisted of primarily negative transference reactions. This led to the therapeutic failure and an accumulation of behavioral symptoms. The negative transference reactions were not resolved.

Pfeffer in 1959 and in a follow-up study in 1961 had a sample of fifteen patients in his research geared toward the examination of outcome of psychoanalytic treatment. Nine patients were seen at the New York Psychoanalytic Institute and six were seen privately in metropolitan New York. Judgments were based on the patients' therapists and other skilled therapists. The therapists rated their patients at the beginning and at the end of therapy. The other raters evaluated the patients during four to six post-therapy sessions. These sessions were conducted anywhere from two to six years after therapy terminated. Pfeffer found that the reduction of the transference reactions led to the disappearance of behavioral symptoms (p.440). The following behavioral characteristics were examined: a) sexual roles; b) occupational roles; c) marital difficulties; and d) depression. Pfeffer illustrated with the following examples. A homosexual woman was able to establish heterosexual relationships, married and had children. Another patient had a faltering career and was able to establish a new meaningful position. A patient's depression was alleviated. A patient with marital problems was able to work out her difficulties with her husband.

Truax (1971) approached the subject of transference and therapeutic outcome by examining group psychotherapy sessions of juvenile delinquents. The study involved eight psychotherapy groups of young male and female delinquents. Therapists included psychiatrists, psychologists and social workers, all of whom were experienced and professionally trained. Truax used Freud's definition of transference. Truax found "that the occurrence of negative transference in group psychotherapy with juvenile delinquents is associated with positive therapeutic benefits (p.135)." "The occurrence of negative feelings toward the therapist as an authority figure leads to some resolution and therefore somewhat better therapeutic outcome (p.136)."

There are numerous positive as well as negative aspects in the research cited above. None of the researchers defined "resolution." The value of the use of the word can be questioned, for if transference behavior is, indeed, a universal phenomenon existing in all interpersonal relationships, then "resolution" is impossible and diminution is more likely. Alexander and French (1946), Pfeffer (1959, 1961), Rawn (1958) and Truax (1971) did not have any control groups. Rawn (1958) had only one patient. Truax (1971) and Grummon and John (1954) did attempt to spell out the specific behavior that was modified through the use of resolving the transference. There is, however, sufficient evidence that the resolution or diminution of transference behavior leads to positive behavioral changes.

C. Statement of the Problem

The problem of this investigation is to explore whether interpretations to the client of the client's transference behaviors by the social worker during the therapeutic process results in 1) lessening of the transference behavior; 2) avoiding premature discontinuance; and 3) enhancing positive affective and behavioral changes.

Several different strategies have been developed to deal with this problem. However, certain assumptions illustrated in the literature and basic to the problem must first be specified: 1) Transference is an inevitable occurrence in human relationships and it assumes a particularly prominent and critical role in ongoing therapeutic relationships; 2) Clients' transference behavior interferes with appropriate continuance and desired outcome; 3) Social workers may or may not engage in interpreting clients' transference behavior; 4) Social workers' interpretations to the clients of the clients' transference behavior is one way of managing the transference. Interpretations may be effective in diminishing the transference behavior. Although not specifically supported by the literature, a social worker's stance of passivity vis-a-vis the client's transference behavior may either lead to a preservation or an exacerbation of the transference behavior; 5) Interpretations of transference behavior may have different effects at various times during the therapeutic process. Clients may demonstrate more anxiety in the initial phase of treatment as the social worker interprets the client's transference behavior; 6) The various

treatment sessions constitute a sequence of a therapeutic endeavor; and 7) The diminution of the transference behavior results in positive affective and behavioral changes.

Freud (1905 - [1901]-) offered one stratagem to deal with the problem when he stated that in order to appropriately handle the transference behavior, the therapist should interpret transference phenomena to the patient. The therapist does this by bringing into consciousness that which is unconscious, the transference. This is usually difficult for the patient and may lead to new defensive maneuvers. Sullivan (1953) and Fromm-Reichmann (1950) agree with Freud's views. Social workers, including Garrett (1941, 1949), Lyndon (1948), Katz (1948), and Hollis (1969), related Freud's concepts to the client-social worker relationship and stated that the social worker should interpret to the client the client's transference behavior. These theoreticians added, however, that the interpretation of the transference behavior is not needed with all clients and, thus, should be made only when appropriate. Another stratagem is offered by Rogers (1951), who stated that while the therapist should be aware of the role the client is attributing to him, the transference behavior will resolve itself if the therapist is accepting and non-judgmental toward the client. Alexander and French (1946) and social workers such as Perlman (1957) and Biestek (1951) follow this position. Behaviorists offer still another stratagem. They state that the therapist need not focus on the transference, but rather on the behavior as needing modification (Wolpe and Lazarus, 1967, and Thomas, 1970). The

behaviorists have gained much from the social-learning theoreticians and have focused their attention on the concept of transferring learning, especially with regard to current behavioral practices. However, exactly as Freud spoke about the inevitableness of transference, the literature regarding social-learning theory illustrates the inevitableness of transferring learning (Lunden, 1969). Stimulus generalization, for example, as a law of learning points to the universality of individuals transferring learning from one situation to another to the extent the latter situation is perceived as similar to the original situation (Lunden, 1969, p.103).

Freud's and Rogers' stratagem for handling transference behavior were said to lead to the resolution of the transference phenomena which indicated the cure of the client. The empirical data illustrated in the previous section clearly demonstrated that the diminution of the transference behavior does, indeed, lead to the alleviation and disappearance of behavioral symptoms. However, the timing of the transference interpretations have not been examined, and thus, there is no empirical data concerning the relationship between the timing of interpretation of the transference behavior and the diminution of the behavior. Although some social workers either follow Freud or Rogers, there is little empirical data in the social work literature concerning transference phenomena.

Freud (1905 -[1901]-) and Garrett (1941, 1949) also point out that interpretations of transference behavior may lead to

the further manifestation of transference. This is especially true in the early phase of treatment. Since the act of transferring behavior from one person to another is basically an unconscious process, bringing into consciousness this behavior may be upsetting and the client may tend to react toward the therapist in the same manner he reacted toward his parents or siblings when he was upset as a child.

For the purpose of this study, transference is operationally defined as the shift of behaviors and feelings from any person onto the social worker. (Examples: 1) A female client who hated or loved her mother may experience hate or love feelings with other female figures, e.g., the social worker. 2) A male client who distrusted his father may distrust other people.) The transference may be overt; e.g., "I hate you. You remind me of my father." "I love you. You are really helpful." The transference may also be covert; e.g., "My doctor has been very helpful." "The teacher doesn't know anything about teaching. He is really not good." Interpretations of the transference is operationally defined as the verbalization of the transference behavior by the social worker to the client. (Examples: 1) "Your hostility toward me was really meant to be directed toward your mother." 2) "Your warm feeling toward me was the way you felt toward your father.") The examples are overt statements by the social worker about the client having condensed the social worker with his parents. The social worker could also make limited interpreted statements such

as: 1) "It was important to you that the doctor was helpful. You seem to view me the same way." 2) "You feel that I'm like the teacher and am really not a good therapist."

D. Hypotheses

H1

During the early sessions (five through eight) of social work treatment, the frequency of the client's transference behavior will be greater when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior.

H2

During the later sessions (seventeen through twenty) of social work treatment, the client's transference behavior will be less frequent when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior.

H3

The client's transference behavior will exhibit more reduction between the early and later phases of treatment when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior.

H4

Clients will continue in treatment for a longer period of time when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior.

H5

The client's affective and behavioral symptoms will be alleviated to a greater degree when the social worker interprets to the client the client's transference behavior from the early through the later phases of treatment than when the social worker does not interpret the transference behavior.

CHAPTER II - METHOD

A. Selection of Clients

Clients used to test the preceding hypotheses were drawn from people applying for treatment at Family Service of Detroit and Wayne County and Family Services of Greater Toledo during the period from July 1, 1972 through March 31, 1973. Clients were randomly assigned to the Interpretive group - Group A, and the Non-Interpretive group - Group B.* They were asked to continue in treatment once a week for at least twenty weeks. This was necessary because of the need to determine the difference in the clients' transference behavior and also in the social workers' interpretations of that behavior over a period of time. The female clients were randomly assigned to female social workers and the male clients were randomly assigned to male social workers. Clients were between twenty-one and forty-seven years of age. Children, adolescents and people over forty-seven were excluded from the study. Psychotic clients were also omitted. The necessity of the above factors stems from the fact that these variables have an idiosyncratic impact on the transference behavior (Freud, 1905 -[1901]-; Garrett, 1941; Hollis, 1969).

*The social workers identified themselves as interpreters or non-interpreters of transference behavior. However, the raters found that the non-interpreters actually did indeed interpret but less frequently.

The client population totaled 39 people of which 19 were in the Interpretive group (Group A) and 20 were in the Non-Interpretive group (Group B). Males and females were divided almost equally; 5 men and 14 women were in Group A; and, 7 men and 13 women were in Group B.

Sixteen clients in Group A completed the early phase of treatment (sessions five through eight) and twelve clients completed all twenty treatment sessions. Group B had fifteen clients who completed the early phase and nine clients who completed the later phase of treatment. Group A had in both the early and later phases of treatment two clients whose taped sessions were inaudible. There was one client whose taped sessions were inaudible in both the early and later phases of treatment in Group B. Table I illustrates the clients by sex by groups. Appendix A contains the clients' identifying data.

TABLE I

Number of Cases and Client Sex

Group	N	Client Sex M	F
A	19	14	5
B	20	13	7

B. Selection of Social Workers

Social workers were selected for this study based on their management of transference behavior. They were asked whether or not they usually interpret to the client the

client's transference behavior. Eight social workers comprised a group that usually interprets to the client the client's transference behavior, the Interpretive group (Group A). Nine social workers were in a group that usually does not interpret the transference behavior, the Non-Interpretive group (Group B). All social workers attended an accredited School of Social Work and have a Master's Degree in Social Work. Each social worker had at least two and not more than fifteen years of treatment experience after receiving their Master's Degree.

Clinical descriptive data for each client was completed by the social worker during the initial phase of treatment. A second clinical summary was completed at the termination of treatment if the client attended at least seven sessions.

There were three male and five female social workers in Group A, five of whom had had their own therapeutic experience and three had none. In Group B, three social workers were male and six were female, five of whom had had their own therapeutic experience and four had none. Table II lists some descriptive data about the social workers. Appendix B contains the social workers' identifying data. The social workers in both groups have similar characteristics.

TABLE II

Number of Social Workers, Social Workers' Sex, Social Workers' Own Therapeutic Experience

Group	N	Social Workers' Sex		Social Workers' Own Therapy	
		M	F	Therapy	No-Therapy
A	8	3	5	5	3
B	9	3	6	5	4

A summary in table form of the clients' and social workers' identifying data can be found in Appendix C. It is noted that the clients tend to be younger, have more children, more divorces, less education and less income than the social workers. These sociological factors are expected as middle-class social agencies are attempting to help usually lower-class families. The sociological factors were similar in both the Interpretive and Non-Interpretive groups.

C. Selection of Raters

The raters were selected on the basis of their expertise concerning transference behavior. Each rater has a Master of Social Work Degree and at least five years post degree experience. They rated the existence of client transference behavior and the social workers' interpretations of the transference behavior by using the operational definitions stated in Chapter I, pages 44-45. A questionnaire was utilized for this procedure (Appendix H, number 8). Each rater had a tape recording and typewritten material for each session selected for analysis.

Clients' changes were determined by the raters in two areas, affective and behavioral changes. The raters evaluated the clinical data completed by the social workers. Each rater was asked to rate all clinical data of those clients who had completed at least seven treatment sessions. Appendix D contains the raters' general identifying data.

Reliability of Raters

Inter-rater reliability regarding the clients' transference behavior and the social workers' interpretations of the behavior was evaluated by having all three raters judge the same sessions used for analysis. To check the inter-rater reliability, the Pearson product-moment correlation was utilized. Correlations between judges A and B, A and C, and B and C regarding the ratings of the clients' transference behavior and social workers' interpretations of the transference behavior for the early phases, first and second sessions, as well as the later phases, first and second sessions, were determined. The inter-rater reliability data regarding the clients' transference behavior are shown in Table III and the inter-rater reliability data regarding the social workers' interpretations are shown in Table IV. Table V shows the percent agreement of the raters in determining the affective and behavioral changes for the clients.

The average correlations for the clients' transference behavior, .84 in the early phase of treatment, and .83 in the later phase are statistically significant at the .01 level, showing better than chance expectations and reliability of the raters in determining the clients' transference behavior.

TABLE III

Inter-Rater Reliability of Clients' Transference Behavior

Source	Early Phase				Later Phase			
	1st Session		2nd Session		1st Session		2nd Session	
	dF	R	dF	R	dF	R	dF	R
Judges A & B	27	.93	27	.88	16	.71	16	.84
Judges A & C	27	.84	27	.83	16	.84	16	.93
Judges B & C	27	.75	27	.81	16	.83	16	.83

The average correlations for the social workers' interpretations, .76 in the early phase of treatment, and .75 in the later phase are statistically significant at the .01 level, showing better than chance expectations and reliability of the raters in determining the social workers' interpretations.

TABLE IV

Inter-Rater Reliability of Social Workers' Interpretations

Source	Early Phase				Later Phase			
	1st Session		2nd Session		1st Session		2nd Session	
	dF	R	dF	R	dF	R	dF	R
Judges A & B	27	.83	27	.85	16	.90	16	.67
Judges A & C	27	.78	27	.60	16	.94	16	.49
Judges B & C	27	.82	27	.64	16	.90	16	.59

Table V shows that there was a high percentage of agreement between the raters as to the clients' affective and behavioral changes. Twenty-nine out of a total population of thirty-one clients, or 94%, had an 83% or better agreement factor between the raters.

TABLE V

Inter-Rater Reliability of Clients' Affective and Behavioral Changes

Group	N	100% Agreement	83% Agreement	67% Agreement
A	16	11	3	2
B	15	10	5	0

D. Selection of Treatment Sessions for Analysis

The hypotheses for the present study are primarily concerned with the difference in the clients' transference behavior over a period of treatment time. Sessions selected for analysis reflected this difference. Therefore, treatment sessions were randomly chosen from an early phase of treatment (sessions five through eight) and a later phase of treatment (sessions seventeen through twenty). Two sessions from each phase were randomly selected for analysis. A fifteen minute segment commenced ten minutes after the session began and was considered representative of the entire data. Although all treatment sessions were tape recorded on cassettes, six cassettes (three in the early and later phases) were inaudible. Thus, a total of 94 treatment sessions were used for analysis. This total represented 58 treatment sessions in the early phase and 36 sessions in the later phase. The Pearson product moment correlation was utilized to determine the statistical association between the clients' transference behaviors and the social workers' interpretations of

the transference behaviors for the individuals. The statistically significant differences between the Interpretive and Non-Interpretive groups concerning the clients' transference behavior, and also, the social workers' interpretations of the behavior were determined by using the Students t-test. The statistically significant differences between the Interpretive and Non-Interpretive groups regarding the length of treatment time were determined by utilizing the Students t-test. The chi-square was used to determine the statistical significance concerning the affective and behavioral changes for the clients.

CHAPTER III - FINDINGS

A. Clients' Transference Behavior and Social Workers' Interpretations of the Transference Behavior

Hypotheses I, II and III were operationalized and tested in the following way. The clients' transference behavior was defined as the clients' shift of feelings and behaviors from any person onto the social worker. The social workers' interpretations of the clients' transference behavior were defined as the social workers' verbalization of the transference behaviors to the client. The hypotheses were tested by having three raters judge the existence of the clients' transference behavior and the social workers' interpretations of that behavior in the treatment sessions over a period of time. The raters listened to tape recordings and read typewritten transcripts of the treatment sessions.

To test hypotheses I, II and III the clients and the social workers were divided into two groups on the basis of the social workers' management of the clients' transference behavior. One group of social workers usually interpreted the clients' transference behavior. These social workers and the clients they saw were in the Interpretive group, Group A. The other group of social workers usually did not interpret the transference behavior. These social workers and the clients they saw were in the Non-Interpretive group, Group B. The social workers in both groups conducted the treatment sessions in their usual manner. Tables E-1 and

and E-II in Appendix E report the totals of the data used for hypotheses I, II and III.

Hypothesis I predicted that in the early sessions (five through eight) of social work treatment the frequency of the clients' transference behavior will be greater when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior.

Tables VI and VII illustrate the comparison of the means of the social workers' interpretations of transference and the clients' transference behaviors in both Interpretive and Non-Interpretive groups. The correlation data regarding the individuals are reported in Table VIII.

Table VI shows that the Students t-test was statistically significant at the .05 level indicating that there were a significantly greater number of social workers' interpretations of clients' transference behavior within the Interpretive group as compared to the Non-Interpretive group. Table VII shows that the mean score of the clients' transference behavior was greater in the Non-Interpretive group than in the Interpretive group. The Students t-test was not statistically significant and was in the opposite direction predicted.

TABLE VI

Comparison of Means Between the Interpretive and Non-Interpretive Groups of Social Workers' Interpretations of Transference Behavior in the Early Phase of Treatment

Group	N	Mean	Var	SD	df	t
A	14	2.98	4.47	2.12	28	1.87
B	15	1.84	.69	.83		

TABLE VII

Comparison of Means Between the Interpretive and Non-Interpretive Groups of Clients' Transference Behavior in the Early Phase of Treatment

Group	N	Mean	Var	SD	df	t
A	14	15.65	13.58	3.68	28	-1.09
B	15	17.22	16.29	4.04		

The correlation r, in Table VIII, although not statistically significant at the .05 level, was in the direction predicted. However, hypothesis I was not confirmed.

TABLE VIII

Correlation Between Clients' Transference Behavior and Social Workers' Interpretations of the Behavior in the Early Phase of Treatment in the Interpretive and Non-Interpretive Groups

Group	df	Pearson Correlation
A	12	.09
B	13	.11
A and B	27	.01

Hypothesis II predicted that during the later sessions (seventeen through twenty) of social work treatment, the clients' transference behavior will be less frequent when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior. The Students t-test found in Table IX was not statistically significant but was in the direction predicted. The mean of the social workers' interpretations in Group A was about three times that of Group B. The Students t-test in Table X was not statistically significant and the mean of the clients' transference behavior was slightly greater in the Interpretive group than in the Non-Interpretive group. This was in the opposite direction predicted.

TABLE IX

Comparison of Means Between the Interpretive and Non-Interpretive Groups of Social Workers' Interpretations of Transference Behavior in the Later Phase of Treatment

Group	N	Mean	Var	SD	df	t
A	10	1.60	4.24	2.06	17	1.56
B	8	.54	.30	.54		

TABLE X

Comparison of Means Between the Interpretive and Non-Interpretive Groups of Clients' Transference Behavior in the Later Phase of Treatment

Group	N	Mean	Var	SD	df	t
A	10	15.8	9.32	3.05	17	.09
B	8	15.68	6.44	2.54		

The correlation r for Group A, in Table XI, was almost statistically significant at the .05 level, but was in the opposite direction from the one predicted. Hypothesis II was not confirmed. During the later phase of treatment as in the early phase of treatment, there was a positive correlation between the clients' transference behaviors and the social workers' interpretations of that behavior.

TABLE XI

Correlation Between Clients' Transference Behavior and Social Workers' Interpretations of the Behavior in the Later Phase of Treatment in the Interpretive and Non-Interpretive Groups

Group	df	Pearson Correlation
A	8	.52
B	6	.07
A and B	16	.41

Hypothesis III predicted that the clients' transference behavior will exhibit more reduction between the early and later phases of treatment when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference. Table XII illustrates that the mean of the social workers' interpretations was greater in the Interpretive group than in the Non-Interpretive group. The Students t-test was statistically significant at the .10 level. Table XIII reports that the mean of the clients' transference behaviors in the Interpretive group was about one-half of that in the Non-Interpretive group. Group B did exhibit a greater reduction of clients' transference behaviors between the early and later phases of treatment. Thus, this result was in the opposite direction predicted but not statistically significant.

TABLE XII

Comparison of Means Between the Interpretive and Non-Interpretive Groups of Social Workers' Interpretations of Transference Behavior Between the Early and Later Phases of Treatment*

Group	N	Mean	Var	SD	df	t
A	10	4.83	9.69	3.11	16	1.66
B	8	2.86	3.67	1.91		

*The social workers' interpretations to the client found in the early and later phases were added together.

TABLE XIII

Comparison of Means Between the Interpretive and Non-Interpretive Groups of Clients' Transference Behavior Between the Early and Later Phases of Treatment*

Group	N	Mean	Var	SD	df	t
A	10	.45	27.91	5.28	16	-.15
B	8	.82	20.87	4.56		

*The client's transference behaviors in the later phase of treatment were subtracted from the behaviors in the early phase.

The correlation r, in Table XIV, although not statistically significant at the .05 level was in the direction predicted. However, hypothesis III was not confirmed.

TABLE XIV

Correlation Between Clients' Transference Behavior and Social Workers' Interpretations of the Behavior Between the Early and Later Phases of Treatment in the Interpretive and Non-Interpretive Groups

Group	df	Pearson Correlation
A	8	-.38
B	6	.07
A and B	16	-.24

B. Length of Treatment Time of Clients in the Interpretive and Non-Interpretive Groups

The fourth hypothesis predicted that clients will continue in treatment for a longer period of time when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior. The data used to test this hypothesis are reported in Table XV. Group A had 16 clients, 78.9%, who completed the early phase of treatment (sessions 5-8) and 12 clients, 63.2%, who completed the later phase (sessions 17-20). Group B had 15 clients, 80%, who completed the early phase and 9 clients, 45%, who completed the later phase. The data indicates that clients in Group A tended to stay in treatment over a longer period of time. The Students t-test demonstrates that the outcome was in the direction predicted and is statistically significant at the .20 level. Thus, the fourth hypothesis was tentatively supported. More data, however, needs to be collected to determine the statistical significance with greater reliability and validity.

TABLE XV

Comparison of Means Between the Interpretive and Non-Interpretive Groups of the Length of Treatment Time

Group	N	Mean	Var	SD	df	t
A B	19 20	16.11 12.55	44.32 46.16	6.66 6.79	38	1.65

C. Client Affective and Behavioral Changes

Hypothesis V predicted that the clients' affective and behavioral symptoms will be alleviated to a greater degree when the social worker interprets the clients' transference behavior from the early through the later phases of treatment than when the social worker does not. The data used to test this hypothesis are reported in Tables XVI and XVII. Table XVI reports the client affective changes and Table XVII reports the client behavioral changes. The chi-square test was used to determine the statistical significance of the hypothesis. Both the client affective and behavioral changes were statistically significant at the .01 level and in the direction predicted. The hypothesis was supported.

TABLE XVI

Raters' Evaluations of Clients' Affective Changes

Group	N	Affective Changes Alleviated	Not Alleviated	X^2
A	16	41	7	7.49
B	15	26	19	

TABLE XVII

Raters' Evaluation of Clients' Behavioral Changes

Group	N	Behavioral Changes Alleviated	Not Alleviated	X^2
A	16	41	7	5.37
B	15	28	17	

CHAPTER IV - DISCUSSION

The social workers involved in this study were divided into two groups: The Interpretive group - Group A; and the Non-Interpretive group - Group B. The division was based on the social workers' management of the transference. Those social workers who stated that they usually interpret the clients' transference behavior were assigned to Group A. The social workers who usually do not interpret the transference behavior were assigned to Group B.

The social workers in the Interpretive group saw fourteen clients during the early phase of treatment (sessions five through eight). For the two sessions randomly selected for this phase, there was an average of 2.98 interpretations of the transference behavior to the clients. The social workers who were in the Non-Interpretive group saw fifteen clients during the early phase of treatment, and there were 1.84 interpretations of the clients' transference behavior. For the two sessions randomly selected for the later phase of treatment (sessions seventeen through twenty), the social workers in the Interpretive group saw ten clients and averaged 1.6 transference interpretations. The social workers in the Non-Interpretive group saw eight clients and averaged .54 transference interpretations.

The clients were assigned randomly to the Interpretive and Non-Interpretive groups. The average number of client transference behaviors were not significantly different in

the Interpretive and Non-Interpretive groups for both the early and later phases of treatment except there was a slight decrease of clients' transference behavior in the later phase of treatment in the Interpretive group.

The social workers' evaluations of the clients included an assessment of the clients' childhood feelings, behaviors, and role assignments in relationship to their parents, siblings, and/or significant others. This assessment was based on the clients' verbalization of their childhood experiences. The clients' perceptions of their childhood relationships determines the current transference behavior. Psychological projective tests might have contributed further information about the clients' current psychological status but the administration of such tests was not feasible.

The raters determined the roles and feelings the client attributed to the social worker during the early and later phases of treatment. This was accomplished by having the raters listen to the tapes and reading transcripts of the sessions used for the analysis. This assessment was thought to be helpful in determining whether or not the client actually attributed to the social worker feelings and behaviors once attributed to his parents, siblings, and/or significant others when he was a child. Appendix F illustrates the roles and feelings regarding clients' relationships during childhood.

A. Clients' Transference Behavior and Social Workers' Interpretations of the Transference

The association between the clients' transference behavior and the social workers' interpretations of the

behavior has not been explored in the social work literature (Garrett, 1941, 1949; Hollis, 1969). This association has only been lightly explored in the psychiatric, psychoanalytic, and psychological literature (Alexander and French, 1946; Pfeffer, 1959, 1961; Rawn, 1958). On the bases of the data collected and the methodology used in this study, the association between the clients' transference behavior and the social workers' interpretations of the transference behaviors was not statistically significant for either the early or later phase of treatment.

There were less clients' transference behaviors when the social workers interpreted the transference in the early phase of treatment. This data does not support other research (Alexander and French, 1946). Transferring feelings and behaviors from one person to another, especially when someone is seeking treatment, is an unconscious process and apparently provokes anxiety within the client. The social worker's verbalization to the client of the transference behavior may lead the client to react in similar manners as he did when anxious as a child (Freud, 1905 -[1901]-; Garrett, 1941, 1949; Lyndon, 1948).

The data also indicated that there was an increase in the frequency of the social workers' interpretations of the transference and the clients' transference behaviors in the later phase of treatment. The increase was not as great as in the early phase of treatment and was in the opposite direction predicted. However, when comparing the clients'

transference behaviors and the social workers' interpretations of that behavior between the early and later phases of treatment - the continuim that actually exists in treatment - we note a slight reduction in the clients' transference behaviors when the social worker did not interpret the transference. This reduction, although in the opposite direction predicted, was not statistically significant and does not support other research (Freud, 1905 -[1901]-; Alexander and French, 1946; Pfeffer, 1959, 1961; Garrett, 1941, 1949; Lyndon, 1948).

Apparently, twenty treatment sessions are not sufficient to see a statistical significance in the decrease of the clients' transference behavior (Reed and Syyne, 1969). More data in terms of a greater number of treatment sessions and a larger client population needs to be collected. Also, the social workers in the Non-Interpretive group who stated that they "never interpret transference" did indeed make transference interpretations. Either these social workers did not know what interpreting transference meant or would not acknowledge their interpretive behavior, albeit relatively infrequent. The raters also determined the appropriateness of the transference interpretations and found an average of 15% more transference behaviors judged needing interpretations by the social workers in the Interpretive group. The reason these clients' transference behaviors were not interpreted is unknown. One inference may be the social worker did not recognize the transference; another may be that they deemed the timing was inappropriate. An alternative explanation

may be that the 15 minute segment of the treatment session used for analysis may not have provided sufficient data for the raters to determine if the clients' behavior was indeed transference or was a realistic response to the social worker's behavior.

B. Length of Client Treatment Time

Clients who were seen in the Interpretive group had a mean number of sessions of 16.11, as compared to those clients in the Non-Interpretive group who had a mean of 12.55. The Interpretive group had 12 clients or 63.2% who completed all 20 treatment sessions; whereas, the Non-Interpretive group had 9 clients or 45% who completed all 20 sessions.* Therefore, clients whose transference behavior was interpreted by the social worker did tend to continue in treatment over a longer period of time than those clients whose transference behavior was not interpreted. The data was statistically significant at the .20 level. More data of a larger number of treatment sessions needs to be collected. This finding supports the research of Alexander and French (1946) and Pfeffer (1959, 1961).

C. Client Affective and Behavioral Changes

The results of the social workers' interpretations of the clients' transference behavior is the most important aspect of this study. The positive affective and behavioral changes which occurred during treatment were determined by

*Some clients continued past 20 sessions depending on the clients' needs.

what the client said, his behavior in the treatment sessions, and by the social worker's observations. The changes were related to what the client stated as problem(s), what the social worker observed as problematic behaviors when the client was first seen, and to the client's situation at the termination of treatment. (Appendix G illustrates the clients' affective and behavioral changes.)

The social workers' interpretations to the client helped the client see people in a more realistic manner and less as transference figures. The clients were able to deal more appropriately with current inter-personal relationships at the conclusion of the treatment as compared to when they were first seen.

The data indicated that there was a statistical significance in the alleviation of the client's affective and behavioral symptoms when the social worker interpreted to the client the client's transference behaviors, as compared to when the social worker did not interpret the transference behaviors. This supports other researchers (Alexander and French, 1946; Pfeffer, 1959, 1961) and other theoreticians (Garrett, 1941, 1949; Lyndon, 1948; Katz, 1948; Hollis, 1969).

CHAPTER V - SUMMARY

An inevitable occurrence within the client-social worker relationship is the phenomenon of transference. Clients transfer onto the social worker feelings and behaviors once directed toward parents, siblings, and significant others. The transference within the relationship can be manipulated by interpretations resulting in changes for the client.

The focus of this study is the exploration of the transference phenomenon within the context of the client-social worker relationship. Specifically, the study explores the association between the client's transference behavior and the social worker's interpretations to the client of the transference for the following consequences: 1) The effect of interpretations and non-interpretations on the existence of the transference behavior; 2) The client continuance; and 3) The client's affective and behavioral changes.

Hypotheses regarding the association between the client's transference behavior and the social worker's interpretations to the client of that behavior are: Hypothesis I - During the early sessions (five through eight) of social work treatment, the frequency of the client's transference behavior will be greater when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior. Hypothesis II - During the later sessions (seventeen through twenty) of social work treatment, the client's transference behavior will be

less frequent when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior. Hypothesis III - The client's transference behavior will exhibit more reduction between the early and later phases of treatment when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior.

The hypothesis regarding client continuance states: Hypothesis IV - Clients will continue in treatment for a longer period of time when the social worker interprets to the client the client's transference behavior than when the social worker does not interpret the transference behavior.

The hypothesis regarding client changes states: Hypothesis V - The client's affective and behavioral symptoms will be alleviated to a greater degree when the social worker interprets to the client the client's transference behavior from the early through the later phases of treatment than when the social worker does not interpret the transference behavior.

Thirty-nine clients and seventeen social workers drawn from Family Service of Detroit and Wayne County and Family Services of Greater Toledo participate in this study. The clients and social workers are randomly assigned to the Interpretive group and the Non-Interpretive group based on the social workers' management of transference. The Interpretive group consists of nineteen clients and eight social

workers. The Non-Interpretive group has twenty clients and nine social workers. Three raters are used to determine the existence of the clients' transference behavior and the social workers' interpretations to the client of the behavior. The raters judge the same treatment sessions used for analysis. The raters' inter-reliability is statistically significant for the clients' transference behaviors and the social workers' interpretations of the transference. There also is a high percentage of agreement between the raters as to the affective and behavioral changes of the clients.

Treatment sessions selected for analysis are randomly chosen from the early and later phases of treatment. Two sessions from each phase are randomly selected for analysis. A fifteen-minute segment commencing ten minutes after the session begins is analyzed and is assumed for the purpose of this study to be representative of that session. Thus, a total of 94 treatment sessions, 58 sessions in the early phase and 36 sessions in the later phase, are used for analysis.

Hypotheses (I, II and III) concerning the association between the client's transference behaviors and the social worker's interpretations to the client of the transference are not supported by the data to a statistically significant degree. The frequency of the client's transference behaviors is less in the early phase of treatment and slightly greater in the later phase when the social worker interprets to the client the transference. However, between the early and later phases of treatment, there is a greater reduction of client's transference behaviors when

the social worker does not interpret the transference behaviors. These results are discussed primarily in terms of a need for a larger population to determine statistical significance with greater reliability and validity.

The client continuance hypothesis deals with the prediction that clients will stay in treatment over a longer period of time if their transference behavior is interpreted. The results of this hypothesis are in the direction predicted and are statistically significant at the .20 level.

To test whether or not the social workers' interpretations of the clients' transference behavior result in affective and behavioral changes, the social worker prepares clinical descriptive data which are then judged by the raters. The results indicate that the clients' affective and behavioral changes are in the direction predicted and statistically significant at the .01 level.

Thus, this study demonstrates that the clients seen by social workers for treatment transfer feelings and behaviors they once directed onto their parents, siblings, and significant others onto the social worker. The clients' transference behaviors are slightly more frequent over the course of treatment when the transference is interpreted to the client by the social worker. However, this result is not statistically significant, so the hypothesis cannot be said to be supported by these data. These results do not conform to psychoanalytic theory and previous research regarding diminution of transference behavior. The clients tend to stay in

treatment over a longer period of time, avoiding premature termination, when their transference behaviors are interpreted to them by the social worker. This result is statistically significant. Most important, the transference behaviors can be manipulated by interpretations to promote positive affective and behavioral changes within the client. This result is also statistically significant. These latter two results conform to psychoanalytic theory and previous research on the subject.

APPENDICES

APPENDIX A

CLIENTS' IDENTIFYING DATA[1]

CODE NAME	SEX	AGE[2]	RELI-GION[3]	MARI-TAL STATUS	NO.OF CHN.	AGES OF CHILDREN	EDUCATION	INCOME	OCCUPATION	GROUP A*	GROUP B**
001	F	30	P	M	1	4 yrs.	H. School	6-10,000	Housewife		X
002	F	22	P	Sep.	2	14 mos.& 4 yrs.	H. School	6-10,000	Housewife		X
003	F	44	P	Sep.	3	13,16 & 20 yrs.	H. School	6,000	Housewife	X	
004	F	30	P	M	2	3&6 yrs.	H. School	6,000	P-T Sales	X	
005	F	24	C	M	1	6 months	1-3 yrs. College	6-10,000	Housewife	X	
006	M	25	N	M	2	1&3 Yrs.	B.A.	6-10,000	Ins.Sales		X
007	F	30	P	M	2	1&2 yrs.	H. School	6-10,000	Housewife	X	
008	F	27	P	S	0	----	H. School	6,000	Secretary		X
009	M	35	N	M	2	7 & 10 yrs.	1-3 Yrs. College	10,14,000	Fireman		X
010	F	25	C	D	2	1&3 yrs.	H. School	6,000	Housewife	X	
011	F	24	C	S	0	----	H. School	6,000	Student	X	
012	F	30	P	M	2	3&5 yrs.	H. School	10,14,000	Housewife		X
013	F	30	C	D	2	5&7 yrs.	H. School	6,000	Office Clerk	X	
014	F	30	C	Sep.	0	----	1-3 yrs. College	6,000	Secretary		X
015	M	26	0	Sep.	0	----	B.A.	6-10,000	Driver Training Instructor	X	
016	M	47	P	D	1	13 yrs.	H. School	10,14,000	Factory Worker	X	
017	M	25	N	S	0	----	1-3 yrs. College	6,000	Student		X

APPENDIX A (CONT'D.)

CODE NAME	SEX	AGE[2]	RELIGION[3]	MARITAL STATUS	NO.OF CHN.	AGES OF CHILDREN	EDUCATION	INCOME	OCCUPATION	GROUP A*	GROUP B**
018	M	21	P	S	0	----	H. School	$6,000	Machine Operator	X	
019	M	24	P	S	0	----	1-3 yrs. College	6,000	Student	X	
020	F	30	P	M	4	1,4,7 & 10 yrs.	B.S.	6-10,000	Teacher	X	
021	M	33	O	M	0	----	M.A.	6-10,000	Teacher		X
022	M	37	C	M	0	----	Less H.S.	6-10,000	Bus Driver		X
023	M	35	J	S	0	----	C.D.	6-10,000	Teacher	X	
024	F	33	P	M	3	6,8, & 10 yrs.	R.N.	10-14,000	Housewife		X
025	F	22	P	D	1	3 yrs.	H. School	6,000	Receptionist		X
026	F	29	P	M	3	1,3, & 6 yrs.	H. School	22,000+	Housewife	X	
027	F	45	N	M	5	5,13,15, 19, & 20 yrs.	H. School	6-10,000	Supermarket Cashier	X	
028	M	33	N	Sep.	5	6,8,10, 11, & 13 yrs.	Less H.S.	6-10,000	Soil Driller		X
029	F	31	C	M	5	5,6,10, 11, & 12 yrs.	Less H.S.	6-10,000	Housewife Waitress	X	
030	F	21	P	Sep.	3	Twins 1, & 2 yrs.	H. School	6,000	Housewife		X
031	F	23	N	Sep.	1	3 yrs.	H. School	6,000	Unemployed	X	
032	F	39	C	M	4	8, 15, 16, & 18 yrs.	1-3 yrs. College	6-10,000	Bank Teller		X
033	M	26	N	S	0	----	1-3 yrs. College	6,000	Student Cab Driver		X
034	F	30	P	M	2	7 & 9 Yrs.	1-3 yrs. College	10-14,000	Housewife		X

APPENDIX A (CONT'D.)

CODE NAME	SEX	AGE[2]	RELIGION[3]	MARITAL STATUS	NO. OF CHN.	AGES OF CHILDREN	EDUCATION	INCOME	OCCUPATION	GROUP A*	GROUP B**
035	F	30	P	M	1	7 yrs.	H. School	$10-14,000	Real Estate Agent		X
036	F	26	P	D	1	3 yrs.	H. School	6,000	Beautician	X	
037	F	30	C	Sep.	5	2,3,8,9, & 11 yrs.	H. School	10-14,000	Housewife		X
038	F	24	C	D	1	4 yrs.	H. School	6,000	Homemaker		X
039	F	25	C	M	2	2 & 3 yrs.	1-3 yrs. College	6-10,000	Housewife	X	

1. All clients are Caucasian.

2. Clients' ages as of July 1, 1973

3. P=Protestant, C=Catholic, J=Jewish, N=None, O=Other

* Interpretive

** Non-Interpretive

APPENDIX B

SOCIAL WORKERS' IDENTIFYING DATA[1]

CODE NAME	SEX	AGE[2]	RELIGION[3]	MARITAL ST.	NO. OF CHN.	AGES OF CHILDREN	EDUCATION	INCOME	PROFESSIONAL EXPERIENCE (YRS.)	THERAPEUTIC EXPEPIENCE	GROUP A*	GROUP B**
101	F	32	J	M	2	4 yrs.,& 17 mos.	MSS	$9,000	2-5	None	X	
102	F	31	P	M	1	1 yr.	MSW	9-11,000	6-9	6 months	X	
103	F	26	N	M	0	----	MSW	9-11,000	2-5	1 yr. & 10 mos.		X
104	M	31	N	S	0	----	MSW	9-11,000	2-5	None		X
105	F	35	N	M	1	12 yrs.	MSW	11-13,000	2-5	None		X
106	M	37	N	M	2	7 & 10 yrs.	MSW	15,000 +	10-13	3 years	X	
107	F	25	N	M	0	----	MSW	9-11,000	2-5	2 months		X
108	F	27	C	D	0	----	MSW	9-11,000	2-5	1 yr & 6 mos.		X
109	M	25	C	M	0	----	MSW	9-11,000	2-5	None		X
110	M	29	P	M	2	2 & 4 yrs.	MA	11-13,000	2-5	None	X	
111	M	35	P	M	2	5 & 9 yrs.	MSW	15,000 +	10-13	8 months	X	
112	M	38	P	M	1	20 mos.	MSW	11-13,000	6-9	None		X
113	F	34	O	M	2	8 & 11 yrs.	MSW	9-11,000	2-5	1-1/2 mos.		X
114	F	47	P	M	1	15 yrs.	MSW	11-13,000	10-13	None		X
115	F	44	J	M	1	16 yrs.	MSW	9-11,000	2-5	4 yrs. & 5 mos.	X	
116	F	52	J	M	1	16-1/2 yrs.	MSW	15,000 +	14-15	None	X	
117	F	27	J	M	0	----	MSW	9-11,000	2-5	2-1/2 yrs.	X	

1. All social workers are Caucasian.

2. Social workers' ages as of July 1, 1973.

3. P=Protestant, C=Catholic, J=Jewish, N=None, O=Other

* Interpretive

** Non-Interpretive

APPENDIX C

CLIENTS' AND SOCIAL WORKERS' IDENTIFYING DATA SUMMARIZED IN TABLE FORM

TABLE - C I

Number and Sex of Clients and Social Workers

Group	Number		Sex	
	Clients	Social Workers	Clients M F	Social Workers M F
A	19	8	5 14	3 5
B	20	9	7 13	3 6

TABLE - C II

Age and Religion of Clients and Social Workers

Gp.	Ages		Religion	
	Clients 20-30/31-41/42-52	Social Workers 20-30/31-41/42-52	Clients P-C-J-N-O[1]	Social Workers P-C-J-N-O
A	14 - 2 - 3	2 - 4 - 2	9-6-1-2-1	3-0-4-1-0
B	14 - 6 - 0	4 - 4 - 1	9-5-0-5-1	2-2-0-4-1

1. P=Protestant, C-Catholic, J=Jewish, N=None, O=Other

TABLE - C III

Marital Status of Clients and Social Workers

Group	Marital Status	
	Clients M - D - Sep. - S[1]	Social Workers M - D - Sep. - S
A	8 - 4 - 3 - 4	8 - 0 - 0 - 0
B	10 - 2 - 5 - 3	7 - 1 - 0 - 1

1. M=Married, D=Divorced, Sep.=Separated, S=Single

TABLE - C IV

Number of Children and Ages of Children of Clients and Social Workers

Gp.	Number of Children		Ages of Children	
	Clients 0-1-2-(3-5)	Social Workers 0-1-2-(3-5)	Clients 0/1-5/6-10/11+	Social Workers 0/1-5/6-10/11+
A	5-4-5- 5	1-3-4- 0	5-17 - 7 -10	1- 6 - 3 - 2
B	6-4-5- 5	5-3-1- 0	6-14 - 14 - 6	5- 1 - 1 - 3

TABLE - C V

Education and Income of Clients and Social Workers

Gp.	Education		Income	
	Clients -HS/HS/-Col./Col.	Social Workers Graduate Degree	Clients -6/6-10/11+	Social Workers -6/6-10/11+
A	1 -12- 3 - 3	8	4 - 13 - 2	0 - 3 - 5
B	2 - 9- 6 - 3	9	4 - 10 - 6	0 - 4 - 5

APPENDIX D

RATERS' IDENTIFYING DATA[1]

CODE NAME	SEX	AGE[2]	RELIGION[3]	MARITAL STATUS	NO. OF CHN.	AGES OF CHILDREN	EDUCATION	INCOME	PROFESSIONAL EXPERIENCE (YRS.)	THERAPEUTIC EXPERIENCE
A	F	37	P	M	2	3 & 7 Years	MA	0	6-9	3 Years & 6 Months
B	F	37	P	M	2	10 & 11 Years	MSW	$11,001-13,000	10-13	4 Years & 2 Months
C	F	62	P	M	0	----	MSW	0	17 +	5 Years

1. All raters are Caucasian.

2. Raters' ages as of July 1, 1973.

3. P=Protestant

APPENDIX E

TOTALS OF DATA FOR HYPOTHESES I, II AND III

The data indicates that there were about twice as many social workers' interpretations of clients' transference behavior in both the early and later phase of treatment in the Interpretive group as compared to the Non-Interpretive group. There were also about 20% more clients' transference behaviors in the later phase of treatment in the Interpretive group than in the Non-Interpretive group. However, the clients in the Non-Interpretive group during the early phase had 16% more transference behaviors than those clients in the Interpretive group. (The totals represent the average totals of the three raters.)

TABLE E-1

Totals of Clients' Transference Behaviors and Social Workers' Interpretations of the Behavior Used for Hypotheses I and II

Phase of Treatment	Interpretive Group-A				Non-Interpretive Group-B			
	N	C.T.B.[1]	S.W.I.[2]	0/0	N	C.T.B.[1]	S.W.I.[2]	0/0
Early	14	219.1	41.75	.19	15	258.3	27.3	.11
Later	10	158	16.03	.10	8	125.4	7.32	.06

1. C.T.B. = Clients' Transference Behaviors

2. S.W.I. = Social Workers' Interpretations

TABLE E-II

Totals of Clients' Transference Behaviors and Social Workers' Interpretations of the Behavior Used for Hypothesis III

Phase of Treatment	Interpretive Group-A				Non-Interpretive Group-B			
	N[1]	C.T.B.[2]	S.W.I.[3]	0/0	N[1]	C.T.B.[2]	S.W.I.[3]	0/0
Early	10	162.5	32.33	.20	8	132	15.6	.12
Later	10	158	16.03	.10	8	125.4	7.32	.06

1. The N consists of only those clients who continued from the early through the later phase of treatment.

2. C.T.B. = Clients' Transference Behaviors

3. S.W.I. = Social Workers' Interpretations

APPENDIX F

ROLES AND FEELINGS REGARDING CLIENTS' RELATIONSHIPS DURING CHILDHOOD

The roles that children usually assign to their parents, siblings, and/or significant others were judged to be the following: 1) Powerful Authority; 2) Ideal Model; 3) Rival; 4) Favorite Child; and/or 5) Giver of Affection (Freud, 1905 -[1901]-; Alexander and French, 1946; Garrett, 1949; Colby, 1951). There was a determination of the percent agreement factor between the raters' evaluation of the clients' assigned roles and feelings toward the social workers and the social workers' assessment of the roles assigned to the parents, siblings and/or significant others, as well as the clients' feelings toward those people. The percent agreement factors for the roles assigned to the parents, siblings, and/or significant others and to the social worker are shown in Table F-I. The percents ranged from a low of 10.3% agreement to a high of 39.8% agreement factor, and does not appear significant.

TABLE F-I

Percent Agreement Factor Between Social Workers and Raters Regarding Clients' Assigned Roles Toward Important Figures in His Childhood and Toward the Social Worker

Group	Father		Mother		Brother		Sister	
	E[1]	L[2]	E[1]	L[2]	E[1]	L[2]	E[1]	L[2]
A	33.8	36.45	38.7	32.85	13.55	14.4	15.2	12.5
B	39.8	38.75	32.75	28.95	18.05	15.7	10.3	14.2

1. E = Early Phase of Treatment

2. L = Later Phase of Treatment

The feelings that children usually assign to parents, siblings, and/or significant others were judged to be the following: A) Positive Feelings - Love, Affection, Admiration, Friendly, Trust, Fondness, and Warm; B) Negative Feelings - Hate, Distrust, Anger, Hostile, Defiance, Jealousy, and Rage (Freud, 1905 -[1901]-; Colby, 1951; Garrett, 1949; Lyndon, 1948). The data are shown in Table F-II. The percent agreement factor between the social workers and the raters regarding the clients' feelings toward important figures in his childhood and toward the social workers ranged from a low of 34.6% agreement to a high of 59.95% agreement. This appears to be somewhat of a greater significance than in the client role assignments.

TABLE F-II

Percent Agreement Factors Between Social Workers and Raters Regarding Clients' Feelings Toward Important Figures in His Childhood and Toward the Social Worker

Group	Father		Mother		Brother		Sister	
	E[1]	L[2]	E[1]	L[2]	E[1]	L[2]	E[1]	L[2]
A	44.25	47.15	49.85	48.15	46.75	50.1	34.4	52.75
B	47.3	50.05	57.85	52.55	53.8	59.95	43.4	53.35

1. E = Early Phase of Treatment

2. L = Later Phase of Treatment

APPENDIX G

AFFECTIVE AND BEHAVIORAL CHANGES

A. The affective changes related to the client's feelings about himself and others. Specifically, the feelings were: A) Positive Feelings - Love, Affection, Admiration, Friendliness, Fondness, Trust and Warmth; B) Negative Feelings - Hate, Distrust, Anger, Hostility, Defiance, Jealousy, and Rage. Clients reported the following affective changes: "I feel better now." "I can trust my husband." "I like you." "I still dislike my son." "I distrust my boss." "I cannot stand my brother." "I hate myself."

B. The behavioral changes deal with individual adjustments, marital, parent-child, sexual, financial and employment situations. Specifically, clients reported the following behavioral changes: "My wife and I are getting along better." "We are having more sexual relations." "I stopped hitting my son." "I still do not get to work on time." "We seem to mis-manage our money." "I do not have sex with him."

APPENDIX H

RESEARCH INSTRUMENTS

1. LETTER TO THE EXECUTIVE DIRECTORS OF FAMILY SERVICE OF DETROIT AND WAYNE COUNTY AND FAMILY SERVICES OF GREATER TOLEDO

Dear Executive Director:

I am writing to ask if it would be possible for some of your professional staff to participate as therapists in a doctoral research study aimed at identifying transference elements in the client-social worker relationship. I have taken the liberty of enclosing a modified form of the research plan.

The aim of the research is to study intensively social work treatment and the transference phenomenon as it occurs in clients seeking treatment from social workers at Family Service agencies. Thus, the study should contribute to the understanding of effective elements in social work treatment.

The plan is to select social workers, each of who would see two clients once a week for at least twenty weeks. One half of the social workers would comprise a group that usually interprets clients' transference behavior, and the other half in a group that does not interpret transference behavior.

The study would require a clinical evaluation for each client at the end of the second therapy session, and also at the end of the twenty sessions. The treatment with the clients is to be taped on cassettes. I would like to assure you that the amount of time your staff will be asked to give to this study will not exceed four hours, excluding the amount of time spent in direct treatment.

All data collected will be carefully coded so that the clients' identity will not be made available except on the specific request of the therapist involved.

Any social worker on your staff able to participate in this study can let me know by returning the enclosed form, or by contacting me directly. I can be reached at my office, Area Code 313, 557-1104, or my home 341-6438.

If you or any possible participant have any questions, please do not hesitate to call me.

Sincerely yours,

Aaron A. Goldstein, CSW

2. RESEARCH DESIGN

I. Introduction

The general aim of this doctoral dissertation research is to make an intensive study of the transference behavior in the client-social worker relationship and to see what the relationship is between the method of handling the transference behavior and the outcome of that behavior.

Although there have been numerous theoretical papers on transference behavior in psychiatry and psychology, little has been published in social work journals. What is more important, empirical data is almost nil. The importance of the transference in the therapeutic relationship has been well established (Freud, 1905 [1901]; Greenson, 1967; Orr, 1954; Garrett, 1941, 1949; and Katz, 1948). The empirical data that is available has demonstrated that the resolution of the transference leads to positive behavioral changes (Alexander and French, 1946; Rogers and Dymond, 1954; Pfeffer, 1959, 1961; and Truax, 1971).

Current social work literature has de-emphasized the client-social worker relationship. This study is primarily aimed at developing basic knowledge regarding the transference phenomena in social work treatment and to refocus our attention onto the client-social worker relationship.

II. Method

A. Selection of Clients

Clients to be used in this study will be drawn from those people applying for social work treatment at Family Service of Detroit and Wayne County and Family Services of Greater Toledo from August, 1972 through March, 1973. Clients will be selected on the basis of the following:

1. Each client will continue in treatment for at least twenty weeks, once a week, for a total of twenty sessions. This is necessary because of the need to determine the difference in the client's transference behavior over a period of time.

2. The clients will be of the same sex as their social workers.

3. Clients who are between twenty-one and forty-seven years of age will be used for this study. Children, adolescents, and people over forty-seven will be omitted.

4. Psychotics will be excluded from this study.

5. Clients meeting these criteria will be randomly selected and assigned to the social worker.

B. Selection of Social Workers

Social workers will be selected for this study on the basis of their management of transference behavior. One half of the social workers will comprise a group that usually interprets to the client the client's transference behavior. The other half will be in a group that does not interpret the transference behavior. The following additional criteria will also be used in determining the selection of social workers:

1. All social workers must have attended an accredited School of Social Work and have a Master's Degree in Social Work.

2. Each social worker must have at least two and not more than fifteen years of treatment experience after receiving his Degree.

A clinical evaluation for each client will be gathered in the initial and ending phases of treatment. The evaluation will include the client's childhood relationship to his parents, siblings, and significant others.

For the purpose of this study, transference is operationally defined as the shift of behaviors and feelings from any person onto the social worker. Interpretation of the transference is operationally defined as the verbalization of the transference behavior by the social worker to the client.

C. Selection of Treatment Sessions for Analysis

The hypotheses for the present study are concerned with the difference in transference behavior over a period of treatment time. Sessions selected for analysis will reflect this difference. Therefore, sessions will be

chosen from the early phase of treatment (five through eight) and the later phase of treatment (seventeen through twenty).

Two sessions from each phase will be selected for analysis. A fifteen minute segment of each selected session will be analyzed. This fifteen minute segment will commence ten minutes after the session begins. The segment will be considered representative of the entire data. Thus, four sessions of each client will be selected for analysis.

All treatment sessions will be tape-recorded on cassettes. Sessions selected for analysis will also be typewritten. Where necessary, tape recorders will be made available to the social worker on a loan basis for the duration of the treatment with the research cases.

D. Selection of Raters

The raters will be selected on the basis of their expertise concerning transference behavior. Each rater must have a Master of Social Work Degree, and have at least five years of therapeutic experience after having received this Degree. They will judge the existence of transference behavior by using the appropriate definitions. A questionnaire will be utilized for this procedure. Each rater will have a tape recording and typewritten material for each session selected for analysis.

Inter-rater reliability will be determined by having three raters judge the same sessions used for the analysis. The raters will be also asked to determine the behavioral and affective changes of each client by judging the pre and post treatment clinical evaluation.

III. Significance of this Research

A. The collection of a sample of basic, raw data of social work treatment, involving professionally qualified social workers, and including a measure of pre and post treatment evaluations.

B. The present study is one of establishing an understanding of the transference phenomena in social work treatment and quantifying levels of client change. The dimension chosen to be analyzed has been shown by prior research to be reliably measurable and has been drawn from several theoretical views.

C. Social workers will be able to concentrate upon their work with clients and will be able to give relatively unbiased samples of their in-treatment behavior. They are required to give just four hours total time to the study outside of their usual in-treatment time. The use of raters will allow the social workers to work full time on their treatment without the usual bother of making assessments during treatment and administrating research materials.

3. SOCIAL WORKERS PARTICIPATION RELEASE

I would like to participate as a research social work therapist.

_____
Signature

_____
Address

_____
City State

Telephone:
Office_____

Home_____

Please return this form or contact me by telephone if you think you might be able to participate in this study.

Mail to:

Aaron A. Goldstein, CSW
17117 West Nine Mile Road, Suite 1419
Southfield, Michigan 48075

Telephone: Area Code 313 - 557-1104

4. SOCIAL WORKERS IDENTIFYING DATA

1. Name: Dr.___ ___ Mr.___ ___ Ms.___ ___ Miss___ ___
   Mrs.___ ___
   (First initial of first and last names)

2. Address: City_____ State_____

3. Date of Birth_____

4. Race: White_____
   Black_____
   Other_____

5. Sex: Female_____
   Male_____

6. Religion: Catholic_____
   Jewish_____
   Protestant____
   Other_____
   None_____

7. Marital Status:
   Married_____
   Single_____
   Divorced_____
   Widowed(er)_____
   Separated_____

8. Number of Children: _____

9. Ages of Children:
   _____

10. Education:
    College Degree_____
    Graduate Degree_____
    Master_____
    Ph.D._____

11. Yearly Income:
    Below $ 9,000_____
    $ 9,000 - $11,000_____
    $11,001 - $13,000_____
    $13,001 - $15,000_____
    Over $15,000_____

12. Professional Experience: (Post-Master's Degree)
    2 - 5 years_____
    6 - 9 years_____
    10 - 13 years_____
    14 - 17 years_____

13. Therapeutic Experience:

a. Psychoanalysis: _____years, _____months

1) M.D. Analyst_____
2) Non-M.D. Analyst_____

b. Psychotherapy (Casework): _____years, _____months

1) M.D. Analyst_____
2) Non-M.D. Analyst_____
3) Social Worker_____
4) Psychiatrist_____
5) Psychologist_____

c. None: _____

d. Current: _____ Past: _____

5. CLINICAL EVALUATION INSTRUCTIONS

TO: Social Workers

RE: Clinical Evaluation Instructions

FROM: Aaron A. Goldstein, CSW

Please respond to all parts of the evaluation. Section A should be completed by the end of the second treatment session. Section B should be completed at the end of the twentieth session; Section B should be completed only if the client attended at least seven sessions. If additional space is required in responding to any part of the evaluation, please attach additional sheets of paper.

If you have any questions, please feel free to contact me at:

Area Code 313 - 557-1104 or
341-6438

Thank you for your cooperation in this study.

6. CLINICAL EVALUATION

Client's Name:_____ _____

Social Worker's Name:_____ _____

Number of Sessions Attended:_____

Section A
(To be completed by the end of the second treatment session.)

I. Identifying Information:

Name: Dr. __ __ Mr. __ __ Ms. __ __ Miss __ __
Mrs. __ __
(First initial of first and last names.)

Address: City_____ State_____

Race: White_____
Black_____
Other_____

Religion: Protestant_____
Catholic_____
Jewish_____
Other_____
None_____

Sex: Male_____ Female_____

Birth Date:_____

Marital Status: Married_____
Single_____
Divorced_____
Widowed(er)____
Separated_____

Number of Children:_____

Ages of Children:_____
_____

Education: Less than High School Diploma_____
High School Graduate_____
1 - 3 years of College_____
College Degree:
Masters_____
Doctorate_____
Professional Degree_____
Vocational Education____

II. Reason for Applying:

Why is the client seeking treatment: His statement of the problem(s), or his inability to state the purpose or reason for treatment. Duration of the difficulties.

III. Description of Client:

Description should include physical appearance as well as behavioral and affective mannerisms of the client. This might include evidence of affect or absence of it, appropriateness of affect, how he tells about himself and his problems, his attitude toward himself, his degree of organization, kinds of defenses used, evidence of genetic aspects of the problem, and evidence of degree of health and pathology, and pertinent history.

IV. Client's Childhood Relationship Toward Parents, Siblings and Significant Others:

	Father	Mother	Brother(s)[2] Number ____	Sister(s)[2] Number ____	Significant Others
Positive Feelings:[1]					
Love					
Affection					
Admiration					
Friendly					
Trust					
Fondness					
Warm					
Negative Feelings:[1]					
Hate					
Distrust					
Anger					
Hostile					
Defiance					
Jealousy					
Rage					
Roles:[3]					
Powerful Authority					
Ideal Model					
Rival					
Favorite Child					
Giver of Affection					

1. Rate: 5 - most to 1 - least, 0 - unknown.
2. Rate only predominat sibling.
3. Rate: Check one role for each person.

V. Statement of the Problem:

Social worker's statement as to the client's difficulties. This includes a causative and dynamic description of the situation. Please include all behavioral difficulties.

VI. Diagnostic Impressions:

Client's Name:_____ _____

Social Worker's Name:_____ _____

Number of Sessions Attended:_____

Section B

(To be completed by the end of the twentieth treatment session. Complete this section only if the client attended at least seven sessions.)

I. Description of Client:

Description should include physical appearance, as well as behavioral and affective mannerisms of the client. This might include evidence of affect or absence of it, appropriateness of affect, how he tells about himself and his problems, his attitude toward himself, his degree of organization, kinds of defenses used, evidence of pathology and pertinent history.

II. Statement of the Problem:

Social worker's statement as to the client's difficulties. This includes a causative and dynamic description of the situation. Please include all behavioral difficulties.

III. Diagnostic Impressions:

IV. Changes in the Situation:

List all changes, including affective and behavioral changes which occurred during the twenty sessions.

7. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Family Services of Greater Toledo to use tapes of therapy sessions for educational purposes and treatment evaluation purposes. I understand that names will be deleted from the tapes.

_____
Signature

_____
Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Family Service of Detroit and Wayne County to use tapes of therapy sessions for educational purposes.

_____
Signature

_____
Date

8. QUESTIONNAIRE INSTRUCTION

TO: Rater

RE: Doctoral Dissertation Questionnaire

FROM: Aaron A. Goldstein, CSW

This study calls for the evaluation of cassette tapes along with the transcribed material. There are four fifteen minute segments, commencing ten minutes after the session begins, for each client.

Please fill out one questionnaire for each transference behavior you recognize within the fifteen minute segment. Respond to all questions. If for one reason or another you are unable to answer a question, please state your reason.

An important part of this Dissertation is to pinpoint the changes between the beginning phase of treatment and the ending. Please complete the section on Client Changes.

Please use the following operational definitions in responding to the questionnarie:

> "For the purpose of this study, transference is operationally defined as the shift of behaviors and feelings from any person onto the social worker. Interpretation of the transference is operationally defined as the verbalization of the transference behavior by the social worker to the client."

When necessary, tape recorders will be made available to you on a loan basis. If you have any questions, please feel free to contact me at my office, 313 - 557-1104, or my home, 313 - 341-6438.

Thank you for your cooperation.

(Please use additional paper when necessary.)

Rater's Name: _____ _____ Client's Name: _____ _____

#_____ Social Worker's Name: _____ _____

Session Number: _____

9. QUESTIONNAIRE

1. Has the client's communication reflected a transference behavior:

   Yes____

   No_____

   Comments_____

   If your answer to the above was "Yes," please answer the following:

   Which statement reflected the transference behavior?

2. Was the client's transference statement regarding the client's

   a. Father _____
   b. Mother _____
   c. Brother(s) _____
   d. Sister(s) _____
   e. Significant others _____

3. What role did the client ascribe to the social worker?

   a. Powerful authority _____
   b. Ideal model _____
   c. Rival _____
   d. Favorite child _____
   e. Giver of affection _____
   f. Other_____
      (Be specific)

4. What feelings were directed toward the social worker:

Positive Feelings	Negative Feelings
Love _____	Hate _____
Affection _____	Distrust _____
Admiration _____	Anger _____
Friendly _____	Hostile _____
Trust _____	Defiance _____
Fondness _____	Jealousy _____
Warm _____	Rage _____

5. Did the social worker interpret the transference behavior to the client?

   Yes _____

   No _____

   Comments _____

   If your answer to the above was "Yes," please answer the following:

   Which statement reflected the interpretation?

6. Do you think the interpretation was correct?

   Yes _____

   No _____

   Comments _____

Rater's Name: _____ _____ Client's Name: _____ _____

Social Worker's Name: _____ _____

10. CLIENT CHANGES

Please list all changes, including affective and behavioral changes, as stated on the initial evaluation and the ending evaluation.

I. Difference between initial and final evaluations:

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BIBLIOGRAPHY

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