TRANSFERENCE, TRANSFERENCE DISSIPATION, AND IDENTIFICATION IN SUCCESSFUL VS. UNSUCCESSFUL PSYCHOTHERAPY

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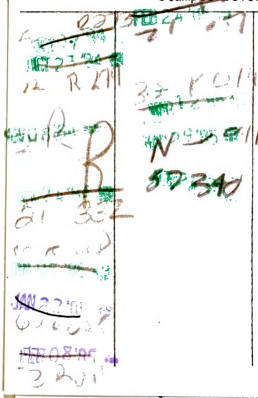

ABSTRACT

TRANSFERENCE, TRANSFERENCE DISSIPITATION, AND IDENTIFICATION IN SUCCESSFUL VS. UNSUCCESSFUL PSYCHOTHERAPY

by James Edward Crowder

A client's transference of behaviors from familial and extrafamilial relationships to the therapist is a frequent occurrence in psychotherapy and a phenomenon which the therapist can manipulate to promote change. The resolution of the transference reactions in psychotherapy has often been regarded as indicative of client change. The study of the relationship between the occurrence of transference and transference resolution and outcome of therapy was a primary focus of this research.

The clinical observation that clients, during the course of psychotherapy, often take on characteristics of their therapists was a second primary focus of this research. Clinicians have frequently considered identification of a client with his therapist as a factor promoting client change. The relationship between identification and psychotherapy outcome was investigated, as well as the relationship between identification and the sex similarity and dissimilarity of the study subjects in each client-therapist dyad. Also investigated was the question whether the behavioral similarity of a client and his therapist at the end of therapy reflected identification or a change toward normality.

A secondary purpose of this study was to examine, during psychotherapy, the interpersonal behaviors of the clients and therapists in

successful vs. unsuccessful cases. The question of whether successful vs. unsuccessful therapists differed in their interpersonal behaviors was investigated. Likewise, the possibility was explored that the interpersonal behaviors of clients in successful vs. unsuccessful cases differed.

Hypotheses regarding transference were that clients in the successful group would transfer more behaviors from parents and significant others to their therapists during the middle phase of psychotherapy than would clients in the unsuccessful group, and, similarly, that dissipation of transference would be greater in the successful than in the unsuccessful group. Identification hypotheses consisted of the prediction that clients in the successful group would identify more with their therapists than would clients in the unsuccessful group. Within the successful group, one hypothesis was that clients would become more similar to their own therapists than to an "average" successful therapist. It was also hypothesized that, within the successful group, clients who were of the same sex as their therapists would identify more with their therapists than would clients who were of the opposite sex of their therapists. Exploratory questions were asked regarding possible differences in interpersonal behaviors of clients and therapists in successful vs. unsuccessful cases. No specific predictions were made regarding those possible differences.

Twenty-five cases were selected for the study from those on file in the tape library at the Michigan State University Counseling Center. These cases were divided into (N=15) successful and (N=10) unsuccessful cases based on ratings of client's pre- and post-MMPI profiles by three judges. Fifteen-minute segments of three sessions in each of the

early, middle, and late stages of therapy were selected for analysis to test the hypotheses and investigate the exploratory questions.

The interpersonal circumplex (Leary, 1957) was used to rate the behavioral interactions of the study subjects, as well as the reported behaviors of clients with their parents and others. Thus the segments of the psychotherapy sessions were rated twice. The first time, the interaction of the client and therapist was rated, and the second time, the reports of the client's interaction with parents and others were rated. The interactions were rated by two graduate students following a training period during which they established the ability to use the system reliably.

The test of the transference and transference dissipitation hypotheses involved comparing the client's reported behaviors toward his parents and significant others with his actual behaviors toward the therapist at different stages of therapy. Since the hypotheses concerned differences between the groups, the similarity of the compared behaviors in one group was contrasted with the similarity of the compared behaviors in the other group. The results indicated that transference and transference dissipitation was no greater in the successful than in the unsuccessful group. Further analysis of the data revealed that transference and transference dissipitation, as the study was designed to measure them, did not occur in either of the groups. These results were discussed in terms of (1) the probability that the selection of the sessions for the measurement of transference was unsatisfactory, and (2) the limitations of the overall methodology in studying transference and transference dissipation.

Testing the identification hypotheses involved comparing the behaviors of the client in psychotherapy with his therapist's

behaviors. The hypothesis that clients in successful therapy would identify more with their therapists than clients in unsuccessful therapy was rejected. Further, within neither group was the process of identification demonstrated. The prediction that, in the successful cases, clients would behave more similarly to their own therapists than to an "average" successful therapist was rejected. The hypothesis that identification would be greater in same-sex dyads as compared to opposite-sex dyads of successful cases was also rejected. It was suggested that the roles of the therapist and client demanded separate behaviors, and, consequently, that the method used to study identification was not appropriate.

Significant differences were found when the behaviors of the clients in successful and unsuccessful cases were compared. The significant differences in the behaviors of the clients in the two groups dissipated over time in psychotherapy. Clients in the successful group, as compared with clients in the unsuccessful group, were significantly more hostile-competitive and support-seeking, and less passive-resistant and supportive-interpretive in early interviews. They were also more support-seeking and less passive-resistant in the middle interviews, but the client groups did not differ significantly in their behaviors during the late sessions.

The interpersonal behaviors of successful therapists and unsuccessful therapists were found to be significantly different in early and late interviews. Successful therapists, as compared with unsuccessful therapists, were more hostile-competitive, and less passive-resistant in early interviews, and more supportive-interpretive and less hostile-competitive and passive-resistant in the late interviews.

These findings were discussed in terms of the possible relationship between the different group behaviors and outcome. The need for further research was cited to determine whether initial differences in interpersonal behaviors of the clients in the two groups caused the differences in the interpersonal behaviors of their therapists.

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By

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DEDICATION

To Jean and to Jimmy

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CHAPTER I

INTRODUCTION

In the past, a large segment of psychotherapy research has been devoted to determining the efficacy of psychotherapy. Lack of control of relevant variables, as well as ignorance of factors determining the outcome of therapy, has led to difficulty in interpreting the results of the research and suggests that investigators may utilize their time more profitably by studying process variables and their relationship to outcome of psychotherapy. The need for further research on variables affecting outcome in psychotherapy is especially critical because of mounting evidence that psychotherapy, in some cases, is actually harmful to clients.

The common procedure of comparing psychotherapy-treated groups with no-treatment controls in order to determine the efficacy of psychotherapy is a useful design, but some investigators have failed to control potent factors. Kiesler (1966) isolated a number of myths prevalent in psychotherapy research which casts a shadow over the results of those studies. One of these myths is that clients are more similar than different, and, likewise, that therapists are more alike than different. These assumptions have prevented researchers from controlling patient variables crucially relevant for response to psychotherapy. Even client variables such as severity of maladjustment and nosological type are not usually controlled although they are known to

have prognostic significance. The therapist uniformity assumption may be even more crucial. The belief that patients in groups receiving psychotherapy from different therapists are receiving identical treatment is patently false.

A second myth which is prevalent in psychotherapy research is what Kiesler called the "spontaneous remission" myth. The belief that two-thirds of the clients who receive no treatment will improve anyway may be attributed to Eysenck's (1952) report. Kiesler reviewed a number of rebuttals to Eysenck's report, and listed a variety of reasons for rejecting Eysenck's use of the two studies upon which Eysenck depended in establishing the two-thirds figure as a baseline of improvement without therapy. Yet some psychotherapy studies compared improvement rates of treated clients with the mythical two-thirds who would recover without treatment. Even when clients are divided into treatment and no-treatment groups at the institution from which they are seeking treatment, the no-treatment group may be a misnomer because members of this group may seek out nonprofessional help with their problems (Bergin, 1967).

The lack of control of client and therapist variables may account for the findings of a number of studies covered by Bergin's (1967) review of psychotherapy research which tended to show no significant difference in the average amount of change between psychotherapy-treated clients and no-treatment controls. In some of the studies, Bergin noted that, although the average amount of change of treated and untreated groups tended not to be significantly different, the

> criterion, or change, scores for treatment groups attain a much wider dispersion than do those of control groups... Typically, control subjects (Ss) improve somewhat, with the varying amounts

> of change clustering about the mean. On the other hand, experimental Ss are typically dispersed all the way from marked improvement to marked deterioration (Bergin, 1967, p. 137).

Thus it appears that psychotherapy is helpful to some clients and harmful to others.

This finding indicates that psychotherapy research should not be focused on the question of whether therapy is better than no treatment (or spontaneous remission). Quite clearly, some clients improve more than no-treatment controls, and some deteriorate. It should be the task of psychotherapy research to determine the factors which account for improvement and deterioration in psychotherapy-treated cases. When these factors are isolated, it will be more meaningful to compare psychotherapy with no treatment than it is at the present time.

Psychotherapy outcome apparently depends on (1) client personality characteristics, (2) therapist personality characteristics, (3) client behavior and (4) therapist behavior from moment to moment in therapy, and (5) therapeutic processes occurring over an extended period of time (e.g., transference). None of these factors has been exhaustively studied, nor their relationship to outcome or to each other adequately specified, although some progress has been made in some of the areas. For example, Leary (1957) related client personality characteristics as measured by the MMPI to client behavior in psychotherapy. The Rogerian group has studied the relationship between therapist interview behavior and psychotherapy outcome (Bergin, 1967). Psychotherapy research needs to deal with each of these areas, their interrelationships, and the manner in which they combine to determine outcome. In the distant future, convergence of these research findings would hopefully lead to an understanding of all the variables important to psychotherapy.

For the present, it appears that psychotherapy investigators will have to content themselves with the study of much less than the total configuration of psychotherapy. Kiesler (1966) believes that the hope for a definitive study of psychotherapy, proving once and for all its effectiveness and defining the process by which it works, is unrealistic. Rather, he states that the

> business at hand for therapy (just as for any other) research seems clear: painstaking involvement with delineated problems until repeated replication of individual findings has been demonstrated, and subsequent attack of closely related or ancillary questions (p. 127).

The present study is hopefully a step which will contribute to knowledge of the manner in which differences in processes of psychotherapy relate to outcome of therapy. Transference, transference dissipation, and identification of a client with his therapist is studied to determine whether differences in these phenomena exist during the psychotherapy of successfully and unsuccessfully treated cases. If differences can be empirically demonstrated, it would be the task of future research to relate these differences to factors upon which these processes depend.

REVIEW OF THE LITERATURE

Transference

Origin and Evolution of the Concept

The publication of *Studies on Hysteria* in 1895 (Breuer & Freud, 1957) marked Freud's first public statement on transference phenomena, although by his statements it is apparent that he had been aware of the phenomena and had dealt with the phenomena in therapy for some time. As an example of transference, Freud wrote of an experience

which he had had with a female patient. By the time he was writing the *Studies on Hysteria*, he had given up the use of hypnosis in favor of his pressure technique to get at repressed memories. Once, when he attempted to apply the pressure technique to the patient, she was unable to associate. She later reported to him that she had been unable to associate because she had had the wish that he would kiss her. Her first memory following this confession was of having had the wish years earlier in relation to a man with whom she was talking. This wish was the origin of one of the patient's hysterical symptoms. Freud wrote that transference "on to the physician takes place through a *false connection* (Breuer & Freud, 1957, p. 302)."

After this first public statement on the phenomenon, Freud made may conflicting statements on the issue. As Orr (1954) pointed out, Freud employed "the term 'transference' in a confusing variety of ways (p. 623)." Below, an attempt is made to present Freud's views on transference, to delineate some reasons for the confusion as to what is meant by transference, and to present more recent theoretical viewpoints on the phenomenon.

Definition of transference. By "transference," Freud meant several distinct phenomena. In addition to using the term as it is used in dynamic psychotherapy today, he used it as a general term which included the subconcepts of "positive" and "negative" transference, and "transference neurosis." He also viewed transference as equivalent to suggestion, which further complicated the issue.

The publication of the Dora case in 1905 was the occasion for the first definition which Freud attached to the concept. It has not lost its usefulness. He defined transference as

> new editions or facsimilies of the tendencies 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 (1959b, p. 139).

As a specific example, he wrote of Dora that she "kept anxiously trying to make sure whether I was being quite straight-forward with her, for her father 'always preferred secrecy and roundabout ways' (p. 141)." Later, in his introductory lectures (Freud, 1952), he made explicit his view (which he had implied in his earlier works) that in order to qualify as transference behavior, the behavior must be inappropriate in the present context. Thus transference behavior is behavior which existed in a previous relationship and is inappropriate in the present relationship.

In addition to the general definition above, Freud (1959a) divided transference into "positive" (affectionate feelings) and "negative" (hostile feelings). Further, he divided positive transference into conscious friendly or affectionate feelings on the one hand, and what he referred to as the extensions of these feelings in the unconscious, i.e., repressed erotic feelings, on the other hand.

Freud (1959c) devoted an entire paper to the erotic component of positive transference, which he called "transference-love." Freud stated that this kind of transference situation "retarded the development of psychoanalytic therapy for ten years (p. 378)." In this paper, Freud added nothing new to the general concept of transference, but expanded on the difficulties imposed by the declaration of a female client that she is in love with her therapist. He viewed transference-love as being closely related to normal love, but different from it in that (a) it is more intense, (b) it serves as resistance to recollection,

and (c) it is more clearly grounded in unconscious, infantile love-objects than normal love.

An additional subconcept of transference which Freud developed was "transference-neurosis" (Freud, 1959e). This term was obviously an outgrowth of Freud's theory of the Oedipus complex. He wrote that the

> new state of mind (transference-neurosis) has absorbed all the features of the illness; it represents, however, an artificial illness which is at every point accessible to our interventions (p. 374).

By transference neurosis, Freud apparently meant the reinstitution of the patient's generic conflict in psychotherapy. For example, a patient whose basic conflict was castration anxiety resulting from an unresolved Oedipus complex would be said to be in the throes of a transference neurosis if he were manifesting the castration fear in relation to the therapist.

Freud also used transference as a subconcept of displacement (Silverberg, 1948). This use of transference occurred in *The Interpretation of Dreams* (Freud, 1955) to denote the displacement of affect from unconscious to preconscious ideas (day's residue) in dreams. Apparently, Freud never used transference in this manner again.

Transference as suggestion was a distinct and troublesome (to the student of Freudian psychology) meaning of transference for Freud. Although, at first, he linked transference as suggestion to the friendly and affectionate part of positive transference, he later connected suggestion and transference in general (Freud, 1952, 1959a, 1959b). Transference in this sense, according to Freud, was an essential ingredient of therapy which allowed the therapist to influence the client toward health.

Freud's definition of transference as the revivication of behavior in a relationship where it is inappropriate is widely accepted. However, with the exception of transference neurosis, the other subconcepts and meanings which he attached to transference are found only in the very orthodox psychoanalytic literature. Transference as suggestion and as a subconcept of displacement of affect topographically are clearly not in line with the above definition of transference. Also, the positive and negative feelings which he included under positive and negative transference would not fit the criterion of inappropriateness which he established (e.g., the friendly and affectionate feelings may be accounted for by the client's expectation of help from the therapist), and, moreover, would seem to require that a non-transference relationship be an affect-free relationship.

But the wide variety of behaviors pointed to as manifestations of transference has resulted in the use of other terms to represent a portion of these behaviors. Anna Freud (1946) divided transference into transference of libidinal impulses and transference of defense. Kepecs (1966) suggested the addition of two terms, which are basic primary trust and transference symbiosis. Healy, Bronner, and Bowers (1930) distinguished three phases of therapy in terms of transference. In the first phase, negative and/or positive transference occur. In the second phase, the transference neurosis arises, and in the third phase, dissolution of the transference occurs and analysis is terminated. Alexander and French (1946) distinguished latent transference reactions from transference. Latent transference reactions denote behavior which is appropriate under some conditions but does not change when conditions change, thereby indicating its stereotyped character.

Under transference, Freud included both specific, isolated instances of impulse expression (Breuer and Freud, 1957) and general reaction patterns (Freud, 1959b). This differentiation is almost equivalent to Anna Freud's (1946) terms of transference of libidinal impulses and transference of defense. In the interpersonal theories, as opposed to Freud's libidinal theory, the transference of patterns of behavior was elaborated on.

According to the Sullivanian use of transference (Sullivan, 1938), certain integrative patterns of behavior are organized during the development of the child's personality. There is a self-in-relation-to A pattern, a self-in-relation-to B pattern, etc., for all important people to whom the child had to adjust in the course of his early development. These patterns stand as prototypes for the person's later interpersonal relationships. Writing on the Sullivanian use of transference, Rioch (1943) provides this example:

> a young girl, who had a severely dominating mother and a weak, kindly father, learned a pattern of adjustment to her mother which could be briefly described as submissive, mildly rebellious in a secret way, but mostly lacking in spontaneity. Toward the father she developed a loving, but contemptuous attitude. When she encountered other people, regardless of sex, she oriented herself to them partly as the real people they were, and partly as she had learned to respond to her mother and father in her past (pp. 149-150).

Alexander and French (1946) also subscribe to this view, i.e., that transference is repetitive, stereotyped, inappropriate behavior patterns.

In Freud's first extensive description of transference, he believed that only neurotics transferred behavior (Freud, 1959b). However, he later wrote that the neurotic's tendency to transfer was only an intensification of a universal characteristic (Freud, 1952), but that only neurotics classified under "transference neuroses" (i.e., hysteria,

anxiety and obsessional neurosis) were capable of establishing a transference relationship. Here, Freud was probably referring to transference as suggestion. The "transference relationship" seems to be what is commonly referred to as a "working relationship" between therapist and client. Regardless of his meaning here, however, it has been demonstrated that therapy utilizing psychoanalytic principles can be successfully applied to clients classified in categories other than that of "transference neuroses."

Freud's statement that the occurrence of transference was limited to those patients included in the transference neuroses has been cogently refuted. Rioch (1943), in fact, believes that patients classified under narcissistic neuroses (i.e., psychoses) establish relationships consisting of essentially nothing but transference illusions. Rosen (1954) stated that transference is more intense in psychoses than in neuroses. Zavitzianos (1967) has shown that juvenile deliquents also manifest transference behavior.

When Freud wrote of the transference relationship, he was referring to transference as suggestion. Those who challenged his point of view concerning the lack of transference in the psychoses and other diagnostic categories used transference in the sense of transfer of behavior patterns. Confusion such as this arose because Freud never clearly distinguished the multiple meanings of transference in his writings.

However, the discovery of the inappropriate transfer of behavior patterns from the client's past interaction to the client's interaction with the therapist (as opposed to the client's reality-oriented behavior), is one of Freud's most valuable contributions to the understanding of human behavior. Transference in this sense has been a central

concept of the interpersonal theorists, and represents the meaning of transference which was empirically studied in the present research.

Motivation for transference. Szasz (1963) reviewed Jones' (1953) biography of Freud and pointed out that Freud developed the concept of transference before the publication of *Studies on Hysteria* in 1895. According to this account, Freud's explanation of the concept to Breuer allayed Breuer's anxiety (which was created by the erotic feelings of Breuer's patient, Anna O) by convincing him that Anna O's feelings were directed toward someone in her past -- not really toward Breuer. This explanation, according to Szasz, allowed Breuer and Freud to proceed with the writing of *Studies on Hysteria*. Thus Szasz argued that the development of the concept and the use of the concept in psychotherapy often serves as a defense for the therapist. That is, by interpreting the client's behavior toward the therapist as really directed toward someone in the client's past, the therapist does not have to deal with the behavior on a personal level.

Freud's first example of transference, quoted above, in which the patient had the wish that he would kiss her, may have been interpreted as transference for just this reason. The fact that whether behavior is called transference or not is based on the judgment of the therapist (Wolstein, 1964) provides the therapist with the opportunity to use that interpretation for his own defensive needs. Therefore, the therapist may interpret reality-oriented behavior as transference to reduce his anxiety.

There are some different opinions as to what motivates the client to transfer behavior to the therapist. Freud first wrote of transference phenomena in the context of listing difficulties with the pressure

technique. He noted that some resistances might interfere with the recovery of repressed memories. He wrote that resistance may occur because

> the patient is frightened at finding that she is transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis (Breuer & Freud, 1957, p. 302)."

Thus, from Freud's first development of the concept, he viewed transference as a manifestation of resistance.

Although he gave up the pressure technique in favor of free association, he continued to view transference as one of the patient's resistances to the recovery of repressed memories:

> Now as we follow a pathogenic complex from its representative in consciousness (whether this be a conspicuous symptom or something apparently quite harmless) back to its root in the unconscious, we soon come to a place where the resistance makes itself felt so strongly that it affects the next association, which has to appear as a compromise between the demands of this resistance and those of the work of exploration. Experience shows that this is where transference enters on the scene ... Over and over again, when one draws near to a pathogenic complex, that part of it which is first thrust forward into consciousness will be some aspect of it which can be transferred; having been so, it will then be defended with the utmost obstinacy by the patient (Freud, 1959a, pp. 316-317).

As resistance, however, he only included the erotic component of positive transference and negative transference. And where the transference feelings were overwhelmingly negative, Freud saw no possibility of cure.

Thus throughout his writings, Freud viewed transference as a resistance against recovery of painful memories. Specifically, he believed transference was a resistance which made the repressed material inaccessible to treatment in that the patient attempted to act out the material instead of reproducing it. And he (Freud, 1933) conceived of transference as an instance of the "repetition-compulsion." Beginning

with the premise that instincts are directed toward the reinstatement of an earlier state of things, Freud wrote:

> We may assume that as soon as a given state of things is upset there arises an instinct to recreate it, and phenomena appear which we may call "repetition-compulsion." ... And in the realm of the mind, too, we shall not have far to seek for evidence of the presence of that compulsion. It has always surprised us that the forgotten and repressed experiences of early childhood should reproduce themselves in the reactions involved in the transference (pp. 145-146).

Interpersonal theorists view the situation somewhat differently. Rioch (1943) believed that Freud was right to regard transference as resistance, but not as resistance which prevented the recovery of repressed memories:

> As a matter of fact, the tendency of the patient to reestablish the original reference frame is precisely because he is afraid to experience the other person in a direct and unreserved way. He has organized his whole system of getting along in the world, bad as that system might be, on the basis of the original distortions of his personality and his subsequent vicissitudes (p. 152).

Alexander and French (1946) believe that transference behavior is resistance in the sense that it sometimes occurs as a result of the client's unwillingness to face his major conflict. Specifically, they note that clients frequently report data from their life which occurred prior to the period during which their neurosis began, and, at the same time, begin to transfer feelings from these earlier periods. When this happens, the transference is a manifestation of resistance against facing the painful emotions associated with the central conflict.

Importance of transference for psychotherapy. It is clear that transference, at first considered only a troublesome defense against recovery of repressed memories, took on increased significance in Freud's work. At one point, he stated that it was not the

interpretations of the patient's associations nor the handling of repressed material that is difficult in psychoanalysis, but that "the only serious difficulties are encountered in handling the transference (Freud, 1959d, p. 377)." Interpersonal theorists are in agreement:

> The great complexity of the psychiatric interview is brought about by the interviewee's substituting for the psychiatrist a person or persons strikingly different in most significant respects from the psychiatrist. The interviewee addresses his behavior toward this fictitious person who is temporarily in the ascendancy over the reality of the psychiatrist, and he interprets the psychiatrist's remarks and behavior on the basis of this same fictitious person. There are often clues to the occurrence of these phenomena. Such phenomena are the basis for the really astonishing misunderstandings and misconceptions which characterize all human relations, and certain special precautions must be taken against them in the psychiatric interview after it is well under way (Sullivan, 1954, pp. 26-27).

Alexander and French (1946) view psychotherapy as revolving around the transference relationship, and suggest that inadequate handling of the transference accounts for many failures and interminable cases.

As noted above, Freud believed that only negative transference and the erotic component of positive transference served as resistance for the patient. But "the conscious and unobjectionable component of (positive transference) brings about the successful result in psychoanalysis as in all other remedial methods (1959a, p. 319)." The friendly and affectionate part of positive transference allowed the physician to have influence on the patient: "In so far we readily admit that the results of psychoanalysis rest upon a basis of suggestion... (1959a, p. 319)." In his introductory lectures (Freud, 1952), Freud made it clear that, in his opinion, transference clothed the physician with authority, and gave the patient faith in his findings and in his views.

In connecting suggestion with friendly, cooperative feelings as Freud originally did, it seems clear that he merely meant that the therapist must have a favorable impact on the client, that the client must be capable of establishing a cooperative, relatively trusting relationship with the therapist, and that the client must want help and expect that the therapist is competent to give it. Thus he seemed to mean that to help a client, the therapist and client must have a "working relationship."

In any event, as it was pointed out above, suggestion as transference cannot be cogently defended with the definition of transference which Freud used. But the concept of transference as the transfer of behavior from a previous problematic interaction to the therapeutic relationship has been of value to psychotherapy.

Although in many instances Freud wrote of transference as a hindrance to psychotherapy, from the beginning he felt that it was no great barrier:

> transference of this kind brought about no great addition to what I had to do. For the patient the work remained the same: she had to overcome the distressing affect aroused by having been able to entertain such a wish even for a moment; and it seemed to make no difference to the success of the treatment whether she made this psychical repudiation the theme of her work in the historical instance or in the recent one connected with me (Breuer & Freud, 1957, p. 304).

Later, transference was seen by Freud as helpful to treatment in that (a) it helped the patient to arrive at a sense of conviction of the validity of interpretations, and (b) after interpretation of a transference, the patient had access to new memories (Freud, 1959b). In addition, although Freud never explicitly stated that the goal of recovering repressed memories had changed, the statement below certainly

suggests that he saw personality change as the result of working out conflicts in the "here-and-now" interaction rather than the interpretation of historical interactions:

> This struggle between...recognition and the striving for discharge, is fought out almost entirely over the transference-manifestations. This is the ground on which the victory must be won, the final expression of which is lasting recovery from the neurosis. It is undeniable that the subjugation of the transference-manifestations provides the greatest difficulties for the psycho-analyst; but it must not be forgotten that they, and they only, render the invaluable service of making the patient's buried and forgotten love-emotions actual and manifest; for in the last resort no one can be slain *in absentia* or *in effigie* (Freud, 1959b, p. 322).

In the introductory lectures (Freud, 1952), although he saw the therapeutic aspect of analytic therapy residing in the client-therapist relationship in which the early conflicts are revived, Freud conceptualized the process in terms of his libido theory:

> He (the neurotic) would be well if the conflict between his ego and his libido came to an end, and if his ego again had the libido at its disposal. The task of the treatment, therefore, consists in the task of loosening the libido from its previous attachments, which are beyond the reach of the ego, and in making it again serviceable to the ego (p. 462).

Freud (1952) attempted to establish a relationship between resolution of the transference as the cure in therapy on the one hand, and resolution of the ego-libido conflict as the cure on the other hand. He wrote:

> It is well here to make clear that the distributions of the libido which ensue during and by means of the analysis afford no direct inference of the nature of its disposition during the previous illness. Given that a case can be successfully cured by establishing and then resolving a powerful father-transference to the person of the physician, it would not follow that the patient had previously suffered in this way from an unconscious attachment

> of the libido to his father. The father-transference is only the battlefield on which we conquer and take the libido prisoner; the patient's libido has been drawn hither away from other 'positions' (pp. 463-464).

The libido is supposedly concentrated in the transference, and

> the battle rages round this new object and the libido is made free from it. The change that is decisive for a successful outcome of this renewed conflict lies in the preclusion of repression, so that the libido cannot again withdraw itself from the ego by a flight into the unconscious (p. 463).

Thus the libido is mobilized in the transference, then freed from the transference upon transference resolution. Preclusion of repression prevents the recurrence of withdrawal of libido from the ego. Freud developed a sufficient explanation of the development of neurosis and its cure around the concept of transference, but somehow felt compelled to use additional concepts without increased explanatory or practical significance.

The usefulness of transference behavior in psychotherapy which Freud noted above has been accepted by the interpersonal theorists. Transference behavior has become, in some instances, the phenomena from which entire theories of neurosis have been developed, and transference resolution has been accepted as the criterion for successful outcome (Alexander & French, 1946; Wolstein, 1964).

Additionally, the notion of manipulation of the client's transference behavior to achieve therapeutic aims has expanded the usefulness of transference behavior in psychotherapy. Alexander and French (1946) have written on this technique most extensively. Alexander (1965) believes that the therapist, by assuming a role opposite that which the patient attempts to force on him, will counteract the transference and provide a corrective emotional experience for the patient

in relatively few sessions in some cases. Karon (1963) presents himself as a strong transference figure (father figure) to acute schizophrenic patients in order to speed up the therapeutic process.

Successful therapy has been conceptualized as a process of positive and/or negative transference, transference neurosis, and transference resolution. This present study equates transference and transference neurosis (as does Alexander and French, 1946), and rejects the notion that the initial positive or negative effect is transference in the sense of transfer of behavior patterns. Thus successful therapy is conceived in terms of three stages by the present experimenter: (1) reality-oriented behavior, (2) transference, and (3) transference dissipation.

Research on Transference

The importance of transference phenomena to psychotherapy in general, and psychoanalysis in particular, is not reflected in the amount of empirical research devoted to these phenomena. When one reviews the literature, he is struck by the fact that while theoretical papers abound, research on the phenomena is exceedingly meager. Below, investigations which were intended as studies of transference are reported, after which it is argued that most of them are not studies of transference in any of its meanings reviewed above.

Franco (1965) studied the relationship between children's perception of their teacher and their perception of their mother. She argued that if the children's perception of their teacher and their mother were significantly related, the relationship would indicate less independent and therefore less objective perceptions than if no such relationship existed, and that the significant correlation could be

considered an operational definition of a transference component since the teacher would be the same for all children whereas the mother would be different for each child.

Seventy-five children in two kindergarten classes were asked, "What will teacher (or mother) say (or do)?" at the end of a number of incomplete stories. The stories focused on the role of authority figures as helper and disciplinarian. The responses were scored in terms of discipline or helpfulness on scales ranging from one to nine. The children were tested four weeks after opening of the school year and about seven months later.

The results indicated a significant degree of "transference." At the first testing, the product-moment correlation coefficient computed between perception of teacher and perception of mother was +.50 on the discipline scale and +.45 on the helpfulness scale. At the second testing, the correlations were quite similar: +.52 on the discipline scale and +.44 on the helpfulness scale. There were some differences in transference scores obtained when children were divided into three groups (cooperative, submissive, or rebellious) by their teacher.

Apfelbaum (1958) conducted a study that was somewhat similar to Franco's study. He administered the MMPI and a specially designed Q sort to 100 undergraduate and graduate clients at a university clinic. In the before-therapy testing session, the clients had not met their therapists. They were asked, on the Q sort, to describe their expectations of what their therapist would be like by separating cards into two stacks, those containing items most, and those containing items least, descriptive of their prospective therapist.

He obtained three clusters, and designated them A, B, and C. The expected therapist characteristics could be described in two dimensions. One dimension was labeled warmth, nurturance, and protectiveness at one extreme, and coldness, indifference, and detachment at the other. The former was characteristic of cluster A, whereas the latter was characteristic of cluster C, and cluster B fell somewhere between these extremes. The other dimension was labelled directiveness vs. nondirectivness, which principally separated cluster B (more nondirective) from the other two clusters.

Significant differences in MMPI profiles between clusters A and B were found. Also, MMPI T score comparisons revealed significant differences between clusters A and B, and B and C. Clusters A and C manifested more psychopathological scores than cluster B.

Thirty-three of sixty-five clients who remained in therapy until termination was mutually agreed upon by client and therapist were retested (they had remained in therapy for 12 weeks). The large correlation obtained between pre and post Q sorts reflected no significant change in client expectations of therapist characteristics.

Crisp (1964a) attempted to measure positive and negative transference. Ss were asked to select 20 adult people, 10 of whom had to be the S's father, mother, spouse or boyfriend, S, a frightening person, an autoritarian person, a good friend, someone S disliked, the words "ideal father," and the words "ideal mother." The other 10 people were five men and five women of S's choosing. Ss wrote the names of these 20 people on cards and numbered them from 1 to 20.

A total of 36 constructs were selected from a pilot study. Thirty-three were related to common needs and personality traits. The remaining three key constructs were "ideal dependable father," "my G.P.,"

and "the psychiatrist," or where the test was applied to patients, their psychiatrist's name was used.

As E read each construct, each S picked out 10 of his 20 cards bearing the names of people most representative of that construct. E recorded the numbers on the 10 chosen cards.

Matching scores were calculated between each of the three key constructs. The correspondence between the scores for "ideal dependable father" and the two doctor figures was taken as a measure of transference. Low correspondence between the scores of "ideal dependable father" and the doctor figures was regarded as a measure of negative transference. High correspondence between the scores was called positive transference. The experimenter felt that the use of this indirect method to study transference would help hide the fact that comparisons were being made, and additionally, militate against a practice effect if the test were repeated. He later reported a slight modification of this method (Crisp, 1964b).

Crisp (1964a) reported the results of two studies using the above methodology. In the first study, Crisp used non-patients as Ss and divided them into two groups based on social class. Social class I consisted of professionals, and social class III consisted of clerical workers. An equal number of males and females were in each group. Each S had a different G.P. He found that negative transference was greater toward the G.P. from social class I than from social class III, but greater toward the psychiatrist from social class III than from social class I. But within social class I, negative transference was greater toward the G.P. than toward the psychiatrist.

In study two, Crisp compared the data obtained with the normal Ss in study one with data obtained from neurotic patients. Five of these patients were monosymptomatic phobics, outpatients, who had seen a psychiatrist once with a view toward having behavior therapy. Five more were inpatients, suffering from neurotic depression, who had been seen once by a psychiatrist with a view toward beginning psychotherapy. Each S had a different G.P. No significant difference was found in the construing of G.P. and psychiatrist within the neurotic group. However, neurotics did manifest significantly more positive transference toward the psychiatrist than did either of the normal groups.

Mueller (1969b) used the interpersonal diagnosis schema developed by Freedman, Leary, Ossorio, & Coffey (1951) to study transference behavior. The Freedman *et al.* method was designed to study modes of interpersonal interaction by scoring each communication unit (uninterrupted speech) by each participant in interpersonal interaction into one or more of 16 categories of interpersonal behavior. By rating both the interaction between the client and therapist as it occurred, and the *reported* behavior of the client's interaction with others, and then comparing these ratings, he was able to demonstrate, empirically, that transference and counter-transference behavior occurs in psychotherapy.

In addition, Mueller found that there were certain latent effects of client and therapist behavior in psychotherapy. Hostile-competitive client behavior in early interviews was positively correlated with hostile-competitive and passive-resistant therapist behavior in later interviews. On the other hand, early therapist hostile-competitiveness was positively correlated with later client hostile-competitiveness.

Also, he demonstrated that in early interviews, boastful, rejecting, and distrustful client behavior elicits either the same kind of behavior from the therapist or stimulates the therapist to attempt to control the relationship. In later interviews, however, the therapist tends to withdraw from client hostility. Also, in later interviews, client trust elicits affiliative behavior, and client nurturance is reciprocated by therapists.

Mueller (1969a) noted additional information which he derived from the above data. He divided the clients into low and high transferring groups, and studied the differences in behavior in psychotherapy of the two groups. From his analysis of these data, he concluded that low transferring subjects either remain distrustful of, or nurture, their therapists, and that this may prevent the development of "a relationship of sufficient detph to provide the opportunity for developing transference reactions (p. 16)."

Franco's (1965) and Apfelbaum's (1958) studies are not, strictly speaking, measures of transference. Transference involves behavior on the part of the person who is exhibiting transference, but Franco and Apfelbaum are measuring the expectation and/or perception of someone else's behavior. Only to the extent that one's perception of another person's behavior is related to his interaction with the other person are these studies measuring transference. The relationship is not perfect. For two people can perceive a person as dominating, which might lead one to relate to that person in a submissive manner whereas the other may be competitive with dominating people. In addition, Franco's study employing very young children poses a problem in that it is usually assumed, when behavior is labeled transference, that the people exhibiting the behavior have had ample opportunity to learn to

relate to people in accordance with their differences, whereas Franco's subjects must be regarded as having had little opportunity (because of their youth) to do so. In Crisp's (1964a) study, the fact that "ideal dependable father" was not a real person with whom the Ss had ever interacted removes what he was studying from the realm of transference.

Mueller's research conforms more closely to the concept of transference as developed by Freud and expanded on by the interpersonal theorists than the other studies. He studied actual behavior in the client-therapist interaction, and actual client-other behaviors (if the client's reports are accepted as valid). The criterion of inappropriateness of the behavior in the client-therapist relationship, however, was not demonstrated. Mueller's method of studying transference utilizing the Leary (1957) interpersonal circumplex appears to be the most appropriate method available and thus was selected as the method for use in the present research.

Identification

Alexander and French (1946) stated that

> one of our most important therapeutic tasks is to help the patient distinguish neurotic transference reactions that are based upon a repetition of earlier stereotyped patterns from normal reactions to the analyst and to the therapeutic situation as a present reality. It is a fundamental part of all psychotherapy to teach the patient that his neurotic reactions are in accord with old, out moded patterns, that they are anachronistic, and to help him acquire new ways of reacting that conform more closely to the new situations (pp. 71-72).

These "new ways of reacting" to situations which had previously elicited transference reactions may come partly from what has been described as a client's identification with his therapist. Menninger (1958) describes the identification as follows:

> what the psychoanalyst believes, what he lives for, what he loves, what he considers to be the purpose of life, what he considers to be good and what he considers to be evil, become known to the patient and influence him enormously not as "suggestion" but as inspiration. A degree of identification with the analyst is inevitable although not necessarily permanent (p. 91).

Psychotherapists ascribe various degrees of importance to the phenomenon of identification in psychotherapy. Albert (1968), Honig (1963), and Lampl-de Groot (1956) view identification of a client with his therapist as a very strong force in psychotherapy. Albert (1968) and Honig (1963) recommend that the therapist actively offer himself as an identification figure by injecting opinions and value judgments in the psychotherapy sessions, while others feel that the therapist should remain as veiled as possible so that transference manifestations will be uncontaminated and more strikingly unrealistic.

The Meaning of Identification

The concept of identification, like that of transference, has several different meanings. Koff's review of the literature on identification ended with the wry comment that "when we meet an individual member of the family 'identification' we ought to be properly introduced, using both first and last names (1961, p. 369)."

According to Freud, there are two types of identification. Anaclitic identification (Freud, 1959f) results from the threat of loss of a loved object. This threat motivates the person to "incorporate" characteristics of the loved object. The second type of identification, which is defensive or aggressive identification (Freud, 1949), occurs as the outcome of the resolution of the Oedipus conflict in which the child adopts the characteristics of the like-sex parent, thereby reducing anxiety over anticipated punishment for his incestuous wishes and at

the same time vicariously receiving gratifications of the opposite-sex parent.

In psychoanalytic theory, the terms "introjection," "incorporation," and "identification" are sometimes used interchangeably (Koff, 1961). Usually, however, introjection and incorporation are used to refer to the process by which identification is achieved.

The occurrence of matching responses is usually referred to as "imitation" in experimental psychology. A number of distinctions between imitation and identification has been proposed (Bandura & Walters, 1963). Identification has sometimes been reserved for matching behavior involving meanings, whereas imitation was used to refer to highly specific acts. It has been proposed that in identification, emotional attachment is an antecedent condition, but that in imitation, it is unnecessary or absent.

Some writers prefer to reserve imitation as a term applying to matching behavior in the presence of the model, and identification as involving the performance of the model's behavior in the model's absence. Others think of imitation as the dependent variable and identification as the independent variable. Identification and imitation

> encompass the same behavioral phenomenon, namely, the tendency for a person to reproduce the actions, attitudes, or emotional responses exhibited by real-life or symbolized models (Bandura & Walters, 1963, p. 89).

The distinction between the terms is largely tradiational and none of the diverse distinctions proposed has commanded a majority of adherents. Therefore, for purposes of this study, the terms may be regarded as synonymous.

In the present research, actual interpersonal behavior patterns was the aspect of identification selected for study, and the Leary (1957) interpersonal behavior rating system was regarded as a useful method for categorizing interpersonal behavior.

Research on Identification

Schrier (1953) had patients fill out a questionnaire containing items measuring 22 personality traits before and after therapy. Their therapists also, at the beginning of therapy, completed the questionnaire on themselves and on their patients, and at the end of therapy again rated their patients on the questionnaire. In addition, judges rated identification, positive rapport, and therapeutic success from transcripts of interviews conducted by the experimenter with both patients and therapists in the initial and final stages of therapy.

Schrier found that, at the end of therapy, identification (measured by the correspondence of final self-ratings by patients and self-ratings by therapists on the one hand, and final self-ratings by patients and ratings of patients by their therapists on the other hand), positive rapport, and therapeutic success were highly correlated. By examining the patient self-ratings before and after therapy and comparing them with the single therapist self-rating, he was able to demonstrate that the greater correspondence between patient and therapist self-ratings was due to patient change and not to therapist change.

Welkowitz, Cohen & Ortmeyer (1967) compared the value systems of therapists and patients. Forty-four patients had been seen by their 38 therapists for periods ranging from one to nine months when the Ways to Live scale and the Strong Vocational Interest Blank were

administered. Two weeks later, therapists rated improvement of their patients on a six-point scale: (1) much worse, (2) worse, (3) no improvement, (4) some improvement, (5) moderate improvement, and (6) marked improvement.

The conditions of pairing patients with therapist did not suggest that value similarity was the basis of the pairing. Yet, these investigators found that (1) therapists did not share a homogeneous value scheme, (2) the value similarity between therapists and their own patients was greater than the value similarity between therapists and random not-own patients, (3) patient-therapist value similarity tended to increase as a function of length of time in therapy, and (4) there was a significant positive relationship between extent of patient-therapists value similarity and perception of patient improvement by the therapist.

The similarity of three dimensions of communication in the client-therapist dyad was studied by Lennard & Bernstein (1960). From tape recordings of psychotherapy sessions, they counted the number of primary system references (deals with reciprocal client-therapist role relations), evaluative propositions (those which give or ask for appraisals to statements of value), and affective propositions (those which are directed toward or express feeling or emotions), in sessions one and two, five and six, and two sessions from the third and fourth months of therapy. They found an increasing correlation over time. For the primary system references, the increasing correlation was accounted for by change on the part of both therapist and client, but the client changed more rapidly. In the case of evaluative and affective propositions, the cause of the increased correlations could not unambiguously be attributed to either therapist or client change.

Thus it appears that the observation that a client identifies with his therapist, in various respects, will stand up under empirical investigations. However, it has not been shown that the identification is a condition of successful outcome. The finding of a significant positive relationship between extent of patient-therapist value similarity and perception of patient improvement (Welkowitz *et al.*, 1967) is reduced in significance by the fact that therapist judgment of client improvement is not highly correlated with other outcome measures (Apfelbaum, 1958). And in the Schrier (1953) study, it is quite possible that the change in correspondence of patient and therapist self-ratings was a result of the patient's change toward normality and not a result of greater identification of the patient with the therapist. In order to demonstrate identification, Schrier would have to show that self-ratings of patients who were treated successfully were more highly correlated with self-ratings of their particular therapists than with other therapists.

Usefulness of the Interpersonal Circumplex in Psychotherapy Research

The method used to study interpersonal interaction in the present research has a rather short but important history. It was successfully used to study transference and countertransference (Mueller, 1969b) as reported above. The method has been used in other psychotherapy research as well. It was used by Rausch, Dittman, and Taylor (1959) to compare the interaction of hyperaggressive boys early and late in residential treatment. Each boy was observed in six settings in which his interaction with both peers and adults were recorded, and the observations were repeated after 1-1/2 years in treatment. It was found that the interpersonal behavior of the children had changed

considerably, apparently toward goals of the treatment program. With adults, the children had decreased their hostile-dominant behavior and increased their friendly-passive behavior.

Rausch, Farbman, and Lewellyn (1960) compared interaction differences of hyperaggressive and normal boys in different social settings, and hyperaggressive boys early and late in the treatment program, again using the circumplex. As the treatment of the disturbed boys progressed, they came to act much more like normal boys. Most of the change in behavior of the disturbed boys was manifested in their relationships with adults, rather than with peers. These authors also found that normal children varied their behavior in accordance with specific social settings more than the disturbed children did.

The circumplex was used by MacKenzie (1968) to study the differences in the interaction of normal and clinic family members. The circumplex differentiated the families in the following respects: (1) normal family members expressed more friendly behavior to each other than clinic family members, (2) clinic mothers were significantly more dominant than normal mothers, and the dominance of the clinic mothers was of a more aggressive type, (3) clinic mothers were more narcissistic and demanding than normal mothers, and (4) clinic sons were more passive-aggressive than normal sons.

Swensen (1967) used the circumplex to study some aspects of psychotherapy. Swensen hypothesized that therapists of different theoretical persuasion behave differently in therapy and that these differences can be usefully described with the interpersonal interaction circle based upon the dominance-submission and love-hate dimensions. He rated one published case of each of three therapists (Rogers, Ellis, Wolberg). He assumed that the cases were successful because they were

published. He found that the point which best described the interpersonal behavior of each person in each therapist-client dyad was located at approximately opposite places on the circumplex.

Swensen also rated the dominance and love scores of clinical psychology graduate students and clients at a University Psychological Services Center. The circumplex was divided into quadrants and each S was located in a quadrant based upon his score for each of the two variables. He found that, after therapy, clients were more improved when the therapist and client were opposite on dominance and submission. There was a trend for greater client improvement when the therapist and client were similar on the love-hate dimension.

STATEMENT OF THE PROBLEM

Transference and Transference Dissipation Hypotheses

The determination of the relationship between the occurrence of transference and its dissipation, identification of a client with his therapist, and outcome of psychotherapy was the goal of this study.

As stated earlier, in terms of client behavior, successful therapy may be regarded as consisting of three stages: reality-oriented behavior, transference behavior, and transference dissipation. However, the clinical observation of these stages in successful psychotherapy has never been empirically confirmed.

The transference hypotheses predicted that unsuccessful psychotherapy would differ from successful psychotherapy in the latter two phases of therapy. Therapy may be unsuccessful (1) because transference occurred but was inadequately dealt with so that the client ended treatment having gone through essentially the same interaction which originally was unresolved and which brought him to psychotherapy;

(2) because transference never occurred due to client distrust (Mueller, 1969a). If one of these factors occurred in some unsuccessful cases, and the other factor was present in other unsuccessful cases, the interaction of these factors would result in less total transference in a sample of unsuccessful cases when compared with total transference in a sample of successful cases. In the final stage of therapy, in the unsuccessful cases in which transference occurred, it was assumed that it would not dissipate. Thus dissipation was predicted to be greater in successful than in unsuccessful cases.

Although these phases were conceived to occur in order regardless of the length of therapy, the duration of each phase was assumed to vary depending on the multitude of factors which worked to lengthen or shorten treatment. The first and third phase should be seen most clearly at the beginning and ending sessions, respectively, whereas the second phase should have occurred somewhere between these two. It was decided that the second stage would most probably have occurred during the middle sessions of each case.

The transference hypotheses are specified as follows:

H1: In the middle sessions of psychotherapy, the degree of transference of client behavior from the parents to the therapist will be greater in successful than in unsuccessful psychotherapy.

H2: In the middle sessions of psychotherapy, the degree of transference of client behavior from significant others to the therapist will be greater in successful than in unsuccessful psychotherapy.

H3: Transference of client behavior from the parents to the therapist will dissipate more at the end of successful than at the end of unsuccessful psychotherapy.

H4: Transference of client behavior from significant others to the therapist will dissipate more at the end of successful than at the end of unsuccessful psychotherapy.

Identification Hypotheses

This study was concerned with only one aspect of identification: similarity of two people in respect to the kind of behavior patterns used and their frequency of usage, in interpersonal interaction. Identification was assumed to increase with each succeeding session in successful psychotherapy, and was expected not to occur in unsuccessful psychotherapy. Thus a client's behavior should be more similar to his therapist's behavior at the end than at the beginning of successful psychotherapy, if identification had occurred. But for this increased similarity to reflect more than a change toward normality, the similarity of behavior of any client-therapist dyad should be greater than the similarity of behavior of a client and therapists other than his own. It was predicted that identification of a client with a therapist occurred to a greater extent when they were of the same sex.

Specific hypotheses regarding identification follow:

H5: In late sessions of psychotherapy, identification of a client with his therapist will occur to a greater extent in successful than in unsuccessful psychotherapy.

H6: In late sessions of successful psychotherapy, a client will identify more with his therapist than with other therapists.

H7: In late sessions of successful psychotherapy, identification of a client with his therapist will be greater when the therapist is the same sex as the client than when he is not.

In addition to these specific hypotheses, the data were examined to determine whether significant differences exist in the emotional conditions that the clients and therapists establish in relation to each other. Comparisons in terms of the emotional conditions were made between successfully-treated vs. unsuccessfully-treated clients, and successful vs. unsuccessful therapists.

CHAPTER II

METHOD

Subjects and Setting

Psychotherapy cases used to test the preceding hypotheses were drawn from those on file in the tape library of the Counseling Center at Michigan State University. The clients were university students who reported to the Counseling Center for help with a variety of personal problems and who agreed to participate in research. Their therapists included staff members, interns, and practicum students in clinical and counseling psychology. In addition to tape recordings of the therapy sessions, client and therapist ratings of the outcome of therapy and a variety of test data were available on the cases. Descriptive data on the cases used in the study may be found in Appendix A.

Selection of Cases

The cases used to test the hypotheses were selected from among those on file in the tape library on the basis of two criteria. The first criterion for selection was that the case must have continued for at least nine sessions. This criterion was thought necessary because of the need to sample interaction at points separated in time and to exclude those cases which, because of their brevity, would seem to prohibit the development of the processes under scrutiny. Also, this criterion would appear to eliminate some cases in which the goal

may have been something other than personality reorganization (e.g., such as educational-vocational problems).

The second criterion was that both pre- and post-therapy MMPI profiles had to be available for each case used in the study. For various reasons, both MMPIs were not available for all cases on file in the library. Since the MMPI data were used to determine outcome of each case in order to test the hypotheses this criterion was essential.

A number of cases which met these criteria were rejected for other reasons. One case was rejected because the client changed therapists, which would seem to affect the processes under study. An additional case was discarded because the client's pre-therapy MMPI profile revealed no T-scores above 60, which suggested a lack of significant pathology and perhaps a contraindication of the need for psychotherapy. Three cases were excluded due to the fact that some psychotherapy sessions which were regarded as critical had not been tape-recorded. After these five cases had been rejected, a total of 25 cases were left to complete the sample.

Analysis of MMPI Data

The pre-psychotherapy and post-psychotherapy MMPI profiles were rated by three judges who had considerable experience with MMPI interpretation and thus were considered expert judges. Two senior staff members at the Counseling Center at Michigan State and a graduate student in counseling psychology at Michigan State served as the MMPI judges.

Instructions to the judges were as follows:

Objective: To determine changes on the MMPI as an indication of psychological change.

1. Compare pre-counseling and post-counseling profiled MMPI scores for each subject. Consider the nine common scales (Hs + .5K, D, Hy, Pd + 4K, Mf, Pa, Pt + 1K, Ma + 2K, Sc + 1K).
2. Score the change as follows:
   5 = satisfactory
   4 = partly satisfactory
   3 = no change
   2 = partly unsatisfactory
   1 = unsatisfactory
3. In order to establish intra-judge reliability, please score each profile twice; one week apart.

For purposes of this study, the cases were dichotomized into successful and unsuccessful cases on the basis of the judges' ratings. To make the dichotomy, (1) the average of all ratings for each client (two ratings of each client by each judge) was obtained, and (2) each client whose average rating was $\leq$ 3.00 was regarded as an unsuccessful case, and, conversely, each client whose average rating was > 3.00 was regarded as a successful case. Using this procedure, the final sample of (N=25) cases used in this study consisted of 15 successful and 10 unsuccessful cases. Table 1 lists descriptive data on the groups. Appendix B contains raw ratings and average ratings of the 25 clients by the three judges.

Table 1

Number of Cases, Client, Sex, Therapist Sex, Mean and Range of Sessions in Each Group

Group	N	Client Sex		Therapist Sex		Mean Sessions	Range of Sessions
		Male	Female	Male	Female		
Successful	15	5	10	11	4	15.4	10-24
Unsuccessful	10	5	5	8	2	19.4	9-41

Reliability of MMPI Judges

To check the inter-judge reliability, the intraclass correlation formula (Ebel, 1951) was used. Two reliabilities are reported in Table 2. The "reliability of ratings" in the table refers to the

Table 2

Inter-Judge Reliability of MMPI Ratings of 25 Cases by Three Judges by Ebel's Intraclass Correlation Formula

Source	df	SS	MS	Fs	Reliability of ratings[a]	Reliability of average ratings[b]
Clients	24	90	3.75	7.21*	+.67	+.86
Judges	2	10	5.00			
Error[c]	48	25	.52			
Total	74	125				

a. $$r = \frac{MS_{clients} - MS_{error}}{MS_{clients} + (df_{judges}-1)\ MS_{error}}$$

b. $$r = \frac{MS_{clients} - MS_{error}}{MS_{clients}}$$

c. Since the final ratings on which the decision to call a case successful or unsuccessful was based on averages of ratings from all judges, the "between-raters" variance was removed from the error term (Ebel, 1951).

* $p < .005$

reliability of the average of all ratings of all judges for each client. This latter index of reliability is the appropriate measure for this study because the placement of cases into successful and unsuccessful groups was based on the average of all ratings of each case.

The intra-judge reliability was determined by two methods. In the first method, the range of ratings was collapsed so that a rating of one, two, or three was called unsuccessful, and a rating of four and five was called successful. The percentage of agreement between first and second ratings for each judge on these dichotomous units was then determined. The second method utilized the Pearson product-moment correlation coefficient between first and second original ratings (the complete one to five scale) of each judge. The intra-judge data are shown in Table 3.

Table 3

Intra-Judge Reliability of MMPI Ratings of 25 Cases

Judge	Percentage agreement	Pearson Correlation	t computed from Pearson correlation[a]
Judge 1	100	+.94	13.16*
Judge 2	84	+.83	7.06*
Judge 3	100	+.97	18.43*

a. $t = r \sqrt{(N-2)/(1-r^2)}$

* $p < .001$

Thus, for this study, in which the reliability of average ratings is the appropriate inter-judge reliability index, and in which both methods of computing intra-judge reliability are meaningfully related to the manner in which the data are used, the obtained reliabilities are significantly better than chance expectations and provide a reliable index of client change from beginning to end of therapy.

Selection of Sessions for Analysis

It was assumed that the relationship between transference and sessions in successful psychotherapy is curvilinear, and that the relationship between identification and sessions of successful psychotherapy is linear. Sessions for analysis were selected in such a manner that the likelihood of the sessions representing the three phases of successful therapy in terms of transference was believed to be maximized, while, at the same time, they would provide a check on the linearity of the process of identification over sessions of successful therapy.

Therefore, to test the hypotheses, data were selected from cases at three different points. These are referred to as "early," "middle," and "late" sessions. The first three sessions ("early" sessions), the median session and the session before and after the median session ("middle" sessions), and the last three sessions ("late" sessions) of each case were selected. Thus nine sessions of each case, a total of 225 sessions, were selected for analysis.

In the studies described in Chapter I which used the interpersonal circumplex, the usual procedure was to analyze a part of the available data, and to regard this part as representative of the entire data. Such a procedure was used in this present research, in which a 15-minute

segment of each selected session was analyzed. This 15-minute segment was begun at 15 minutes into the session, and ended at 30 minutes into the session. The selection of this particular 15-minute segment served to eliminate the standard greetings and leave-takings which are characteristic of the beginning and ending of sessions, thus maximizing the probability of rating only significant interaction.

The above procedures for selection of sessions and segments were not always adhered to. The tape-recordings of 15 of the selected sessions were unclear, which necessitated selection of segments of other sessions for analysis. In these instances, the procedure was to rate a 15-minute segment bewteen 30 and 45 minutes into the hour of a session within the same period of therapy as the desired session. Therefore, 15 sessions out of the sample had 30 minutes instead of 15 minutes of interaction rated.

Method of Interaction Analysis

The method which was used in this research is the interpersonal diagnosis schema developed by Freedman, Leary, Ossorio, and Coffey (1951), elaborated on by Leary (1957), and as used by Mueller (1969b). According to this method, each communication unit (uninterrupted speech) by therapist and client is scored in terms of one or more of 16 interpersonal reflexes arranged around a circumplex. The reflexes are defined in terms of two major axes: a dominant-submissive and an affiliative-disaffiliative axis. The illustrative verbs of the reflexes are dominate, boast, reject, punish, hate, complain, distrust, condemn self, submit, admire, trust, cooperate, love, support, give, and teach. The circumplex is represented in Figure 1.

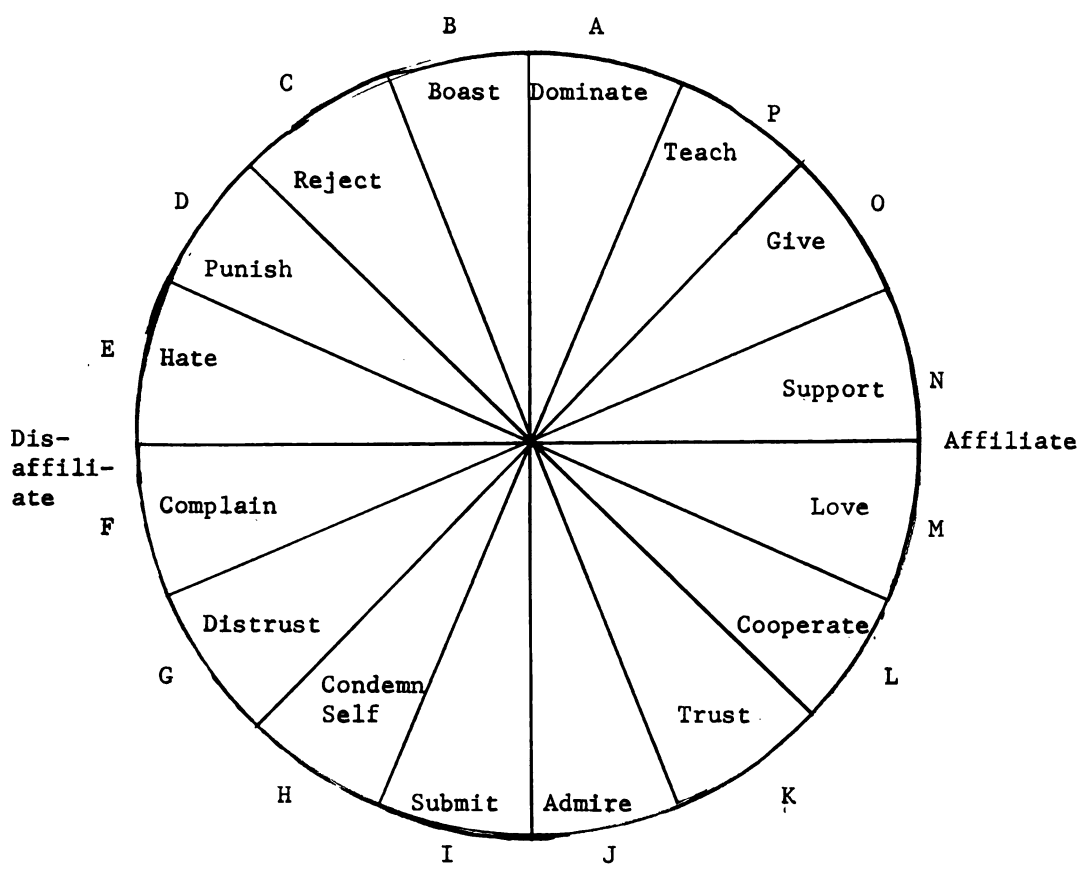

Fig. 1. The interpersonal circumplex.

In the interpersonal method of analysis, the interpersonal behaviors of the individuals in interaction are conceptualized as attempts on the part of each person to establish an emotional state in the interaction which tends to elicit predictable responses from others in the interaction. The term "interpersonal reflex" is especially descriptive because it connotes the high predictability of interpersonal responses. The concept of the interpersonal reflex is that the

behavior of a person in interpersonal interaction consists of an automatic tendency to respond to the behavior of the person with whom he is interacting (Freedman *et al.*, 1951; Leary, 1957).

Research on this interpersonal system of diagnosis has indicated that (1) classes of behaviors elicit predictable responses, (2) the more emotionally disturbed an individual, the more limited is the range of reflexes he uses, (3) patterns of interpersonal reflexes differ from individual to individual, and (4) certain patterns characterize particular emotional problems (Leary, 1957).

Rating Interpersonal Interaction

All 225 segments were rated by the criterion judge, who was a graduate student in counseling psychology. The criterion judge's ratings were the ones used to test the hypotheses.

The investigator served as the reliability judge in scoring the interpersonal interaction. The reliability judge had previous experience in using this method of interaction analysis and trained the criterion judge. Training of the judges to a point of acceptable reliability required about 40 hours. Training time was spent by both judges listening to psychotherapy tapes and rating the interaction together, or by judges rating the tapes separately, then comparing ratings and discussing discrepancies as they arose. Short training sessions were also required when checks on reliability, which were made at various times during collection of the data, indicated that more training was in order. In such cases, retraining was always conducted on non-study psychotherapy tapes.

The task of the judges in rating the behaviors of the client and therapist was to empathize with the person exhibiting the behavior,

from the position of the target of the behavior (Freedman *et al.*, 1951). The judges rated each communication unit by first locating it on the circumplex by quadrant (i.e., in terms of the axes), octant, and then by particular reflex. When multiple reflexes within the same communication unit occurred, the judges scored them sequentially. Appendix C contains the scoring manual used by the judges.

Speed and accuracy of scoring was facilitated by reading the interaction on typescripts as it was listened to on the tape recorder. Typescripts were available on approximately 50% of the sample.

To test transference hypotheses, it was necessary to score the tapes twice. The first scoring consisted of rating the client-therapist interaction. In the second scoring, the client-other interaction as reported by the client, was rated. For the second scoring, the judge had to determine both the reflex and the target of the behavior. Potential targets were father, mother, male authority figure, female authority figure, male peer, female peer, brother, sister, and other. Since the 15-minute segments of some cases contained very few client-other interactions, the criterion judge rated the remaining 45 minutes of the first session of all cases for additional client-other behavior.

Selection and Rating of Reliability Segments

Sixty-five of the 225 segments of the sample (about 30%) were chosen to determine the reliability of the judges in rating the interpersonal behaviors. The reliability segments were selected so that the early, middle, and late sessions would be approximately equally represented. Beyond this consideration, selection of the reliability segments was random, and the sequence of rating the reliability segments was random within the total sample.

Typescripts were made available for all reliability segments. The typescripts of reliability segments were necessary so that the criterion judge could indicate to the reliability judge the number of each communication unit and the number of reflexes scored within each communication unit. This information was needed in order to compare the ratings for reliability.

Dittmann's $\overline{R}$ (Dittmann, 1958) was used to compute the inter-rater reliability. Reliability of the raters in judging the client-therapist interaction is reported in Table 4, and reliability of the raters in judging client-other behavior is reported in Table 5. On the 2979 ratings of client-therapist interaction, the judges achieved reliability of +.62, whereas on the 317 ratings of client-other interaction, they achieved reliability of +.69. These reliabilities are similar to those reported by Mueller (1969b), who reported reliability of client-therapist reflexes at +.64 and reliability of client-other reflexes at +.73. Conversion of the obtained reliabilities in the present study into t scores of 57.65 for client-therapist interaction and 23.19 for client-other interaction indicates that these reliabilities are very improbable chance events. Therefore, the data were considered adequate to test the study hypotheses.

Table 4

Percentage Agreement Scores, Dittmann's $\overline{R}$, and $\underline{t}$ Tests Reported for Client-Therapist Interactions for 25 Cases Based on 65 15-Minute Tape Reliability Segments

Agreement discrepancy[a]	Units of agreement	% of agreement	Cumulative %	Dittmann's δ[b]	$\overline{R}$[c], $\underline{t}$[d]
0-D	1586	.532	.532	0	$\overline{R}$ = +.62
1-D	300	.101	.633	300	$\underline{t}$ = 57.65*
2-D	269	.090	.723	538	
3-D	343	.115	.838	1029	
4-D	147	.049	.887	588	
5-D	78	.026	.913	390	
6-D	146	.049	.962	876	
7-D	88	.029	.991	616	
8-D	22	.007	.998	176	
Total	2979				
Sum (δ)				4513	

a. 0-D = perfect interjudge agreement, 8-D = bipolarity of interjudge agreement.

b. δ = number of categories between the ratings of the judges.

c. For a 16 variable circumplex, Dittmann's $\overline{R} = 1 - \frac{\sum \delta^2 / h}{4}$

d. $\underline{t} = 1.706\ \overline{R}\ \sqrt{n}$

* $\underline{p} < .001$

Table 5

Percentage Agreement Scores, Dittmann's $\overline{R}$, and t Tests Reported for Client-Other Interaction for 25 Cases Based on 59[a] 15-Minute Tape Reliability Segments

Agreement discrepancy[b]	Units of agreement	% of agreement	Cumulative %	Dittmann's δ[c]	$\overline{R}$[d], t[e]
0-D	154	.486	.486	0	$\overline{R}$ = +.69
1-D	73	.230	.716	73	t = 23.19*
2-D	38	.120	.836	76	
3-D	16	.050	.886	48	
4-D	13	.041	.927	52	
5-D	9	.028	.955	45	
6-D	5	.016	.971	30	
7-D	6	.019	.990	42	
8-D	3	.009	.999	24	
Total	317				
Sum (δ)				390	

a. Six of the 65 reliability segments contained no client-other interactions.

b. 0-D = perfect interjudge agreement; 8-D = bipolarity of interjudge agreement.

c. δ = number of categories between the ratings of the judges.

d. For a 16 variable circumplex, Dittmann's $\overline{R} = 1 - \frac{\sum_{i=1}^{n} \delta/n}{4}$

e. $t = 1.706\ \overline{R}\sqrt{n}$

* $p < .001$

CHAPTER III

RESULTS

Transference and Transference Dissipation Hypotheses

As clients interact with their therapists during the course of psychotherapy, they often recall and report interactions that have transpired between themselves and others. The similarity between these two sets of interactions was a principal focus of this research. The degree of similarity in the two sets of behaviors was studied at different points in therapy and is referred to in this study as transference and transference dissipation.

The transference hypotheses were operationalized and tested in the following way. The transference hypotheses involved comparing the two sets of client reactions: client reactions toward his therapist and his reported reactions to his parents and significant others. The hypotheses were constructed to test, separately, the transference of the client's behaviors from parents to the therapist, and the transference of the client's behaviors from significant others to the therapist. Likewise, the hypotheses were set up so that the dissipation of those same interactions could be tested separately.

Transference of client behaviors from parents to the therapist was operationally defined as the similarity of the client's behaviors toward his parents as they were reported to the therapist, and the client's behaviors toward the therapist as the client interacted with

the therapist *during the middle interviews*. Similarly, transference of client behaviors from significant others to the therapist was operationally defined as the similarity of the client's behaviors toward significant others as they were reported to the therapist, and the client's behaviors toward the therapist as the client interacted with him *during middle interviews*.

The operational definition of the dissipation of the transference of client behaviors from parents to the therapist was the degree of similarity of the client's behaviors toward his parents as he reported them to the therapist, and the client's exhibited behaviors toward the therapist *in late interviews*. The dissipation of transference of client behaviors from significant others to the therapist was operationally defined as the similarity of the client behaviors toward significant others as he reported them during psychotherapy, and the client's actual behaviors toward the therapist *in late interviews* of therapy.

Transference and transference dissipation between groups. Hypothesis one stated that the transference of client behaviors from the parents to the therapist would be greater in successful than in unsuccessful psychotherapy. The statistical test of the hypothesis involved comparing the successfully-treated and the unsuccessfully-treated clients in terms of the similarity of their reported behaviors toward their parents and their actual behaviors toward their therapists in middle sessions of psychotherapy. The degree of similarity of the compared behavior patterns in hypothesis one as well as in the other transference and transference dissiptation hypotheses was measured by the Cronbach and Gleser (1953) D statistic. The D score provides a measure of the

similarity of two profiles. The lower the D score, the greater is the similarity between the profiles, or, as used in this study, the lower the D score, the greater was the similarity of the compared behavior patterns. Student's t test was used to determine whether compared D scores were significantly different.

The procedure used to obtain the mean D scores to test hypothesis one is presented in detail. The logic used to obtain the mean D scores to test other hypotheses of transference and transference dissipation was similar.

To test hypothesis one, the Ss were divided into successful and unsuccessful groups on the basis of MMPI ratings. For each S of each group, the proportion of behaviors reportedly sent by the client to his parents was determined for each of the sixteen categories of the circumplex. Next, the proportion of behaviors in each category of the circumplex sent from the client to the therapist in middle sessions was calculated. For each category of the circumplex, the proportion of client-to-parents behaviors was subtracted from the proportion of client-to-therapist behaviors in middle interviews. These differences were then squared and summed. The square root of the sum of the squared deviations was the D score. This D score was obtained for each S in each group, and a t test for a significant difference between the mean D scores of each group was computed.

The greater the similarity of client-to-parents and client-to-therapist behaviors in each group, the smaller was the mean D score of each group, and the greater was the degree of transference in each group. Thus, for hypothesis one to be accepted, it would have to be demonstrated that the mean D score of the successful group was significantly smaller than the mean D score of the unsuccessful group.

Table 6 lists the results of the test of hypothesis one. As indicated by the mean D scores in Table 6, the transference of client behaviors from the parents to the therapist in the middle sessions was greater in the unsuccessful group than in the successful group, a difference opposite in direction from the one predicted. Thus hypothesis one was not supported. The insignificant t score in Table 6 indicates that the groups did not differ significantly in the degree of transference of client behaviors from parents to the therapist.

Table 6

t Test of Differences Between the Patterns of Reported Client-to-Parents and Client-to-Therapist Behavior During Middle Interviews in Successful vs. Unsuccessful Psychotherapy Cases

Group	N	$\bar{X}$	SD	t
Successful	14[a]	.5679	.0517	.947 n.s.
Unsuccessful	10	.5189		

a. In one case, no client-to-parents behaviors were reported.

n.s. = not significant

Hypothesis two predicted that the degree of transference of client behaviors from significant others to the therapist would be greater during the middle sessions of psychotherapy in the successful than in the unsuccessful group. The data used to test hypothesis two are reported in Table 7. Note that the mean D score of the unsuccessful group is lower than the mean D score of the successful group, which indicates that transference was greater in the unsuccessful group.

The difference in the D scores, although insignificant according to the t score in Table 7, is in the opposite direction from the one predicted, and, consequently, hypothesis two was rejected.

Table 7

t Test of Differences Between the Patterns of Reported Client-to-Significant Others and Client-to-Therapist Behaviors During Middle Interviews in Successful vs. Unsuccessful Psychotherapy Cases

Group	N	$\bar{X}$	SD	t
Successful	15	.5526	.0544	.079 n.s.
Unsuccessful	10	.5483		

Hypotheses three and four were concerned with the degree of the dissipation of transference behaviors in the two groups. Hypothesis three stated that the transference of client behaviors from the parents to the therapist would dissipate more at the end of successful than at the end of unsuccessful psychotherapy. Table 8 lists the results of the test of hypothesis three. Although the direction of the differences between the mean D scores is consistent with hypothesis three, the t score obtained was not significant. Thus hypothesis three was rejected.

In Table 9, the data used to test hypothesis four are presented. Hypothesis four predicted greater dissipation of the transference of client behaviors from significant others to the therapist in successful than in unsuccessful psychotherapy. The reported client-to-significant others behaviors were compared with actual client-to-therapist behaviors

in late interviews of psychotherapy. Hypothesis four received no support. The differences between the mean D scores were opposite in direction from the predicted differences. However, the differences between the mean D scores were not significant.

Table 8

t Test of Differences Between the Patterns of Reported Client-to-Parents and Client-to-Therapist Behaviors During Late Sessions in Successful vs. Unsuccessful Psychotherapy Cases

Group	N	$\bar{X}$	SD	t
Successful	14[a]	.5668	.0699	.923 n.s.
Unsuccessful	10	.5023		

a. In one case, no client-to-parents behaviors were reported.

Table 9

t Test of Differences Between the Patterns of Reported Client-to-Significant Others and Client-to-Therapist Behaviors During Late Sessions in Successful vs. Unsuccessful Psychotherapy Cases

Group	N	$\bar{X}$	SD	t
Successful	15	.5389	.0460	.378 n.s.
Unsuccessful	10	.5563		

Transference and transference dissipation within groups. The previously stated and tested hypotheses concerned differences in *degree* of transference and transference dissipation between the successfully-treated and unsuccessfully-treated groups. Two assumptions underlying the transference and transference dissipation hypotheses were that (1) transference would occur in each group, and (2) dissipation of transference would occur in each group.

To examine these assumptions, the data were first plotted in Figure 2 and Figure 3. The data in Figure 2 represent the transference of client behaviors from the parents to the therapist in early, middle, and late sessions of psychotherapy. Figure 3 contains the plots of transference of client behaviors from significant others to the therapist in each period of therapy. The points in the figures represent the similarity of the compared behavior patterns at each period of therapy. The points are mean $\underline{D}$ scores, and it will be remembered that they are inversely related to the similarity of the compared behavior patterns.

The study hypotheses concerned differences between the points in the figures during middle and late sessions of psychotherapy. To examine the assumptions, the focus in the figures was shifted to the slope of the lines between sessions for each group. If the assumption that transference occurs in both groups were correct, the downward slopes in the lines from early to middle interviews would represent significant increases in similarity of the compared behavior patterns.

The data in Table 10 indicate that, although the similarity of the compared behaviors increased in each group from early to middle sessions of psychotherapy, no significant increases in similarity existed. Thus, the assumption that transference would occur in both groups received no support.

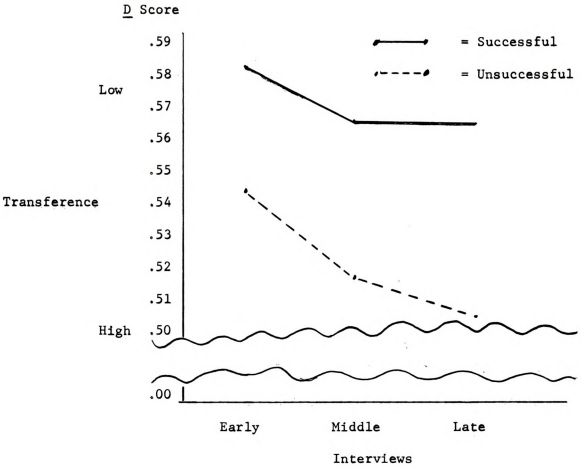

Fig. 2. Transference of client behavior from parents to the therapist over three periods of successful and unsuccessful psychotherapy.

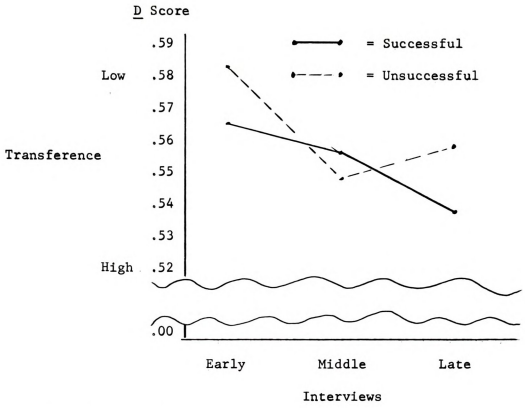

Fig. 3. Transference of client behavior from significant others to the therapist over three periods of successful and unsuccessful psychotherapy.

The transference dissipation assumption involved the slope of the lines between middle and late sessions in Figures 2 and 3. If the assumption were valid, the lines would slope upward from middle to late sessions, and the slope of the line for each group would represent a significant decrease in similarity of the compared behaviors.

It may be seen in the figures that transference dissipation may have occurred in only one instance. In Figure 3, the line which represents the similarity of the compared behavior patterns of the clients in the unsuccessful group slopes upward from middle to late sessions.

Table 10

t Test Comparing Transference Differences Between Early and Middle Sessions Within Each Group

Group	N	Early Sessions $\bar{X}$	Middle Sessions $\bar{X}$	SD	t Score[a]
Client-to-parents vs. client-to-therapist					
Successful	14[b]	.5815	.5679	.0199	.683 n.s.
Unsuccessful	10	.5442	.5189	.0308	.821 n.s.
Client-to-significant others vs. client-to-therapist					
Successful	15	.5672	.5526	.0181	.807 n.s.
Unsuccessful	10	.5811	.5483	.0265	1.238 n.s.

a. t test for related measures was used.

b. In one case, no client-to-parents behavior was reported.

This decrease in similarity of the compared behavior patterns of the clients in the unsuccessful group from middle to late sessions was then tested for significance. The t score of the differences between the mean D scores was not significant, as may be seen in Table 11. Consequently, the assumption that transference dissipation would occur in each group was not supported. According to the data, transference dissipation did not occur in either of the groups.

Identification Hypotheses

It has often been observed that clients, during the course of psychotherapy, begin to act in some ways in a manner similar to their

Table 11

t Test of Differences Between the Patterns of Reported Client-to-Significant Others and Client-to-Therapist Behaviors in Middle Sessions vs. Late Sessions of Unsuccessful Psychotherapy

N	Middle Sessions $\bar{X}$	Late Sessions $\bar{X}$	*t*[a]
10	.5483	.5563	.417 n.s.

a. *t* test for related measures was used.

therapists. The similarity between the client's and the therapist's behaviors during psychotherapy was a second principal focus of this research.

Testing the identification hypotheses involved comparing two sets of behaviors: the behaviors of the clients and the behaviors of their therapists as the clients and therapists reacted to each other during the course of psychotherapy. The reported client behaviors toward others were not used in any way to test the identification hypotheses.

The set of client behaviors used to test the hypotheses were those which were directed toward the therapist during the late interviews of psychotherapy. The set of therapist behaviors with which the late-interview client behaviors were compared consisted of all therapist behaviors toward the client in early, middle, and late sessions. Thus identification of a client with his therapist was operationally defined as the similarity of the behaviors of the client toward the therapist in late interviews and the behaviors of the therapist toward the client in all interviews.

The Cronbach and Gleser (1953) D statistic provided a direct measure of the degree of similarity between the compared behavior patterns to test the identification hypotheses. As noted previously, the D score is inversely related to the degree of similarity of the compared behaviors. Student's t test was used to determine whether significant differences existed between the compared groups in terms of identification.

Identification between groups. Hypothesis five stated that identification would be greater in late sessions of therapy of successful cases than in late sessions of therapy of unsuccessful cases. The mean D scores obtained by comparing each client's behaviors in late sessions with all of his therapist's behaviors in each group separately are presented in Table 12. These means were compared by use of the t test, as reported in Table 12, and were found not to be significantly different. In fact, as evidenced by the direction of the differences between the means, the behaviors of the unsuccessfully-treated clients in late interviews and their therapists in all interviews were more similar than the behaviors of the successfully-treated clients and their therapists. Hypothesis five was rejected.

Table 12

t Test of Differences Between the Patterns of Client-to-Therapist Behaviors During Late Sessions and All Therapist-to-Client Behaviors in Successful vs. Unsuccessful Cases

Group	N	$\overline{X}$	$\overline{X}$	t
Successful	15	.7695	.0433	1.048 n.s.
Unsuccessful	10	.7241		

To test hypotheses six and seven, only the behaviors of the clients and therapists in the successful group were compared. Hypothesis six concerned differences in similarity of the behaviors of successfully-treated clients and their own therapists on the one hand, and of the behaviors of successfully-treated clients and the "average" successful therapist on the other hand. Hypothesis seven predicted differences in similarity of behaviors of successfully-treated clients and their own therapists based on whether the client and therapist pairs were of the same or of the opposite sex.

To examine the data in terms of hypothesis six, that in late sessions of successful psychotherapy a client would identify more with his own therapist than with other therapists, an "average" successful therapist's profile of behaviors was constructed by combining all the successful therapists' behaviors into a single profile. This was accomplished by adding the numbers of behaviors exhibited by all therapists over all interviews for each category of the circumplex, calculating the average number of behaviors in each category, and then converting the averages into proportions. Each successfully-treated client's late-interview behaviors were compared with the behaviors of the "average" successful therapist, and a mean $\underline{D}$ score for this group was obtained. To test the hypothesis, this mean $\underline{D}$ score was compared with the mean $\underline{D}$ score obtained when the late-interview behaviors of each successful client was compared with all behaviors of his particular therapist.

Hypothesis six was rejected on the basis of the data in Table 13. The differences between the behaviors of the successfully-treated clients in late interviews and the "average" successful therapist were somewhat less than the differences in behaviors of successfully-

treated clients in late interviews and the behaviors of their own therapists. Hypothesis six, consequently, received no support. The *t* test of the mean differences, although opposite in direction from the one predicted, was not significant.

Table 13

t Test of Differences Between the Patterns of Client-to-Therapist Behaviors in Late Interviews and Own Therapist vs. "Average" Successful Therapist-to-Client Behaviors in All Successful Cases

Group	N	$\bar{X}$	$\bar{X}$	*t*
Own-Therapist	15	.7665	.0287	.345 n.s.
"Average" Therapist	15	.7566		

Hypothesis seven predicted greater client identification with his own therapist when the therapist was of the same sex than when the therapist was of the opposite sex in successfully-treated cases. To test this hypothesis, the successfully-treated cases were divided into two groups. One group consisted of all those cases in which the client and therapist were of the same sex. The other group consisted of those cases in which the therapist was the sex opposite that of the client. The similarity of the behaviors of the client and his own therapist in one group was compared with the similarity of the behaviors of the client and his own therapist in the other group.

Table 14 contains the results of the *t* test of hypothesis seven. Although there was more similarity of behaviors in the same-sex dyad than in opposite-sex dyads, the difference was not significant.

Table 14

t Test of Differences Between the Patterns of Client-to-Therapist Behaviors During Late Interviews and All Therapist-to-Client Behaviors in Same-Sex vs. Opposite-Sex Client-Therapist Pairs in Successful Psychotherapy

Group	N	$\bar{X}$	SD	*t*
Same-Sex Pairs	6	.7591	.0615	.301
Opposite-Sex Pairs	9	.7776		

Identification within groups. The identification hypotheses, like the transference and transference dissipation hypotheses, predicted differences in *degree* of identification between groups. Identification of clients with their therapists was assumed to occur in both groups.

To examine this assumption, Figure 4 was constructed. The points in the figure represent mean D scores of the compared client and therapist behaviors of each group. The points at each period of therapy were obtained by comparing the client's behaviors *at that period of therapy* with his own therapist's behaviors in all the periods of therapy, for successful and unsuccessful groups separately. It will be recalled that the D score is inversely related to the similarity of compared behaviors.

Hypothesis six concerned the differences between the points, in Figure 4, in late sessions of therapy. Considering identification within each group instead of between groups, the slope of the lines between early and late sessions becomes the relevant data in the figure.

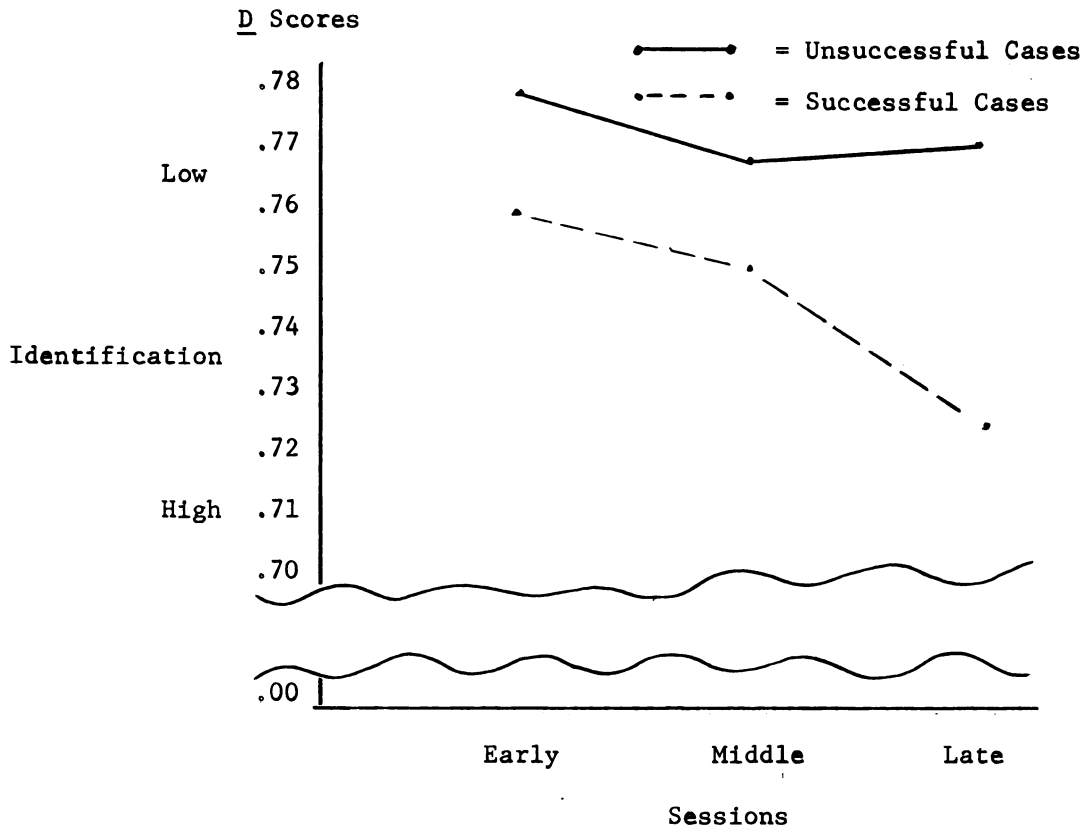

Fig. 4. Identification of clients with their own therapists in three periods of successful and unsuccessful psychotherapy.

Increasing identification in each group would be represented in the figure by a downward slope of the lines from early to late sessions. Note that the lines do show a downward trend from early to middle sessions, after which the slope of the line representing the unsuccessful group continues its downward course, but the slope of the line representing the successful group reverses direction. However, the slope of the line representing the successful group was more gradual between the middle and late sessions than between the early and middle sessions. Therefore, the plotted data indicate that identification may have occurred in each group. Therefore, the difference between the mean D scores of early and late sessions of each group was tested for significance.

The results of the t tests on the data in the figure are reported in Table 15. None of the t scores was significant. Thus the assumption that identification occurred in each group was not supported.

Table 15

t Test of Differences Between the Patterns of All-Therapist-to-Client Behaviors and Client-to-Therapist Behaviors During Early vs. Middle Sessions in Successful and Unsuccessful Cases

Group	N	Early Sessions $\bar{X}$	Late Sessions $\bar{X}$	SD	t[a]
Successful	15	.7786	.7695	.0169	.552 n.s.
Unsuccessful	10	.7592	.7241	.0296	

Exploratory Questions

The possibility that the emotional conditions that clients and therapists set up with each other differ in successful and unsuccessful cases was a secondary focus of this study. The successfully-treated clients and unsuccessfully-treated clients were compared in terms of their reactions to their therapists. Similarly, the reactions of successful and unsuccessful therapists were compared to determine whether they were different.

In all the analyses previously done in this study, groups were compared in terms of differences between proportions of behaviors in each of the 16 categories of the circumplex. However, data are frequently analyzed in terms of octants and/or quadrants of the interpersonal circumplex (Mueller, 1969b; Raush *et al.*, 1959).

Since the questions about possible differences in the behaviors of successfully-treated and unsuccessfully-treated clients, and successful and unsuccessful therapists were exploratory in nature, the behaviors were compared in terms of quadrants of the circumplex. An advantage of studying the behaviors in terms of quadrants instead of single reflexes was that the ratings of quadrant behaviors were more reliable. This fact is apparent in Table 4 and Table 5, where it may be seen that the reliability of the raters increased as the agreement discrepancy was increased from zero to eight. Thus the broader the category of the circumplex into which behaviors are rated, the greater is the reliability of those ratings.

The quadrants of the circumplex are differentiated by the dominance-submission and affiliation-disaffiliation axes (refer to Figure 1). For example, the quadrant consisting of reflexes BCDE is bordered by the dominance pole of one axis and the affiliation pole of the other axis. The verbal descriptions of the quadrants may vary according to the nature of the relationship under study (Mueller, 1969b; Raush *et al.*, 1959). Appropriate descriptions of the quadrants when the relationships under study are psychotherapy relationships follow (Mueller, 1969b): hostile-competitive (reflexes BCDE), passive-resistant (reflexes FGHI), support-seeking (reflexes JKLM), and supportive-interpretive (reflexes NOPA).

To examine the data in terms of differences in quadrant behaviors of the participants in successful and unsuccessful cases, the proportion of behaviors of each client and therapist in each reflex of the circumplex was converted into proportion of quadrants. This was done by summing the proportion of behaviors in each of the four reflexes in each quadrant across all Ss in the unsuccessfully-treated and

successfully-treated client group, and in the unsuccessful and successful therapist group. The quadrant behaviors of each group was determined for each of the three periods of therapy separately.

Comparison of behaviors of successfully-treated and unsuccessfully-treated clients. The actual behaviors of the successfully-treated and unsuccessfully-treated clients were compared during the course of psychotherapy to determine whether they reacted differently to their therapists. The comparisons were made in terms of the proportions of behaviors in each quadrant of the circumplex sent by each group to their therapists.

This exploratory question was first examined by plotting the quadrant behaviors of the groups. The quadrant behaviors were plotted in early, middle, and late sessions separately, and these plots are illustrated in Figures 5, 6, and 7, respectively.

In Figure 5, it may be noted that the clients in the successful group differed from the unsuccessful group in all quadrant behaviors sent to the therapist. It appears that the successfully-treated clients, in comparison with the unsuccessfully-treated clients, were more hostile-competitive and support-seeking, and less passive-resistant and supportive-interpretive in the early interviews.

The middle-interview data in Figure 6 show a convergence of the two groups in their behaviors, when these data are compared with the early-interview data. In the middle interviews, the groups were very similar in terms of hostile-competitive and supportive-interpretive behaviors. Although they were divergent with respect to passive-resistant and support-seeking behaviors in the middle interviews, the amount of the differences decreased from the early interviews. However, the direction of the differences in passive-resistant and support-seeking behaviors remained the same in the middle interviews.

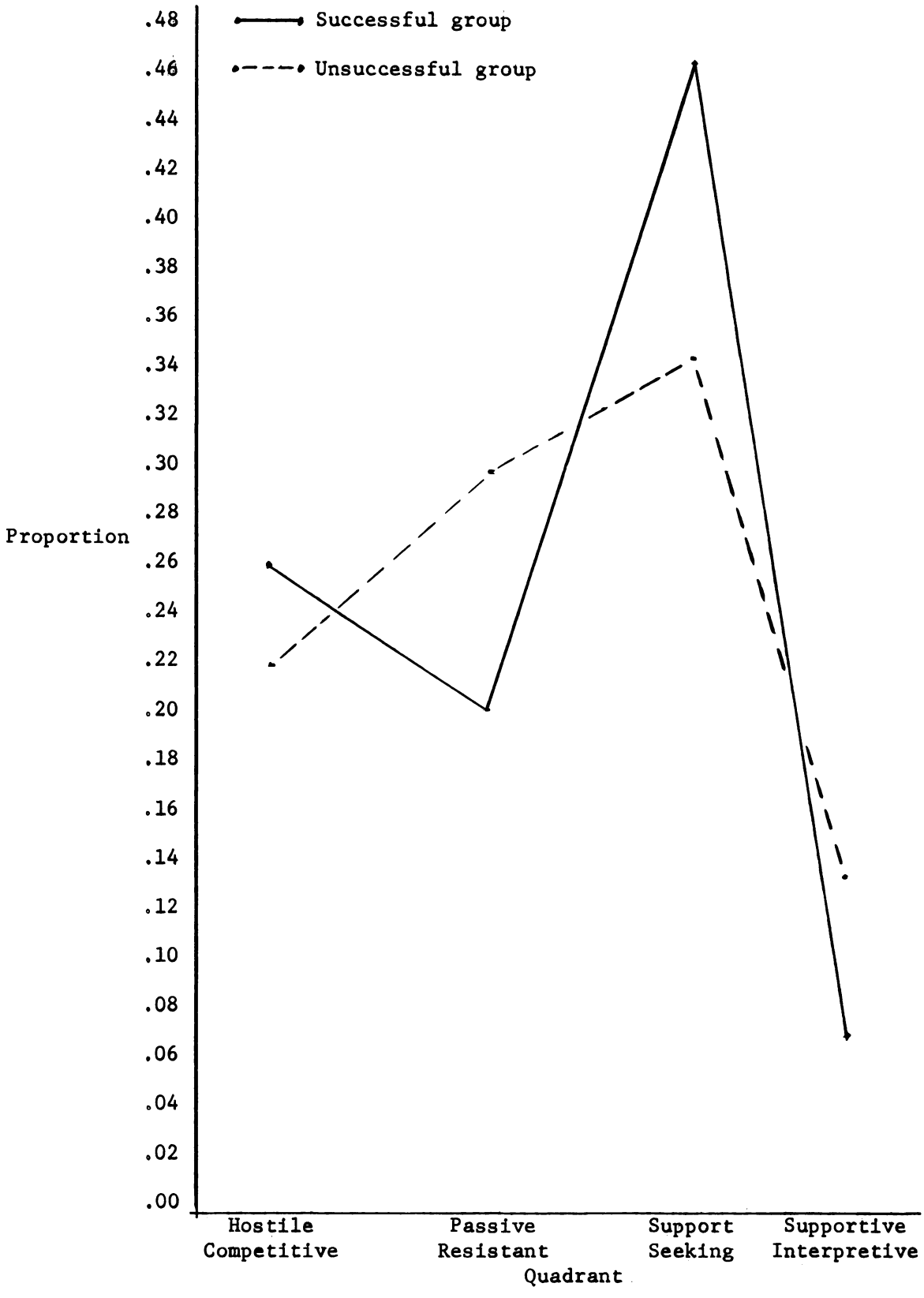

Fig. 5. Proportion of behaviors in each quadrant of the circumplex sent to therapists by successfully-treated and unsuccessfully-treated clients in early interviews.

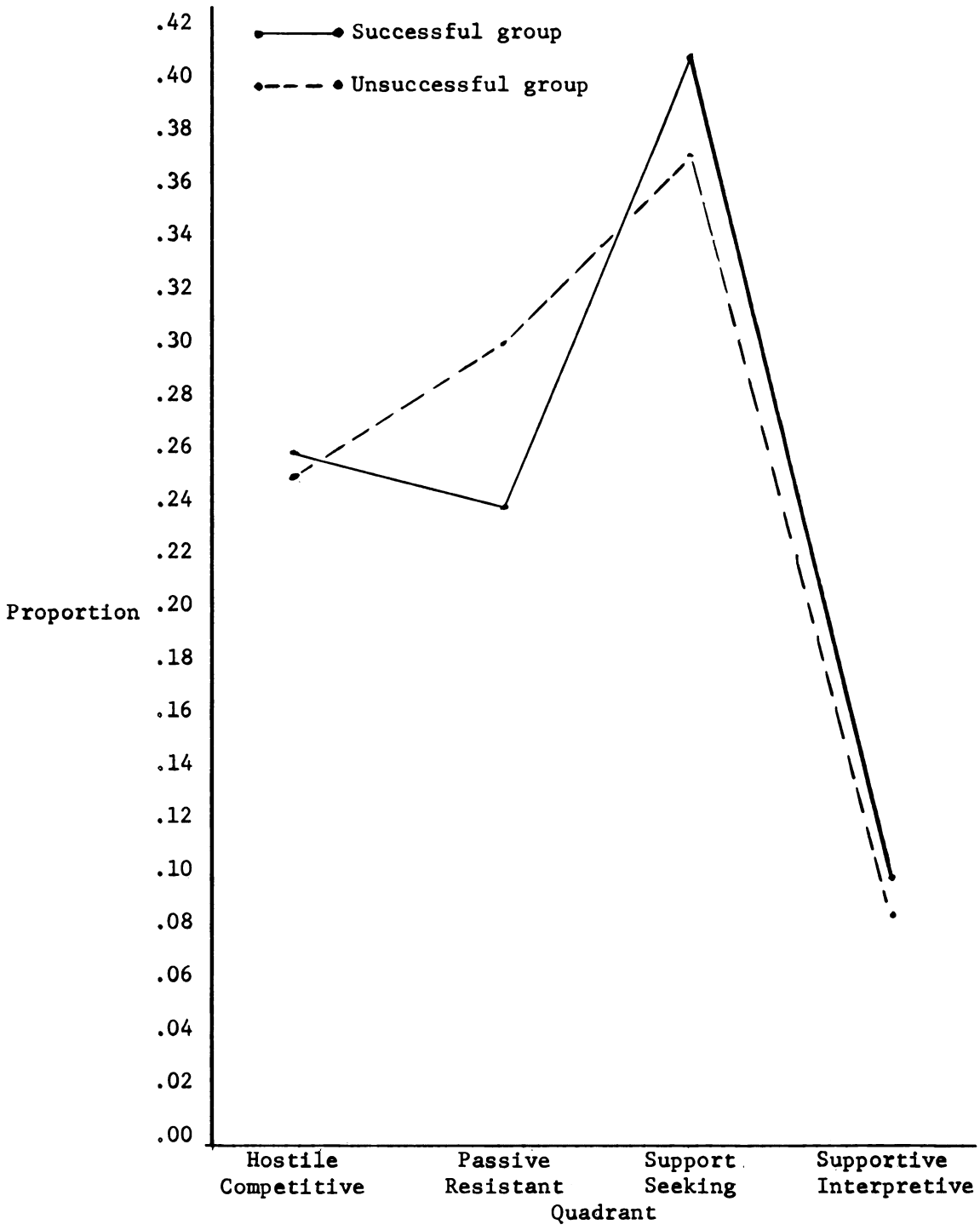

Fig. 6. Proportion of behaviors in each quadrant of the circumplex sent to therapists by successfully-treated and unsuccessfully-treated clients in middle interviews.

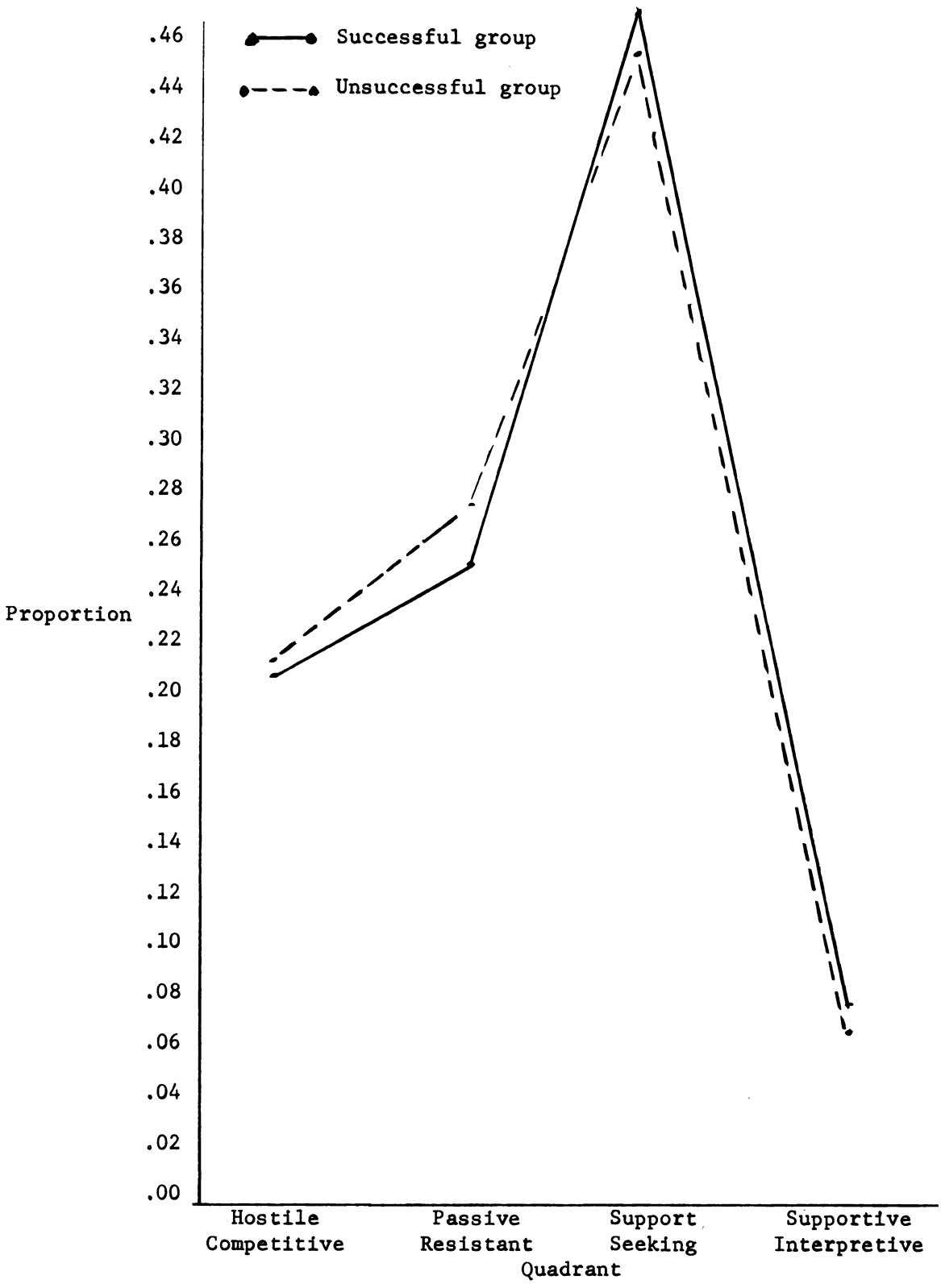

Fig. 7. Proportion of behaviors in each quadrant of the circumplex sent to therapists by successfully-treated and unsuccessfully-treated clients in late interviews.

The plots of the behaviors of the two groups in the late interviews in Figure 7 reveal greater similarity between the groups in late interviews than in the other interviews. In late interviews, the groups reacted very similarly to their therapists.

The differences between the groups in terms of their behaviors toward their therapists, apparent in the figures, were then tested to determine whether they were significant. The test of significance between the groups in terms of quadrant behaviors consisted of calculating z scores from the differences in proportions of behaviors of the groups in each quadrant (Bruning & Kintz, 1968). The results of the tests are reported in Table 16.

The data in Table 16 indicate that the successfully-treated and unsuccessfully-treated clients differed in their behaviors in all quadrants of the circumplex in the early interviews, and in two quadrants in the middle interviews, but that no significant differences in the quadrant behaviors of the two groups existed at the end of therapy. In the early interviews of psychotherapy, successfully-treated clients were significantly more hostile-competitive and support-seeking and significantly less passive-resistant and supportive-interpretive than the unsuccessfully-treated clients. In the middle interviews, the significant differences and their directions were maintained between the groups in terms of passive-resistant and support-seeking behaviors. The significant differences found in the other two quadrants in the early interviews were no longer evident in the middle interviews. Although no significant differences existed between the groups in late interviews, the trend was for successfully-treated clients to interact more affiliatively (support-seeking and supportive-interpretive) than the unsuccessfully-treated clients.

Table 16

Comparison of Behaviors of Successfully-Treated and Unsuccessfully-Treated Clients Sent to Their Therapists in Three Periods of Psychotherapy: A Quadrant Analysis

Period of therapy	Quadrant	z Score[a]
Early	DH Competitive-Hostile (BCDE)	2.84**
	SH Passive-Resistant (FGHI)	-6.41***
	SL Support-Seeking (JKLM)	7.08***
	DL Supportive-Interpretive (NOPA)	-6.63***
Middle	Competitive-Hostile (BCDE)	.47
	Passive-Resistant (FGHI)	-4.11***
	Support-Seeking (JKLM)	2.41*
	Supportive-Interpretive (NOPA)	1.73
Late	Competitive-Hostile (BCDE)	- .36
	Passive-Resistant (FGHI)	-1.61
	Support-Seeking (JKLM)	1.07
	Supportive-Interpretive (NOPA)	1.35

a. In each quadrant, the proportion of behaviors of the successful group was subtracted from the proportion of behaviors of the unsuccessful group. Therefore, a negative z score indicates a larger proportion of behavior of the unsuccessful group in that particular quadrant. A positive z score indicates that the proportion of behavior was greater in the successful group.

* $p < .05$ (two-tailed test).

** $p < .01$ (two-tailed test).

*** $p < .001$ (two-tailed test).

Comparison of behaviors of successful and unsuccessful psychotherapists. The actual behaviors of the successful and unsuccessful therapists were compared in order to determine whether their behaviors toward their clients were different. The behaviors of the two groups of therapists were compared in terms of quadrants at each period of therapy as were the behaviors of the clients.

The quadrant behaviors were plotted and are shown in Figures 8, 9, and 10. The therapist behaviors were plotted separately for each stage of therapy.

In Figure 8, the early-interview quadrant behaviors of the therapists are plotted. The plots in the figure indicate that the successful and unsuccessful therapists were very similar in the proportions of their behaviors in the support-seeking and supportive-interpretive quadrants, but that the successful therapists tended to be more hostile-competitive and less passive-resistant than the unsuccessful therapists.

The lines in Figure 9 which represent middle-interview therapist behaviors reveal no differences between the groups. However, the data for the late interviews in Figure 10 suggest that the groups may be significantly different in three of the quadrants. A comparison of the plots in Figure 10 for the two groups indicates that the successful therapists, in late interviews, were more supportive-interpretive and less passive-resistant than their less successful colleagues.

The differences between the proportion of behaviors of the two groups were tested for significance, and the results are reported in Table 17. The z scores in Table 17 reveal that the groups differed significantly in the proportion of hostile-competitive and passive-resistant behaviors which they exhibited in early interviews. In the middle interviews, no significant differences in the behaviors of the

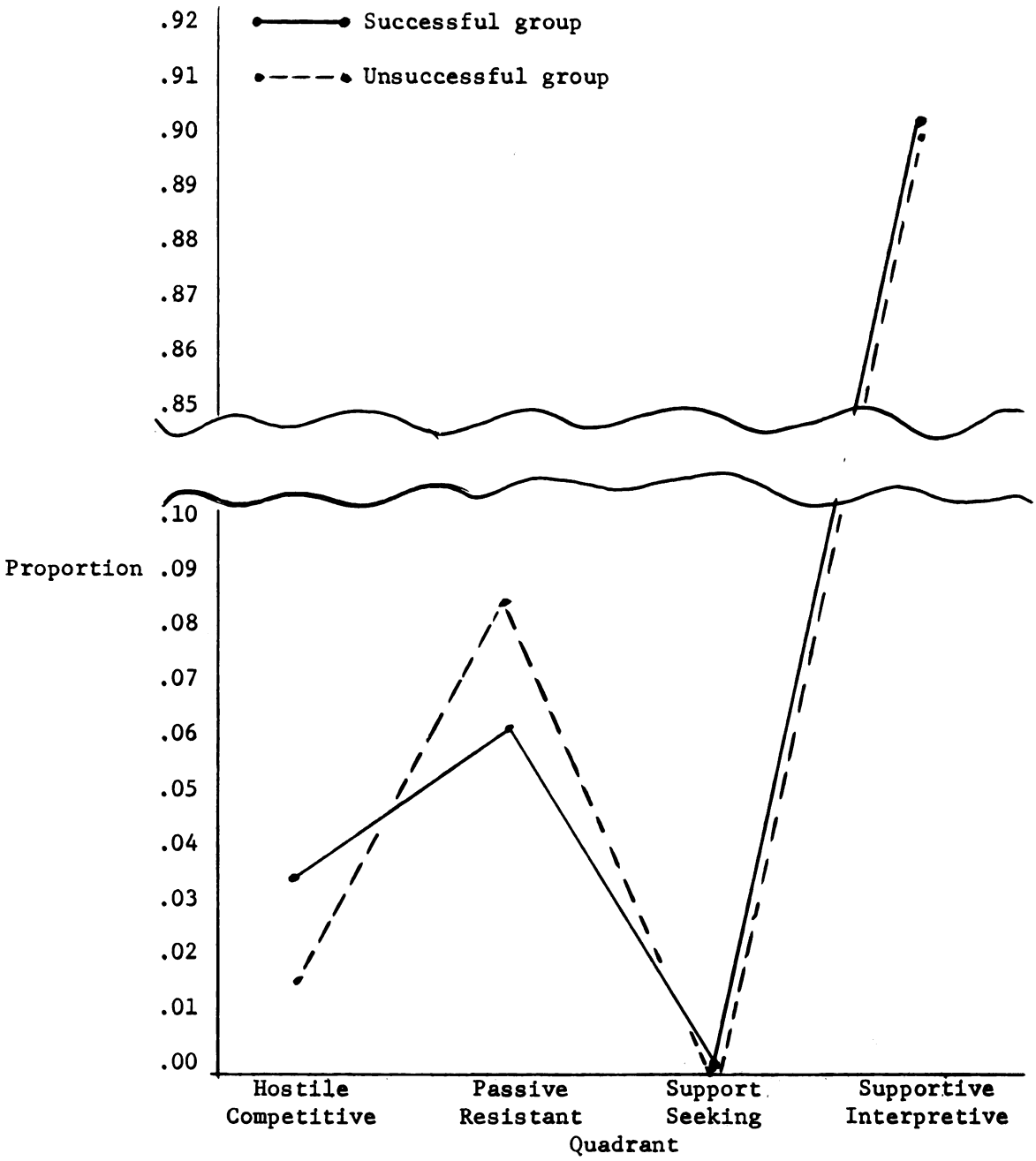

Fig. 8. Proportion of behaviors in each quadrant of the circumplex sent to clients by successful and unsuccessful therapists in early interviews.

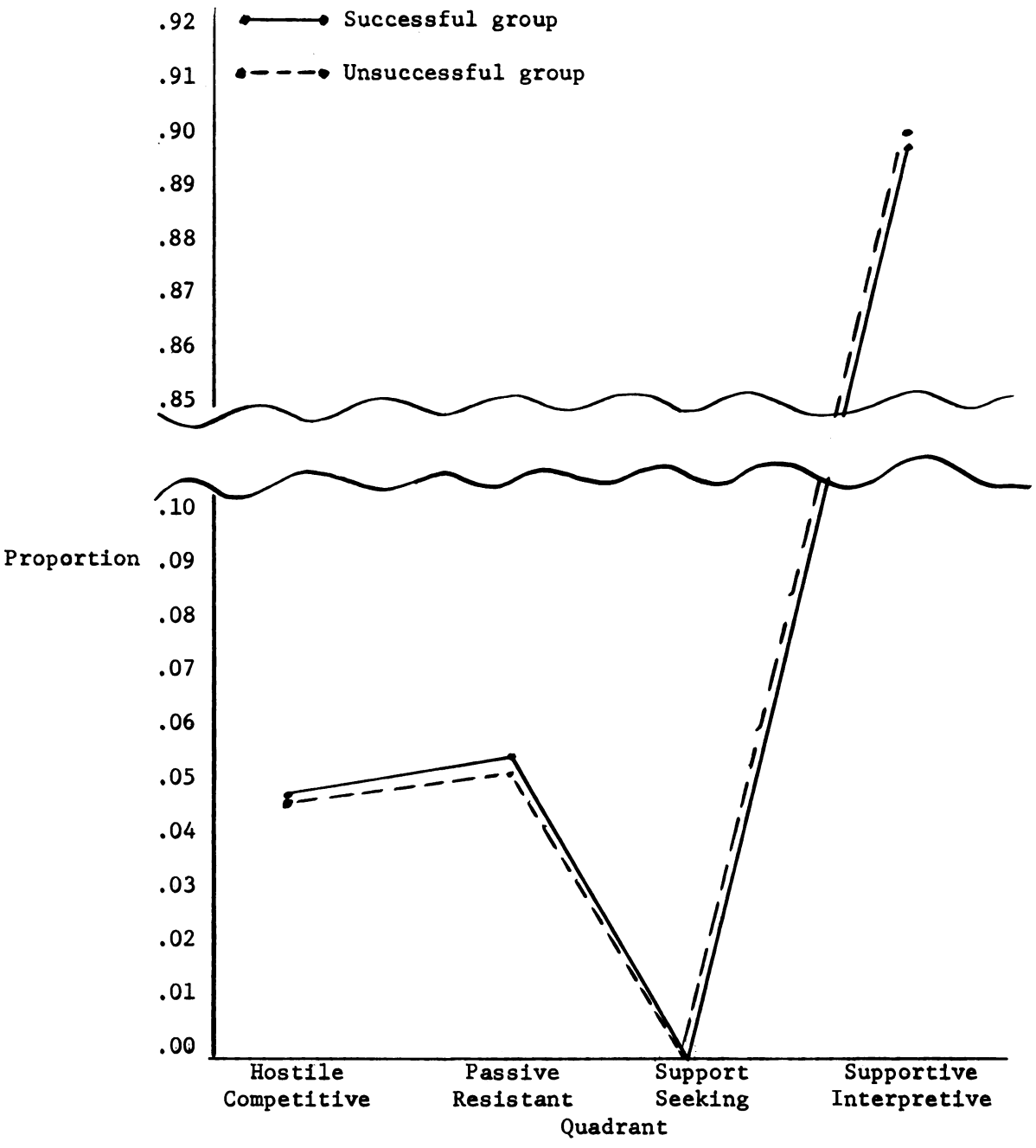

Fig. 9. Proportion of behaviors in each quadrant of the circumplex sent to clients by successful and unsuccessful therapists in middle interviews.

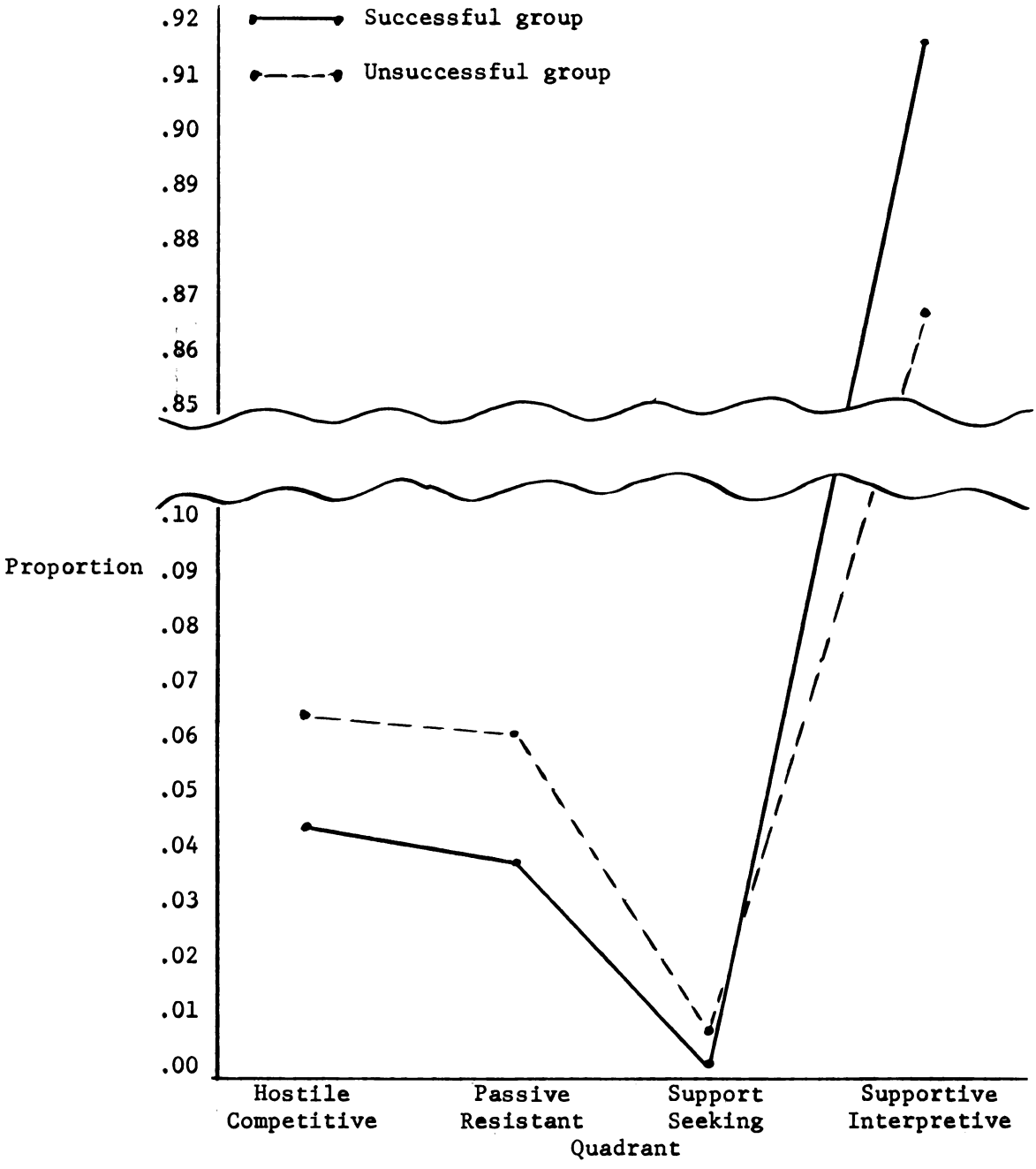

Fig. 10. Proportion of behaviors in each quadrant of the circumplex sent to clients by successful and unsuccessful therapists in late interviews.

Table 17

Comparison of Behaviors of Successful and Unsuccessful Therapists Sent to Their Clients in Three Periods of Psychotherapy: A Quadrant Analysis

Period of therapy	Quadrant	z Score[a]
Early	Competitive-Hostile (BCDE)	3.05**
	Passive-Resistant (FGHI)	-2.45*
	Support-Seeking (JKLM)	1.82
	Supportive-Interpretive (NOPA)	.28
Middle	Competitive-Hostile (BCDE)	.13
	Passive-Resistant (FGHI)	.24
	Support-Seeking (JKLM)	.00
	Supportive-Interpretive (NOPA)	- .18
Late	Competitive-Hostile (BCDE)	-2.47*
	Passive-Resistant (FGHI)	-3.08**
	Support-Seeking (JKLM)	-1.54
	Supportive-Interpretive (NOPA)	4.20***

A. Proportions of quadrant behaviors of unsuccessful therapists were subtracted from proportions of quadrant behaviors of successful therapists. Therefore, negative z scores indicate that the proportion of behaviors of unsuccessful therapists is greater than the proportion of behaviors of successful therapists, and positive z scores indicate that the difference is in the opposite direction.

* $p < .05$ (two-tailed test).

** $p < .005$ (two-tailed test).

*** $p < .001$ (two-tailed test).

groups were found. In the late interviews, the groups were significantly different in their hostile-competitive, passive-resistant, and supportive-interpretive behaviors.

In the early interviews, the successful therapists were more hostile-competitive and less passive-resistant than the unsuccessful therapists. The direction of the differences in hostile-competitive behaviors between the groups reversed in the late interviews. However, the successful therapists continued to react less passive-resistantly than the unsuccessful therapists in the late interviews as they had in the early interviews. Additionally, in the late interviews, the successful therapists had become significantly more supportive-interpretive than the unsuccessful therapists.

CHAPTER IV

DISCUSSION

Transference and Transference Dissipation Questions

On the basis of the data and methodology of this study, transference and transference dissipation cannot be regarded as processes which differentiate successful and unsuccessful cases of psychotherapy. No significant differences were found between the groups when they were compared in terms of transference in the middle sessions, and dissipation of transference, in the late sessions, of client behaviors from parents and significant others to their therapists.

Transference questions. The prediction that the transference of client behaviors from parents and others to the therapist would be greater in successful vs. unsuccessful psychotherapy was tested and rejected. Transference was measured in the middle sessions of therapy. The data revealed that the clients in the unsuccessful group, more than the clients in the successful group, tended to react to their therapists as they had reacted to their parents and others, but this trend was not significant.

The similarity of the behaviors of clients toward their therapists and toward their parents and others was then examined within each group. The data showed that, in middle sessions as compared to late sessions, each group of clients sent to their therapists behaviors which were more similar to the behaviors which they had sent to their parents and others.

The increase in similarity of the compared behaviors was greater in the unsuccessful group than in the successful group. However, the increase in similarity of the compared behaviors in neither group reached statistical significance. Consequently, transference was not empirically demonstrated in either group.

The fact that transference could not be empirically demonstrated in either of the groups, when the process was examined within groups over time, seems to be in conflict with Mueller's (1969b) study in which the occurrence of the transference of client behaviors from parents and others to the therapist was demonstrated. However, these discrepant results may be due to a difference in the methods used in the two studies.

In order to maximize the probability of rating psychotherapy sessions in which transference occurred, Mueller used two criteria to select sessions for analysis. These were (1) high client anxiety and (2) change in the client's perception of his relationship with his parents. The rationale for selecting transference sessions based on the first criterion was that it had often been observed that transference reactions are more likely to occur when the client's anxiety is high. The second criterion was based on the probability that a change in the client's perception of his relationship to his parents would reflect discussion of significant interactions with his parents.

It seems likely that Mueller's method of selecting transference sessions was superior to the method used in the present research in which the median session and the sessions before and after the median session were selected as sessions in which transference occurred.

In retrospect, there are other and more basic assumptions in research designed to study transference which need reconsideration.

The practice of using the client's behaviors toward the therapist in early interviews as a baseline against which his behaviors toward the therapist in later interviews is compared assumes that the client's early-interview behavior is non-transference. This assumption is questionable. It may be that some clients are transferring behaviors at the very beginning of therapy. If this were the case, then the use of the early interview client behaviors as a baseline would attenuate the difference between the "non-transference" and "transference" sessions, and transference may not be statistically demonstrated when it actually occurred.

A questionable basic assumption involved in comparing client behaviors toward his parents and others with client behaviors toward his therapist is the assumption that the therapist's behaviors have no influence on the behaviors which the client exhibits in therapy. Therapists are probably generally, but certainly not always, blank screens upon which clients project transference figures to which they react.

Invalidity of this assumption could result in the labelling of behaviors as transference when, in fact, they were not. This is possible because some behaviors which the client sends to his parents are usually not appropriate in therapy. However, in some interactions in therapy, these behaviors may become appropriate. For example, if a therapist is critical of a client, it would be appropriate for the client to become angry at the therapist. Now if the client had described interactions with his parents in which he had become angry, the similarity of the client's reaction to the therapist and his reaction to the parents would appear to be an instance of transference unless the therapist's stimulation of the client's reaction to him were considered.

The question of whether the client's behaviors toward his therapist are similar to his behaviors toward his parents because of transference or because of reactions to the therapist's stimulation is a difficult one to answer because the therapist may have been previously stimulated by the client to counter-transfer behaviors. Thus, in the example cited above, the client may have provoked the therapist to be as critical of him as his parents had been.

The difficulty may be resolved by testing whether transference occurred only in cases in which the therapist's behaviors remained constant from early sessions to later sessions while the client's responses changed as therapy proceeded. In these cases, the client's change in behaviors could not be attributed to a change in stimulation on the part of the therapist. The results of a study of transference which used only these cases would be less ambiguous than were those results previously reported.

It may be that these instances are randomly distributed during therapy, and that their effect on the measure of transference is negligible. But it is also possible that reactions to the therapist become more like those which the client exhibited toward parents and others solely because of the non-countertransferred stimulation of the therapist. In later interviews as compared with early interviews, it is conceivable that therapists begin to act much more like the clients' parents for reasons other than reaction to the client's need for counter-transference. Thus if parents often were rejecting of the client, and the therapist begins rejecting the client in interviews after the early sessions, the therapist's rejection of the client may be an instance of therapist transference, a reaction not influenced by the client's behaviors.

The procedure, used in this study, of rating only portions of the ongoing therapist-client relationship introduces some invalidity into the data. The interpersonal meanings of specific behaviors would often become clear only when the behaviors were considered within the context of the interaction which occurred previous to the rated behaviors. Clients' statements of laudable changes in their interactions with others might take on different meanings when the statements are considered in terms of previous interactions rather than out of context. Examination of the previous interactions, for instance, might reveal that the client is nurturing the therapist instead of expressing genuine appreciation for his helpfulness. If nurturing the therapist were a transference behavior, it would very likely go unrecorded as such unless the rater knew the quality of the previous therapist-client interaction.

Transference dissipation questions. Since transference dissipation logically presupposes the prior occurrence of transference, it was somewhat superfluous to examine the data in respect to transference dissipation after failing to demonstrate that transference had occurred.

However, the argument against using the initial client reactions to the therapist as a baseline of reality-oriented client behaviors left open the possibility that transference occurred but was not measured. Therefore, since the initial client reactions to the therapist did not enter into the measure of transference dissipation, it was meaningful to consider transference dissipation without being able to demonstrate the occurrence of transference.

The prediction that transference dissipation would be greater in the successful than in the unsuccessful group was tested and rejected. In the late sessions, the behaviors of the clients in the successful

group toward their therapists were no more dissimilar to their behaviors toward their parents and significant others than were the behaviors of the clients in the unsuccessful group toward their therapists and toward their clients and significant others.

The trend, however, was for the clients in the successful group to exhibit more transference dissipation when the behaviors were transferred from parents, and for the clients in the unsuccessful group to exhibit more transference dissipation when the behaviors were transferred from significant others. These trends were evident when the degree of transference dissipation was examined between groups during the late sessions of therapy.

The data were then examined within each group to determine whether transference dissipation had occurred in either group between middle sessions and late sessions of therapy. The data indicated that transference dissipation had not occurred in either group, but that a trend existed toward dissipation of transference of client behaviors from significant others to the therapist in the unsuccessful group.

The previous statement that the method used to select "transference" sessions was perhaps inferior and that the use of better criteria for selection of those sessions might have resulted in the demonstration of transference in this study contains implications concerning the validity of the finding that transference dissipation did not occur in either group. It will be recalled that, within each group, transference dissipation was measured by the difference between the similarity of the compared behavior patterns in middle sessions vs. late sessions. Transference dissipation would have been indicated by greater dissimilarity in the compared behaviors in late sessions than in middle sessions. If the middle sessions were not the best "transference

sessions," the difference in similarity between compared behaviors in these sessions and the late sessions would not be as great as it should be. Consequently, the measure of transference dissipation used in this study may not have been adequate. Thus the possibility that transference dissipation occurred in each group in this study must be left open, and the question of whether transference dissipation occurs in successful cases more than in unsuccessful cases must be left unresolved.

Identification Questions

An attempt to measure some aspects of a client's identification with his therapist was made by comparing the behaviors of the client and therapist. It was assumed that if identification occurred, the client's behaviors toward the therapist over the course of psychotherapy would become more similar to the therapist's behaviors toward the client.

One prediction was that successfully-treated clients would identify more with their own therapists than would unsuccessfully-treated clients with their own therapists. The data showed that the behaviors of the unsuccessful group of clients and therapists were more similar than the behaviors of the successful group of clients and therapists. This difference, opposite in direction from the one predicted, was not significant however.

A second set of predictions involved differences in identification between subgroups of the successful cases. One prediction was that clients in the successful group would identify more with their own therapists than with the "average" successful therapist. Possible changes in client behaviors during psychotherapy might reflect increasing normality. The therapists are assumed to be more "normal" than

clients. Therefore increased similarity in the behaviors of the clients and therapists could possibly be interpreted as an increase in normality of the client rather than an increase in the identification process.

An "average" successful therapist's profile of behaviors was constructed from the profiles of behaviors of all successful therapists. The comparison in late interviews of the similarity of the client's behaviors toward his own therapist and this "average" therapist's behaviors with the similarity of the client's behaviors toward his own therapist and the behaviors of his own therapist revealed no significant differences between the groups. However, there was a trend for the client's behaviors in late sessions to be more similar to the "average" therapist's behaviors.

The cases in the successful group were then divided, and the question of whether the degree of identification differed in same-sex client-therapist dyads and in opposite-sex client-therapist dyads was investigated. Since a high degree of identification of a person with a person of the opposite sex is considered abnormal, it was predicted that identification would be greater in same-sex dyads. Although the data indicated a difference in that direction, the difference was insignificant.

The data were examined between early and late sessions within each group to determine whether identification could be demonstrated in either group. Between early and late sessions, both groups showed increasing similarity of client and therapist behaviors. The greatest increase was in the unsuccessful group. However, neither of the increases in similarity was significant.

If these findings are taken to mean that identification of a client with his therapist does not occur, they obviously are in conflict with a number of other studies (e.g., Schrier, 1953; Welkowitz *et al.*, 1967), and clinical observations (e.g., Albert, 1968; Lampl-de Groot, 1956). Thus it is possible that the method used to study identification in this research was undesirable.

It may be that interpersonal behaviors are not subject to the process of identification. Schrier (1953) and Welkowitz *et al.* (1967) studied different aspects of identification. However, identification in terms of interpersonal reactions seems plausible.

A better explanation appears to be that the role relationships of client and therapist are so rigidly defined that clients would rarely ever behave as the therapist in the relationship. In this study, the behaviors of the therapists were most frequently supportive-interpretive, and the clients exhibited support-seeking behaviors more than any other. Intuitively, it seems that these therapist and client behaviors are most appropriate for their respective roles.

If it is assumed that role-appropriate behaviors are the most therapeutic, then similarity of therapist and client behaviors in psychotherapy would be expected to be greater in unsuccessful cases. Thus the trend for greater similarity found in the unsuccessful cases in this study becomes understandable. This increased similarity in the unsuccessful cases, in the late sessions, was contributed by the therapist's abandonment of his appropriate role, as evidenced by the fact that although successful vs. unsuccessful clients did not differ significantly in their behaviors in these sessions, the successful and unsuccessful therapists did. Furthermore, the data show that the successful therapists were more supportive-interpretive in late sessions than the unsuccessful therapists.

In retrospect, then, it appears that the method used to study identification was inappropriate because of the client and therapist role requirements. The client-with-therapist identification in terms of interpersonal behaviors might best be studied by comparing the therapist's and client's behaviors with others outside of the psychotherapy relationship, where their behaviors would have more freedom to covary.

Exploratory Questions

The questions discussed here are whether successful and unsuccessful therapists, and successfully and unsuccessfully-treated clients differed in the behaviors that they exhibited in psychotherapy. These questions were explored in a general way by comparing the groups of clients and the groups of therapists in terms of broad classes of behaviors.

These broad classes of behaviors are representative of the quadrants of the interpersonal circumplex. These quadrant behaviors each consist of four reflexes of the circumplex. The quadrants are defined in terms of the dominance-submission and affiliation-disaffiliation axes. Beginning at the dominance pole and proceeding counterclockwise around the circumplex, the quadrants were labeled as follows: hostile-competitive, passive-resistant, support-seeking, and supportive-interpretive.

At each stage of therapy, comparisons of the quadrant behaviors were made. The quadrant behaviors of the successful group and unsuccessful group of clients were examined to determine whether differences existed between the groups in terms of the proportions of their behaviors in each quadrant. The successful and unsuccessful therapists were compared in a similar manner.

Comparison of the groups in terms of quadrants has some advantages and disadvantages. The disadvantages include the fact that combining different categories into quadrants results in some information loss, i.e., groups may differ in terms of quadrant behaviors but it would be impossible to determine which of the specific behaviors within the quadrants accounted for the differences. Combining the reflexes might have the effect of canceling out the differences. The advantages are that differences in reflexes may not reach significance, but these differences could summate to reach significance, and that quadrant behaviors are more reliably rated than reflex behaviors.

Comparison of the clients. The results of the analysis revealed that clients in successful vs. unsuccessful therapy differed significantly in some quadrant behaviors in early and middle sessions, but that their quadrant behaviors in late sessions were not significantly different. In the early sessions, the client groups differed significantly in all quadrant behaviors, whereas in the middle sessions they differed in two classes of behaviors. Thus, in terms of their quadrant behaviors, the client groups converged over the course of therapy.

As it was previously pointed out, intuitively, it would seem that client behaviors in the support-seeking class are more conducive to the process of effective psychotherapy than client behaviors in the other categories. Support for this assumption was indicated by the analysis of some of the differences in the behaviors of the client groups. In the early and middle sessions, the successfully-treated clients sent proportionately more support-seeking behaviors to their therapists than the unsuccessfully-treated clients. Likewise, the clients in the successful group were less passive-resistant in early

and middle sessions, and less supportive-interpretive in early sessions, than clients in the unsuccessful group. Apparent lack of support for the assumption comes from the finding that clients in the successful group, during early sessions, were more hostile-competitive than clients in the unsuccessful group.

It may be that passive-resistant client behaviors inhibit therapeutic interaction more than hostile-competitive client behaviors, and that they are also less flexible than supportive-interpretive or hostile-competitive client behaviors. That this is probably the case is illustrated by the fact that in the middle interviews the clients were no longer differentiated by their hostile-competitive and supportive-interpretive behaviors, but continued to be different in the same direction in passive-resistant behaviors. Added support comes from Leary's (1957) report that clients differentially diagnosed could be differentiated by their interpersonal behaviors, and that clients diagnosed as depressives used proportionately more behaviors in the passive-resistant quadrant than other clients. Since depressives are notorious for their fortitude in resisting change, the suggestion is that differences between clients in regard to their passive-resistant behaviors is a reliable index of their prognosis in therapy.

Although more rigid than supportive-interpretive and hostile-competitive behaviors, passive-resistant behaviors are subject to change. In the late interviews, the client groups were no different in respect to passive-resistance, and a close examination of the data revealed that the increased similarity between the groups in the late interviews as compared to the middle interviews in terms of passive-resistance was contributed by a decrease in the proportion of passive-resistant behaviors on the part of the clients in the unsuccessful group.

Comparison of the therapists. The question of whether the successful and unsuccessful therapists differed in terms of their quadrant behaviors was examined in the same manner as the similar question about the clients. The analysis indicated that the successful and unsuccessful therapists differed significantly in some quadrant behaviors in early and late sessions but that they were not different in the middle sessions.

It would seem that behaviors of therapists can be differentiated in terms of their appropriateness to the role of the therapist. Supportive-interpretive behaviors seem to be most appropriate for the therapist while the other quadrant behaviors seem to be less appropriate. The findings in the late interviews are consistent with this assumption. The successful therapists in these interviews were significantly more supportive-interpretive, and less hostile-competitive and passive-resistant than unsuccessful therapists. In early interviews, too, the successful therapists were less passive-resistant than the unsuccessful therapists. Inconsistent with the assumption was the finding that successful therapists were more hostile-competitive in early interviews.

It is interesting that, in the early interviews, clients and therapists in each group were similar to each other and different from the other group with respect to their within-group interpersonal behavior. That is, successful therapists and their clients were proportionately more hostile-competitive and less passive-resistant than the unsuccessful therapists and their clients. These findings suggest that hostile-competitive behaviors elicit hostile-competitive behaviors and that passive-resistant behaviors pull behaviors of the same kind in the early sessions of psychotherapy. This interpretation is consistent with Leary's (1957) report regarding the kinds of behaviors elicited by

categories of the circumplex. It is more closely comparable, however, to Mueller's (1969b) study in which he found that, in early interviews, client hostile-competitive and therapist hostile-competitive behaviors were significantly correlated, as were their passive-resistant behaviors.

An interesting question arises at this point: if the above behaviors elicit the same kind of behaviors, did the clients or their therapiests initially stimulate those behaviors in the other participant in the interaction? This question cannot be answered on the basis of the data collected in this research. In the above discussion of the findings in relation to the client behaviors in successful vs. unsuccessful groups, the assumption was made, however, that clients who interacted more passive-resistantly were more difficult to treat. That assumption was supported by the observation that prognosis in therapy is somewhat dependent on psychiatric classification, and that psychiatric classification is related to characteristic types of interpersonal interaction. That assumption was further supported by the finding in this research that unsuccessfully-treated clients were more passive-resistant in their behaviors than successfully-treated clients.

A corrollary of the assumption that clients provided the initial stimulation of the correlated behaviors is that clients may have more control over the relationship than therapists. Additional consideration of role relationships of clients and therapists and typical behaviors of each suggests that this may, in part, be true.

The role requirements of therapists may provide more rigid boundaries for their responses than the role requirements of clients. The data indicate that this is true. Both unsuccessful and successful groups of therapists, regardless of the period of therapy, respond supportive-interpretively 85 to 92% of the time. Therefore, only a

small proportion of their responses are free to vary. The quadrant most frequently used by the clients is the support-seeking quadrant. However, only 35 to 47% of their responses are included in this category. Consequently, they used other types of behaviors more frequently than therapists. Thus they are more likely to provide stimulation in the hostile-competitive and passive-resistant quadrants, and these behaviors are apparently reciprocated by therapists a small proportion of the time.

Yet therapists obviously have some effect on the behaviors of their clients. But the dimensions along which therapists vary and which are critical to the effect of the therapist on the client may not be measured by the interpersonal rating system. Therapists may differ more in the quality of their supportive-interpretive behaviors than in the frequency of those behaviors. Ratings of therapist behaviors into this quadrant are not based upon their potency. An attempt to reflect feelings is rated into this quadrant without regard to its adequacy. Interpretations, as long as the intention on the part of the therapist is to be helpful, are rated similarly without regard to their accuracy.

Returning to the data, the assumption is, therefore, that the initial therapist hostile-competitive and passive-resistant behaviors were stimulated by the clients. Also, the differences between the therapists in late interviews may have been latent responses to client reactions. Thus early and middle sessions passive-resistant behaviors on the part of the clients in the unsuccessful group may have stimulated their therapists to respond passive-resistantly and hostile-competitively in the late interviews. This possibility is partially supported by Mueller's (1969b) finding that early client passive-resistance was

significantly related to therapist passive-resistance later on in therapy.

The discussion of the findings in the present research that the unsuccessfully-treated and successfully-treated clients and unsuccessful and successful therapists differed significantly in the proportions of some classes of their behaviors included an assumption that should be tested by future research. Whether it is the clients and not their therapists who stimulated the differences between the groups should be tested empirically. This could be accomplished by studying the interpersonal behaviors of several clients with the same therapist. If the interpersonal behaviors of the therapist vary from client to client, support for the assumption would be provided.

CHAPTER V

SUMMARY

A client's transference of behaviors from familial and extra-familial relationships to the therapist is a frequent occurrence in psychotherapy and a phenomenon which the therapist can manipulate to promote change. The resolution of the transference reactions in psychotherapy has often been regarded as indicative of client change. The study of the relationship between the occurrence of transference and transference resolution and outcome of therapy was a primary focus of this research.

The clinical observation that clients, during the course of psychotherapy, often take on characteristics of their therapists was a second primary focus of this research. Clinicians have frequently considered identification of a client with his therapist as a factor promoting client change. The relationship between identification and psychotherapy outcome was investigated, as well as the relationship between identification and the sex similarity and dissimilarity of the study subjects in each client-therapist dyad. Also investigated was the question whether the behavioral similarity of a client and his therapist at the end of therapy reflected identification or a change toward normality.

A secondary purpose of this study was to examine, during psychotherapy, the interpersonal behaviors of the clients and therapists in

successful vs. unsuccessful cases. The question of whether successful vs. unsuccessful therapists differed in their interpersonal behaviors was investigated. Likewise, the possibility was explored that the interpersonal behaviors of clients in successful vs. unsuccessful cases differed.

Hypotheses regarding transference were that clients in the successful group would transfer more behaviors from parents and significant others to their therapists during the middle phase of psychotherapy than would clients in the unsuccessful group, and, similarly, that dissipation of transference would be greater in the successful than in the unsuccessful group. Identification hypotheses consisted of the prediction that clients in the successful group would identify more with their therapists than would clients in the unsuccessful group. Within the successful group, one hypothesis was that clients would become more similar to their own therapists than to an "average" successful therapist. It was also hypothesized that, within the successful group, clients who were of the same sex as their therapists would identify more with their therapists than would clients who were of the opposite sex of their therapists. Exploratory questions were asked regarding possible differences in interpersonal behaviors of clients and therapists in successful vs. unsuccessful cases. No specific predictions were made regarding those possible differences.

Twenty-five cases were selected for the study from those on file in the tape library at the Michigan State University Counseling Center. These cases were divided into (N=15) successful and (N=10) unsuccessful cases based on ratings of client's pre- and post-MMPI profiles by three judges. Fifteen-minute segments of three sessions in each of the early, middle, and late stages of therapy were selected for analysis to test the hypotheses and investigate the exploratory questions.

The interpersonal circumplex (Leary, 1957) was used to rate the behavioral interactions of the study subjects, as well as the reported behaviors of clients with their parents and others. Thus the segments of the psychotherapy sessions were rated twice. The first time, the interaction of the client and therapist was rated, and the second time, the reports of the client's interaction with parents and others were rated. The interactions were rated by two graduate students following a training period during which they established the ability to use the system reliably.

The test of the transference and transference dissipation hypotheses involved comparing the client's reported behaviors toward his parents and significant others with his actual behaviors toward the therapist at different stages of therapy. Since the hypotheses concerned differences between the groups, the similarity of the compared behaviors in one group was contrasted with the similarity of the compared behaviors in the other group. The results indicated that transference and transference dissiptation was no greater in the successful than in the unsuccessful group. Further analysis of the data revealed that transference and transference dissipation, as the study was designed to measure them, did not occur in either of the groups. These results were discussed in terms of (1) the probability that the selection of the sessions for the measurement of transference was unsatisfactory, and (2) the limitations of the overall methodology in studying transference and transference dissipation.

Testing the identification hypotheses involved comparing the behaviors of the client in psychotherapy with his therapist's behaviors. The hypothesis that clients in successful therapy would identify more with their therapists than clients in unsuccessful therapy was rejected.

Further, within neither group was the process of identification demonstrated. The prediction that, in the successful cases, clients would behave more similarly to their own therapists than to an "average" successful therapist was rejected. The hypothesis that identification would be greater in same-sex dyads as compared to opposite-sex dyads of successful cases was also rejected. It was suggested that the roles of the therapist and client demanded separate behaviors, and, consequently, that the method used to study identification was not appropriate.

Significant differences were found when the behaviors of the clients in successful and unsuccessful cases were compared. The significant differences in the behaviors of the clients in the two groups dissipated over time in psychotherapy. Clients in the successful group, as compared with clients in the unsuccessful group, were significantly more hostile-competitive and support-seeking, and less passive-resistant and supportive-interpretive in early interviews. They were also more support-seeking and less passive-resistant in the middle interviews, but the client groups did not differ significantly in their behaviors during the late sessions.

The interpersonal behaviors of successful therapists and unsuccessful therapists were found to be significantly different in early and late interviews. Successful therapists, as compared with unsuccessful therapists, were more hostile-competitive, and less passive-resistant in early interviews, and more supportive-interpretive and less hostile-competitive and passive-resistant in the late interviews.

These findings were discussed in terms of the possible relationship between the different group behaviors and outcome. The need for further

research was cited to determine whether initial differences in interpersonal behaviors of the clients in the two groups caused the differences in the interpersonal behaviors of their therapists.

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APPENDICES

APPENDIX A

Study Cases

Client ID	Therapist Sex	Client Sex	Number of Interviews	Therapist Level[a]	MMPI Outcome Rating[b]
011 ✓	M	F	18	I_1	S
017	F	F	16	I_1	S
021	M	M	10	I_2	S
024 ✓	F	M	12	S	S
031 ✓	M	M	19	I_1	U
037 ✓	M	M	17	I_1	S
039 ✓	M	M	9	I_1	U
040	F	F	17	I_1	U
042 ✓	M	F	18	S	U
043 ✓	M	M	16	S	U
044 ✓	M	M	14	S	S
046	M	M	9	P	U
047	M	F	12	P	S
050 ✓	M	F	13	P	S
054	M	F	41	P	U
801	M	F	24	S	S
812	M	F	12	S	S
817 ✓	F	F	20	S	U
818 ✓	M	F	16	I_1	S
823 ✓	M	F	21	I_2	U

Client ID	Therapist Sex	Client Sex	Number of Interviews	Therapist Level[a]	MMPI Outcome Rating[b]
828	M	F	13	S	S
831 ✓	M	M	24	S	U
845 ✓	F	F	15	I_1	S
848 ✓	F	F	12	I_2	S
859	M	F	12	S	S

a. I_1 = first-year intern, I_2 = second-year intern, S = senior staff, P = practicum student.

b. S = successful case, U = unsuccessful case.

APPENDIX B

MMPI Ratings

Client ID	Judge 1 Ratings 1st	Judge 1 Ratings 2nd	Judge 2 Ratings 1st	Judge 2 Ratings 2nd	Judge 3 Ratings 1st	Judge 3 Ratings 2nd	Average Ratings of All Judges
011	5	5	5	5	5	5	5.00
017	4	4	3	4	2	2	3.17
021	4	4	1	2	4	4	3.17
024	5	5	5	5	5	5	5.00
031	4	4	1	2	3	3	2.83
037	4	4	1	2	4	4	3.17
039	4	4	1	2	3	3	2.83
040	3	2	3	3	3	3	2.83
042	3	3	4	1	2	2	2.50
043	2	3	4	2	3	3	2.83
044	5	5	3	4	4	5	4.33
046	5	4	2	2	2	2	2.83
047	5	5	5	5	5	5	5.00
050	5	5	4	4	5	5	4.67
054	4	4	2	2	3	3	3.00
801	5	5	2	2	4	4	3.67
812	4	5	3	3	3	3	3.50
817	1	2	3	3	2	2	2.17
818	5	5	5	5	5	5	5.00
823	2	2	1	1	2	2	1.67

Client ID	Judge 1 Ratings 1st	Judge 1 Ratings 2nd	Judge 2 Ratings 1st	Judge 2 Ratings 2nd	Judge 3 Ratings 1st	Judge 3 Ratings 2nd	Average Ratings of All Judges
828	4	5	4	4	4	4	4.17
831	2	1	1	1	2	3	1.67
845	5	5	5	5	5	5	5.00
848	5	5	5	5	5	5	5.00
859	5	4	5	5	5	5	4.83

APPENDIX C

Scoring Manual for the Interpersonal Behavior Rating System[1]

General Considerations

The interpersonal circumplex consists of 16 reflexes (categories) of interpersonal behavior, into which all interpersonal behaviors may be rated. It is divided into quadrants by orthogonal axes. The vertical axis covers the dimension of dominance-submission, while the horizontal axis represents the affiliative-disaffiliative (or love-hate) dimension.

In rating behaviors into categories, the behaviors are first judged in terms of the axes, and thus the behaviors are placed into quadrants of the circumplex. Then, a behavior is judged into a specific category within the quadrant by matching it with the descriptive terms of those categories. Statements sometimes include behaviors of more than one category, in which case multiple scorings should be used.

Problems arise because (1) the categories are not mutually exclusive, (2) the meaning of behaviors are determined partly by the context in which they occur, (3) affect and content (i.e., words) are sometimes incongruent, and (4) raters may use different levels of interpretation. These problems are demonstrated below by the use of a few examples.

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[1] Freedman, M. B., Leary, T. F., Ossorio, A. G., and Coffey, H. S. The interpersonal dimensions of personality. *Journal of Personality*, 1951, 20, 143-162.

Consider the client statement: "I like you." If this statement were genuine, it would be rated "M". If it were said sarcastically, it would be rated "D". If it came after an interpretation which the client did not want to deal with, it would be rated "F".

For another example, consider the following client statement: "You look tired today." If this statement connoted genuine sympathy, it would be rated "N". If it came out of the client's guilt for seeking help from the therapist, it is possible to argue that it should be rated "H", but this rating would require deeper interpretation than the sympathetic "N".

The client statement, "I don't trust you," implies distrust "G" and rejection "C". It is necessary to choose one or the other in this rating system.

In rating the client and therapist behaviors, the following priorities are listed so that the above problems will be minimized: (1) Context takes precedence over affect, (2) affect takes precedence over content, and (3) interpretation does not go beyond the immediate context.

Three types of reported client-to-other behavior are scored. These are (1) client's reports of actual interaction with others, (2) client's fantasized interaction with others (includes wishes, desires, should-haves, and fears), and (3) client's feelings about others as reflected in his statements about them. The following examples illustrate these categories:

(1) C: "My parents told me that I shouldn't get serious about any girls while I'm here. I told them to stay out of my affairs."

(2) C: "I wish I had some close friends."

C: "I'm afraid that people will reject me."

C: "I should have told her off."

(3) C: "I distrust my parents."

C: "They are selfish people."

Below, examples of behavior for each category are listed, and, where deemed helpful, explanatory statements are included. It is impossible to provide examples for some of the meanings of some reflexes, because the meanings are sometimes very dependent on the tone of voice, e.g., sarcastic behavior (reflex "D").

Examples of Behavior for Each Category

Reflex "B" (Boasting, Self-Stimulating, Narcissistic, Intellectualizing Behavior

Therapist and client "B".

1. Therapist or client is boastful. Examples:

   C: "I made the highest score on the final examination."

   C: "Looks like I really helped you."

2. Wandering, free-associating, conversation in which the speaker provides his own stimulation. This category usually applies more to the client than the therapist. Examples would include client statements in which a "list" of activities since the previous session is covered without emotion, and without a previous therapist eliciting question. This is generally a long, rambling statement, which may have been started by a therapist question, but which continued with the client

providing his own stimulation. In this case, the client's statement would be rated in two parts, the answer to the therapist's question would be rated an "L", and the rest of the client's statement a "B".

3. Therapist or client intellectualizes.

   Therapist example:

   C: "I feel really affectionate toward you."

   T: "That's because you once had that feeling toward your father."

   Client example:

   T: "What is it that's troubling you?"

   C: "I haven't worked out my Oedipus complex."

Client-to-other "B".

1. Client reports boasting to others.

   C: "I told him how wonderful I am."

2. Client reports having been narcissistic with others.

   C: "I took advantage of her."

Reflex "C" (Rejecting, Withholding, Competing, Accusing)

Therapist and client "C".

1. Client or therapist rejects previous statement (regardless of whether previous statement was true). Examples:

   C: "No, that isn't right. What bothers me is that no one seems to really care for me." In this example, the "No, that isn't right" would be rated "C". The second part would be rated "P" if no strong emotions were attached to it. Of course, if the client

expressed feelings of hurt or sadness, the second part may be rated "K". A "no" statement following a therapist question with no point of view attached (i.e., where therapist does not make a positive statement that is subsequently rejected) should be rated "L" instead of "C".

2. Client and therapist are arguing, competing, usually with an undercurrent of hostility.

   Examples:

   T: "You can find people like that in New York."

   C: "I've looked and there are no people like that here."

   T: "You haven't looked in the right places. You've met only a few people here."

   C: "I know I can't find people like that here. I need to go somewhere else."

   The first therapist statement in this interchange may not be rated a "C", depending on the previous client statement that elicited it. For instance, if the previous client statement had been "I need to find some people that I could trust," the first therapist statement above might be rated "P".

3. Client or therapist refused a previous suggestion, directive, etc.

   T: "I will not see you twice a week."

   C: "No matter what you say, I won't stay here."

Client-to-other "C".

1. Client reports rejection of others.

   C: "I don't like him."

2. Client reports competing with others.

   C: "I tried to beat him at his own game."

Reflex "D" (Sarcastic, Threatening, Punishing Behavior)

Therapist and Client "D".

T: "If you don't get out of that relationship, I'll stop seeing you."

C: "People are going to keep bugging me until I kill myself."

Client-to-other "D".

C: "I told him that if he continued to harass me that I wouldn't see him anymore."

Reflex "E" (Hate, Attack, Disaffiliate)

Therapist and Client "E".

T: "Get out of my office."

C: "Go to hell."

T: "You're an idiot."

Client-to-other "E".

C: "She's nothing but a whore."

C: "I broke up with him."

C: "I hate my mother."

Reflex "F" (Complain, Rebel, Nag, Sulk, Passively Resist)

Therapist and Client "F".

1. Client passively resists therapist's interpretation put in the form of statement or question.

   Examples:

   a. T: "Sounds like you get anxious around competent females."

      C: "I don't know."

   b. T: "Is it that your boyfriend reminds you of your father in some ways?"

      C: "I don't know. (pause) One thing that really disturbs me is that I can't concentrate when I study."

   c. T: "Do I hear some resentment in there?"

      C: "I don't know. (pause) You may be right. Yeah, I wasn't aware of it but I really do resent him for that."

   Note: In example a, the client's "I don't know" is rated "F", because it indicates passive resistance to the therapist's statement. In these cases, the client is demonstrating an unwillingness to even consider the validity of the statement, but at the same time is not flatly rejecting it either. In example b, the "I don't know" is followed by the change of subject. In this case, it is rather obvious that the change of subject is a defensive maneuver, seemingly unrelated to the therapist's

question. The "I don't know" should be scored "F", and the change of subject should be scored "A". In example c, the "I don't know" was intended to indicate thoughtfulness, an attempt to deal with the therapist's question, which is validated by the rest of the client's statement. In this example, the "I don't know" is not scored, but the remainder of the statement should be enclosed in parentheses and scored "L".

2. Sometimes the therapist or client angrily withdraws (sulks), with some such comment as "I don't know." These should be scored as "F".

Client-to-other "F".

C: "I resented his saying that, but I didn't say anything."

C: "When Dad yelled at me, I went to my room and didn't come out for hours."

Reflex "G" (Distrust, Suspect, Be Skeptical)

Therapist and client "G".

1. Therapist or client expresses skepticism at the previous statement of the other party. Examples:

"What?"

"What do you mean?"

"Maybe."

The first two examples would be scored "G" when the previous statement and its meaning were perfectly clear. The "maybe" expresses incomplete acceptance, or, better, neither rejection nor acceptance, but does express skepticism.

2. Therapist or client is suspicious of feelings, motives, etc., expressed by the other party. Examples:

   C: "I don't think you really like me."

   T: "Are you sure you're dealing with the thing that's really bugging you?"

   Note: If the statement is an unconditional rejection or accusation (e.g., "You don't like me!"), it should be rated "C", not "G".

Client-to-other "G".

C: "I didn't believe her."

C: "Sometimes, it seems like no one can be trusted."

Reflex "H" (Condemn Self, Withdraw)

Therapist and client "H".

C: "I feel worthless."

T: "You wouldn't feel that way if I were a good therapist."

Client-to-other "H".

C: "I guess I should have confronted him, but I didn't know what to say, so I left."

Reflex "I" (Submit, Defer, Obey)

Therapist and client "I".

1. Client or therapist submits more to avoid confrontation than to accept a statement because of its validity. This sometimes occurs after an argument, or to end an argument.

2. Client expresses extreme helplessness, inability to cope, without underlying belief that change is possible, that therapist will help.
3. "I guess so," and "yeah" responses, which are total responses, when the therapist is actually trying to elicit elaboration on something, or after therapist has made a statement about something.

Client-to-other "I".

C: "I didn't want to go to college, but Mom insisted."

C: "They take advantage of me."

Reflex "J" (Ask Opinion, Praise, Admire)

Therapist and client "J".

C: "What should I do?"

C: "You're the best therapist in the Counseling Center."

Client-to-other "J".

C: "I asked her what she would do if she were me."

C: "They're all so great -- intelligent and sensitive."

Reflex "K" (Ask for Help, Depend, Trust)

Therapist and client "K".

C: "This problem arose which I hope you will help me with..."

Client-to-other "K".

C: "I trust her."

C: "I depend on them."

C: "I asked him to help me repair the car."

Reflex "L" (Cooperate, Confide, Collaborate, Agree)

Therapist and client "L".

1. Client cooperates with therapist, works on problems, answers questions, elaborates on reflective or interpretive statements. Examples:

   T: "How old is your sister?"

   C: "She's 18."

   T: "It sounds like you have difficulty in accepting positive feelings."

   C: "Yeah, I think you're right. The other day my roommate said she liked me, and..."

   Note: a. Sometimes it is difficult to discriminate between elaboration and self-stimulating conversation. In general, self-stimulating conversation is much longer, and less affect-laden. Also, the focus of self-stimulating conversation shifts frequently.

   b. When the client's agreement comes after an argument, is less sincere, and without elaboration to support it, "I" instead of "L" should be scored.

2. Client's "Yeah" statements which merely lubricate comments coming from the therapist. Examples:

   T: "You remember last week when we were talking about sex."

   C: "Yeah."

   T: "You got very angry with me."

C: "Yeah."

T: "Well, I was wondering why that made you mad."

Client-to-other "L".

C: "I went over and started a conversation with her."

C: "We told each other our problems."

Reflex "M" (Affiliate, Identify With, Love)

Therapist and client "M".

T: "I really like you."

C: "I feel close to you today."

Client-to-other "M".

C: "I dated him for two years."

C: "I care a lot about my Dad."

C: "We seem to have the same feelings about everything."

Reflex "N" (Support, Sympathize, Reflect Feelings, Reassure, Generalize Conscious Feelings, Approve, Nurture, Therapeutic Probe)

Therapist and client "N".

C: "I'm sure you're intelligent, and capable of making it here." (Support, reassure)

T: "Sounds like you're very lonely, and feeling incapable of establishing any real friendships." (Reflect feelings)

T: "You said that your father really preferred your brother?" (Therapeutic probe)

C: "Looks like you're very tired today." (Sympathize)

C: "Well, I think you're doing a very good job." (Support)

Note: The above therapist statements are rated "N" only if he is responding to data and feelings in the previous client statements. For instance, if the third therapist statement above had come after a client had said "I had final exams yesterday," the therapist statement would be rated "A" (Directive). As a rule of thumb, reflecting feelings, therapeutic probes, generalized feelings, when rated "N", must come after a client statement which contained that data that is reflected, generalized, etc. Of course, support and reassurance, to be rated, does not suffer this limitation. The client statement above is rated "N" if it seems genuinely sympathetic; the fact that it may be prompted by guilt over receiving help is irrelevant to the rating system.

b. Reassurance occasionally turns into an argumentative, competitive exchange, in which the first therapist statement should be rated "N", but the following ones should be rated "C": Example:

T: "I know you can handle it." (Supportive)

C: "I know I can't!" (Angry)

T: "No, you don't *want* to, but I know you can!"

Client-to-other "N".

C: "I told her that everything would turn out all right."

C: "I can understand her feelings about that."

Reflex "O" (Give Help, Interpret Beyond Conscious Feelings)

Therapist and client "O".

T: "If ;you feel up tight next week, we could meet twice."

T: "Your relationship with your boyfriend appears to be similar to the one you had with your father."

Client-to-other "O".

C: "Mom had her hands full, so I helped her with the dishes."

C: "I wish I could help him feel better about himself."

Reflex "P" (Advise, Teach, Give Opinion, Inform)

Therapist and client "P".

1. Therapist or client gives opinion, acts as authority on the state of things in the world. Examples:

   T: "The way I see myself as being helpful to you is in trying to understand you, and in the process, helping you to understand yourself."

   T: "To get some information about your interests, you should take the Strong."

   T: "You may have that feeling, but not be aware of it. It may be unconscious."

   C: "In my experience, I've found that people in this society are like that."

   C: "To make money farming, you have to do most of the work yourself. If you hire people to work for you, your expenses will be greater than your income."

Note: a. "P" is often scored after "C" in the same statement (example: "No, I don't really feel that way. The way I feel is..."). Of course, if rejection is not followed by explanation, "P" would not be scored. If the whole statement is a rejection of the previously stated point of view, with an argument as to why the speaker's point of view is correct, or just an assertion that he is right, the whole thing should be scored "C". "C..."A" or "C..."B" might also be scored (i.e., rejection might be followed by a change of subject or self-stimulating conversation).

b. Sometimes, statements of the way things are in the world are made to reassure, and should therefore be scored "N" instead of "P". Example:

C: "I really feel like I'm coming apart!"

T: "When people begin to change, they often feel like they're disintegrating. That seems to be what's happening to you."

Client-to-other "P".

C: "I taught him how to water ski."

C: "When he asked for my advice, I told him what I would do."

Reflex "A" (Dominate, Direct, Command, Diagnostic Probe, Independent Behavior)

Therapist and client "A".

1. Therapist or client changes subject, begins new topic.

   Note: Occasionally, a change of subject should not be rated "A". Example:

   C: "Yes, I do have finals next week. (pause) I hate you."

   In this example, strong emotion is expressed in the change of subject. In this case, the rating would be "L"..."E".

2. Therapist asks questions of an information-gathering kind. Example:

   T: "How old are you?"

3. Therapist or client is dominating, bossy. Example:

   T: "Do your studying between three and six o'clock." (When no advice was asked for.)

Client-to-other "A".

C: "I said, 'Judy, quit school and go to work.'"

c: "I decided to leave my parents, because I felt like it was time for me to stop depending on them so much."