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A METHOD FOR ASSESSING PATIENT WORK IN THE TRANSFERENCE

by

Annette DeMichele

A dissertation submitted to the Graduate Faculty in Psychology
in partial fulfillment of the requirements for the degree of
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Abstract

A Method for Assessing Patient Work in the Transference

by

Annette DeMichele

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This study involves the development and application of a new research measure aimed at tracking patient work in the transference. Unlike existing transference-related measures that formulate central relationship patterns or dynamic themes, the measure developed here codes patient associations on the basis of whether, and how directly, the patient speaks about reactions to the analyst or the treatment situation.

An existing measure, the Patient's Experience of the Relationship with the Therapist (PERT), was used as a starting point (Gill and Hoffman, 1982). Although PERT is the only other measure that attempts to map onto the moment to moment manifestation of the transference in the unfolding analytic process, it has been little used in psychotherapy research, largely due to problems in attaining interrater reliability. A significant modification that was made to the PERT scheme was to replace its central feature of coding implicit allusions to the transference with a variable intended to capture the indirect, often fleeting, references patients make to the analyst or the treatment. Such references may well signify the same kind of clinical process PERT was uniquely poised to detect, without the level of inference and subjectivity inherent in that coding scheme.

The measure created in this study, Verbal Indicators of the Transference (VIT), was applied by two independent raters to thirty-six sessions taken from the

early, middle and late phases of three recorded psychoanalyses. Reliability was assessed and ratings support the viability of the measure. In addition, two exploratory hypotheses concerning the effects of focusing analytic work on the transference were tested. Findings indicate that in the sessions under study the most productive kind of therapeutic interaction was one in which the patient referred to the analyst or treatment and the analyst followed with a transference interpretation, as compared to clinical sequences where the patient referred to the analyst or treatment but the analyst did not encourage elaboration, or sequences where there was no indication that the transference was live for the patient but the analyst introduced it.

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"[T]he problem of 'objectifying' the classification of the patient's verbal behavior is so complex that when you begin to think hard about it the most natural response is to throw up your hands in despair." Paul Meehl, Some methodological reflections on the difficulties of psychoanalytic research.

I. INTRODUCTION[1]

Psychoanalysis is a unique and potentially powerful treatment method. Yet precisely how psychoanalysis cures--what factors or conditions contribute to its effectiveness--remains largely an open question. Indeed, whether psychoanalysis is a valid enterprise at all has become an increasingly suspect notion, particularly in the context of the economic and social forces currently shaping the health care industry in the United States.

Repeated challenges from the larger community notwithstanding, psychoanalytic theories of treatment are all too often steadfastly defended by those within the profession in the absence of empirical support. Although research on the process and outcome of psychoanalysis could serve to inform both its supporters and detractors, such efforts are neither easily undertaken nor readily embraced.[2] A recent observation by Emde and Fonagy (1997)--underscoring the importance of psychoanalytic research-- raises as well its complicated import in that accepted theoretical beliefs are necessarily challenged: "[A] culture of research in psychoanalysis involves a shift from choosing between useful theories according to the cogency of argument (as in much of our past discourse) to choosing between useful theories according to evidence" (p. 644).

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[1] This research project was generously funded by the International Psychoanalytical Association and the Fund for Psychoanalytic Research of the American Psychoanalytic Association.

[2] For a thoughtful discussion of the numerous obstacles to systematic psychoanalytic research, see Reppen's (1982) interview with Merton Gill. It is worth noting that, although this discussion occurred almost two decades ago, virtually all of the problems cited by Gill continue to plague the field today.

Since Freud, there has been a proliferation of useful theories and technical proposals aimed at pinning down the mechanisms of change at the heart of the psychoanalytic method. The relative roles of free association, unconscious fantasy, insight, interpretation, analytic neutrality, genetic reconstruction, resistance analysis, all have been the subject of much deliberation and fruitful dissent. While participants in the process have claimed that "structural changes" in personality can be achieved, researchers have struggled even to define such effects, let alone systematically connect them to what actually transpires in treatment.

Along these lines, while analysis of transference constitutes a central tenet of the psychoanalytic method, how or to what extent transference is linked to the therapeutic success of psychoanalysis has only begun to be examined as a research question. There is considerable theoretical support for the idea that helping patients to elaborate their reactions to, or fantasies about, the analyst is an important component of effective treatment. To what extent, or under what circumstances, this may be true--beyond the weight of the most persuasive argument or compelling case report--is not exactly known.

It is possible, for example, to posit that when the here-and-now transference is most active and articulated in the treatment setting, patients will be most emotionally available for meaningful and lasting change to occur. Conversely, a failure to focus on the analysis of the transference in the here-and-now may limit, or even impede, therapeutic progress. While there is essentially no empirical foundation underlying such a perspective, it can claim strong theoretical roots (Freud, 1912, 1917; Strachey, 1934; Gill, 1979, 1982).

The aim of this study is to develop a psychoanalytic process measure that can be used to test this theoretical position and related clinical questions concerning the role of transference in psychoanalytic treatment. Specifically, the study will entail the design of a research method capable of capturing and characterizing the ebb and flow

of the patient's direct as well as indirect work in the transference, over the course of a session or an entire treatment. Once such a method is reliably established, it will be possible to investigate various hypotheses regarding the effects of focusing analytic work on the transference.

Unlike existing transference-related measures that formulate central relationship patterns or dynamic themes, the measure developed here will seek to identify and categorize the moment to moment process in a session that reflects the patient's involvement in the treatment relationship. In particular, statements will be coded on the basis of whether, and how directly, the patient speaks about reactions to the analyst or the treatment situation.

An existing process measure, the Patient's Experience of the Relationship with the Therapist (PERT), will be used as a point of departure. Developed by Merton Gill and Irwin Hoffman in the early 1980's, PERT remains the only process measure that seeks to identify when a patient is talking about the relationship with the analyst, and when a patient is not doing so but is unconsciously alluding to it. Unfortunately, the measure has been little used in psychotherapy research, largely due to problems in attaining interrater reliability.

By building on PERT's central theoretical premise--that there is clinical value in helping patients to elaborate transference feelings and fantasies--the measure developed here, Verbal Indicators of the Transference (VIT), will identify explicit references to the relationship with the analyst, along with more indirect, fleeting references the patient makes to the analyst or the treatment. It is obviously not possible to specify the various intrapsychic meanings that may be linked to a patient's choice either to talk or not to talk about the analytic relationship, or perhaps to raise expressly the specter of the relationship or the treatment but not to pursue it further. However, an essential first step in unpacking these potential meanings, and in examining the potential clinical value of focusing analytic work on the transference,

is to develop a process measure that can clearly delineate when and how patients do invoke the analyst or the treatment in their associations.

Although all of the references coded by the VIT measure will be express--and in that sense "conscious"--the measure's category of indirect or peripheral references may very well locate important verbal clues or markers which represent the tip of unarticulated--often unconscious--fantasies about the analyst. In this way, while the VIT measure will not necessarily tap directly into unconscious displacements, which was the unfulfilled goal of the PERT scheme, it not only will identify an intriguing clinical phenomenon that no other measure has reliably captured, but it may well point to a clinical process closely related to the one that PERT was uniquely poised to detect, without the level of inference and subjectivity inherent in that coding scheme.

The reliability of the VIT measure was initially tested in a pilot study in which two independent judges coded nine sessions from three recorded psychodynamic psychotherapy cases. Reliability ratings and descriptive findings from that study will be presented.

In the expanded study to be undertaken, a formal coding manual will be created, and the VIT measure will be applied by two independent judges to thirty-six sessions taken from the early, middle and late phases of three recorded psychoanalyses with differential outcome ratings.[3] More definitive reliability ratings will be obtained, and two hypotheses concerning the treatment effects associated with the patient's work in the transference will be investigated.

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[3] One of the benefits of this particular data set is that it was designated for collective research purposes by the Collaborative Analytic Multi-Site Project (CAMP) of the American Psychoanalytic Association. Consequently, sessions from this same data set have been used in a whole host of other psychoanalytic research projects. This sets the stage ultimately not only for a convergent analysis using the data generated here, but more generally, for this study to enrich and inform a specific, growing body of treatment research.

II. LITERATURE REVIEW

A. Psychoanalytic Perspectives on Transference

The discovery of transference was surely one of Freud's (1912, 1915, 1917) most remarkable contributions. It is a concept that unites psychoanalysts (Freud, 1914; Wallerstein, 1988), and is as beguiling as it is powerful. Perspectives on its meaning and the role it plays in the treatment process have shifted dramatically from the early days of psychoanalysis, when Freud believed that the transference "brought about no great addition" (Breuer and Freud, 1893, p. 304) to the work of the analysis, to the current view of some theorists that the transference may be "the main vehicle of analysis" (Ellman, 1991, p. 11, n. 6).

Transference was first referenced by Freud in his Studies on Hysteria (Breuer and Freud, 1893) in which he described the process of the patient "transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis. This is a frequent, and indeed in some analyses a regular, occurrence. Transference onto the physician takes place through a false connection" (p. 304). In his Fragment of an Analysis of a Case of Hysteria (1905), he elaborated the concept further: "What are transferences? They are new editions or facsimiles 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. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the physician at the present moment" (p. 139).

In grappling with this strange and compelling phenomenon, Freud initially saw the transference as a distraction to the real work of the treatment, which was rooted in the excavation of pathogenic memories. However, as his conceptualization of pathogenesis shifted, he recognized that a patient's transference reactions conveyed crucial information about his or her psychic life, and moreover, performed

"the inestimable service of making the patient's...impulses immediate and manifest" (Freud, 1912, p. 108). This latter point took on tremendous importance in terms of technique along with the realization that, as Freud put it, "[I]t is impossible to destroy anyone *in absentia* or *in effigie*" (Freud, 1912, p. 108). In sum, Freud (1925) came to view working with the transference as "the most important part of the technique of analysis" (p. 43).

An overwhelming diversity of viewpoints has since taken hold with regard to the definition of transference and its place in the treatment process. Laplanche and Pontalis (1973) speak to this issue in their oft cited dictionary of psychoanalytic terms: "The reason it is so difficult to propose a definition of transference is that for many authors the notion has taken on a very broad extension, even coming to connote all the phenomena which constitute the patient's relationship with the psycho-analyst. As a result the concept is burdened down more than any other with each analyst's particular views on the treatment--on its objective, dynamics, tactics, scope, etc. The question of the transference is thus beset by a whole series of difficulties which have been the subject of debate in classical psychoanalysis" (p. 456).

Cooper (1987) has sketched out two major divisions in current day theories of transference. He refers to the first as the historical model, which construes transference as an enactment of an earlier relationship. Under this model, transference interpretation is aimed at helping the patient to gain insight into the ways in which early infantile relationships are distorting or impinging on the relationship with the analyst. He refers to the second as the modernist model, which construes transference as a new experience rather than an enactment of an old relationship. Under this model, transference interpretation is used to bring to consciousness all aspects of this new experience, which includes its colorings from the past.

Consistent with Cooper's (1987) historical model, Wachtel (1997) has discussed the notion of a "woolly mammoth" model of psychic life which leads to a

conceptualization of transference as a simple replication of archaic remnants of the past, frozen in time and unchanged by subsequent experience. He offers an alternative framework based on the patient's cyclical re-creation of interpersonal events, which acknowledges the impact of the analyst's behavior, and the relationship with the analyst, on the patient's perceptions and transference reactions. In particular, he (1987) has advanced a "schema" model of transference in which the patient's reactions and fantasies are understood as both an assimilation to internal schemas *and* an "accommodation to the reality of the analyst and the interaction" (p. 34).

Wachtel's (1987, 1997) formulations highlight an important issue as to whether a distinction should be drawn between transference and aspects of a real relationship with the analyst. Though the transference is fundamentally embedded in the patient's relationship with the analyst, it has been argued that there exists a "real relationship" between patient and analyst, separate and apart from the transference (Zetzel, 1956; Greenson, 1965). Others have asserted that all aspects of the working relationship are integral aspects of the transference (Brenner, 1979).

In a similar fashion, some have stressed the value of interpretations that focus on the patient's real life experiences (Stone, 1967), while others have taken the position that only transference interpretations are likely to be mutative (Strachey, 1934). Specifically, Strachey contended that an interpretation must be not only emotionally immediate, but directed to "the point of urgency" which is "nearly always to be found in the transference" (1934, p. 73). In speaking of "the point of urgency," he invoked Melanie Klein (1952) who believed that, "[I]t is only by analysing the transference situation to its depth that we are able to discover the past both in its realistic and phantastic aspects" (p. 242).

Decades later, Merton Gill's (1979, 1982) views on the treatment process were to evolve such that he became one of the most influential proponents of a consistent focus on manifestations of the transference in the current analytic situation. Gill

(1982) cited Freud's structural model for the proposition that, "[T]he repetition of the past should be encouraged as much as possible in the transference within the analytic situation because it is best dealt with there...." (p. 6). He believed that the best way of accomplishing this was for the analyst to listen for allusions to the transference in associations that are not manifestly about the patient's relationship with the analyst. Such allusions are not expressed more directly because patients experience a great deal of resistance to becoming aware of transference feelings and fantasies, and to focusing analytic work there. Working with the transference was described by Gill (1979) as the "aspect of analysis which involves both analyst and patient in the most affect-laden and potentially disturbing interactions" (p. 266).

In this way, Gill spoke to the complicated relationship between transference and resistance, echoing the idea first elaborated by Freud (1912, 1915) that transference is an enormously difficult phenomenon with which to work, for the patient as well as the analyst. Indeed, a recent paper by Grinberg (1997) poses the question, "Is the transference feared by the psychoanalyst?" He suggests that the current multiplicity of theories about transference may be linked to analysts' fears of its dangers, and that theory--and even interpretation--may be used by the analyst in the service of defense when faced with the anxiety aroused by the intensity of the patient's feelings.

B. Research Concerning the Transference

1. Prevailing research methods that assess transference

An array of research measures have tried to operationalize the idea of transference (Luborsky et al., 1986; Luborsky and Barber, 1994), each bringing to bear its own theoretical assumptions about what transference is and how it manifests itself in the treatment setting. Each has struggled with the fact that transference, in addition to being a difficult phenomenon to handle clinically, is a complicated concept to operationalize. Indeed in a recent review, Luborsky and Barber (1994)

have referred to available measures as "transference-related measures" rather than "transference measures" (p. 153), given that there is still insufficient evidence for their relation to the concept of transference.

Existing measures primarily identify central relationship patterns or dynamic themes that reoccur in a patient's productions during psychotherapy or psychoanalytic sessions. The leading one is Luborsky's (1976, 1977; Luborsky & Crits-Christoph, 1990) Core Conflictual Relationship Theme (CCRT). The CCRT measure identifies narratives, dubbed Relationship Episodes (RE's), spontaneously told by patients about interactions with others, including the therapist. Luborsky (Luborsky et al., 1985; Luborsky, 1990b) has put forth the idea that the nature of a patient's transference pattern as measured by the CCRT corresponds with many of Freud's observations about transference.

Other relationship pattern measures include Horowitz's (1994) Configurational Analysis; the Mount Zion Psychotherapy Research Group's Plan Formulation Method (Weiss et al., 1986); Dahl's (1988) Fundamental Repetitive and Maladaptive Emotion Structures: Perry's (1994) Idiographic Conflict Formulation; and Benjamin's (1986) Structural Analysis of Social Behavior. Similar to the CCRT, these measures assess transference by piecing together a patient's overarching conflict-based relationship patterns, as evidenced by associations about either the therapist or other people. In so doing, they focus not so much on *when* the transference is active in the patient's mind or in the treatment setting, as on *what* the nature of the transference is that the patient puts into play.

A different methodological approach is taken in studies that aim to assess *how much* transference is manifest in a treatment hour (Gelso et al., 1997; Piper et al., 1999). These studies generally involve single item measures that assess global aspects of transference ranging from amount to overall quality, i.e., positive or negative. Such measures can be applied either by an independent rater or the

therapist, using some sort of Likert-type scale.

For example, Graff and Luborsky (1977) have developed a post-session checksheet, designed for clinicians to fill out at the end of each session, which includes five-point rating scales for concepts such as transference and resistance. Transference is defined as: "[T]he degree to which the patient is dealing with material that is overtly or covertly related to the analyst. This material would be a manifestation of or a displacement from an early important object relation. The previous object, however, does not have to be mentioned; it may be inferred by the rater because of the presence of distortion, strong affect, inappropriateness, etc." (Graff and Luborsky, 1977, p. 476).

A similar approach is taken by the Missouri Identifying Transference Scale (Multon et al., 1996), which is used to obtain therapists' global ratings of positive and negative transference. The Vanderbilt Psychotherapy Process Scale (Suh et al., 1986) also includes variables for patient focus on transference and analyst focus on transference, which are coded by independent raters on a five-point scale to yield an overall score for each therapy session. While ratings of this sort are usually made on the basis of an entire session, the scales can be applied to smaller segments of a session as well (Luborsky et al., 1979).

Another class of measures assesses transference by looking at the patient's feelings about the therapist, derived not from the process of a session but from independent reports (Chance, 1952; Fiedler and Senior, 1952; Arachtingi and Lichtenberg, 1998). These measures typically involve some form of questionnaire or interview that calls upon patients to describe both their therapist and important figures in their lives, including parents or early parental figures. For example, Ben-Tovim and Greenup (1983) have developed a method of representing transference using serial dyadic grids filled out by patients at the conclusion of each session. Specifically, transference is assessed by comparing patients' descriptions in the grid

of feelings about the therapist to feelings about other people in their lives. Transference is considered to be reflected in the extent to which the relationship with the therapist and other relationships are similarly construed by the patient. Other instruments of this sort are based on principles of attachment theory, advancing the idea that patients' attachment patterns in the treatment relationship may usefully inform conceptualizations of the transference (Mallinckrodt et al., 1995; Diamond et al., 1999).

Finally, the transference may be assessed using qualitative research methods. For instance, Gelso and colleagues (Gelso et al., 1999) recently developed a semistructured interview which was administered to therapists in order to obtain information concerning their perceptions about how transference operates and how it is resolved in long-term dynamic therapy.

2. Research that examines the impact of transference work

Research into the effects of focusing therapeutic work on the transference has generally been approached from one of three angles. The first employs a global assessment of transference as a starting point, and looks for a relationship between the amount of transference and some other variable that often is related to outcome. The second, which represents the overwhelming majority of studies in this area, is conducted from the vantage point of the analyst's interventions, i.e., transference interpretations are used as the independent variable. Lastly, an important group of studies has produced findings concerning the treatment effects associated with the patient's references to the therapeutic relationship. Each of these bodies of research is discussed below.

a. Effects associated with a greater overall focus on the transference

Using analysts' post-session ratings of amount of transference, Graff and Luborsky (1977) have found that in successful psychoanalyses, transference increases

over the course of treatment. Concomitantly, they found that resistance ratings dropped over time in those treatments. In discussing their findings, they point out that rated transference may include more recognizable evidence of the transference. In this way, they suggest that what their ratings detected may not have been an actual increase in transference per se, but rather an "increase in transformation of what was latent transference to recognized manifest transference" (Graff and Luborsky, 1977, p. 487).

Gelso and colleagues (1997) have used similar rating scales to investigate the relationship between amount of transference and level of insight in predicting outcome in short term (12 sessions) psychotherapy. They have found that a combination of high transference and high emotional insight is associated with positive outcomes, whereas a high transference-low emotional insight combination is negatively related to outcome. This is true whether the transference is rated as positive or negative.

Important to note is that both of these studies raise the issue of the complicated interaction between transference and other variables, such as resistance and insight, in making any predictions about outcome. Moreover, as is often the case in researching psychoanalytic concepts, neither of these studies had a large enough sample to permit any definitive conclusions to be drawn regarding the role of the various factors under investigation in predicting treatment outcome.

b. Effects of transference interpretations

A substantial amount of research has been conducted in an effort to determine the impact of the analyst's interpretation of the transference (Henry et al., 1994). One branch of this research is somewhat analogous to the studies discussed above in that the frequency of transference interpretations is the subject of investigation. Piper and colleagues (1991), who are responsible for a good deal of the published research in

this area, have found that a high use of transference interpretations is associated with a weaker alliance and less favorable outcome in short term (20 sessions) psychotherapy.

The correlation between frequency of transference interpretations and poor outcome has been borne out in other studies (Henry et al., 1993; Hoglend et al., 1993). Yet a correlation between frequency of transference interpretations and *better* outcomes also has been shown (Malan, 1976; Marziali, 1984). In contrast to both sets of competing conclusions, some findings suggest *no* relationship between the frequency of transference interpretations and outcome (Piper et al., 1986; McCullough et al., 1991).

Not only is it difficult to reconcile these findings, but certain methodological limitations cut across all of these studies. Specifically, all were conducted in the context of short term treatments. All were correlational, leaving open the possibility that alternative explanations exist for the findings presented. None looked at timing or accuracy of interpretations. Confounding variables, such as patient characteristics, were not addressed. For example, difficult or resistant patients may be more likely to elicit interpretations that focus on the treatment relationship (Holland et al., 1998; Piper et al., 1999).

The other category of research that concerns the analyst's focus on the transference involves not the frequency, but the immediate effects of transference interpretations. Here too the findings are mixed. Silbershatz et al. (1986) have found no differences in patients' immediate benefits following transference versus nontransference interpretations. Instead they have found that patient productivity in the several minutes following an interpretation can be predicted by the interpretation's suitability, i.e., the degree to which it is compatible with the patient's plan (Silbershatz et al., 1986; Fretter et al., 1994).

Joyce and Piper (1993) reached a slightly different conclusion, namely that as long as transference interpretations are interposed sparingly and precisely, i.e., incorporating a careful formulation of the patient's dynamics, they can produce positive immediate effects. Along these lines, a number of studies have found variable responses to transference interpretations. McCullough et al. (1991) classified patient immediate responses to transference interpretations as either affective or defensive, and determined that sequences of transference interpretations followed by affect were significantly correlated with positive treatment outcomes. In a study using three psychoanalytic patients, Luborsky et al. (1979) found that each patient had his or her own characteristic response style that was also connected to treatment outcome. In particular, an increase in transference in response to the analyst's interpretation of the transference was observed in the two successful cases.

All of the studies that have looked at patients' responses to transference interpretations have used word blocks or minutes immediately following the interpretation to locate relevant patient effects. However, a patient's response to an intervention, particularly one as potentially loaded as a transference interpretation, may not only occur in the immediate aftermath of the analyst's statement. There is one study that accounts for the possible lag between a transference interpretation and its therapeutic effect. Pessier and Stuart (2000) have assessed patient responses over the course of an entire session, using Luborsky's (1990a) Relationship Episodes as a clinically meaningful unit of study for observing the effects--or the efficacy--of the analyst's interventions. Their findings suggest that transference work may initially inhibit patient speech, yet facilitate patient progress in the remainder of the session.

A final note with regard to research focused on the effects of the analyst's transference interpretations is that no study has put together the potential impact of the analyst's focus on the transference with the role of the patient's focus on the

transference. In other words, how the patient is situated vis a vis the transference *prior* to the analyst's explicitly bringing it up, and whether this might impact how the patient responds, has not been the subject of investigation.

c. Effects of the patient's associations about the transference

A few studies have explored what occurs in a session when a patient talks about the relationship with the therapist. The earliest study to do so was Luborsky's (1973) investigation of momentary forgetting. He linked the interruption of the patient's thought process, i.e., momentary forgetting, with the idea that it was the prospect of expressing some thought *in the presence of the therapist* that led to the forgetting. Specifically, he found a correlation between explicit references to the therapist and subsequent instances of momentary forgetting.

Holland et al. (1998) have included references to the therapist or therapy as a dimension in The Rutgers Psychotherapy Progress Scale. They have analyzed segments of patient speech coded with this dimension from two short term psychotherapy cases, and have found that neither patient spontaneously made reference to the therapist, but rather the therapist initiated such discussions when manifest resistance was detected. In the case where there was more resistance, the therapist initiated transference discussions far more often, which resulted in higher average ratings for references to the therapist in the case with poorer outcome (Holland et al., 1998).

Two recent studies have produced findings concerning the effects during a patient's associations about the therapist or treatment relationship. During explicit narratives about the analyst coded with Dahl's (1988) FRAMES, levels of symbolizing as measured by Bucci's (1997b) Computer assisted Referential Activity (CRA) have been shown to drop (Sammons and Siegel, 1997). During narratives about the therapist coded with Luborsky's (1990a) Relationship Episodes (RE's),

both Referential Activity (RA) (Bucci, 1993)[4] and scores on the Patient Experiencing Scale (EXP) (Klein et al., 1986) have been shown to drop (Pessier and Stuart, 2000).

An interesting wrinkle uncovered by Pessier and Stuart (2000) arose in the context of examining the effects of patients' associations about the analyst when they occurred on the heels of a transference interpretation. They found that patients who *did* tell a narrative about the therapist after a transference interpretation demonstrated higher levels of RA and EXP over the course of the session than patients who *did not* respond with a narrative about the therapist.

All of these findings are consistent with the theoretical idea that talking directly about the relationship with the analyst is often conflict-ridden, and may inhibit the patient's speech, increase anxiety or defensiveness, or be associated with higher levels of resistance. It should be noted that none of these studies was able to look at what happens when the patient more subtly, perhaps unconsciously, invokes the treatment relationship.

C. The Original PERT Coding Scheme

While existing research measures have contributed enormously to the work of studying and understanding transference, there has yet to have been developed a method that can reliably map onto the moment to moment manifestation of transference in the unfolding analytic process. This in turn has limited the scope of existing research aimed at assessing the effects of focusing therapeutic work on the transference.

The one coding scheme that attempted to track the moment to moment flow of

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[4] Both RA and CRA are measures of what Bucci (1993, 1997b) has defined as the process of forming active links between nonverbal and verbal representational systems. RA is scored by judges on segments of transcripts that are rated on a 10-point scale along four dimensions: Concreteness, Specificity, Clarity and Imagery. CRA is the computerized version of RA developed by Mergenthaler and Bucci (1993), which compares words in a patient transcript with customized dictionaries modeled after the RA subscales.

transference work was PERT (Gill and Hoffman, 1982a), which was designed to operationalize Gill's (1979) theoretical position concerning the centrality of working in the here-and-now transference. Rather than describing the nature of the patient's conflicts as reflected in the transference, PERT was based on the idea that *how* the patient moved in and out of talking about transference feelings and fantasies was a key factor in studying the role and impact of transference on the treatment process.

The coding scheme identified various kinds of verbal references patients made to the treatment relationship.[5] The centerpiece of the scheme--the *Jxr* variable--called upon a coder to identify when patients, while not talking manifestly about the relationship with the analyst, were nonetheless alluding to it. In this way, PERT lent itself to an examination of resisted aspects of the relationship, which the patient wishes at once to conceal and to reveal.

Set forth below are Gill and Hoffman's (1982a) definitions of the original PERT variables. Also provided are some useful coding illustrations.

1. PERT variables[6]

.x: Communications about matters manifestly other than the patient's experience of the relationship with the analyst.[7]

r: Communications that refer directly to the patient's experience of the relationship with the analyst.

.xr: Communications that express awareness of a parallel between experience

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[5] Gill and Hoffman (1982a) used "transference" and the "treatment relationship" interchangeably.

[6] The original PERT system contained variables for coding analyst speech as well as patient speech. Because the method presented here will entail only the categorization of patient speech, PERT's variables for coding analyst speech will not be included.

[7] Under the original PERT system, associations about matters other than the patient's experience of the relationship with the analyst were not actually coded, but were designated by implication as falling within the *x* variable. The reason for this was an expectation that most sessions would contain predominantly *x* material, and that it would be burdensome to code all of it directly.

outside and experience inside the analytic situation where the emphasis is on clarification of the experience inside.

rx: Communications that express awareness of a parallel between experience inside the analytic situation and experience outside where the emphasis is on clarification of the experience outside.

Jxr: An inference by the judge that there is an implicit allusion to the patient's experience of the relationship with the analyst in communications that are not manifestly about the relationship. *Jxr* codings must be justified according to specified rules, as discussed below.

Jrr: An inference by the judge that there is an implicit allusion to an unspoken aspect of the patient's experience of the relationship with the analyst in communications that are manifestly about the relationship. These must be justified in the same way that *Jxr* codings are justified.

Because it is obviously possible "to mechanically suggest that any associations about outside matters have implications for the patient's experience of the relationship" (Gill and Hoffman, 1982a, p. 144), judges must establish a certain kind of evidentiary basis when making the kind of inference inherent in the *Jxr* and *Jrr* codes. This basis can take one of two forms. First, a *Jxr* or *Jrr* code could be based on a previous or a subsequent *r* code. In this case, the judge is justified in calling a statement an allusion to the relationship because the patient at some point has referred directly to the relationship.

Secondly, a *Jxr* or *Jrr* code could be based on something the judge finds noteworthy in the circumstances of the session, particularly in the analyst's verbal or nonverbal behavior, that may have contributed to the patient's experience of the relationship. Such behaviors on the analyst's part include apologizing for being late, announcing a schedule change or upcoming vacation, giving advice to the patient, criticizing the patient, or disclosing something personal. These behaviors would be

coded as either *Potentially Significant Events* (if the judge notes them as they occur), or *Retrospectively Significant Events* (if the judge identifies them only with hindsight after the patient has indirectly alluded to them).

2. Coding illustrations[8]

a. Retrospective *Jxr*:

> "He came over to drink beer, and to have this conversation which was a little difficult. I pretended to be enjoying it, enjoying him, you know, in the spirit of good fellowship and shit and stuff, but I really wanted to be--well, I didn't want to be reading but you know, I felt that this was the thing that, that was keeping me from reading and that hassled me. I really fucking resented it a lot. You know among my friends, they're respecting and always have really respected my wanting to do my own thing. And you know, even if they were planning a party or some sort of social gathering hoping that I'd be there or, to smoke dope, you know, I'd say, you know, I could just say, I think I'm going to stay in my room and read tonight. And that's it, you know, that's my own thing and nobody would bother me about it or encourage me to do otherwise. But you know, with a guy like this [clears throat] he's just in another world totally from that. And, you know, he wouldn't understand if I said that, you know, he would be insulted and that kind of shit. You know it was kind of a hassle."

On the basis of these lines alone, this material would be scored *x*. Although the judge might hypothesize that there are allusions in the material to the relationship with the analyst, i.e., the patient's resentment of the involvement he feels the analyst demands of him, there is no independent evidence that the feelings expressed are related to what is going on in the treatment relationship. It is not until a bit later in the session that this kind of evidence surfaces:

> "This morning I, like didn't particularly feel like coming here, you know. Because like, I don't know, I felt some kind of, you know, I felt like I didn't need it. I guess I was just, you know, my spirits were a little raised. If only now I could get out of the bag of feeling that I have to...."

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[8] The coding illustrations provided here were used by Gill and Hoffman (1982a) in their initial presentation of the PERT coding scheme.

Because this material constitutes an explicit reference to the relationship with the analyst, it is coded *r*. Moreover, a retrospective coding of *Jxr* for the earlier material is now justified. In other words, the previous *x* material is considered retrospectively as having implicitly elaborated the meaning expressed in the subsequent *r* material. Gill and Hoffman (1982a) were particularly interested in how the earlier displaced elaboration could be seen as including ideas about the analyst's internal reactions--an aspect of patients' experience of the treatment relationship that they believed is often strongly resisted.

b. No *Jxr* when the only basis is a parallel to a typical feature of the analytic situation:

> "This woman bag is real bad for me. The woman that I'm going ape shit over now is a woman I've never even seen. I think I told you about the telephone operator who I made a date with. And I keep calling her back but she's never home and I talk to her roommate. That's been a big hassle because I keep, you know hoping she'll be there, that she'll talk to me. I've never even seen this girl, I mean, I don't know anything about her, you know."

A judge could think that this material warrants a *Jxr* coding because of the striking parallel to a typical, relatively constant feature of the analytic situation--in this instance, the analyst's anonymity. Similar examples mentioned by Gill and Hoffman (1982a) were material related to relationships with authority figures, relationships characterized by a lack of reciprocity, helping relationships, and frustrations of various kinds. However, it is not difficult to imagine how almost anything the patient says could be somehow linked to such constant features of the analytic situation. Consequently, such criteria are without sufficient discriminating value. Only a specific, immediate circumstance or occurrence in the session (a *Significant Event* code) or an explicit reference to the relationship by the patient (an *r* code) could justify a *Jxr* coding here. Hence, the material cited above would simply be coded *x*.

c. Straightforward *Jxr*:

> "When I finally got through to her roommate yesterday and found out that she wasn't going to be in, like all the woman obligations just went off me. I knew that there was nothing I could do to find a woman and, you know, there was kind of a relief."

A *Jxr* coding would be warranted based on the preceding *r* material cited above, namely the patient's statement that he did not feel like coming to his session that morning. Gill and Hoffman (1982a) offered the following potential interpretation of the latent transference issues: "From what you said earlier about feeling you had to come here today even though you felt you didn't need to, it seems you might well have been relieved if, for some external reason, we couldn't meet today" (pp. 153-154). They hypothesized that the patient, under the influence of resistance, conveyed details about his experience of the treatment relationship by talking about it implicitly before and after his explicit reference to it. In the implicit references, the analyst is represented in displaced form, first by the friend and then by the woman.

d. Retrospective *Jxr*:

> "The fantasy that really turned me on was this, you know, heterosexual sadistic fantasy. I mean just really fucking the shit out of some girl and her being, you know, prostrate before my, you know, my massive organ. And uh, I described to you before how, you know, the idea of girls doing things that are really, had a lot of indignity about them....
>
> ...Well, now I'm getting that same feeling that, you know, I'm sort of talking about worthless shit. Because, and you know, my basis for thinking that is the fact that you haven't said anything. Jeez, we go through this same nonsense every session, it's just amazing to me. I'm sort of ashamed that my mind isn't a little more creative, to think of different hassles. You know, it's sort of boring going through the same hassle four times a week, for what at this point seems like a timeless period."

The first portion of this material would be initially coded *x*, but in light of the subsequent *r* material, it would be interpreted retrospectively as a *Jxr*. Gill and

Hoffman (1982a) explained that, after considering the subsequent *r*, the *x* material would be understood as reflecting an identification with the analyst, that is, the patient attributes to himself what he preconsciously attributes to the analyst. They suggested that a subsequent interpretation could focus either on the patient's experience as the victim of indignity and torture in the analysis, or on his representation of the analyst as the torturer, or on both: "Maybe you feel that I am sitting back here sadistically enjoying my power over you while you are forced to go through all kinds of contortions in order to gratify me. It's humiliating for you" (p. 155). They emphasized that being especially alert to the mechanism of identification could help judges to recognize many implicit references to the patient's experience of the treatment relationship that might otherwise pass unnoticed.

D. The Fate of the PERT Scheme

Unfortunately, Gill and Hoffman were never able to establish the reliability of PERT,[9] or to use it to test any clinical hypotheses (Hoffman, personal communication). The coding scheme has essentially lain dormant since their initial development of it.[10] As described more fully below, the unavoidable complexity of its coding task, particularly the degree of subjectivity involved in attempting to apply its variables, undercut PERT's otherwise promising potential to contribute to the field

[9] Gill and Hoffman's preliminary findings not only were mixed, but represented, in their words, only "a very crude estimate of agreement" (1982a, p. 161), having been based on aggregate, as opposed to unit-by-unit, agreement. This meant that they compared how many times in a session independent judges each located particular variables, but they did not determine whether judges were coding the same patient material in the same manner.

[10] There is one published study that applied just the *Jxr* variable in comparing novice and experienced therapists' skill in handling the transference in adolescent treatment (Church, 1993).

of psychoanalytic research.[11]

III. STATEMENT OF PROBLEM

When the PERT coding scheme was first introduced, it represented an innovative and important advance in available psychoanalytic research methods. Indeed, in seeking to develop an empirical measure capable of being mapped so closely onto such a complex clinical phenomenon, namely the manifestation of the transference, Gill and Hoffman were enormously ambitious. Yet the very fact that PERT aimed to operationalize such an abstract clinical process not only was at the heart of its unique appeal, but was central to its ultimate demise.

On a very concrete level, because there is no available coding manual, a researcher who wants to be trained in applying the PERT system must turn to the few published papers that describe its variables. While those variables, from a theoretical standpoint, are stated clearly enough, they are not so straightforward in their application. The coding scheme is essentially a system of categorizing various kinds of verbal references patients may make to the treatment relationship. However, actual patient speech reveals a range of references that do not fit so neatly into the PERT categories. As a result, a coder must repeatedly fall back on some subjective process of evaluating whether a particular statement falls within the description of what a given variable is intended to encompass. Needless to say, this kind of subjectivity undermines the conceptual foundation of the system and wreaks havoc on efforts to achieve adequate interrater reliability.

For example, sometimes the kind of reference a patient makes to the relationship is relatively unambiguous. If a patient says to the analyst, "I'm angry at

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[11] Merton Gill's death undoubtedly contributed to PERT's failure to become a force in the field of psychoanalytic research. At the same time, persisting problems in attaining interrater reliability were openly acknowledged by Gill and Hoffman (1982a), and were overwhelmingly confirmed in extensive coding efforts undertaken in the early stages of this project using the PERT scheme.

you," it will be pretty clear to a coder that the patient is referring directly to his or her experience of the relationship with the analyst. A statement that refers to feelings about the treatment, i.e., "I didn't feel like coming here today," is slightly more removed than one that directly invokes the analyst, but a coder still will be likely to see this as a communication that refers to the relationship. However, when a patient refers to the treatment directly, but in a way that does not spell out his or her attitude or feeling toward it, e.g., "I had to stop working early today so I could come here," it is not so easy to determine the appropriate code from the existing PERT scheme.

Teasing apart the various options for coding this last statement will help to illustrate some of the ambiguities embedded in the PERT system. Although it may seem to be a stretch to call this last statement a direct reference to the patient's experience of the relationship with the analyst, the parameters of the *r* variable could be drawn broadly enough to include *any* direct reference to the treatment. However, this would dilute the variable, in the sense that a statement such as, "I had to stop working early today so I could come here," is very different from a statement such as, "I'm angry at you." In other words, a substantially wide range of clinical phenomena would be covered by the same coding variable.

Alternatively, the statement could be coded *x*, meaning that it is about a matter manifestly other than the patient's experience of the relationship. This would, however, present the same issue concerning the scope of the variable, at least to the extent that one believes there is something potentially noteworthy about invoking the treatment as the patient does in this statement. Put another way, by coding this statement *x*, a distinction that PERT could otherwise detect would be lost--namely, that between associations which are exclusively about an outside matter, and associations which are on balance, or even overwhelmingly, about an outside matter but nonetheless also make reference to the analyst or the treatment.

It may be that this is the nature of the distinction that the *xr* and *rx* codes were

intended to capture. Yet again, these variables do not provide such a good fit. It is one thing for a patient to refer to outside and inside experiences side by side in his or her associations, but it is quite another for the patient to express an awareness of a parallel between both experiences with the intent to clarify one or the other. The above statement hardly reflects this latter kind of clinical process.

Trying to understand the clinical process underlying the *xr* and *rx* codes, moreover, raises problems that go beyond the coding dilemma presented by the above statement. These variables call upon the coder to discern whether a patient is expressing awareness of a parallel between experiences inside and outside the analytic situation, and if so, which experience the patient is seeking to clarify. The variables seem to be aimed at capturing moments of insight that are leveraged from within the transference--the patient's equivalent perhaps of a type of transference interpretation, i.e., "I think you are experiencing me the same way that you experienced your mother when you were growing up."

Thus, a prototypical *xr* coding might be: "I think I'm starting to understand why I get so mad at you sometimes. It's just like how I used to feel with my mother." Here it seems pretty clear that the patient is recognizing a parallel between how she feels with the analyst and how she felt with her mother. In addition, it is fairly easy to infer from the way the associations are phrased that the patient is emphasizing the clarification of the analytic relationship.

Yet typical analytic associations are not tailored in a manner that fits so seamlessly with the PERT definitions. Sometimes patients bring together inside and outside material without expressing awareness of any parallel between them. For example, if a patient says, "I always feel sad when we talk about the fights I get into with my mother," how should this be coded? The patient is not expressing a "parallel" between the two experiences as would be the case in making a statement such as, "I get mad at you when we talk about this the same way I get mad at my

mother!" One possibility is that "parallel" could be defined as including any "connection" the patient makes between outside and inside experience. However, putting aside the added difficulty of deciding which experience the patient is intending to emphasize in the above statement, is it even clear that the patient is making a connection between the two experiences? If the patient's ensuing associations were to focus exclusively on how he feels in the aftermath of his fights with his mother, with no further reference to how he feels in the treatment setting, the apparent connection would seem to be more speculative.

This points to an important question with regard to whether a parallel or a connection must be conscious in order to be coded. When a coding scheme calls for a determination as to whether a patient was "aware" of something, or what a patient "intended" to emphasize, questions of levels of knowing inevitably come into play, entangling a coder in the subjective task of trying to discern, from a verbal transcript, what may have been in a patient's mind.

This issue cuts to the core of the weakness in the PERT coding scheme. Not only can a patient's conscious, or at least stated, meaning sometimes be difficult to discern and neatly categorize, but attempting to code a patient's less conscious motives is even more riddled with clinical nuance and subjectivity. For this reason, appropriately applying the centerpiece of the PERT scheme--coding implicit allusions to the transference--is the method's most unmanageable feat.[12] Specifically, applying the *Jxr* and *Jrr* variables requires a coder to constantly assess what was going on inside a patient on an unconscious level. This is an enormously subjective task for an empirical research measure.

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[12]While it is true that coding implicit allusions does not require a determination concerning the patient's awareness--as is the case with the *xr* and *rx* codes-- this problem is effectively turned inside out, rather than being eliminated by the *Jxr* and *Jrr* codes. These codes require the judge to discern the existence of a phenomenon of which the patient is, by definition, unaware.

Moreover, as Gill and Hoffman themselves recognized, allusions to the transference can be read into *any* patient material, particularly if one approaches a session with the theoretical belief that transference is ubiquitous. Although they endeavored to address this problem by requiring a certain kind of justification when an implicit allusion to the transference is coded, the rules they proposed are easily stretched to the point of being rendered ineffectual. As long as a session contains something in the interaction that can be called a "significant event," or some codable direct reference to the relationship with the analyst, just about any material that on the surface does not appear to be transference related can be construed as having some unstated meaning shaped by the patient's experience of the relationship.

Bringing subjective clinical judgment to bear in this way is not, in and of itself, problematic. In fact, it is precisely this aspect of a coding scheme that can safeguard its clinical relevance, which is no small or simple matter in the development of a psychoanalytic process measure. However, if a measure cannot be reliably applied, it can never attain the status of a viable research tool.

In sum, the point here in underscoring the subjectivity embedded in applying the PERT variables is not to suggest that there is a right or a wrong way to code particular patient material, but rather that the coding scheme needs to be built on predetermined, clinically and methodologically sound decisions about how to handle certain kinds of statements when they arise. The problem with the existing PERT scheme is that there are too many gray areas which leave the coder at a loss as to how to apply the variables. With no guidance or direction from the coding scheme, independent coders are unlikely to handle ambiguous statements in a consistent fashion. Not only does this inevitably eat away at interrater reliability, but it undermines the conceptual framework of the coding scheme.

Ironically perhaps, it makes tremendous clinical sense that applying the PERT scheme is so riddled with ambiguity. The whole idea behind PERT is that patients

have a hard time talking about their experience of the relationship with the analyst. It is inherently conflict-ridden, something likely to be simultaneously approached and avoided. Consequently, instead of talking directly about concerns, desires or fantasies linked to the relationship with the analyst, patients inevitably speak of such things in subtle, masked--often unconscious--ways. By definition then, such references should not lend themselves to quick recognition or easy categorization.

This may mean that PERT embodies a good clinical idea that simply cannot be operationalized. Alternatively, it may mean that a different means of operationalizing the clinical thinking behind PERT needs to be tried. Putting this proposition to the test is one of the major challenges of the current project.[13]

IV. PRIOR WORK ON THIS PROJECT[14]

The study that will be undertaken here is an outgrowth of ongoing efforts to develop a new method for assessing patient work in the transference, using the PERT system as a point of departure. Below is a description of that work. In order to assess the reliability of the measure developed here, and to further refine its variables prior to embarking on an expanded study, a pilot study was conducted using nine sessions from three recorded psychodynamic psychotherapy cases. Reliability ratings and descriptive findings from that study are presented.

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[13] This is not to suggest that a new measure will map as closely onto PERT's underlying analytic concepts, nor that measuring what may be more easily measured is an end to be pursued. Rather, the point is to underscore both the difficulty and the importance of striking a meaningful balance between preserving the complexity of psychoanalytic concepts under study and operationalizing those concepts so that they may be studied.

[14] The prior work that is outlined here was presented in June, 1999 at the 30th annual meeting of the Society for Psychotherapy Research in Braga, Portugal, and in December, 1998 to the CAMP group at the annual meeting of the American Psychoanalytic Association in New York.

A. Development of a Method for Coding Direct and Indirect Work in the Transference

1. Defining transference

The first step in developing a process measure aimed at assessing transference is to establish an operationalized definition of the concept. Because transference is an abstract, psychological construct, *any* process measure that attempts to locate or describe it will inevitably involve some degree of inference. Similar to psychoanalytic concepts such as defense or resistance, it does not lend itself to clear, unequivocal identification based on a patient's verbal productions. In other words, transference is not the sort of phenomenon that one can simply place one's finger on in a transcript.

Existing transference-related measures each define the term in their own way. As discussed above, these measures have primarily been structured around identifying central relationship patterns or dynamic themes that reoccur in a patient's productions. The measure developed here will come at the concept from a different angle. Specifically, it will seek to identify and categorize the moment to moment process in a session that reflects the patient's involvement in the treatment relationship. Statements will be coded on the basis of whether, and how directly, the patient speaks about reactions to the analyst or the treatment situation.

The measure thus will be based on the theoretical assumption that a window into the transference can be framed around the patient's experience of the treatment relationship.[15] In particular, the measure will be anchored in the idea that patients, in some fashion, live out with the analyst certain inner conflicts, as well as attempted

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[15]This is not to say that transference cannot be detected elsewhere as well, but the focus of the coding scheme developed here will be on the treatment relationship. It is important to bear in mind that the measure developed here will not pinpoint *the* transference. Rather it will identify certain tangible events which--it is proposed--bear a close relationship to the phenomenon known as transference.

solutions to those conflicts. As a result, patients invariably have all sorts of thoughts and feelings, expectations and fantasies, about the analyst and the treatment situation.

For purposes of the coding scheme developed here, these reactions will be understood as reflecting the transference.[16] One way, among others, that such reactions manifest themselves in the treatment situation is through statements the patient makes about the analyst or the treatment. For this reason, the coding scheme will be structured so as to systematically target statements that are overtly or covertly related to the patient's experience of the treatment relationship.

2. Categorizing patient references to the transference

The original PERT scheme attempted to code moments in the process when patients made conscious reference to having the analyst in mind, as well as when patients invoked the analytic relationship only implicitly. The latter coding task required judges to speculate as to the unconscious contents of the patient's mind. The goal of the method developed here will be to capture verbal indicators of the same sort of clinical phenomena as the original PERT scheme, with less inference and subjectivity.[17]

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[16]In this sense, the measure will not stake out a difference between the patient's experience of the treatment relationship and the transference. Some may consider this definition of the transference to be overbroad. For example, it includes thoughts and feelings that could be construed as part of a "real" relationship, instead of, or in addition to, a "transference" reaction. There is a distinction, however, between a theoretical and an operational definition of a psychological concept. While there are many competing theoretical definitions of transference, it is necessary to select and abide by one in developing a research measure. The definition used here is thus not intended to be held out as *the* definition of the term--there is hardly sufficient consensus in the field on this score--but rather as the one that will be employed in this particular research method.

[17] Notwithstanding any question as to whether the kinds of indirect references identified here can be ultimately linked to preconscious and unconscious material related to the transference, one important goal in developing and applying this method is to have the capacity to examine empirically whether these fleeting, unelaborated references are worth taking note of in the process of analytic listening and technique.

The key to accomplishing this can be found by taking a closer look at the actual ways in which patients refer to the relationship with the analyst. As the original PERT scheme recognized, sometimes patients speak exclusively about matters *other than* the relationship with the analyst. A patient comes to session upset and confused about a conversation he had the previous night with his girlfriend, and proceeds to tell the story of what happened. At times like this, a review of the patient's associations may well reveal that, on a manifest level, no reference is made to the analyst or the treatment situation.

At other times, patients focus quite explicitly on thoughts or feelings they have in response to the analyst. A patient comes to session convinced that the analyst disapproves of a recent decision she made, and describes how uneasy and trapped this makes her feel. During such moments, a patient's associations convey a clear sense that she experiences herself as involved in a relationship with her analyst.

Defined in this fashion, these two categories of patient speech are relatively unambiguous and are fairly easy to spot. And indeed, there are plenty of times in a session when a patient's associations are actually this straightforward. However, there are also many instances when patients, while in the midst of talking about other things, see fit to mention their analysts or their treatment in some small, unelaborated way, or to very subtly commingle thoughts or feelings about their analyst with stories about outside relationships or situations. These associations hardly rise to the level of being *about* the patient's experience of the relationship with the analyst, yet, at a minimum, they are manifestly not devoid of reference to the idea of the analyst.

Such associations mark a new category of patient speech. They differ from implicit allusions in that they are actual, express references to the analyst or the treatment. The *Jxr* variable was aimed at identifying moments when the relationship with the analyst was on the patient's mind, even though he or she was in no way referring to it. In contrast, the associations identified here mark moments in the

process when the patient *is* referring to the relationship, but in a manner that is very subtle or indirect.

The method developed for this study, Verbal Indicators of the Transference (VIT), will therefore divide patient speech into three main categories. Two of the categories will be modeled after the *x* and *r* variables of the original PERT scheme, although the parameters of these variables under the VIT system will be more clearly delineated. The third category will replace PERT's attempt to code implicit allusions to the transference with a variable aimed at capturing the kind of indirect references described above.

The coding categories can thus be outlined as follows:

x: Associations that do not reference the analyst or treatment situation.

i: Associations that indirectly or peripherally reference the analyst or treatment situation.

r: Associations that directly reference the analyst or treatment situation.

Some coding examples will help to illustrate the distinctions between the three categories. The *x* variable will be very much like the one that existed in the original PERT scheme, but the creation of a separate category for indirect references will serve to remove from the *x* category certain kinds of ambiguous associations that may have ended up there simply because no other available category provided a better fit. In addition, the elimination of the *Jxr* category means that coders will no longer have to analyze all *x* material to determine if any hidden allusions to the transference may be located there. The following segment of patient material would be coded with the *x* variable:

> "I had one dream, I had a--like a lot of real--real weird dreams. (louder) Joe had insomnia last night; I stayed at his house. He just um, couldn't fall asleep all night, so he was like up, (whispers) he was like up, and I woke up and I heard this banging, and I go what was that noise? And he goes, "Oh, I'm shaving.' He was like shaving in the middle of the night and then he made some--I--I dunno, you know, I

> kept waking up and he'd be doing different things, you know, real quietly in his apartment. Sometimes he'd calm me down. So anyway I kept waking up, and so when I wake up and I'm dreaming, I can tell him one of my dreams. And at one point, he um, got up for awhile and--it was like 5:45--I woke up and he said, he was gonna make breakfast. So we started talking, for like an hour we talked and I told him about this one dream I had, um, it was like about my grandmother dying."[18]

At the other end of the associative spectrum will be material coded with the *r* variable. The hallmark of this material will be that it conveys a sense that the patient is in a relationship with the analyst. Frequently these associations will include some reference to affect or fantasy experienced in connection with the analyst. Examples include:

> "I have something that's bothering me about what you said. (sighs) Maybe we should talk about it."

> "It's like you're really an authority, and you're supposed to know what's important for me to talk about, and if I'm doin', you know, running on a loop, then I should kind of try and listen to what you're saying, and--or, listen to what you've said, and see how it's important. Because I don't trust myself at all. Cause what I think isn't very important. And I really want you to tell me what I should do with Bobby, you know? I really want you to tell me, 'I think this is an on-and-off relationship, get out of it,' you know? But you won't, and I know that."

Finally, material coded with the new *i* variable will capture certain types of references that, in a sense, fell between the cracks in the original PERT scheme. Associations in this category often will sound simply like off-hand remarks or throw-away comments. Indeed, they rarely will be more than passing references, yet they will be noteworthy in that they expressly touch on the idea that the analyst or the

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[18] Note that the description of a situation in which the patient's boyfriend is someone to whom she tells her dream could be construed as having transferential meaning, but indirect transference references are only coded under the new system if they are express in the patient's productions.

treatment exists, or that the patient is engaged in the act of speaking to another person. In making these kinds of statements, it is as if the patient is verbally registering that the analyst has a presence in his or her mind. These statements will arise in the midst of *x* material, and although the analyst or treatment will be mentioned, the analytic relationship will not be the focus of the patient's associations:

> "I was thinking on the way in here...."
>
> "I know this is going to sound stupid to you, but...."
>
> "Last time when we were talking about...."
>
> "I always feel sad when we talk about my mother...."
>
> "Like you've said a couple of times that I don't take care of myself in relationships...."
>
> "I like to have Tuesday nights free because I know I have to get up the next day, come to my session, and then go to work...."
>
> "Whenever things are going well in my life, I get bored and depressed. I've realized that before and I just realized that sitting here."

The appearance of these types of verbal markers in the patient's associative flow raises the specter that some reaction to the presence of the analyst has been activated inside the patient. Unlike implicit allusions,[19] these references have the benefit of being explicit statements, and thus should lend themselves more readily to reliable coding. What makes them worth coding--or what makes them clinically

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[19] Associations that previously may have been construed as implicit allusions to the transference, and thus coded with the *Jxr* variable, will be coded under the new system with either the *x* or the *i* variable. Specifically, patient material that may contain some hidden allusion, but that in no way references the analyst, will simply be coded *x*; and material that may contain some hidden allusion *and also* contains some indirect or peripheral reference to the analyst will be coded *i*.

interesting--is the idea that they may represent the patient's struggle to articulate something about the relationship with the analyst. In other words, these passing references may constitute express, verbal cues linked to the transference.

From the standpoint of technique, one possibility is that they may point to moments when something about the relationship with the analyst is more alive in the patient's mind and possibly ripe for interpretation. In this sense, tracking these fleeting, indirect references to the relationship with the analyst may approach PERT's unfulfilled promise of reliably identifying "the preconscious points of attachment of the transference in the analytic situation" (Gill and Hoffman, 1982a, p. 139).

B. Pilot Study

A pilot study was conducted in order to assess the reliability of the VIT measure, and to further refine its variables prior to undertaking a more expanded study. Below is a description of the method, followed by a presentation and discussion of the relevant findings.

1. Method

The pilot study coding was done on transcripts of audio-recorded sessions from three completed psychotherapy cases.[20] Three consecutive sessions were selected from each of the three cases, producing a data set comprising nine sessions total. Sessions were taken from the early to middle stages of each treatment. All three treatments were psychodynamically oriented, with the length of treatment ranging from fifty-one to ninety sessions.

The three patients were seen at the same outpatient clinic. Each worked with a different therapist. Presenting problems were in the nature of mild depressive or

[20] The fact that these sessions were taken from psychotherapy cases did not impact the goal of the pilot study, which was to test the reliability of the newly crafted variables. However, whether future data sets consist of psychotherapy or psychoanalytic sessions certainly may influence findings derived from the testing of clinical hypotheses.

anxiety symptoms, and difficulties related to work or interpersonal relationships. All three patients executed written consent forms providing for the recording and use of session material for research purposes.

Two independent judges coded the nine transcripts.[21] In addition to the changes to PERT discussed above, a modified version of the original scheme was used to code both analyst speech and certain descriptive aspects of patient speech. Because the expanded study will be confined to an assessment of patient speech along the dimension of references to the treatment relationship, findings related to the additional variables used in the pilot study will not be presented here.

2. Findings

Attached hereto as Appendix A are reliability ratings and descriptive findings derived from the pilot study. For purposes of calculating these figures, transcripts were segmented after the coding was completed into Thematic Units (TUs), each consisting of a single idea (Stinson et al., 1994). Accordingly, findings were obtained by assessing whether a particular type of reference to the therapist or treatment situation was coded in a portion of text designated as a thematic unit.

Reliability ratings were calculated using both percent agreement and Cohen's kappa. The method used for computing percent agreement was to determine the number of thematic units that were coded with a particular reference by both judges, and to divide that figure by the number of thematic units coded with that reference by either judge. Descriptive findings were calculated on the basis of consensus coding.

3. Discussion

The pilot study represented the first formal application of the VIT measure. As can be seen from the attached findings, reliability ratings for identifying patient speech that made *any* reference to the treatment relationship ranged from .71 to .88

[21]While the judges worked independently, they met after the coding of each therapist-patient dyad to discuss consensus.

across the three dyads. (Agreement here included instances where both judges noted a reference, but one thought it was direct while the other thought it was indirect.) Reliability was lower for specifically identifying statements in which the patient described a direct reaction to the therapist or treatment situation (.48 to .86), and statements in which the patient made only a fleeting or passing reference to the treatment situation (.56 to .70). (Agreement here was construed most narrowly, so that instances where one judge thought a statement was direct but the other thought it was indirect, and where one coded either kind of reference but the other coded none, were excluded.)

Given that the parameters of the variables were still in the process of being delineated, it is not surprising that, while the judges did a good job detecting references to the analyst, they did not have as easy a time determining just how a given reference should be categorized. As the coding procedures continue to be fine tuned,[22] it is expected that reliability levels will increase. Nonetheless, the pilot study findings represent tentative affirmation of the capacity of the VIT method to reliably and systematically categorize patient speech along the dimension of direct and indirect references to the analyst or treatment situation.

A review of the descriptive data reveals that more than half of all thematic units (54.6%) contained no reference to the therapist or treatment situation. This kind of finding surely has clinical resonance in the sense that a psychotherapy patient will typically spend the majority of any given session talking about people or events in her current life or from her past. Approximately one-fifth (21.8%) of all thematic units

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[22] Fine tuning the coding procedures will entail a careful review of the pilot data, as well as other session material used in developing the measure, to locate as many patient statements as possible that could be construed as direct or indirect references. Particular attention will be paid to earlier coding disagreements and other ambiguous instances. The goal will be to develop clear coding guidelines and prototypes that can be compiled in a manual and used in training judges.

contained a direct reference to the therapist, which again makes sense clinically in that a patient will sometimes focus expressly on the treatment relationship but, by and large, will tend not to do so most of the time.[23] Almost one-fourth (23.6%) of all thematic units contained an indirect reference to the therapist.

There was considerable variance across the nine sessions in the proportion of patient speech that directly referenced the treatment, ranging from 2.0% to 67.6% of thematic units. There was a bit less fluctuation across sessions in the proportion of patient speech that more subtly or indirectly invoked the treatment relationship, ranging from 22.0% to 45.2% of thematic units.

Particularly intriguing was that in every session there was a consistent, notable level of patient speech that indirectly invoked the analyst or treatment situation. It just may be that these references are linked to some transference reaction that the patient is not yet prepared to verbalize more directly. One way or another, unpacking the clinical meaning of the moments identified by this new variable marks a compelling area for further research.

V. HYPOTHESES

One of the central purposes of this project is to develop a new method for identifying when and how patients are working in the transference. Hence, a major portion of the work to be undertaken involves the creation of a coding manual, and an expanded test of the reliability of the VIT measure. The motivating force behind these efforts, however, is to have the capacity to use the measure to investigate meaningful clinical questions concerning the effects of focusing analytic work on the transference. Therefore, the final phase of the project involves the examination of

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[23] There are, of course, many exceptions to these generalizations about clinical work. Indeed, one reason to develop a process measure that can identify when, and in what manner, patients are referring to the treatment relationship is to have the capacity to go beyond such unsubstantiated generalizations.

two hypotheses that address the interplay between the patient's references to the analyst or the treatment and the analyst's interpretations of the transference.

The central theoretical idea underlying both hypotheses is that the nature of this interplay--between the patient's and the analyst's respective focus, or seeming lack of focus, on the transference--plays an important role in the unfolding clinical process. For example, how the patient proceeds after the analyst brings up the transference for the first time in a session may vary depending on whether or not the patient had something on his mind about the treatment relationship before the analyst intervened. Similarly, if the patient is struggling with some reaction to the analyst, and the analyst responds with an interpretation that does not reference the treatment relationship, the ensuing process may well be different than if the analyst had interposed a transference interpretation.

This approach to examining the interaction between how both patient and analyst are situated vis a vis the transference generates a variety of possible scenarios that can be located in session material. Patients may refer to the transference directly, indirectly, or not at all; and analysts may or may not refer to the transference in their interpretations. The hypotheses proposed here are designed to create a beginning framework for descriptively capturing the different ways in which an analytic couple may invoke the transference in their work together.

Accordingly, set forth below are the hypotheses posed in this study:

1. When a transference interpretation follows a patient's indirect reference to the analyst or treatment situation, as compared to when a transference interpretation is made in the absence of an indirect reference:

    a. patients are subsequently more likely to make direct references to the analyst or treatment situation.

    b. levels of symbolization of emotional experience, as assessed by Computer assisted Referential Activity (Bucci, 1997b), increase.

2. When a patient's indirect reference to the analyst or treatment situation is followed by a transference interpretation, as compared to when a patient's indirect reference is followed by a nontransference interpretation:

a. patients are subsequently more likely to make direct references to the analyst or treatment situation.

b. levels of symbolization of emotional experience, as assessed by Computer assisted Referential Activity (Bucci, 1997b), increase.[24]

VI. METHODOLOGY

The study undertaken here consists of three major components: (i) the continued development of a new method for identifying and characterizing patient work in the transference; (ii) the application of the new measure to thirty-six psychoanalytic sessions by two independent judges and calculation of reliability ratings; and (iii) the evaluation of two hypotheses regarding the effects of direct and indirect patient work in the transference.

A. Further Measure Development

The reliability ratings from the pilot study indicate that the parameters of the VIT measure's variables need to be more rigorously defined. Put more concretely, the pilot study judges encountered certain patient statements that were difficult to code based on the definitions provided for direct and indirect references. To some extent, this is inevitable as there always will be new versions of patient associations not specifically contemplated by the given definitions of the variables. However, in

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[24] CRA typically decreases when patients are talking about the analyst. Consequently, the predictions made here--that direct references to the analyst or treatment will be made *and* that CRA will go up--might seem to be at odds with one another. However, these circumstances may in fact both occur, but not at the same time, *e.g.*, they may happen sequentially. Moreover, although CRA typically decreases during *narratives* about the analyst, it is possible that direct references to the analyst--which may be briefer or less involved--will not necessarily be associated with lower levels of CRA.

order for the system developed here to be a viable one, its variables need further definition, and reliably applying those variables must be more solidly established. For this reason, the initial phase of the project entails the preparation of a detailed coding manual, sufficient to permit the reliable application of the measure not only in this study, but in future research.

B. Application of VIT Measure and Reliability Assessment

Once the manual for the coding scheme is complete, two judges will be trained in applying the VIT measure, and will use the measure to code transcripts of thirty-six psychoanalytic sessions. A description of the data set and the procedures for this phase of the project are set forth below.

1. Data set

Researchers who are part of the Collaborative Analytic Multi-site Project of the American Psychoanalytic Association, originally headed by Wallerstein and later by Bucci, have identified a number of psychoanalytic sessions to be used as a common data set for collaborative research purposes. The sessions used here are a part of that archival data base.[25] Thirty-six sessions will be coded, twelve from each of three recorded psychoanalytic cases. All three patients agreed to the recording and use of session material for research purposes. The sessions consist of four consecutive hours from the early, the middle and the late phases of each of the three treatments.

The treatments were all four or five day a week, classically oriented analyses[26] spanning four to six years. Outcome has been assessed on each case using the Health Sickness Rating Scale applied by independent clinicians to compare the patient's state

[25] These sessions are used with the permission of the Psychoanalytic Research Consortium.

[26] It should be noted that one of the three patients, Patient B, spent a considerable amount of time at the end of her treatment sitting up facing the analyst rather than lying on the couch.

early and late in treatment. Using this method, Case A was rated moderately successful,[27] Case B was rated successful, and Case C was rated unsuccessful (Luborsky et al., 2001). Further details relating to these cases are set forth in Table 1.

2. Procedures

The two judges will code the thirty-six transcripts, using the method developed here for classifying direct and indirect references to the analyst or treatment situation. Coding will be done on a line by line basis, i.e., as judges read through a transcript, they will code each line of text as containing no reference, an indirect reference or a direct reference.

Reliability ratings will be calculated using Cohen's kappa and percent agreement. Two slightly different methods of assessing reliability will be used. The first method includes each and every line as a separate segment, which results in the most stringent test of reliability. Nevertheless, a line of text in a transcript is an admittedly arbitrary segment, and hardly represents a natural element of the speech that constitutes an actual therapy session.

Consequently, the second method is based on "instances" of direct and indirect references, which can appear on a single line or span a number of lines. Reliability turns on whether, when one judge sees an "instance," another judge sees one there as well and codes it the same way.[28] Reliability ratings from both methods will be presented and compared.

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[27] With regard to Case A, there has been considerable debate about its classification as successful or unsuccessful (Bucci, 1997a).

[28] This method also accounts for the fact that judges may spot the same reference and code it the same way, but segment it differently. For example, when faced with the patient statement, "On the way over here, I was thinking about my mother," a judge could code the entire sentence as an indirect reference to the treatment, or he or she could code just the phrase, "On the way over here," as an indirect reference. If a line break occurs in the middle of the sentence, a different segmenting decision could result in a different coding decision on a particular line. This would impact reliability under the first method, but not the second.

C. Analyzing Hypotheses

The final phase of the project involves an evaluation of the two hypotheses set forth above. This requires the application of additional measures and further data analysis, which are described below.

1. Measures

a. Relationship Episodes:

Relationship Episodes (RE's) correspond to patient narratives about relationships with others, including the analyst. They are identified using Luborsky's (1990a) Core Conflictual Relationship Theme (CCRT) scoring method. RE's will be coded on the thirty-six transcripts used here.

b. Computer assisted Referential Activity:

Computer assisted Referential Activity (CRA) is based on Bucci's (1997b) multiple code theory, which conceptualizes emotional information processing within symbolic and subsymbolic systems of the mind. CRA is designed to track when patients are more or less successful at expressing nonverbal experience, particularly emotional experience, in words. It is calculated using computerized procedures that compare words in a patient transcript to customized dictionaries developed by Mergenthaler and Bucci (1999). These procedures will be applied to the thirty-six sessions in this study.

The CRA measure has been used extensively in psychoanalytic and psychotherapy process research (Bucci, 2002). In particular, a variety of existing studies supports the criterion and construct validity of the measure (Mergenthaler and Bucci, 1999).

c. Classifying transference interpretations:

Two independent judges will code each analyst intervention in the thirty-six sessions along two dimensions: (i) to determine whether an analyst intervention constitutes an interpretation; and (ii) to determine whether or not each intervention or

interpretation concerns the transference. For purposes of the first dimension, a simplified version of a coding system developed by Piper, Debbane, De Carufel and Bienvenu (1987) will be applied. The system defines an interpretation as making reference to one or more of the four components of mental conflict outlined in Freud's structural theory, *i.e.*, wish, anxiety, defense and dynamic expression. It provides an alternative to measures used in previous studies (Garduk and Haggard, 1972; Luborsky et al., 1979) which defined interpretations as addressing material outside the patient's conscious awareness, a construct that is much more difficult for judges to reliably identify.

To score the second dimension, a manual will be developed which will provide guidelines and sample prototypes of interventions and interpretations defined as concerning the transference. A transference intervention or interpretation will be defined as one that addresses the patient's experience of an interpersonal relationship with the analyst or the patient's affective reactions to the therapeutic work.

2. Data analysis

After all thirty-six sessions have been coded with the measures outlined above, consensus meetings will be held with each set of judges to resolve coding disagreements. At that point, certain sequences will be identified in each session according to a method developed by Pessier and Stuart (2000) for examining the effects of therapeutic work in the transference.

Specifically, analysis of the data generated by the VIT measure will be built around the first transference interpretation in each session. The rationale for using this interpretation as a benchmark is that it is likely to have the starkest affective impact on the patient. It is the affective impact of transference work that gives it its unique power, and that forms the theoretical foundation for its effectiveness (Freud, 1912, 1917; Gill, 1979). From the patient's perspective, the analyst's introduction of

the transference constitutes a critical event in the unfolding clinical process.[29] While the first time in a session that the analyst speaks to the transference is not necessarily more important clinically than the second or third or fourth time, it does provide the best chance empirically to see the process by which transference takes effect.[30]

Another conceptual building block of the method employed here is the use of Relationship Episodes (Luborsky, 1990a) as an anchoring point for assessing patient effects, i.e., for comparing pre-interpretation and post-interpretation levels of the dependent variable CRA (Mergenthaler and Bucci, 1993). Pessier and Stuart (2000) argue for the use of RE's rather than brief, fixed length segments for two reasons: first, because transference is part and parcel of an interpersonal relationship, and RE's demarcate when the patient is discussing an interpersonal relationship, RE's represent "good hunting ground for transference-related phenomena" (p. 170); and secondly, the telling of an interpersonal narrative suggests that the patient has "integrated and organized an initial response to an interpretation" (p. 170). In other words, having the transference brought into direct focus is intense and often disorganizing--though not necessarily ineffectively so--and hence a patient's response in the immediate aftermath of a transference interpretation may not tell the full story.

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[29] It is possible--although a review of sessions transcripts suggests unlikely--that the patient may make a direct reference to the transference prior to the analyst's first transference interpretation. However, even if this does occur, the idea advanced here is that the first time the analyst points to a reaction or fantasy connected to the transference, the patient is invariably effected, and one way or another, the course of the remainder of the session is impacted as well.

[30] Moreover, after the transference *is* put on the table, it is virtually impossible to unravel the effects of any one subsequent transference interpretation when the patient's associative flow and corresponding internal state already have been impacted by the analyst's initial act of attempting to focus the patient on the transference. Indeed, the problem of attributing patient effects to an immediately preceding transference interpretation when multiple transference interpretations have been made has plagued prior research efforts, which have resulted in fairly inconsistent findings.

Accordingly, the method used here will involve locating in the thirty-six coded transcripts sequences that include RE's told about the same or similar type of other before and after the first transference interpretation. Mean CRA scores will be calculated for each RE, and nonparametric statistical tests (i.e., sign tests that indicate if the dependent measure has risen or fallen rather than using the numerical continuum of the scale) will be used to tabulate how often CRA increases or decreases across RE's told before and after a transference interpretation.

The VIT coding will yield the independent variable used to distinguish the variance in CRA manifested in these sequences. In particular, these sequences will be placed into different descriptive categories that reflect different possible scenarios regarding the interplay of the patient's and the analyst's focus on the transference.

The thrust of the hypotheses set forth above is that the most potent therapeutic interactions will involve the patient's indirect references to the analyst or treatment, followed by the analyst's interpretation of the transference. When this kind of sequence occurs, the transference is live for the patient and the analyst brings it out in the open between them--this is the targeted clinical sequence in this study. To invoke Gill (1979) yet again, "[T]he disguises in which the transference appears have to be interpreted" (p. 273).

In comparison, sequences where the patient is hinting at the transference but the analyst does not encourage her to elaborate, or where there is no evidence that the transference is live for the patient but the analyst brings it up, are likely not to be as effective. Sequences where the transference does not appear to be live for either the patient or the analyst may well be even less effective.

In order to actually make these kinds of comparisons, the VIT data will be used to determine what kind of scenario was played out in the process occurring around the analyst's first transference interpretation. Patient associations occurring prior to the transference interpretation will be reviewed and categorized on the basis

of whether the patient refers to the analyst or the treatment--directly, indirectly or not at all. Rather than looking at a patient's references within a fixed length segment prior to the interpretation, all patient material leading up to the first transference interpretation--at whatever point in the session it occurs--will be considered.[31]

The VIT data at the other end of the sequence will be similarly reviewed and categorized. Specifically, the post-interpretation segment will consist of all patient associations occurring after the first transference interpretation, up until the next transference interpretation. Whether or not the patient refers directly to the analyst or treatment situation in this post-interpretation segment will be used, along with CRA, as a dependent variable.

In sum, differential effects associated with different patterns of patient and analyst work in the transference will be examined. In addition, it will be possible to present various descriptive statistics concerning the appearance of the VIT variables, and their relationships with the constructs coded by the other measures.

VII. RESULTS

Study results are presented below. These include reliability ratings for the VIT measure; descriptive data derived from the application of the VIT measure; and findings pertaining to the two hypotheses stated above. In addition, a copy of the coding manual developed and used in the study is attached hereto as Appendix B.

A. VIT Reliability Ratings

Reliability ratings obtained from the application of the VIT measure to the thirty-six psychoanalytic transcripts used in the study are set forth in Tables 2 and 3. Ratings were calculated in two ways.

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[31] The primary reason for doing so is that how the patient is situated vis a vis the transference will not be reflected solely in the several minutes prior to a transference interpretation.

The first method of calculation counts every line of patient speech in a transcript as a predetermined segment. In a concrete sense, this is consistent with the method of coding, which requires a rater to make a coding decision on each and every line of a session transcript. The corresponding statistical procedure used to determine reliability was Cohen's kappa. This is the most stringent test of interrater reliability.

Ratings derived from the use of this method are contained in Table 2. Kappas were calculated separately for each session transcript. Ratings ranged from .32 to .96 across the three dyads. Mean kappas were computed for each of the three analyst-patient dyads. Mean kappas were .75 for Dyad A, with a standard deviation of .10 and a range of .61 to .88; .65 for Dyad B, with a standard deviation of .11 and a range of .51 to .83; and .64 for Dyad C, with a standard deviation of .17 and a range of .32 to .96. The mean kappa for all sessions was .67, with a standard deviation of .14 and a range of .32 to .96.

Kappa statistics could not be computed for four of the thirty-six sessions because these sessions did not utilize the full range of the VIT scale, *i.e.*, either no *i* codes or no *r* codes were given by one of the two raters for those sessions. It is possible, however, to artificially factor in an *i* or *r* code, and then to calculate some approximation of a kappa score for these sessions. This was done in the most conservative manner possible by adding a false disagreement between the raters. Doing so produced kappas for the remaining Dyad A sessions of .63 (257 lines), .63 (275 lines) and .49 (251 lines), and for the remaining dyad C session of .25 (18 lines).

Using these additional data points, the mean kappas for the three dyads were .71 for Dyad A, with a standard deviation of .12 and a range of .49 to .88; .65 for Dyad B, with a standard deviation of .11 and a range of .51 to .83; and .61 for Dyad C, with a standard deviation of .20 and a range of .25 to .96. The mean kappa for all sessions was .66, with a standard deviation of .15 and a range of .25 to .96.

The second method of calculating reliability uses "instances" of coded references as the defining segment. It is designed to create coding segments based on naturally occurring shifts in the patient's speech. This method results in a more "clinical" unit than a simple line of text, and it corresponds more closely with how a rater actually approaches the coding task.

Using this method, identification by either coder of any kind of transference reference indicated a segment. References that occurred within less than five lines of each other were combined to form one segment. Two reliability checks were performed. The first determined in what percentage of segments both coders marked any kind of transference reference, *i.e.*, *i* or *r*. The second ascertained in what percentage of segments during which both coders identified a transference reference did the coders agree on the nature of the reference.

Reliability ratings were calculated using percent agreement.[32] For the first reliability check, percent agreement was computed by dividing the number of segments in which both coders marked a transference reference by the number of segments in which either coder marked a transference reference. For the second reliability check, percent agreement was computed by dividing the number of segments in which both coders agreed on whether a transference reference was direct or indirect by the number of segments in which both coders marked any kind of transference reference.[33]

Ratings derived from the use of this method are contained in Table 3. Interrater reliability for identifying any reference to the analyst or treatment was best

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[32] Cohen's kappa was not used with this method because there were no predefined coding segments.

[33] In the event that one of the coders marked both direct and indirect references in a segment, agreement turned on whether both coders felt that the patient had reached a level of speaking about the analyst or treatment sufficient to be considered a direct reference.

for Dyad B, although roughly comparable for the three dyads: .74 (67/90) for Dyad A; .79 (123/162) for Dyad B; and .74 (63/85) for Dyad C. Overall for the thirty-six sessions the raters agreed seventy-five percent of the time on whether a reference to the transference had been made.

With regard to the second reliability check, there was a greater degree of variance among the three dyads, with Dyad B yielding the lowest level of agreement: .87 (58/67) for Dyad A; .75 (92/123) for Dyad B; and .94 (59/63) for Dyad C. Overall for the thirty-six sessions the raters agreed eighty-three percent of the time on whether an agreed upon reference to the transference was direct or indirect.

B. Descriptive Data

Descriptive findings obtained from the application of the VIT measure to the thirty-six psychoanalytic transcripts used in the study are set forth in Tables 4-7. Descriptive findings were calculated on the basis of consensus coding.

1. Procedures used for consensus coding

The coding segments that were delineated in the second method used to calculate reliability (based on "instances" of coded references) were used as the basis of the consensus ratings, *i.e.*, agreement was reached on the coding of these segments, not on the coding of each and every line of text individually. Each segment received only one code for consensus purposes, with the relevant inquiry being did the patient material rise to the level of a direct reference. Hence, if an indirect reference to the treatment was made in a segment where the patient also was actively addressing the relationship with the analyst, the segment received an *r* code.

Consensus was achieved in two phases. Specifically, the two raters met at the conclusion of the coding to discuss disagreements in a general sense. Individual coding discrepancies were not addressed at this time, but rather overarching themes and trends in respective coding styles were identified. Following this meeting, the raters independently reviewed all coding disagreements. They were asked to revisit

their original coding decisions in light of their discussions, along with the knowledge this time around that the other rater had had a different take on the reviewed references. The raters were asked to code these references again. At the conclusion of this process, 82 of the initial 128 disagreements had been resolved, leaving 46 coding disagreements to be worked out.

In the second phase of the consensus process, the two raters met again and discussed these 46 disagreements. For each reference, the raters shared with one another the reasoning behind their individual coding decisions. They considered how the different ways of coding the reference in question stacked up with the guidelines set forth in the coding manual. Together they decided which of their positions was more persuasive and more in keeping with the definition of the variables contemplated by the coding scheme. Through this kind of give and take, they were able to reach a final consensus with regard to these remaining disputed references.

2. Findings

Characteristics of the study sample are set forth in Table 4. The average length of sessions[34] was loosely comparable for Dyads A and C, with a mean number of lines per session of 264.8 and 221.7, respectively. Dyad B's sessions averaged roughly twice that, with a mean number of lines per session of 524.9. Both the analyst and the patient in Dyad B spoke considerably more than their counterparts in the other two dyads, with the mean number of lines per session that Analyst B spoke totaling 174.0, as compared to 15.5 for Analyst A and 40.8 for Analyst C, and the mean number of lines per session that Patient B spoke totaling 350.9, as compared to 249.3 for Patient A and 180.8 for Patient C.

[34] Length of sessions was measured by number of lines. Although this is an admittedly arbitrary unit, as changes in fonts and margins will impact the number of lines in a session, the thirty-six transcripts used in the study were all formatted in the same way so that a meaningful comparison of session length for these sessions could still be had.

When patient speech is broken down into the three VIT coding categories, there is a notable degree of variance among the three patients. Notwithstanding their differences, all three patients spent the bulk of their session time speaking about matters other than the analyst or treatment situation, with a mean number of lines per session of 191.6 for Patient A, 227.1 for Patient B, and 109.8 for Patient C. When they did invoke the transference, all three patients on average did so more frequently in a direct rather than an indirect manner, with the mean number of lines per session that each patient made direct reference to the analyst or treatment totaling 42.5 for Patient A, 100.2 for Patient B, and 52.3 for Patient C, as compared to the mean number of lines per session that they indirectly referred to the analyst or treatment, which totaled 15.3 for Patient A, 23.7 for Patient B, and 18.7 for Patient C.

Tables 5 and 6 show the percentage of patient speech that referenced the transference in the sessions under study. Specifically, these tables present mean percentages. To obtain these figures, single session percentages were first computed by adding up the number of lines in a given session that a patient made no reference, indirect reference and direct reference to the analyst or treatment, and dividing those numbers by the total number of lines in the session that the patient spoke. Mean percentages were then calculated by averaging the individual session percentages for all stages of treatment in Table 5, and separately for the early, middle and late stages of treatment in Table 6.[35]

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[35] Findings presented here in the form of mean percentages could be calculated instead as actual percentages, *e.g.*, totaling the number of lines in all twelve sessions that Patient A made direct reference to the transference and dividing this number by the total number of lines that Patient A spoke in all twelve sessions. However, the figures obtained using these two different methods of calculation are extremely close. Although computing straight percentages might be more straightforward, as a conceptual matter mean percentages seem preferable as they provide a figure that denotes what a patient did in a typical session.

Of the three patients, Patient A spent the most time speaking about matters other than the transference, with a mean of 75.7% of lines per session, compared to 65.2% for Patient B and 62.0% for Patient C. Patient C had the highest percentage of indirect references to the analyst or treatment, with a mean of 9.5% of lines per session, as compared to 6.5% for Patient A and 6.9% for Patient B. With respect to percentage of speech devoted to direct references to the analyst or treatment, Patients B and C were essentially the same at 28.0% and 28.6%, respectively, as compared to 17.9% for Patient A. The overall mean percentages for all three patients considered together were 67.6% of lines per session that contained no reference to the analyst or treatment, 7.6% of lines per session that contained an indirect reference, and 24.8% of lines per session that contained a direct reference.

When percentages are calculated separately for the early, middle and late stages of treatment, some interesting trends are revealed in how each patient worked in the transference. For example, as her treatment progressed, Patient A spent less time speaking about matters outside the transference, with a mean percentage of lines per session of 79.2% in the early stage, 77.5% in the middle stage, and 70.3% in the late stage. More of the increased time she spent working in the transference was done through indirect references to the analyst or treatment, with a mean percentage of lines per session of 3.4% in the early stage, 6.2% in the middle stage, and 9.9% in the late stage. Her mean percentage of speech containing direct references to the analyst or treatment was 17.5% in the early stage, dropping slightly to 16.4% in the middle stage, and increasing to 19.8% in the late stage.

Patient B followed a contrary course in that time spent speaking about matters outside the transference increased as her treatment progressed, with a mean percentage of lines per session of 61.0% in the early stage, 66.3% in the middle stage, and 68.3% in the late stage. As between direct and indirect references, she experienced a greater decrease in the amount of time she focused directly on the

relationship with her analyst, with a mean percentage of lines per session containing a direct reference moving from 32.4% in the early stage, to 25.0% in the middle stage, and to 26.6% in the late stage. Her mean percentage of lines per session containing an indirect reference was 6.6% in the early stage, increasing to 8.8% in the middle stage, and finally dropping to 5.2% in the late stage.

Patient C's record displayed the greatest degree of variance. His mean percentage of lines per session that made no reference to the transference was 64.0% in the early stage of treatment, 50.9% in the middle stage of treatment, and 71.1% in the late stage of treatment. Of the three patients, he had the highest mean percentage of lines per session containing indirect references to the transference, 13.7% in the early stage of treatment, which dropped to 8.2% in the middle stage of treatment and then to 6.5% in the late stage of treatment. Patient C also claimed the highest mean percentage of lines per session with direct references to the transference, 40.9% in the middle stage of treatment, as compared to 22.4% in the early stage of his treatment and 22.5% in the late stage of his treatment.

The findings derived from the application of the VIT measure can also be evaluated in the context of the balance between patient and analyst speech that existed in the three dyads. Table 7 sets forth a breakdown of the percentage of patient and analyst speech for all, early, middle and late stages of treatment. These figures were calculated in the same manner as described above for obtaining mean percentages of patient speech that referenced the transference. Specifically, the relative percentage of patient and analyst speech was computed for each of the thirty-six sessions by adding up the number of lines in a given session that the patient spoke and the number of lines that the analyst spoke, and dividing those figures by the total number of lines in the session. Mean percentages were then calculated by averaging the individual session percentages.

There was considerable variance among the three dyads in terms of how much the analysts intervened. The most striking difference was between Analyst A and Analyst B, who had mean percentages of lines per session for all stages of treatment of 5.5% and 31.3%, respectively, as compared to 18.4% for Analyst C.

Also interesting to note was the relative consistency that each analyst did or did not maintain with respect to how active he was in the treatment. Analyst A gradually spoke more, although he was relatively consistent throughout the treatment in terms of how much he intervened, with a mean percentage of lines per session of 4.7% in the early stage of treatment, 5.2% in the middle stage, and 6.7% in the late stage. Analyst B shifted his stance a bit more, with a mean percentage of lines per session of 29.9% in the early stage of treatment, increasing to 35.8% in the middle stage, and dropping back to 28.2% in the late stage. In contrast to his counterparts, Analyst C was quite changeable with regard to how active he was in the treatment, with a mean percentage of lines per session of 8.2% in the early stage of treatment, 27.9% in the middle stage, and 19.1% in the late stage. The high degree of variance in Analyst C's record is especially interesting to consider in light of the corresponding variability noted above in Patient C's work in the transference.

C. Hypotheses

In order to address the two hypotheses posed in the study, certain sequences of patient and analyst speech had to be identified. This required the application of additional research measures as already described in presenting the methodology used in the study. Relevant findings pertaining to these measures are set forth in Tables 8 through 10.

Characteristics of the analyst interventions contained in the thirty-six transcripts are listed in Table 8. Consistent with the findings noted earlier concerning the relative proportion of analyst speech in each of the three treatments, Analyst B logged a substantially greater number of interventions than his colleagues. His mean

number of intervention segments per session was 32.8, compared to 5.6 for Analyst A and 8.5 for Analyst C. An intervention segment was defined as an analyst speech turn, with two exceptions. Brief utterances such as, "Uh," "Uh-huh," or "What?" were not counted, and speech turns that were interspersed with just one or two lines of patient speech were combined to form one segment.

The mean number of interpretations per session for each of the analysts was 2.1 for Analyst A, 8.8 for Analyst B, and 2.8 for Analyst C. Breaking these figures down further, Analyst A averaged 1.1 transference and 1.0 nontransference interpretations per session; Analyst B averaged 7.7 transference and 1.2 nontransference interpretations per session; and Analyst C averaged 2.1 transference and 0.7 nontransference interpretations per session.

Table 9 contains data relating to the Relationship Episode (RE) segments located in the thirty-six transcripts. The mean number of REs per session was 5.4 for Patient A, 7.6 for Patient B, and 5.1 for Patient C. More specifically, the average number of REs about others per session (narratives about a specific person or persons other than the analyst) was 4.3 for Patient A, 5.3 for Patient B, and 3.8 for Patient C. The three patients were roughly comparable in the mean number of REs about general others they told per session (narratives where the patient describes relationships with other people generally, rather than a relationship with a specific person or persons), with 0.3 for Patient A, 0.3 for Patient B, and 0.5 for Patient C. With regard to REs that were about the analyst, Patient B on average told twice as many as her counterparts, with a mean per session of 2.0, compared to 0.9 for Patient

A and 0.8 for Patient C.[36]

Mean Computer assisted Referential Activity (CRA) scores across type of patient speech segment are presented in Table 10. CRA scores were obtained for all RE segments containing at least four full lines of patient speech. (The same procedure was followed for patient speech that did not contain the elements necessary to be classified as an RE, with these segments designated as "Non-RE speech.") The mean CRA score for all speech segments in the data set was -0.17. The mean scores for each patient across all types of speech segments were -0.19 for Patient A, -0.16 for Patient B, and -0.17 for Patient C. When considering mean CRA scores during REs told about others, Patient B's score of -0.12 was notably above the mean for the data set, as compared to Patient A's score of -0.16 and Patient C's score of -0.17. All three patients' mean CRA scores during REs about the analyst fell fairly far below the mean, with Patient B's score dipping the furthest to -0.29, compared to Patient A's score of -0.27 and Patient C's score of -0.22.

With data from these three measures, along with the VIT findings, in hand, sequences of patient and analyst speech could be identified consistent with the method outlined earlier. In particular, the primary sequence implicated in both of the hypotheses in the study is one in which the patient refers indirectly to the analyst or treatment, and the analyst responds with a transference interpretation. The theory advanced here is that this kind of sequence is more likely to be productive[37] than

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[36] These figures represent organized narratives that the patients told about their analysts. To be scored as an analyst RE, a patient's narrative had to express a wish, along with the response she expected to get from the analyst and her own expected reaction to the analyst's response. Hence, while there is some overlap between the classification of analyst REs and the coding of direct references to the analyst or treatment under the VIT system, the former reflects a much more narrowly defined construct.

[37] What constitutes a "productive" outcome is hardly an undisputed matter. Limitations inherent in the choice of dependent variables used in this study will be discussed in the next section.

either one in which the patient does *not* refer to the analyst or treatment and the analyst responds with a transference interpretation, or one in which the patient refers to the analyst or treatment and the analyst does *not* respond with a transference interpretation.

Accordingly, the two hypotheses to be tested predicted that it was more likely that CRA would increase, and that direct references to the analyst or treatment would be made, in the aftermath of sequences in which an indirect reference was followed by a transference interpretation, as compared to sequences in which (1) no reference was followed by a transference interpretation, and (2) an indirect reference was followed by a nontransference interpretation. Hence, the kind of patient/analyst speech patterns that had to be located in the thirty-six transcripts were those that combined either no reference or an indirect reference to the analyst or treatment with either a transference or a nontransference interpretation. In addition, the method used in the study required that for sequences containing a transference interpretation, that interpretation marked the first time in the session that the analyst addressed the transference. Furthermore, sequences had to include RE segments about the same or similar type of other both before and after the targeted interpretation to permit a comparison of CRA scores obtained in these segments.

Only eleven sequences in the thirty-six transcripts met these criteria. Specifically, there were three instances where an indirect reference to the analyst or treatment was followed by a transference interpretation; five instances where an indirect reference to the analyst or treatment was followed by a nontransference interpretation; and three instances where no reference to the analyst or treatment was followed by a transference interpretation. (No sequences were identified where no reference to the analyst or treatment was followed by a nontransference interpretation.) Six of the eleven sequences came from Patient A's case, and the other

five came from Patient C's case. No sequences from Patient B's case met the inclusion criteria for the study.

Within the confines of this limited sample, the findings support the predictions made in the second hypothesis, but not the first. Specifically, CRA increased 33% of the time (1 out of 3 sequences) when an indirect reference was followed by a transference interpretation, as compared to 20% of the time (1 out of 5 sequences) when an indirect reference was followed by a nontransference interpretation and 33% of the time (1 out of 3 sequences) when no reference was followed by a transference interpretation; and direct references to the analyst or treatment were made 67% of the time (2 out of 3 sequences) in the aftermath of an indirect reference followed by a transference interpretation, as compared to 20% of the time (1 out of 5 sequences) in the aftermath of an indirect reference followed by a nontransference interpretation and 100% of the time (3 out of 3 sequences) in the aftermath of no reference followed by a transference interpretation.

Because so few sequences could be used as data points in evaluating the two hypotheses, the scope of the data analysis was expanded as follows: (i) sequences in which the patient made a *direct* reference to the analyst or treatment--either alone or in conjunction with an indirect reference--prior to the targeted interpretation were included; (ii) in sessions where the first transference interpretation was preceded by one or more sequences containing a transference intervention, these sequences were included; and (iii) in sessions where there was an initial transference interpretation that did not occur within an RE sequence, the first sequence that contained a transference interpretation was included.

Fifty-two sequences were identified when this broader set of inclusion criteria was applied to the data. Findings based on this set of sequences are presented in Tables 11 through 13. As described below, the data stack up in a roughly comparable way when the predictions made in the two hypotheses are considered in the context of

these findings. However, not only do these findings provide a much larger sample upon which to base any conclusions, but some interesting trends become evident when the data are viewed through a wider lens.[38]

Table 11 shows the percentage of sequences with increased CRA across the various combinations of patient and analyst speech. CRA increased 44% of the time when a reference to the analyst or treatment was followed by a transference interpretation or intervention. In comparison, CRA increased only 33% of the time when a reference to the analyst or treatment was followed by a nontransference interpretation, and just 25% of the time when no reference to the analyst or treatment was followed by a transference interpretation or intervention. These figures support the predictions made in both hypotheses concerning the impact on CRA of various patterns of patient and analyst work in the transference.

When each of the three patients is considered individually, these trends in the data hold true except in the case of Patient A. For Patient A, CRA increased 43% of the time when a reference to the transference was followed by a transference interpretation or intervention, compared to 50% of the time when a reference to the transference was followed by a nontransference interpretation and 100% of the time (1 out of 1 sequence) when no reference to the transference was followed by a transference interpretation or intervention. For Patient B, CRA increased 54% of the time when a reference to the transference was followed by a transference interpretation or intervention, compared to 33% of the time when a reference to the transference was followed by a nontransference interpretation and 20% of the time when no reference to the transference was followed by a transference interpretation or intervention. For Patient C, CRA increased 33% of the time when a reference to the transference was followed by a transference interpretation or intervention, compared

[38] Broadening the scope of the data analysis also raises issues not contemplated by the original method. These issues will be addressed in the discussion section.

to 0% of the time when a reference to the transference was followed by a nontransference interpretation and 0% of the time when no reference to the transference was followed by a transference interpretation or intervention.

Table 12 shows the percentage of patient/analyst speech sequences that were followed by direct references to the analyst or treatment. Patients referred directly to the analyst or treatment 66% of the time in the aftermath of a reference to the transference that was followed by a transference interpretation or intervention. In comparison, they referred directly to the analyst or treatment only 33% of the time in the aftermath of a reference to the transference that was followed by a nontransference interpretation. This is consistent with the prediction made in the second hypothesis. However, contrary to the prediction made in the first hypothesis, patients referred directly to the analyst or treatment 88% of the time in the aftermath of no reference to the transference followed by a transference interpretation or intervention.

These trends hold true across all three patients. Patient A referred directly to the analyst or treatment 86% of the time in the aftermath of a reference to the transference that was followed by a transference interpretation or intervention; 67% of the time in the aftermath of a reference to the transference that was followed by a nontransference interpretation; and 100% of the time in the aftermath of no reference to the transference followed by a transference interpretation or intervention. Patient B referred directly to the analyst or treatment 54% of the time in the aftermath of a reference to the transference that was followed by a transference interpretation or intervention; 0% of the time in the aftermath of a reference to the transference that was followed by a nontransference interpretation; and 80% of the time in the aftermath of no reference to the transference followed by a transference interpretation or intervention. Patient C referred directly to the analyst or treatment 66% of the time in the aftermath of a reference to the transference that was followed by a transference

interpretation or intervention; 0% of the time in the aftermath of a reference to the transference that was followed by a nontransference interpretation; and 100% of the time in the aftermath of no reference to the transference followed by a transference interpretation or intervention.

Table 13 sets forth the percentage of patient/analyst speech sequences with increased CRA where the analyst addressed the transference. Essentially what this table presents is a breakdown of the effects of transference *interpretations* versus transference *interventions*. When all three patients are considered together, there is somewhat of a differential impact between these two ways of speaking to the transference: CRA increased 50% of the time when a reference to the transference was followed by a transference interpretation and 36% of the time when a reference to the transference was followed by a transference intervention.[39]

The most striking feature, however, of viewing the data from this angle is seen when Patients A and B are considered separately. For Patient A, CRA increased just 20% of the time when a reference to the transference was followed by a transference interpretation, compared to 100% of the time when a reference to the transference was followed by a transference intervention. Not only was the discrepancy in these findings virtually as wide for Patient B, but the trend was in the opposite direction. For Patient B, CRA increased 86% of the time when a reference to the transference was followed by a transference interpretation, compared to only 17% of the time when a reference to the transference was followed by a transference intervention.

Also interesting to note are the overall differences between the three patients with regard to how often CRA increased when the analyst addressed the transference, either through an interpretation or an intervention. Specifically, CRA increased 50% of the time for Patient A in sequences that contained either a transference

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[39] See page 44 for a description of the distinction between interpretations and interventions.

interpretation or a transference intervention, 44% of the time for Patient B, and 29% of the time for Patient C.

VIII. DISCUSSION

A. VIT Reliability Ratings

The study marked the most extensive application of the VIT measure to date. While further work can be done, as described below, to refine the measure and to sort out how best to put it to use in clinical research, the study clearly confirmed the viability of the measure.

The reliability ratings were solid, indeed quite strong in some respects while leaving room for improvement in others. To begin with, the first method that was used to calculate reliability on a line by line basis yielded mean kappas for the three dyads of .75, .65 and .64, which while not reflecting ideal levels of interrater agreement for a psychotherapy process measure, are well within a respectable range, particularly given the newness of the measure.

It was actually surprising that kappas for the three dyads turned out to be as high as they were because not only is Cohen's kappa a very stringent statistical test, but a line by line assessment is an extremely unforgiving way of approaching reliability for a measure like this one. The reason for this is rooted in the nature of the measure's purpose, namely to capture in the free flow of an analytic session when and in what way the patient is talking about the relationship with the analyst. By definition, this is not a cut and dried matter, which is why achieving interrater reliability on a measure like this is so challenging. More to the point here, this is not a phenomenon that occurs with precise beginning and end points.

As a result, the line by line reliability assessment invariably incorporated not just the usual discrepancies between the raters about whether or not a reference had occurred, but also less salient issues within the framework of this measure like whether or not a reference began on line number two hundred or two hundred and ten

of a patient's free associations, or whether a patient shifted from speaking about the transference in an indirect to a direct manner on line eighty or eighty-six. In other words, reliability suffered under this method for reasons that were largely unconnected to the substance of the measure and what it was designed to detect.

Reliability was also influenced in the line by line assessment to the extent the raters brought to bear different coding "styles." In particular, there were times in coding the thirty-six sessions in this study that the raters fell into patterns first identified by Gill and Hoffman as reflecting "lumpers" and "splitters." For example, one of the raters would lump together and code as *r* over a hundred lines of text, while the other rater essentially saw the text the same way but interspersed the *r* coding several times with a handful of *x* lines.

The point here is not to minimize the kind of issues that adversely impacted interrater agreement when considered on a line by line basis. Rather it is to provide a context within which to understand the reliability ratings derived from this method, as well as to raise the idea that for future purposes this kind of reliability assessment may not offer the best fit given the intent behind the VIT measure.

Reliability ratings derived from the second method using instances of coded references as a segment were very promising. The findings were consistent across the three dyads on the question of whether or not the patient had made a reference to the transference, with the coders agreeing roughly three quarters of the time. Once the coders agreed that a reference had occurred, they were as good or often better at agreeing on whether the reference was direct or indirect, with levels of interrater agreement for two of the dyads reaching as high as eighty-seven and ninety-four percent.

These findings are particularly meaningful because the approach to measuring reliability in this method reflects the process that raters are supposed to follow in coding a transcript. Specifically, the coding manual instructs raters to approach the

coding task as a two-tiered process. The first tier consists of noting when the patient shifts from not talking about the analyst or the treatment to talking about such matters. This could take the form of a quick or seemingly innocuous remark, or an elaborate and focused narrative. Either way, the question the rater faces initially is simply whether a reference has been made.

Once the rater determines that the patient has indeed moved from *x* into *i* or *r* territory, the second part of the coding task involves deciding what kind of a reference the patient has made, *i.e.*, should the reference be coded *i* or *r*? The rater's job at that point is to assess whether or not the patient is actively dealing with some aspect of the transference. Is the patient making the analyst, or the experience of the relationship with the analyst, the focus of what he or she is saying? If so, the material is coded *r*. If the material does not rise to this level--if the patient mentions or implicates the analyst or the treatment, but is manifestly focused on talking about something else--the material is coded *i*.

Hence, the process of coding a transcript involves the ongoing application of a two-pronged test: first, the rater determines if the patient has left "neutral" territory and made some kind of reference to the analyst or the treatment; second, in the event that the rater does detect such a shift, he or she determines if the reference is a pointed, affectively charged statement that is anchored in the idea that the patient experiences himself in a relationship with his analyst, or if instead it is a fleeting remark or even a more elaborated observation that invokes the analyst or the treatment but steers clear of focusing attention on the analytic relationship.

With this backdrop in mind, it is encouraging that reliability ratings structured around the actual coding task turned out to be so strong. It means that the raters in this study were doing what they were asked to do with a high level of agreement. This is a very positive result for purposes of the study's goal in establishing the legitimacy of the VIT measure.

A few caveats are in order. The VIT measure is untested beyond this study and the pilot project that preceded it. To further establish the reliability of the measure additional studies should be conducted. In particular, the only raters who have ever been trained to apply the VIT measure are the two raters who were used in this study. Not only were both of these raters well versed in the theoretical thinking behind the VIT measure, but they were the individuals responsible for the actual development of the measure. It will be important to demonstrate that the coding system can be reliably applied by raters who do not bring to the coding task the same level of theoretical knowledge, and moreover, who were never involved in hashing out the parameters of the coding variables. These issues notwithstanding, it is important to be clear that the raters in this study did work independently, and thus the reliability achieved was genuine.

Applying the VIT measure to more and different kinds of data sets will also be an important component of any efforts to further substantiate the reliability of the measure. It was interesting in this study that both raters felt they had the toughest time applying the VIT measure to Dyad B's twelve sessions. This was largely due to the fact that the analyst in that case intervened so much more than his counterparts in the other two cases. (His mean number of intervention segments per session was 32.8, compared to 5.6 for Analyst A and 8.5 for Analyst C.) Not only that, but his interventions focused on the transference much more than those of the other two analysts. (Analyst B's mean number of transference interpretations per session was 7.7, compared to 1.1 for Analyst A and 2.1 for Analyst C.)

These kinds of differences in the session material made coding the patient's speech with the VIT measure tricky at times. For example, it was frequently unclear if Patient B was actually referencing the transference or merely neutrally responding

to something the *analyst* had said about the analytic relationship.[40] While this sort of issue can arise in any case, it seemed to be highlighted in the case of Dyad B both because the analyst brought up the transference so much and because the analyst's intervening so much in general meant that there was a great deal of back and forth between patient and analyst. Indeed, their sessions often felt almost like regular conversations.

This is just one example of how differences in data sets may impact the application of the VIT measure. It is a rather interesting example because it suggests that transcripts which contain a lot of "transference talk" may well be harder to code. In one sense, this is not surprising as this kind of session would really put the VIT variables to the test in that a broad and varied range of potential references would likely be presented, calling upon the raters to grapple with novel coding decisions and uncharted shades of gray. However, to the extent this is the case, it also underscores that, notwithstanding the encouraging results in this study, recognizing and categorizing patient work in the transference remains a very murky process.

In addition to noting these limitations in interpreting the reliability results obtained in the study, a closer look at the actual reliability ratings is warranted to get some sense of when and why the raters ran into coding disagreements.[41] This may provide valuable information with regard to improving the measure, thereby enhancing its reliability in future studies.

The ratings show that the coders disagreed twenty-five percent of the time on whether a reference to the transference had been made. These disagreements could

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[40] A path or sequence analysis might be used to determine who was responding to whom here, but this would necessitate the application of additional measures, and consequently is beyond the scope of the current project.

[41] The ratings that will be examined here are the ones obtained from the application of the second method of assessing reliability, the reason being that this method yielded more descriptive information than the line by line analysis about the nature of the disagreements that arose between the coders.

have arisen in one of two ways: one rater could have spotted an indirect reference while the other saw no reference, or alternatively one rater could have detected a direct reference while the other saw no reference. The bulk of the raters' disagreements--seventy-four of eighty-four--fell into the former category. This makes sense if the coding categories are viewed as existing along a continuum. The discernable difference between a statement that is directly focused on the analytic relationship and one that does not involve the analyst or treatment at all should be greater than the difference between a statement that subtly hints at the transference and one that makes no mention of it.

A review of the *x* vs. *i* disagreements that arose in coding the thirty-six sessions reveals that some instances were relatively clear-cut in terms of why the coders did not see eye to eye. For example, in one session Patient C twice referred to a prior treatment experience: "I was close with Mary for five years and then finally ended that relationship which is when I was in analysis." (Session 4, lines 99-100) and "[T]he question I used to ask Dr. Jones and I guess it's still a question for me--is--is it possible to get and to experience intensely, to be--to feel alive and excited about life and about another person for a long time--on and on and on--with one's wife."[42] (Session 4, lines 60-62) One of the raters coded these statements as indirect references to the analyst or treatment, while the other rater viewed them as containing no reference to the analyst or treatment. The consensus was to treat these statements, and others like them, as not making any reference to the transference, the rationale being that they did not refer to the current treatment or analytic relationship and hence fell outside the scope of what the VIT variables are intended to capture. Disagreements like this one were resolved fairly easily and resulted in bright line principles that could govern similar examples in the future.

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[42] Any names or other identifying information contained in session transcripts have been changed.

However, the vast majority of times that the raters came down in different places with regard to an *x* vs. *i* decision it amounted to a coding toss-up. In fact, during consensus discussions the raters often went back and forth regarding their own original coding decisions, uncertain which way the balance should be tipped with regard to a particular reference. For instance, several times Patient A said things like: "[U]m, and then the other thing I thought of was, um, now I can't remember." (Session 765, lines 295-296) The raters ultimately decided that statements like this should be coded as containing no reference to the treatment. Indeed, on its face, the above statement does not reference the treatment, which was why--in deference to the literal text--the raters came down where they did in making their final coding decision. Yet the raters felt somewhat uneasy about their decision given that this statement constitutes a comment by the patient on her ongoing thought processes in the session. In addition, it did clearly stand out for both raters as a potential reference when they were reading the transcript, meaning they easily agreed that this statement felt different than completely outside-of-the-transference associations.

An example of a close call where the raters were pulled in the opposite direction occurred when Patient A said: "Sometimes we, I feel kind of, I guess, guilty when I say this now, or think about it, but we'll joke about some of the things she does...." (Session 944, lines 241-242) After a great deal of deliberation, the raters decided to code this statement as an indirect reference. The strong affective component was what pushed them over the edge. Nevertheless, as in the example discussed above, they both felt some discomfort about their decision. Although in this instance the patient is registering the fact that she is speaking to someone else and that she has an emotional response to that, neither the analyst nor the treatment situation are expressly mentioned.

In reviewing coding scenarios like these, it is difficult to come up with clear rules which will ensure that future tough calls are made by any two or more

independent raters in the same way. It is also the case that there will always be some coding disagreements and that one hundred percent reliability is a theoretical goal only. However, there still may be some way to improve the current coding system that would account for the kind of close calls the raters encountered in applying the VIT measure in this study.

A review of the other main coding fault line in the study sheds further light on a possible refinement of the measure. Distinguishing between indirect and direct references was not as problematic for the raters as deciding if a reference had been made at all, but those references that ended up yielding coding disagreements frequently were ones where the raters both had gone back and forth initially in trying to decide if the criteria for a direct reference really had been met.

For example, in one session Patient B states: "[M]aybe that's why I sort of don't want to come here--don't want to talk about my mom or my dad in a bad way. (pause) it, uh--it hurts." (Session 4, lines 502-503) One rater coded this as an indirect reference and the other as a direct reference. Final consensus was to call it direct, but the raters agreed that it seemed most comfortably to fall somewhere in-between an *i* and an *r* code. The patient steered clear of mentioning the relationship with the analyst, although she did make a direct, emotionally charged statement about her experience of the treatment. However, it was not crystal clear to either of the raters that the patient was primarily focused on that experience rather than on what it feels like generally for her to talk about her mom and dad. Still they decided that on balance the affective tone of the patient's statement was strong enough to warrant bumping the reference up to an *r* code.

What coding scenarios like these illustrate is that there were times when the coding task was ambiguous not so much because of a lack of clarity in the coding criteria, but because shades of gray exist when trying to impose all or nothing categories on a concept as complex as transference. A possible solution to this

problem would be to change the VIT coding scheme so that it is a continuous rather than a categorical measure. Using a continuous scale would in fact be consistent with the current conceptual framework of the coding scheme in that the categories of no reference, indirect reference and direct reference are intended to exist along a continuum. The modification proposed here would in essence just bring the structure of the measure in line with its conceptual foundation.

To implement this change, a five point Likert scale could be used to rate all references. In this way, the raters would decide where along a continuum a statement fell with regard to how subtly or directly the patient referenced the analyst or treatment situation. This would give a home to statements that strike the rater as constituting more than *x* but not quite *i*, or more than *i* but not quite *r*. It would also address the fact that the *i* and *r* categories arguably ended up covering too wide a range of references.

Certainly using a continuous scale for the measure would not eliminate all coding disagreements, and when confronted with new versions of tough coding calls there may always be a wish for another "in-between" category. Yet it is likely that this kind of modification would go a long way in addressing some of the difficulty the raters encountered in this study.

Moreover, it seems that structuring the coding scheme in this way would be more in keeping with the nature of transference as we understand it clinically. To the extent that the relationship with the analyst becomes a repository for the patient's unconscious conflicts, talking about this relationship is rarely a straightforward matter. The patient's feelings about the analyst, and the intrapsychic meaning attached to those feelings, are often outside awareness and most likely to surface in a way that might best be captured with gradations along a continuum, *i.e.*, the transference may more often be "kind of there" rather than either "there or not."

Thinking of the manifestation of transference in this way is consistent with the

existing thinking behind the VIT measure which led to the idea of differentiating between direct and indirect references to the transference. The modification proposed here would simply address the fact that in practice even these categories may not be nuanced enough when dealing with such a complicated and elusive clinical phenomenon.

B. Descriptive Data

With regard to discussing the descriptive data derived from the application of the VIT measure, limitations really should be noted up front. The study sample was confined to only three patients. Consequently, it is not possible to draw any definitive conclusions concerning the clinical significance of the findings obtained in this study. Furthermore, only twelve sessions each from three very lengthy analyses were evaluated. (Patient A's treatment consisted of 1014 sessions; Patient B's consisted of 324 sessions; and Patient C's consisted of 660 sessions.) Hence even observations about these three patients, including trends that were evident over the course of the early, middle and late stages of their treatments, are based on a very small sampling of sessions, and thus must be viewed as inconclusive.

In addition, the outcome data provided here should not be relied upon as gospel. There are many different ways of assessing outcome. It was possible to use only one method in evaluating the three cases in this study. This method involved a comparison of Health Sickness Rating Scale scores, obtained by third party raters based on a review of select sessions from the early and late stages of the patients' treatments. No other measures were used, and there was no access to any direct information from the patients or analysts. Although the method that was employed constituted an innovative way of coming up with at least some outcome data for these three cases, the data are obviously very limited.

For all of these reasons, clinical impressions offered here should be understood as speculative. That being said, there is much to glean from the data that

is quite interesting and potentially valuable in terms of generating ideas that could be put to use in future projects using the VIT measure.[43]

While there was a fair amount of variance among the three patients, it was interesting to see that overall in the thirty-six sessions studied the patients focused their attention directly on the analyst or treatment one fourth of the time they were speaking. While they still spent most of their time talking about other matters, this was a notably high percentage given how difficult it generally is for patients to discuss their relationships with their analysts.

The three patients spent considerably less time overall speaking about the analyst or treatment in a subtle or indirect way (approximately eight percent of lines on average per session). This finding should be considered, however, in light of the fact that indirect references tend to be very brief, sometimes consisting of only a phrase in a sentence and rarely extending for more than a couple of lines. It is therefore not surprising that the actual number of lines that contained indirect references in an average transcript might seem at first glance to be relatively low.

It is interesting as well to compare the extent to which each of the three patients discussed the analytic relationship, particularly in the context of the relative success of their treatments. As noted earlier, Patient B's treatment was rated successful, as compared to a rating of moderate success for Patient A and a rating of unsuccessful for Patient C. As compared to Patient A, Patient B spent more time during all phases of her treatment speaking directly about the analyst or treatment. This finding raises a question as to whether in these two cases a greater amount of direct work in the transference was associated with better treatment outcome.

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[43] One additional limitation that concerns use of the VIT measure and any discussion of its findings should be reiterated here. While the measure purports to assess verbal indicators of the "transference," it is actually references to the analyst or treatment that are coded. It is understood that whether these two phenomena can be used interchangeably is not a settled question.

However, a closer look at the data also reveals that as Patient B's treatment progressed, she spent increasingly more time speaking about matters outside the transference, while Patient A spent increasingly less time doing so. In fact, in the late stages of their treatments, both patients spent roughly the same amount of time speaking about things unrelated to the analyst or treatment. This trend is arguably at odds with the idea that a focus on the transference might have enhanced treatment outcome.

A look at the breakdown between direct and indirect references may shed some light on the issue. Although both patients spent about the same amount of time discussing the analyst or the treatment at the end of their analyses, Patient B did so in a direct way to a manifestly greater degree than did Patient A. So while the trend noted above remains curious, it may be that an ability to focus in a straightforward way on the analytic relationship, as distinct from a more subtle or unconscious way, served Patient B particularly well. It also may be that Patient B's speaking less about the analytic relationship as her treatment wore on meant that, having addressed the transference, she was freer to look at and work on her actual life issues.

When Patient C's treatment is brought in as an additional point of comparison, drawing tentative conclusions like this becomes more complicated. Although Patient C's treatment was rated unsuccessful, he spent the most time overall speaking directly about the analytic relationship. The middle phase of his treatment is especially striking in that he spent over forty percent of his time referring directly to the analyst or treatment. Indeed, this was the highest percentage of direct references scored in any phase of treatment across the three dyads. (The lowest percentage of time any of the three patients spent talking about matters outside the transference also occurred in the middle phase of Patient C's treatment.)

What this suggests is that a large amount of work in the transference is not necessarily a good thing. A look at what actually occurred in Patient C's analysis

bears this out. Patient C and his analyst became very combative with one another, particularly in the middle phase of the treatment when the analyst's participation increased sharply. Patient C spoke often about how he did not feel understood or supported by his analyst. Certainly he is not the only analytic patient who has ever felt this way. Yet discussions of Patient C's feelings about his analyst were strikingly contentious, and seemed ultimately to have a mostly destructive impact on their work together.

These findings suggest an idea that surely has a great deal of clinical resonance. Namely, it is not simply the quantity of transference work, but the quality of it that matters. Certainly it is also possible that the relative success or failure of the three cases in this study was completely unrelated to the patient's focus on the analytic relationship. For instance, it may be that Patient C failed to improve not so much because the transference work was so seemingly destructive, but because the work did not get applied to his life very much. Future studies incorporating the VIT measure will never be able to establish a causal link between work in the transference and treatment outcome. However, it should be possible to link the VIT variables to other measures that assess various qualities of the analytic work. For example, it may be that an increased focus on the transference is only beneficial in the context of a strong alliance, or that a greater emphasis on the transference only works well during certain phases of a treatment or with certain kinds of patients.

Perhaps the most provocative trend in the data arose in the context of how Patients A and C used indirect references to the analyst or treatment. Patient A began her treatment with the lowest proportion of indirect references logged for any phase of treatment across the three dyads. Over the course of her analysis, the number of indirect references she made steadily increased. Patient C, on the other hand, began his treatment with the highest percentage of indirect references made by the three

patients in any phase of treatment. As his treatment progressed, he made fewer and fewer indirect references to the analytic relationship.

A possible interpretation of these findings is that Patient A gradually became more involved in the relationship with the analyst, and not only was able to allow the treatment and the analytic relationship in small ways to be increasingly on her mind but could give voice to this in session. Viewed in this way, the findings suggest that indirect references reflect how much a patient is unconsciously willing to make her experience of the analytic relationship known.

In contrast, Patient C seemed to enter treatment ripe for immersing himself in the transference. Unlike the other two patients, he had been in treatment before and he gave the impression from the beginning that he had heightened expectations of the analyst. However, as his treatment progressed, he clearly felt more and more alienated and misunderstood. It is likely that over time he felt less safe internally to permit his feelings about the analyst to surface, and was less able to give himself over to the treatment experience. Again, to the extent that this interpretation of the findings has any merit, it would seem that what the indirect references variable is picking up on is the patient's investment in the transference.

The last area of interest to note in reviewing the descriptive data is the interplay between the patient's work in the transference and aspects of the analyst's behavior that were assessed in the study. While this relationship will be examined in greater detail in the context of discussing the hypotheses posed in this study, some general thoughts will be presented here.

Throughout all phases of treatment, Analyst A and Analyst B were relatively consistent in terms of their level of activity as measured by how much they spoke in session. As already noted, these were the two treatments in the sample that were assessed as having positive outcomes. In contrast, Analyst C was quite variable, with his participation being especially low in the early phase of treatment when Patient C

made so many indirect references to the transference. Patient C was himself quite variable, exhibiting the greatest variance of the three patients in terms of his work in the transference. Whether patient influenced analyst here or analyst influenced patient--or neither, or indeed both--cannot really be said, but together these findings are intriguing, particularly given the poor outcome in the case.

Another striking phenomenon was either just how much Analyst B spoke or just how little Analyst A did. Given that there is no standard amount to use as a benchmark, it would do little more than belie a theoretical bias to characterize one or the other as aberrant. Combined with the fact that both of these cases produced positive results, albeit to different degrees, the marked disparity in the analysts' styles is all the more noteworthy. One thing that can be said is that we can all rest easy in knowing that there is more than one way to conduct a successful analysis.

It is true that Patient B showed greater improvement by the end of her analysis. Whether this had anything to do with how active Analyst B was is an open question.[44] Furthermore, these findings obviously tell us nothing about the content or quality of the analysts' interventions. We also do not know whether these analysts always worked as they did in these treatments or whether they adapted their styles for these particular patients. The findings do, however, raise the question of whether certain kinds of patients do better with certain kinds of analysts.

A few additional points are worth mentioning about Analysts A and B. Analyst A's participation, while changing very little, steadily rose over the course of the analysis. At the same time, Patient A gradually spoke less and less about matters outside the transference, and also increasingly referenced the analyst or the treatment in an indirect way. To the extent that there is any connection between these findings, it may be that the analyst's increased presence, so to speak, facilitated the patient's

[44] Whether Patient B's improvement even had anything to do with her analysis cannot actually be said.

movement toward expressing thoughts about the relationship. It may also be that the patient was moving in this direction anyway, and the analyst became more vocal in response to the patient's increased focus on the transference.

Analyst B not only spoke much more than his counterparts in the other two dyads, he interpreted the transference substantially more. It certainly may be that this aspect of the treatment had something to do with the successful outcome in the case. In addition, similar to Analyst A as noted above, Analyst B's involvement generally rose and fell with the level of indirect references to the transference made by Patient B. Could it be that an increase by the patient in subtle references to the analyst or treatment coupled with increased intervention by the analyst facilitates the work of the treatment?

Finally, it is interesting that although Analyst B focused on the transference so much more than the other two analysts, Patient B did not follow suit. Overall she spoke about the analyst or treatment less than Patient C did, and while she spent more time doing so than Patient A, the difference was nothing like the disparity that was evident between Analyst B and the other analysts in terms of their focus on the transference. Moreover, as described earlier, Patient B spent less time discussing the transference as her analysis progressed, despite her analyst's determination to keep the work focused there.

There is no way of knowing how much Patient B would have focused on the transference had her analyst not done so to the extent that he did. Yet these findings do raise a question as to what the impact of the analyst's stance was on the patient. One thing that can be said is that these findings challenge the idea that a patient's focus on the transference is simply an iatrogenic response to the analyst's transference interpretations. If this was the case, Patient B certainly would have been expected to speak more than she did about the analytic relationship. Further exploration of this issue will have to await a future study.

C. Hypotheses

Before discussing the specific findings as they relate to the two hypotheses tested in the study, it is worth taking a moment to revisit the original intent behind developing the VIT measure, and to assess whether the goals contemplated at the outset of the study have been accomplished. The primary motivation in undertaking this project was an interest in exploring the importance of transference in the clinical setting, combined with a lack of research tools or studies capable of evaluating the impact of the patient's work in the transference. The objective of the study was to create a research measure that not only could reliably track the moment to moment manifestation of the transference in a session transcript, but could be used ultimately to tell us something about the clinical process in that session. Would data derived from the application of the measure reflect something of the richness of what transpired in the consulting room, and inform our understanding of a particular treatment? And in particular, would we learn anything about the impact of focusing analytic work on the transference?

As already discussed, the goal of establishing the reliability of the VIT measure has largely been met. Future work certainly can serve to solidify the findings obtained in this study, but at this point the VIT measure clearly can be considered a viable research tool.

Although demonstrating reliability was a make or break feature of the project, doing so was also only a means to approaching the other aims outlined above. Whether this viable research tool could tell us anything useful about the clinical process in the sessions under study constituted the broader challenge of the work undertaken here. The descriptive data discussed earlier represented tentative affirmation of the clinical utility of the VIT measure. As described below, the findings obtained in conjunction with the application of the other research

instruments used in the study go considerably further in confirming the measure's value.

Separate and apart from the fate of the theoretical ideas that were tested, these findings tell us a great deal about the effects in these three cases of focusing analytic work on the transference. The data show that there were substantial differences in how the three patients responded to transference work. A closer look at some of these differences offers a window into the three analyses.

1. What the findings reveal about the three cases under study

Whenever the transference was addressed by her analyst, Patient A demonstrated more frequently than the other two patients an increased capacity to express her emotional experience in words.[45] Thus it would seem generally that transference work had a positive effect on her. Yet when she herself brought up something about the treatment or her analyst, Patient A was the only one of the three patients to respond more poorly if her analyst tried to keep the focus on the transference. She also spoke about the transference less than the other two patients. Although her reticence diminished as her treatment progressed, it was indirect references to the analytic relationship, rather than direct references, that steadily increased over time.

This portrait is consistent with the impression conveyed by Patient A in the actual session material. More than the other two patients, she seemed especially tentative when mentioning anything related to her relationship with the analyst. She described early in the treatment how she was afraid of crying in her analyst's presence: "I suppose I feel embarrassed and again it's an immature thing to do, and that I should have to control so I wouldn't do it." (Session 4, lines 26-27) She feared

[45] More concretely, CRA increased most often for Patient A in sequences where the analyst addressed the transference. What CRA measures is the degree to which a speaker can translate nonverbal experiences, primarily emotional experience, into language.

incurring the analyst's disapproval or wrath, and spoke about a tendency to withdraw from people that sometimes was activated in session.

With this backdrop in mind, it is interesting to consider one additional finding. Patient A did not always do poorly when her analyst tried to keep her attention on the transference after she had approached the subject herself. When the analyst interposed a transference *intervention* Patient A responded with an increased capacity to express her emotional experience every time. It was when her analyst offered a transference *interpretation* that she seemed to shut down. It may be that Patient A needed more subtle encouragement to explore her feelings about the analytic relationship.[46]

For example, in one session Patient A begins the hour wondering why she has been feeling so frustrated and moody, and like she wants to keep away from other people. She invokes the treatment in an indirect manner, questioning "whether it's something coming out of here that I'm thinking and I'm not aware I'm thinking and, but I've been getting so I feel more and more tense and more and more frustrated," (Session 7, lines 8-10). She goes on to provide a narrative about how her mood has been affecting her relationship with her husband, during which she again refers to the treatment in an indirect way: "I know I've felt this way before so it can't just be something that's coming out of what I'm thinking here because it just seems like my whole life has been a series of cycles where I'm able to handle things and then, then things get, so I feel as if I just can't handle them and then I well, do my work, whatever it is, and then otherwise just withdraw from people." (Session 7, lines 15-19)

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[46] It may also be that the timing or content of Analyst A's transference interpretations in particular prevented them from connecting up with Patient A's internal experience. Bucci (1997a) has provided a strong critique of the analyst's emphasis on the notion of penis envy as a core conflict for this patient.

Shortly thereafter, the analyst offers the following transference intervention: "And what do you want to do here when you feel here as though you want to withdraw?" (Session 7, line 25) The patient first responds with a narrative about the analyst, in which she states that she "might begin to almost feel antagonistic" toward him. (Session 7, lines 33-34) She ultimately goes on to tell a story about her dating relationships with boys in high school. Similar to the theme in the pre-intervention narrative she told about her husband, she again discusses her tendency to retreat interpersonally. However, this post-intervention narrative is richer in detail and much more emotionally evocative than the earlier one.

In comparison to this example, on several occasions Analyst A's transference *interpretations* seemed to have an inhibiting effect on Patient A's attempts to discuss her emotional experience of the analytic relationship. These interpretations tended to be quite pointed in their emphasis on Patient A's emotional involvement with the analyst. For instance, Analyst A states at one point, "But in fact, right now, and for some time, you are using me to come between you and [patient's husband]." (Session 943, lines 117-118) In another session during which Patient A is on the edges of exploring sexual fantasies about the analyst, he interjects, "And if I won't use my penis, then you'll settle for my words." (Session 942, line 155) Whether or not interpretations like these were in some sense on the mark cannot be said, but whatever the reason, they were not associated with as productive a process as more tempered ways of addressing the transference.

In contrast, Patient B did much better with transference *interpretations* as compared to *interventions*. Moreover, Patient B did better than either of the other patients when her analyst addressed the transference after she had made a reference to it herself. For her, this was plainly the most potent kind of therapeutic interchange. This finding is particularly noteworthy given that her case was rated the most successful of the three.

Perhaps most striking in Patient B's case was just how much both she and her analyst were inclined to speak to the transference. In fact, Patient B made a direct reference to the analyst or treatment in the opening minutes of every session in the study sample. Analyst B typically responded with a transference interpretation--often not a subtle one--and as already noted, these sequences usually resulted in an increase in Patient B's capacity to express her emotional experience.

As early as the second session of the analysis, for instance, Patient B is describing her feelings about lying on the couch, and her analyst interprets that she might be worried that her husband will be jealous, and "maybe you're sort of showing him and yourself and me, that you have no intention of horsing around in any improper way." (Session 2, lines 192-193) He goes on to say that she might be concerned that "psychoanalysts are somewhat loose in their morals," and afraid of him, the analyst, in that way. (Session 2, line 219) Patient B responds by elaborating on her reluctance to lie down in the analyst's presence, and then telling a descriptive narrative about how severe her father could be.

Although Patient B generally did well when her analyst interpreted the transference, this was not the case if he brought it up out of the blue. For example, in one session Patient B is relaying a dream about an ex-boyfriend and her analyst interprets, "Well, it seems pretty clear that he was functioning in the dream as a figure for myself." (Session 159, line 51) Patient B dodges the invitation to explore any thoughts related to the analyst, and instead continues discussing her feelings about the ex-boyfriend in the dream, but in a more disconnected fashion than before the analyst had interpreted the transference.

This sort of disconnected response was most evident in Patient C's case. Of the three patients, he was least likely to react in a productive manner after the analyst addressed the transference. Again, this kind of finding stands out given the poor outcome in the case. This trend held true across all types of sequences studied.

Moreover, it was true even though Patient C himself spent more time talking about the analyst or the treatment, directly or indirectly, than either of the other two patients. This suggests that Patient C did not simply have a problem with focusing attention on the transference, but that there was something about how things went when the transference did come up that was problematic.

As discussed earlier, the tenor of the transference work in Patient C's case tended to be angry and contentious. The findings here serve to connect the dots further in determining precisely what may have contributed to a poor outcome in Patient C's case. Specifically, the data reveal that if the analyst brought up the transference when Patient C had not already put it on the table, or if the analyst failed to bring it up when Patient C had already raised it, there was, each and every time, a corresponding decrease in Patient C's ability to express his emotional experience.

To give just one example, Patient C begins a session talking about his desire to leave his wife, along with his difficulty in bringing himself to do so. In the course of describing his feelings about the situation with his wife, he makes the following direct reference to his relationship with the analyst, after which the analyst offers an interpretation that does not address the transference: [47]

Patient: Your comment the other day was absolutely a hundred percent *wrong* when you said I don't really know what I want. I don't know why you still see it that way. I *know* what I want.

Analyst: No you don't.

Patient: I do.

Analyst: Then why don't you do it?

Patient: Well I've offered explanations for that which don't seem to satisfy you, one of which is--

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[47] Italics were used in the transcription of session material to indicate that the speaker's voice was particularly emphatic.

Analyst: You also want to be comfortable, and you also want *not* to feel *guilty* and you also want for some reason to *remain* in the marriage. I don't think you do know. You know, so maybe it's wrong, maybe I'm wrong and I don't think it's uh, a major issue but you don't strike me as a man who knows what he wants to do.

Patient: I know but maybe I don't want to.

Analyst: If you really knew, in any sense had personal knowledge, you could act on it.

Patient: No. I don't think that's true.

Analyst: Okay.

Patient: And I think there are more reasons than simple ambivalence about something that keeps, keeps us from, from acting uh--

Analyst: I don't know what *that* means. I know, I know what *I* mean when I talk about ambivalence, but I don't know what you just had in mind.
(Session 342, lines 18-35)

Patient C does not bring up his feelings about the analyst again until later in the session. Instead he goes on to discuss his marriage, but his narrative is less emotionally connected than it was before the analyst's interpretation. Certainly there are any number of reasons why this clinical interchange may not have gone so well. Any after-the-fact assessment is admittedly tantamount to Monday morning quarterbacking, but it does seem that Patient C's feelings about the analyst were getting in the way of his exploring his conflicts about his wife, or at least that his upset with the analyst was on his mind. One can only wonder: Would the session have gone differently if Analyst C had responded to this?

It is worth reiterating that factors other than the analyst's handling of the transference may have influenced the clinical process in the examples discussed here. Along these lines, it is especially interesting to consider Wachtel's (1993) work in uncovering the ways in which interventions can be unwittingly accusatory or

demeaning. Subtle differences in phrasing, tone, or underlying attitude toward the patient can have an enormous impact on how a patient hears the message the analyst is trying to convey (Wachtel, 1993; Wile, 1984).

The session material presented above from Case C--in which the analyst is essentially arguing with the patient--offers a fair example of a manner of intervening that is more undermining than facilitative, regardless of the content of the analyst's statements. This is precisely the kind of intervention identified by Wachtel (1993) as implying that the analyst is seeing reality more accurately than the patient is. Similarly, the interpretation Analyst B makes concerning the transferential meaning behind the patient's dream about her ex-boyfriend suggests that the patient does not know what her dream is *really* about. The transference interpretations that have an inhibiting effect on Patient A (about "using" the analyst to come between her and her husband, and settling for the analyst's words instead of his penis) seem not only heavy-handed but implicitly accusatory. How factors like this might intersect with the impact of the analyst's attention to the transference suggests an intriguing topic for future study.

2. The fate of the predictions made in the two hypotheses

Whatever other qualities of the analysts' interventions played a role in these three cases, the findings here do lend credence to the idea that the delicate dance between patient and analyst around discussing the transference has an impact on the ensuing process in a session. In particular, the predictions made in both hypotheses about the effect on CRA of various patterns of patient and analyst work in the transference were borne out. There was a notable difference in the percentage of sequences with increased CRA in the three central types of patient and analyst speech patterns studied. The most productive kind of sequence was one in which the patient raised the transference and the analyst picked up on that theme. When the analyst did

not do so, the ensuing process did not go as well. The process went most poorly when the patient did not refer to the transference but the analyst did in his response.

This last point is especially interesting to consider in light of prior studies that have questioned the efficacy of transference interpretations. The findings here suggest that the effectiveness of transference interpretations is impacted by whether the patient had something on his mind about the analyst or treatment when the analyst intervened. Prior studies that have concluded that transference interpretations are not effective without taking this factor into account may well present a skewed or inaccurate picture. Furthermore, this factor might be particularly salient in studies based on short term therapies, as patients may not be inclined to explore feelings about the therapist so quickly or readily in that context.

In terms of the predictions made in the two hypotheses concerning an increase in direct references to the transference following certain patterns of patient and analyst speech, the findings were mixed. As expected, the patients were more likely to refer directly to the analyst or treatment in the aftermath of their own reference to the transference being followed in kind by the analyst, as opposed to their own reference being followed by a nontransference interpretation. However, the patients were even more likely to refer directly to the analyst or treatment in the aftermath of their *not* referring to the transference and the analyst responding with a transference interpretation or intervention.

This last finding is somewhat curious. The fact that the patients were more likely to refer to the transference on the heels of both kinds of sequences where the analyst addressed the transference is not so surprising. There is simply a greater likelihood statistically that the more transference (or any variable) is already in the air, the more it will continue to be. Yet following this logic, one would expect that direct references would be even more likely to occur after *both* the patient and the analyst were already talking about the transference. It seems that the patients in this

sample felt freer to change the subject when they themselves had had a hand in putting the subject on the table in the first place.

Either way, it was striking just how often these patients referred to the transference after their analysts had done so. It could be that they felt pressured to follow the analyst's lead. It could also be that they welcomed the implicit encouragement to pursue an anxiety provoking topic. Differences like these could usefully be examined in future studies.

3. Limitations and cautions

Overall the findings related to the two hypotheses tested in the study are provocative. That being said, any consideration of these findings is subject to numerous caveats and cautions. To begin with, the limitations discussed earlier in connection with the descriptive data derived from the VIT measure apply in this context as well. This was a small study, based on just three patients and thirty-six sessions. In addition, the outcome data for the three cases were derived from only one method of analysis. Furthermore, the sample size in terms of the number of sequences used in testing the hypotheses was relatively small.[48] This was true not only when considering the eleven sequences obtained by applying the original methodology, but even when using the fifty-two sequences that met the broader set of inclusion criteria. Hence, as interesting as the findings here may be, they obviously have only very limited predictive value.

Moreover, it is important to keep in mind that the data analysis was expanded beyond what was contemplated at the outset of the project. While this yielded substantially more sequences and thereby enriched the data analysis--for example, no

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[48] The sample was also qualitatively limited in that there were no sequences in the thirty-six sessions that contained no reference to the transference followed by a nontransference interpretation. In addition, the method itself was limited in that it was not structured so as to track references to the transference that were followed by no intervention on the analyst's part.

sequences at all from Patient B's case could be considered initially--it did mean that a decision which impacted the data set was made after the data had already been collected. Even though this decision was not based on any belief about how the expanded set of sequences would stack up when evaluating the two hypotheses,[49] any after-the-fact change in methodology is subject to challenge on the grounds that it was not made in a neutral context.[50]

Increasing the number of sequences used in evaluating the hypotheses also resulted in some substantive changes in the predictions that were made. The addition of sequences containing direct references to the analyst or treatment in the pre-intervention segment meant that the focus of the hypotheses was no longer exclusively on the analyst's response to the patient's indirect references to the analyst or treatment. Similarly, the concept of using the first transference interpretation in a session as a benchmark was diluted under the new set of inclusion criteria. The fact that the findings were not very different when using the alternative set of sequences suggests that these changes were not that significant. However, the data set is simply too small to draw any definitive conclusions on this score.

Several cautionary notes are in order with regard to the dependent variables that were used in the study. The findings reflect whether CRA went up or down, but not by how much. Hence sequences in which CRA changed very little were treated the same as those in which it changed dramatically. Similarly, the findings show

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[49] The decision to increase the data set was based on the discovery that the majority of the Relationship Episode sequences contained in the thirty-six sessions could not be used because they just missed meeting one or another of the criteria set forth in the original method, *e.g.*, sequences that contained transference interventions instead of transference interpretations, or sequences that contained both an indirect and a direct reference to the analyst or treatment prior to the targeted intervention instead of only an indirect one.

[50] It should, however, be borne in mind that the findings related to the predictions made in the two hypotheses were not all that different when using the expanded set of sequences as compared to the eleven obtained under the original method.

whether or not a patient referred to the analyst or treatment following a particular sequence, but they indicate nothing about the extent to which the patient delved into the transference or the nature of the patient's associations--was there a momentary reference to the analyst or a lengthy and intensive exploration of aspects of the treatment relationship?[51] Future studies may be able to incorporate aspects of these distinctions in the data analysis.

On a more fundamental level, one must be cautious in discussing the findings not to offer conclusions concerning what makes for a productive clinical encounter in a manner that ends up being removed from what was actually measured. What was measured in this study was whether CRA increased across a sequence, and whether references to the analyst or treatment were made following that sequence. While an argument can well be made that these circumstances point to a positive trend in the work of the treatment, it would be foolhardy to contend either that psychoanalysis is so cut and dried, or that its effects are so easily defined by these two variables.

Perhaps more to the point, the converse of these circumstances--decreased CRA and an absence of references to the transference--cannot necessarily be equated with a poor or unproductive clinical process. Patients will inevitably move in and out of talking about the transference, and will invariably shift back and forth between putting words on their emotional experience and shying away from doing so. This is not to say that taking a snapshot of an analytic hour cannot provide us with valuable information, but rather that such information must be used or presented with care. At base, what the findings here demonstrated were associations between certain clinical variables. What is made of those associations must be viewed simply as theorizing.

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[51] This same issue comes up in the context of the pre-intervention segments where it was noted if the transference was referenced, but not in what way or to what extent.

4. Closing remark

With these limitations noted, one final observation--along the lines of theorizing--can be offered. The findings obtained in the study are consistent with a very simple idea. The analyst's interventions should ideally make contact with what is on the patient's mind. This is hardly a profound premise, yet neither is it a straightforward undertaking when it comes to recognizing and speaking to something as potentially confounding as the transference. In the sessions studied here, when the patient provided clues that the analytic relationship was on his mind, it behooved the analyst to invite exploration of this line of thought. Perhaps these clues represented the patient's way of expressing a wish for the analyst to encourage discussion of what likely was a fraught or charged subject. Alternatively, when there was no whiff of the transference in the patient's associations, it did not serve the process well for the analyst to introduce it. This may have been the patient's unconscious way of communicating that she was not ready or able to tackle such a hot topic--or simply that the transference was not paramount for her at that moment.

Viewed in this way, what is particularly interesting about the findings is that they challenge the ideas of both those who reject the importance of transference interpretations, *e.g.*, Piper et al. (1991), and those who champion them, *e.g.*, Gill (1982). The notion that transference interpretations are ineffective is inconsistent with this study's findings, as they were in fact uniquely effective when patients were poised to discuss the analytic relationship. At the other end of the spectrum, a theoretical position that calls for a persistent and almost exclusive focus on interpreting the transference is also inconsistent with the findings here, as transference interpretations were uniquely ineffective when patients had not broached, at least in a preliminary or indirect fashion, the topic of the analytic relationship.

Thus, it could be said that the study supports an approach to clinical work that is guided by close attention to how the patient is situated vis a vis the transference--an approach ideally that relies on a discerning ear for precisely the kinds of references targeted by the VIT measure. It will be the work of future studies to test this theoretical idea further.

Table 1. Demographic and Sample Information

	Dyad A	Dyad B	Dyad C
Patient Sex	Female	Female	Male
Analyst Sex	Male	Male	Male
Sessions in Treatment	1014	324	660
Number of Sessions Studied	12	12	12
Sessions Used in Study			
Early	4-7	1-4	4-7
Middle	765-768	159-162	340-343
Late	942-945	309-312	652-655
Treatment Outcome	Moderate Success	Successful	Unsuccessful

Table 2. Reliability Analysis for Coding References to the Analyst or Treatment Calculated Using Cohen's Kappa and Session Lines as a Segment

		Dyad A	Dyad B	Dyad C
Early Stage	Session 1 (# of lines)	*	.62 (591)	.70 (295)
	Session 2 (# of lines)	.85 (319)	.56 (664)	.49 (270)
	Session 3 (# of lines)	.77 (199)	.81 (575)	.69 (242)
	Session 4 (# of lines)	.84 (247)	.65 (542)	.96 (276)
Middle Stage	Session 5 (# of lines)	.63 (328)	.51 (477)	.58 (222)
	Session 6 (# of lines)	.68 (364)	.61 (499)	.78 (387)
	Session 7 (# of lines)	.61 (293)	.60 (607)	.66 (183)
	Session 8 (# of lines)	.79 (170)	.63 (433)	*
Late Stage	Session 9 (# of lines)	.73 (236)	.52 (421)	.76 (250)
	Session 10 (# of lines)	.88 (239)	.83 (519)	.56 (200)
	Session 11 (# of lines)	*	.82 (447)	.32 (102)
	Session 12 (# of lines)	*	.58 (524)	.56 (215)
Mean Kappa SD (Range)		.75 .10 (.61-.88)	.65 .11 (.51-.83)	.64 .17 (.32-.96)

*Kappa statistics could not be computed because these sessions did not utilize the full range of the VIT scale.

Table 3. Reliability Analysis for Coding References to the Analyst or Treatment Calculated Using Percent Agreement and References as a Segment

	Dyad A	Dyad B	Dyad C	All Dyads
Interjudge Agreement for Identifying any Reference to the Analyst or Treatment (# of references)	.74 (67/90)	.76 (123/162)	.74 (63/85)	.75 (253/337)
Interjudge Agreement on whether an Identified Reference is Direct or Indirect (# of references)	.87 (58/67)	.75 (92/123)	.94 (59/63)	.83 (209/253)

Table 4. Characteristics of Study Sample: Patient and Analyst Speech

	Dyad A	Dyad B	Dyad C
Number of sessions	12	12	12
Length of sessions Mean # of lines per session SD (Range)	264.8 54.8 (170-364)	524.9 74.8 (421-664)	221.7 93.9 (18-387)
Amount of analyst speech Mean # of lines per session SD (Range)	15.5 10.3 (3-36)	174.0 49.0 (94-252)	40.8 36.9 (6-113)
Amount of patient speech Mean # of lines per session SD (Range)	249.3 47.7 (167-328)	350.9 42.6 (278-431)	180.8 78.5 (12-274)
Amount of patient speech that does not reference the analyst or treatment Mean # of lines per session SD (Range)	191.6 56.8 (106-260)	227.1 37.4 (152-279)	109.8 57.3 (5-205)
Amount of patient speech that indirectly references the analyst or treatment Mean # of lines per session SD (Range)	15.3 9.5 (3-36)	23.7 12.7 (1-43)	18.7 18.2 (0-49)
Amount of patient speech that directly references the analyst or treatment Mean # of lines per session SD (Range)	42.5 27.6 (0-83)	100.2 47.4 (32-191)	52.3 64.1 (0-216)

Table 5. Percentage of Patient Speech that References the Analyst or Treatment

	Patient A	Patient B	Patient C	All Patients
Number of sessions	12	12	12	36
No reference				
Mean % of lines per session	75.7%	65.2%	62.0%	67.6%
SD (Range)	12.6 (52.0-90.1)	11.3 (48.4-81.8)	23.1 (19.7-99.0)	17.1 (19.7-99.0)
Indirect reference				
Mean % of lines per session	6.5%	6.9%	9.5%	7.6%
SD (Range)	4.3 (1.4-13.5)	4.0 (0.3-15.5)	9.7 (0-29.8)	6.5 (0-29.8)
Direct reference				
Mean % of lines per session	17.9%	28.0%	28.6%	24.8%
SD (Range)	12.7 (0-37.6)	11.5 (10.8-47.4)	25.1 (0-78.8)	17.7 (0-78.8)

Table 6. Percentage of Patient Speech that References the Analyst or Treatment in Early, Middle and Late Stages of Treatment

	No Reference (Mean % of lines per session)	Indirect (Mean % of lines per session)	Direct (Mean % of lines per session)
Patient A			
Early Stage	79.2%	3.4%	17.5%
Middle Stage	77.5%	6.2%	16.4%
Late Stage	70.3%	9.9%	19.8%
Patient B			
Early Stage	61.0%	6.6%	32.4%
Middle Stage	66.3%	8.8%	25.0%
Late Stage	68.3%	5.2%	26.6%
Patient C			
Early Stage	64.0%	13.7%	22.4%
Middle Stage	50.9%	8.2%	40.9%
Late Stage	71.1%	6.5%	22.5%

Table 7. Percentage of Patient and Analyst Speech for Early, Middle, Late and All Stages of Treatment

	Early Stage	Middle Stage	Late Stage	All Stages
Dyad A				
Patient Speech (Mean % of lines per session)	95.3%	94.8%	93.3%	94.5%
Analyst Speech (Mean % of lines per session)	4.7%	5.2%	6.7%	5.5%
Dyad B				
Patient Speech (Mean % of lines per session)	70.1%	64.2%	71.8%	68.7%
Analyst Speech (Mean % of lines per session)	29.9%	35.8%	28.2%	31.3%
Dyad C				
Patient Speech (Mean % of lines per session)	91.8%	72.1%	80.9%	81.6%
Analyst Speech (Mean % of lines per session)	8.2%	27.9%	19.1%	18.4%

Table 8. Characteristics of Study Sample: Analyst Interventions

	Analyst A	Analyst B	Analyst C
Number of sessions	12	12	12
Intervention Segments			
Mean per session	5.6	32.8	8.5
SD (Range)	3.1 (1-10)	9.7 (21-52)	4.9 (0-12)
Interpretations			
Mean per session	2.1	8.8	2.8
SD (Range)	1.6 (0-4)	5.0 (1-16)	2.5 (0-8)
Transference Interpretations			
Mean per session	1.1	7.7	2.1
SD (Range)	1.4 (0-4)	4.6 (1-14)	2.3 (0-7)
Nontransference Interpretations			
Mean per session	1.0	1.2	0.7
SD (Range)	1.4 (0-4)	0.9 (0-2)	0.7 (0-2)

Table 9. Characteristics of Study Sample: Relationship Episodes

	Patient A	Patient B	Patient C
Number of sessions	12	12	12
Relationship Episodes (REs)			
Mean per session	5.4	7.6	5.1
SD (Range)	2.1 (3-11)	2.1 (4-11)	2.7 (3-10)
REs about others			
Mean per session	4.3	5.3	3.8
SD (Range)	1.7 (2-8)	1.4 (3-7)	2.5 (0-10)
REs about general others			
Mean per session	0.3	0.3	0.5
SD (Range)	0.5 (0-1)	0.6 (0-2)	0.8 (0-2)
REs about analyst			
Mean per session	0.9	2.0	0.8
SD (Range)	0.8 (0-2)	1.5 (0-4)	1.1 (0-3)

Table 10. Mean Computer Assisted Referential Activity Scores Across Type of Patient Speech Segment

	Patient A	Patient B	Patient C	All Patients
Non-RE speech	-0.21	-0.18	-0.17	-0.19
(# of segments / SD)	(42 / 0.08)	(76 / 0.12)	(18 / 0.09)	(136 / 0.11)
REs about others	-0.16	-0.12	-0.17	-0.14
(# of segments / SD)	(55 / 0.09)	(89 / 0.10)	(68 / 0.10)	(212 / 0.10)
REs about general others	-0.25	-0.27	-0.20	-0.23
(# of segments / SD)	(3 / 0.03)	(3 / 0.08)	(7 / 0.04)	(13 / 0.05)
REs about analyst	-0.27	-0.29	-0.22	-0.27
(# of segments / SD)	(11 / 0.05)	(24 / 0.08)	(11 / 0.08)	(46 / 0.08)
Dreams	---	0.14	-0.02	0.03
(# of segments / SD)	---	(1 / --)	(2 / 0.07)	(3 / 0.05)
All Segment Types	-0.19	-0.16	-0.17	-0.17
(# of segments / SD)	(111 / 0.09)	(193 / 0.12)	(106 / 0.09)	(410 / 0.11)

Table 11. Percentage of Relationship Episode Sequences with Increased Computerized Referential Activity for Patient/Analyst Speech Patterns that Combine Either No Reference or Any Reference to the Analyst or Treatment with Either an Interpretation or a Transference Intervention

	Patient A	Patient B	Patient C	All Patients
No Reference followed by a Nontransference Interpretation	0%	0%	0%	0%
(# of sequences)	(0/0)	(0/0)	(0/0)	(0/0)
No Reference followed by a Transference Interpretation or Intervention	100%	20%	0%	25%
(# of sequences)	(1/1)	(1/5)	(0/2)	(2/8)
Indirect and/or Direct Reference followed by a Nontransference Interpretation	50%	33%	0%	33%
(# of sequences)	(3/6)	(1/3)	(0/3)	(4/12)
Indirect and/or Direct Reference followed by a Transference Interpretation or Intervention	3%	54%	33%	44%
(# of sequences)	(3/7)	(7/13)	(4/12)	(14/32)
All Sequences	50%	43%	24%	39%
(# of sequences)	(7/14)	(9/21)	(4/17)	(20/52)

Table 12. Percentage of Patient/Analyst Speech Sequences Combining Either No Reference or Any Reference to the Analyst or Treatment with Either an Interpretation or a Transference Intervention that are followed by a Direct Reference to the Analyst or Treatment

	Patient A	Patient B	Patient C	All Patients
No Reference followed by a Nontransference Interpretation	0%	0%	0%	0%
(# of sequences)	(0/0)	(0/0)	(0/0)	(0/0)
No Reference followed by a Transference Interpretation or Intervention	100%	80%	100%	88%
(# of sequences)	(1/1)	(4/5)	(2/2)	(7/8)
Indirect and/or Direct Reference followed by a Nontransference Interpretation	67%	0%	0%	33%
(# of sequences)	(4/6)	(0/3)	(0/3)	(4/12)
Indirect and/or Direct Reference followed by a Transference Interpretation or Intervention	86%	54%	66%	66%
(# of sequences)	(6/7)	(7/13)	(8/12)	(21/32)
All Sequences	79%	52%	59%	62%
(# of sequences)	(11/14)	(11/21)	(10/17)	(32/52)

Table 13. Percentage of Relationship Episode Sequences with Increased Computerized Referential Activity for Patient/Analyst Speech Patterns Where the Analyst Addresses the Transference

	Patient A	Patient B	Patient C	All Patients
No Reference followed by a Transference Intervention	0%	0%	0%	0%
(# of sequences)	(0/0)	(0/1)	(0/0)	(0/1)
No Reference followed by a Transference Interpretation	100%	25%	0%	29%
(# of sequences)	(1/1)	(1/4)	(0/2)	(2/7)
Indirect and/or Direct Reference followed by a Transference Intervention	100%	17%	33%	36%
(# of sequences)	(2/2)	(1/6)	(2/6)	(5/14)
Indirect and/or Direct Reference followed by a Transference Interpretation	20%	86%	33%	50%
(# of sequences)	(1/5)	(6/7)	(2/6)	(9/18)
All Sequences	50%	44%	29%	40%
(# of sequences)	(4/8)	(8/18)	(4/14)	(16/40)

Appendix A: Pilot Study Findings

Interjudge Reliability for Identifying Patient Speech that Directly or Indirectly References the Therapist or Treatment Situation

	Percent Agreement (# of TUs)	Kappa (# of TUs)
Patient A	.70 (49/70)	.71 (148)
Patient B	.91 (57/63)	.88 (105)
Patient C	.83 (57/69)	.85 (176)
Overall	.81 (163/202)	.81 (429)

Interjudge Reliability for Identifying Patient Speech that Directly References the Therapist or Treatment Situation

	Percent Agreement (# of TUs)	Kappa (# of TUs)
Patient A	.36 (8/22)	.48 (148)
Patient B	.84 (36/43)	.86 (105)
Patient C	.47 (16/34)	.58 (176)
Overall	.61 (60/99)	.70 (429)

Interjudge Reliability for Identifying Patient Speech that Indirectly References the Therapist or Treatment Situation

	Percent Agreement (# of TUs)	Kappa (# of TUs)
Patient A	.55 (36/65)	.56 (148)
Patient B	.64 (23/36)	.70 (105)
Patient C	.55 (30/55)	.61 (176)
Overall	.57 (89/156)	.62 (429)

Categorization of the Patient's References
to the Therapist or Treatment Situation
(Based on consensus coding)

Dyad Session #	# of TUs	No Reference % of TUs	Indirect % of TUs	Direct % of TUs
Patient A				
1	50	78.0%	20.0%	2.0%
2	42	45.2%	38.1%	16.7%
3	56	53.6%	33.9%	12.5%
Mean % of TUs		58.9%	30.7%	10.4%
Patient B				
1	36	75.0%	19.4%	5.6%
2	37	13.5%	18.9%	67.6%
3	32	40.6%	15.6%	43.8%
Mean % of TUs		43.0%	18.0%	39.0%
Patient C				
1	55	69.1%	21.8%	9.1%
2	66	53.0%	22.8%	24.2%
3	55	63.6%	21.9%	14.5%
Mean % of TUs		61.9%	22.2%	15.9%
All Dyads		54.6%	23.6%	21.8%

Appendix B: VIT Coding Manual

Verbal Indicators of the Transference (VIT) Coding Manual

Verbal Indicators of the Transference (VIT) is a research instrument applied by independent raters to transcripts of psychotherapy or psychoanalytic sessions. It is designed to identify and categorize a patient's work in the transference over the course of a treatment session. Statements are coded on the basis of whether, and how directly, the patient speaks about reactions to the analyst or the treatment situation.

The VIT measure is anchored in the theoretical idea that patients, in some fashion, live out with the analyst certain inner conflicts, as well as attempted solutions to those conflicts. As a result, patients invariably have all sorts of thoughts and feelings, expectations and fantasies, about the analyst and the treatment situation. These reactions are understood--for purposes of this measure--as reflecting the transference. One way, among others, that such reactions manifest themselves in the treatment situation is through statements the patient makes about the analyst or the treatment. For this reason, the VIT measure is structured so as to systematically target statements that are overtly or covertly related to the patient's experience of the treatment relationship.

The reason for describing things a patient might say as "overtly or covertly" related to her experience of the treatment relationship is connected to another important theoretical underpinning of the VIT measure--namely, that talking about the transference is, by and large, not an easy thing for the patient to do. Feelings and ideas about the analyst that are linked to internal conflicts tend to be affectively charged, anxiety provoking, and often unconscious. Consequently, while patients may sometimes talk about these matters directly, frequently they raise them in

indirect or masked ways. The VIT coding categories are intended to account for the different ways in which patients may reference the analytic relationship.

To apply the VIT measure, raters read through session transcripts, formatted with line numbers for reference, and designate the patient's speech as falling within one of the following three categories:

x: Patient associations that do not reference the analyst or treatment situation.

i: Patient associations that reference the analyst or treatment situation, but in a manner that is indirect or peripheral, *i.e.*, even though the analyst or the treatment is mentioned, the thrust of what the patient is saying involves something other than the analyst, or the experience of being with the analyst.

r: Patient associations that reference the analyst or treatment situation, in a manner that is direct, *i.e.*, the analyst, or the experience of being with the analyst, is the target of what the patient is saying.

Set forth below are (i) general guidelines for how to approach the coding task; and (ii) some useful coding examples that illustrate how a rater should designate patient speech using the VIT coding categories.

I. General Coding Guidelines

Raters should start by reading through a transcript once to get a general sense of the session before focusing on the actual coding task. While raters may have the coding categories in mind, or may make some preliminary notes on the transcript, they should approach this first read-through in an open-ended manner without stopping to think about actual coding decisions.

Raters should subsequently embark on a second read-through, this time using a separate sheet of paper to list, as they go along, any instance of patient speech[1] that constitutes a reference to the analyst or the treatment situation, *e.g.*, lines 2-5: *i*; lines 32-56: *r*; lines 111-186: *r*; lines 225-226: *i*. Patient associations that do *not* reference the analyst or treatment situation are--by implication--coded *x*. This means that only patient associations coded *i* or *r* need to be listed on the scoring sheet; patient associations that are *not* listed on the scoring sheet are presumed to have been coded *x* by the rater, and therefore to contain no reference to the analyst or treatment.

The reason that patient associations coded *x* are not listed on the scoring sheet has to do with an important idea concerning the rater's approach to coding a transcript. That is, while transcripts will obviously vary with regard to how much the patient talks about the analyst or the treatment situation, the presumptive or default coding category that should guide a rater's orientation to the material is *x*, *i.e.*, associations that *do not* reference the analyst or treatment situation. What this means is that unless a reference is detected, patient speech is considered simply to fall into the *x* category. In other words, the idea behind the coding task is for raters to have an ear for *when* the patient makes certain kinds of references; so unless and until something in the patient's speech strikes the rater as the kind of reference they are trained to notice, they can proceed with the assumption that they are in the midst of *x* material, and they need not stop and write anything down on the scoring sheet.

Thus, *x* material is the baseline, and the rater's job is to be alert to signals that the patient has left *x* material and has moved into *i* or *r* territory. In this way, the coding task is really a two-tiered process. The first tier consists of noting when the patient shifts from *not talking* about the analyst or the treatment to *talking* about such

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[1] Although analyst speech is not coded under the VIT system, the rater should certainly take the analyst's interventions into account in understanding both the patient's associations and the process between patient and analyst in the session.

matters. This could take the form of a quick or seemingly innocuous remark, or an elaborate and focused narrative. Either way, the question at this stage is simply whether a reference has been made.

Once the rater determines that the patient has indeed moved from *x* into *i* or *r* territory, the second part of the coding task involves deciding *what kind* of a reference the patient has made, *i.e.*, should the reference be coded *i* or *r*? While the parameters of the *i* and *r* variables are outlined below, the rater's job here is really to assess whether or not the patient is actively dealing with some aspect of the transference. Is the patient making the analyst, or the experience of the relationship with the analyst, the focus of what he or she is saying? If so, the material is coded *r*. If the material does not rise to this level--if the patient mentions or implicates the analyst or the treatment, but is really focused on talking about something else--the material is coded *i*.

Hence, the process of coding a transcript involves the ongoing application of a two-pronged test: first, the rater determines if the patient has left "neutral" territory and made *some* kind of reference to the analyst or the treatment; second, in the event that the rater *does* detect such a shift, he or she determines if the reference is an affectively charged statement that is anchored in the idea that the patient experiences himself in a relationship with his analyst, or if instead it is a fleeting remark or even a more elaborated observation that invokes the analyst or the treatment but steers clear of focusing attention on the analytic relationship.

In applying this two-pronged test, there are two major guidelines the rater should keep in mind. The first is to listen to the text. As the coding examples below illustrate, statements coded *i* or *r* include some express reference to the analyst or treatment situation. Once a rater is familiar with the kinds of statements that fall within these categories, there should not be much inference involved in deciding if a reference has been made, and if so, what kind of a reference it is. The bottom line is

that verbal evidence or text is considered first and foremost in deciding how to code a particular statement.

That being said, there are times in a transcript when it is difficult to categorize the verbal text, *i.e.*, something will strike the rater as a potential reference but it will be difficult to figure out how to code it. This leads to the second major guideline, which is that when the text is not clear, the rater should bring context to bear. In other words, in the context of what the patient has been saying or how she is speaking, does it feel like she has the analyst or treatment in mind? Does the patient seem to be moving more in one direction or the other in terms of his inclination to speak about the analytic relationship? Is there anything about the patient's perceived affective state that might inform the coding decision? While questions like these do call for a more subjective assessment on the rater's part, they should appropriately be considered in cases where the actual verbal text is insufficient or ambiguous.

II. Coding Examples[2]

With the above guidelines in mind, some coding examples are provided here to better define the three VIT categories and the kinds of statements that fall within them.

A. Patient associations coded *x*

Patient associations coded *x* do not reference the analyst or treatment situation. The following associations are coded with the *x* variable:

> "I'm always uptight about other people thinking I'm a fagot because--. I know that they know that I don't go out with women, and I don't, you know, and I can't just say: 'oh, Jesus, I'm afraid, man, you know. I'm chicken shit.' What can you say?"

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[2] The session material used here to illustrate the VIT coding categories is primarily based on transcripts from Gill and Hoffman's (1982b) Analysis of Transference, Volume II: Studies of Nine Audio-Recorded Psychoanalytic Sessions.

> "...and another thing. I don't know how much this has to do with it. I, I think it's more the attitude I somehow began the day with but I had my hair done this morning and I finally got around to saying to my hairdresser that I wanted my hair to be done differently. And at that point I wasn't too sure exactly what I wanted and I was still hesitant anyway to direct him too much since I was unsure."

B. Patient associations coded *i*

Patient associations coded *i* reference the analyst or treatment situation, but in a manner that is indirect or peripheral, *i.e.*, even though the analyst or the treatment is mentioned, the thrust of what the patient is saying involves something other than the analyst, or the experience of being with the analyst. Thus, associations coded *i* typically arise in the midst of *x* material. These associations may sound simply like off-hand remarks or throw-away comments. Indeed, they rarely are more than passing references, yet they are noteworthy in that they expressly touch on the idea that the analyst or the treatment exists, or that the patient is engaged in the act of speaking to another person. Although the analyst or treatment is invoked, however, the analytic relationship--or the analyst as a *person*--is not the focus of the patient's associations. The following associations are coded with the *i* variable:

> "I was thinking on the way in here that I really don't like my job anymore."

> "I know this is going to sound stupid to you, but I almost feel better when bad things happen to me."

> "Last time when I started telling you about my father, I was remembering how there were times when he actually wasn't so critical of me."

> "I always feel sad when we talk about my mother."

> "Like you've said a couple of times that I don't seem to take care of myself in relationships."

"I like to have Tuesday nights free because I know I have to get up early the next day, come to my session, and then go straight to work."

C. Patient associations coded *r*

Patient associations coded *r* reference the analyst or treatment situation, in a manner that is direct, *i.e.*, the analyst, or the experience of being with the analyst, is the target of what the patient is saying. Specifically, the hallmark of *r* material is that it conveys a sense that the patient is in a relationship with the analyst. Frequently these associations include some reference to affect or fantasy experienced in connection with the analyst. Note that a sequence of associations coded *r* may also include references to other relationships, or matters other than the analyst, but the thrust of what the patient is conveying concerns the analytic relationship. The following associations are coded with the *r* variable:

"I don't know. I came away with Monday, from Monday, with the impression that I had talked a lot, you know and that, uh, I had been glad to see you back, you know, and I realized what effect your going away had on me. Not what effect but degree, you know, that your going away affected me. And, you know, I started getting all these thoughts about--oh Jesus, you know--I shouldn't become attached to you. You're not a real person. I should become attached to somebody else or something else or (sigh). And it seemed to be a very dependent type of feeling...."

"And it also made me think of, um, how back in the fall whenever Bob and I had intercourse, I would always--well, I don't know exactly how I thought of it then, but somewhere in the thoughts either right then or afterwards would be, 'Now I'll have to talk about it here.' So it was almost as if you could be there watching us."

D. Additional coding scenario

In the patient material presented below, associations coded *i* are italicized and associations coded *r* are underlined. (Associations coded *x* are unmarked.)

"(4 minute silence) I was just about, um, well--two different things in a way--
um, my comparing how I felt yesterday to today. *And then it just seemed to*
parallel having to actually start by saying something here--that there were

lots of things going through my mind while I was, after I came in. But just to begin, no matter what it was I began with, I was finding very hard, just to say the first word. And it was the same thing as yesterday. I had thought about going shopping and I, I couldn't get myself to make the first step outside and, and to go to a store. I just somehow felt as if I couldn't do it and I found lots of excuses not to. And then today I just did, and then it was fine and I, and it didn't bother me and I could make decisions and choices. But I guess that was part of it yesterday--I just didn't feel I could make the decisions that I'd have to make. *Which leads me to wonder: Is there something that I don't want to say, and that's why it was hard to start?* I was, maybe this is it, I don't know, I was thinking of (clears throat) sort of a double reaction I had when I saw the way you were standing holding the door, because my first inclination was you were sort of 'Oh Lord, here we go again' inside, and, impatient. And then, and then immediately I started thinking, 'Well, how could you stand while you're waiting holding the door and what does it matter?' And it--I, I think I'm sort of torn between the two attitudes, but it isn't bothering me the way some days it would completely crush me if I started thinking the way I did at first. I wouldn't get beyond the way I felt at first. For instance, I think if yesterday I'd seen you standing that way and I'd had that initial reaction, that's what I would have thought. (cough) (pause) *I was also thinking when I did get out today, that it, um, I think I've al--, I've said this in other ways,* but I think one reason that I have in the past wanted to have children or a child is because, well, it would sort of give me a direction...."

In this passage, which is taken from the opening of a session, the patient invokes the treatment twice in an indirect way; eventually gives a direct description of a reaction to the analyst; and then makes another indirect reference before shifting to material that does not involve the analyst or the treatment. Note that the patient's comparison of "yesterday to today" on line 2 could be read as an allusion to how the patient feels *in session*, but this statement is coded *x* in the absence of a more express indication that the treatment is being referenced, *e.g.*, "being here today" or subsequent associations that make it clear that the patient is talking about how she feels in treatment.

The associations on lines 2-6 and 12-13 are clearly comments on the patient's experience of being in the treatment situation, and on the experience of speaking in the session. They are coded as indirect references. The reason why they are not coded as direct references is that they do not include any mention of the analyst's

presence or of the patient's experience of being with the analyst. One could certainly infer that the patient's professed trouble getting started in this session not only is related to feelings about the analyst--which her subsequent associations certainly seem to confirm--but in effect is a statement about her experience *of being with the analyst*. However, in what she actually *says* at the start of the session, the patient does *not* link her discomfort to the analyst, nor does she situate herself as engaged in any kind of process with the analyst.

The associations on lines 13-23 encompass a description not only of the patient's experience of being in the session, but of her reaction to the analyst *as a person*, including her perception of how the analyst might feel in relation to her. They are coded as direct references. These associations clearly convey that the patient experiences herself as involved in an affectively charged relationship with her analyst.

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