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AN EMPIRICAL STUDY OF THE AMPLIFYING POWER OF VERBAL  
INTERVENTIONS MADE BY THERAPISTS IN TRAINING

*City University of New York*

PH.D.

1980

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AN EMPIRICAL STUDY OF THE AMPLIFYING POWER OF  
VERBAL INTERVENTIONS MADE BY THERAPISTS IN  
TRAINING

by

GERALDINE MILLER

A dissertation submitted to the Graduate Faculty in  
Psychology in partial fulfillment of the requirements  
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1980

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1980

This manuscript has been read and accepted for  
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## Abstract

# AN EMPIRICAL STUDY OF THE AMPLIFYING POWER OF VERBAL INTERVENTIONS MADE BY THERAPISTS IN TRAINING

BY

Geraldine Miller

Sponsor: Professor Arthur Arkin, M.D.

The present study examines the relative amplifying powers (increase in relevant free association) of four classes of therapist inquiry during psychotherapy: formal interpretation, questions of motive (variant of an interpretation), empathic statements, and questions of fact. A second objective in this research was to determine the nature of the interpretative interventions, both formal interpretations and questions of motive. The clinical inquiry categories under study consisted of: substantive clarification, transference, defense-impulse, and resistance. The relative amplifying powers (increase in relevant free association) related to the above mentioned categories was also examined. A final objective in this investigation was to analyze the verbal activity of the therapist delivering clinical inquiries to the patient.

Evidence was drawn from transcribed verbatim tapes of

therapy sessions enlisting bona fide patients and therapists-in-training.

The results indicated that patient amplification (relevant free association) was greatest with respect to empathic statements. When compared with formal interpretations, patient amplification was greater for questions of motive (variant of an interpretation). The least amount of patient amplification was observed to follow a question of fact.

The second part of this investigation indicated that therapist inquiries cast as substantive clarification questions of motive were most powerful. Patient amplification was also found to be statistically greater after formal defense-impulse and resistance interpretations as well as after resistance questions of motive than defense-impulse questions of motive or inquiries in the transference and substantive clarification classes. A majority of substantive clarification therapist inquiries were cast as questions of motive. However, formal substantive clarification interpretations with the greatest overall therapist verbal activity were found to elicit the least amount of patient amplification. Therapist verbal activity was greater when delivering formal interpretations in the following order: substantive clarification, defense-impulse, resistance, and transference. Questions of motive were also found to be statistically greater in the classes of resistance, defense-impulse, and transference in terms of therapist

verbal activity.

The results of the present study call into question the results of earlier investigations examining the comparative effects of various inquiry techniques. The findings were discussed and suggestions made for future research.

This dissertation is dedicated with grateful acknowledgment for the substantive contribution made by the therapist and patient participants as well as the judges who consented to be involved in the execution of this investigation. Special gratitude is expressed to my sponsor, the advisory committee, and the readers.

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1

## CHAPTER I

### INTRODUCTION

Sail forth, steer for the  
deep waters only...I with  
thee and thou with me.

Walt Whitman

The need for research to separate fact from dogma regarding the efficacy of therapy has been repeatedly recognized from almost all sectors as evidenced by Rogers' (1963) statement:

There is one final implication of this flowering diversity of psychotherapy. I wish to examine several facets of this implication. It is that of necessity we must move toward looking at the facts. And to look at the facts means moving toward research. We are beyond the point where differences will be resolved by the voice of authority or by commitment to an essentially religious type of faith in one point of view as against another.... Such fact-finding processes are an inevitable part of the future of our field if it is to move forward. They need not interfere with the subjective personal quality of therapy itself-but they are essential if we are to find our way out of the present confusing Babel of voices, each with its own 'truth.'

The rationale for this research is to provide empirical evidence regarding psychoanalytic principles. Unfortunately, relevant objective data on psycho-analytically oriented therapy is lacking. Much of the published research to date has focused upon issues of treatment outcome rather than process (Saslow, 1954; Strupp, Hadley, and Gomes-Schwartz, 1977).

The present investigation involves psychotherapy process research using as its raw data the live transcription of communication between the patient and therapist in train-

ing participants to generate hypotheses regarding amplifying power (increase in relevant free association). An important intra-session therapeutic outcome variable is associative freedom, defined as the frame of mind to say the thoughts one is thinking. The reason is that associative freedom is the means by which a patient communicates clinical material. So important was the technique of free association that Freud (1914) called it the fundamental rule and even referred to it as the "sacred rule." One variable related to associative freedom is amplifying power, defined for the purposes of this investigation as the patient's relevant free association to the topic indicated in the previous therapist input, exclusive of switching to a new topic, silence, or reintroduction of a previous topic. The present study investigates the relative amplifying powers of several different types of therapist inquiries in actual therapy sessions, in an attempt to establish guidelines for therapist effectiveness.

This present study was intended to investigate in a psychometric framework and rigorous fashion key aspects of psychoanalytic technique. The motivation for this study relies heavily on the interplay of the therapist's technical skills and the basic working tool of psychotherapy which is patient verbal self exploration. The following terms will be used in this investigation: formal interpretation, questions of motive (variant of interpretation), questions of fact, and empathic statements.

The experimenter believed that it would be useful to design an investigation concerning the contributions of the

psychotherapist to the treatment situation testing hypotheses regarding patient amplifying power (increase in relevant free association). Even though the notion of free association has occupied a central position in psychoanalytic treatment, it has been for the most part neglected as an object of research.

### Domains of the Present Inquiry

The objective of this dissertation is a quantitative investigation of the process of psychoanalytic treatment. Evidence was drawn from transcribed verbatim tapes of therapy sessions enlisting bona fide patients and therapists-in-training.

There are two general purposes to the research plan:

1. To explore the amplifying power (increase in relevant free association) of four classes of therapist inputs: formal interpretation, questions of motive (variant of interpretation), questions of fact, and empathic statements.

These terms are formally defined on pages 6 and 7.

2. To determine the nature of the therapist interpretative interventions, both formal interpretations and questions of motive (clinical inquiry categories consisted of: resistance, substantive clarification, defense-impulse, and transference). This study will attempt to isolate the amplifying power (increase in relevant free association) related to these categories. These terms are formally defined on pages 8 and 9.

### HYPOTHESES

The present research is designed to examine the amplify-

ing power (increase in relevant free association) of four classes of therapist inputs during psychotherapy: formal interpretation, questions of motive (variant of interpretation), empathic statements, and questions of fact. These terms are formally defined on pages 6-7. A second objective in this research is to determine the nature of the interpretative interventions, both formal interpretations and questions of motive (variant of interpretation). The clinical inquiry categories under study consisted of: substantive clarification, transference, defense-impulse, and resistance. These forms are formally defined on page 8-9. This study will also attempt to isolate the amplifying power (increase in relevant free association) related to the above mentioned categories.

A final objective in this investigation will be to analyze the verbal activity of the therapist delivering clinical inquiries to the patient.

On the basis of research and theoretical concepts, to be discussed later in this chapter, the following hypotheses were investigated.

Hypothesis 1A and Hypothesis 1B are not independent.

Hypothesis 1A.

Interpretations, both formal and of motive, have greater amplifying power on relevant free association than do empathic statements, or questions of fact.

Hypothesis 1B.

Questions of motive, variant of interpretation, have greater amplifying power than empathic statements or ques-

tions of fact.

Hypothesis 2.

Formal interpretations have greater amplifying power than the variant of interpretation, questions of motive.

Hypothesis 3.

Substantive clarification interpretations have greater amplifying power than transference, defense-impulse, or resistance interpretations.

Hypothesis 4.

Transference interpretations have greater amplifying power than defense-impulse or resistance interpretations.

Hypothesis 5.

Defense-impulse interpretations have greater amplifying power than resistance interpretations.

## SUMMARY

The hierarchy of specific hypotheses to be tested is that, interpretations, both formal and motive, have greater amplifying power on relevant free association than empathic statements or questions of fact. A sub-hypothesis to be tested is that, questions of motive, a variant of an interpretation, have greater amplifying power than empathic statements or questions of fact. A second hypothesis to be tested is, formal interpretations have greater amplifying power than the variant of interpretation, questions of motive. A third hypothesis to be tested is that, substantive clarification interpretations have greater amplifying power than transference, defense-impulse, or resistance interpretations. A fourth hypothesis to be tested is that transference interpretations have greater amplifying power than defense-impulse or resistance interpretations. A fifth specific hypothesis to be tested is that, defense-impulse interpretations have greater amplifying power than resistance interpretations.

The concepts investigated in this research are formally defined on page 6-7 and 8-9.

### Definitions

The four classes of therapist inputs under investigation are as follows:

1. Formal Interpretation.

Malan (1962), "an interpretation is defined as an intervention in which the therapist suggests or implies an emotional content in the patient over and above what the patient has already openly stated...." For example,

"I believe your anger is related to feelings you may have about your father."

## 2. Questions of Motive.

A sub set of an interpretive intervention. Malan (1962), "...interpretations can be in the form of a question. An example of a 'borderline' interpretation, implying just a little more than the patient said, which is also in the form of a question." For example, "do you think your anger is related to feelings you may have about your father?"

## 3. Questions of Fact.

This can be described as a probe used to obtain a specific piece of information. For example, "what day did this happen on?"

## 4. Empathic Statement.

This can be defined as those therapist remarks which articulate a pre-conscious inference regarding the patient's experience (Paul, 1978). This can be described by the following examples, "I can understand (or appreciate) ...is difficult for you" or "this must be painful for you."

## 5. Miscellaneous.

Those inputs which do not fall into one of the above stated four categories as well as, meaningless vocalizations such as , "uhm; mm; um, etc."

## Interpretative Definitions

The four major classes of therapist interpretative inputs drawn exclusively from formal interpretations and questions of motive (variant of interpretation) under study are

as follows:

1. Resistance.

Statements made by the therapist indicating the patient's overt or covert opposition to the therapeutic process. For example, "It seems as though on the one hand you agree that what I say is valid but you do not seem to derive any help from this." Also, statements made by the therapist such as, "It sounds like you feel that you do not need therapy anymore: but you do, because there appear to be a number of unanswered questions that you still have."

2. Clarification.

Statements made by the therapist to crystallize (or define) the patient's thoughts and feelings around a particular subject, to focus the patient's attention on something requiring further investigation and interpretation, to sort out a theme from apparently diversified material, or to summarize the understanding thus far achieved. They may take the form of questions, mild imperatives, or simplified restatements (Colby, 1951). For example, "You are really very unaccepting of your own feelings. You want them all to be different and you can not accept what you want to feel."

3. Defense-Impulse.

Statements aiming at interpretation or pointing up a defense, such as, "Are you aware of a wish not to think about..." (avoidance). Also, "I wonder if you suspect that you are over-reacting and putting the blame too much on other people" (externalization of blame). The statements were scored utilizing the fourteen defenses outlined by Anna Freud

(1966).

4. Transference.

A whole series of psychological experiences is revived as applying to the person of the therapist at the present moment. Statements such as, "I wonder if you're concerned about impressing me" as well as, "So you naturally think that I, too, like your past figures, will disappoint you."

Theoretical Formulations

The dynamics of the therapist-patient relationship are unique in psychoanalytic psychotherapy. Growing out of a clinician's investigation of problems in treatment, Sigmund Freud gradually developed a theory of personality having its roots in the exigencies of treatment. His pursuit of this pragmatic purpose led him ineluctably to a clinical method enriched and refined by the observations unique to a clinical practice.

In his early work, Studies in Hysteria (1895), Freud begins to discuss the rudiments of a theory of technique. At that time he believed that in hysteria an idea becomes painful because it conflicts with the patient's values, ideals, and moral standards. The "ego" then exerts a counterforce or "defense" which pushes the idea out of awareness. The idea becomes pathogenic because it is repelled. One year later, Freud believed that the repelled idea became pathogenic only if it could be associatively connected with childhood. Treatment is, according to Freud, properly directed toward overcoming the repelling force, the defen-

sive resistance. The idea then emerges, and the symptom disappears. In this early writing Freud makes an explicit statement that psychoanalytic treatment makes great demands upon the patient as well as, upon the therapist - from the former, time, sincerity, and money and from the latter, laborious application and study.

Although elaborations of psychoanalytic technique and practice have flourished since Freud, the underlying hypotheses have not been sufficiently tested by current methods of psychological research (Bergin and Strupp, 1972). For example, The Columbia-Presbyterian Psychoanalytic Clinic is reported to have amassed the largest number of written session note records of psychoanalytic treatment since 1959. They are assisted by computer analyses of the many types of information comparing the patient at the beginning and the end of treatment. Groups of patients are compared with the same diagnosis and the same initial reported degree discomfort. However, the emphasis is on outcome rather than process issues. Strupp (1973) postulates that as a sensitive human being the therapist is a highly complex scientific instrument, whose operational characteristics are still in great need of exploration and specification.

Psychoanalytic practice and research is displaying promising progress in its attempts to formulate testable hypotheses dealing with verifying psychoanalytic concepts. Controlled and quantitative research is greatly assisted by improvements in computer methods for analyzing both data and the content of sessions. An extensive series of computer-

based studies have been in progress at Downstate Medical Center, S.U.N.Y. for a number of years. The initial work was done on Patient A (Gill, Simon, Fink, Endicott, and Paul, 1968; and Dahl, 1972), more recently on Patient C. The research team conducts a detailed analysis of such questions regarding technique as how specific interpretations and interventions influence subsequent session material and how symptoms change over time with respect to interpretations. The raw text of the tape recordings are eventually to be processed by a computer system.

Garfield and Bergin (1978) state that quantitative studies have been made of four concepts that demonstrate the patient's adequacy of production during analytic treatment: productivity, meaningfulness, experiencing, and associative freedom. Of these, associative freedom has been least explored.

### Issues of Technique

A notion basic to this research is technique. Paul (1973) states that technique refers to the manner in which the therapist articulates his/her intentions. Technique is defined as the conduct of psychotherapy; the manner in which the therapist communicates, formulates, and times interpretations. Good technique is a requisite for good therapy. The patient is always communicating something. Technique entails the guidelines, the principles, and the tactical interventions employed by the therapist. The interpretation of resistance, transference, defense-impulse, and substantive clarification are the cornerstones of

psychoanalytic technique (Greenson, 1977). Menninger and Holzman (1973) discuss how the patient and the therapist seek to discover what impulses, defenses, conflicts, resistances, attitudes, and themes are behind or within various verbal and nonverbal forms of communication. The therapist remains the ally of the patient's ego as it struggles with the id and defensive structures. This alliance is essential to psychoanalytic treatment.

The following review will examine therapist interpretations, probes (questions), and empathic statements. In addition, the phenomena of patient resistance, transference, and defense-impulse will be discussed.

### Interpretation

Since Freud, "interpretation" has occupied a central position in psychoanalytic treatment. In one of Freud's (1937) last papers on technique, he states:

The analyst finishes a piece of construction and communicates it to the subject of the analysis so that it may work upon him; he then constructs a further piece out of the fresh material pouring in upon him, deals with it in the same way and proceeds in this alternating fashion until the end.

In theory, employing analytic principles, the therapist ought not to influence the transference situation by any means other than the interpretative mode which becomes the primary therapeutic agent. In practice, a variety of techniques, such as, probes, are employed by analytical therapists with the critical technique being the interpretation.

Hammer (1968) discusses how ever since Freud's earliest

contributions to technique, the use of interpretation in treatment has demonstrated a tremendous staying power at the center of dynamically-oriented psychotherapeutic procedures. Fenichel (1953) states Freud's view of interpretation as similar to:

...the indication given by the teacher of histology to the student as to what he will see in the microscope, without which the student's eye, which is not yet set for microscopic vision, would not see anything.

Interpretation, according to Paul (1973), has two major variables: its formulation and its timing. Also, it articulates an intention and it communicates understanding.

Cooper (1968) defines interpretation as including all statements or comments made by the therapist to the patient for the purpose of clarifying or enabling recognition of the overt or covert meaning of behavior, thought or feeling at any particular time, or statements for the purpose of intervention. This is clearly consistent with Colby's (1951) description of interpretations, phrased in one of several ways, the therapeutic intent of which is to confront the patient with some aspect which is being defended against. The grammatical forms are common to everyday nontechnical language. The therapist interventions appear to reflect the direction of natural conversation (Labov and Fanshel, 1977). Paul (1973) advises that interpretations be broken down into parts in a gradual or stepwise fashion. The interpretative mode is kept in play, with the therapist delivering terse and direct statements utilizing qualifiers such as:

maybe, perhaps, or it seems that.... The aim is to keep the issue focused and to break the interpretation down into parts thinking of these parts as a connected whole as well as articulating in a manner that can be accepted by the patient's ego. The delivery is tentative, terse and affords the patient the opportunity to reject the statement or to go on to arrive at the next interpretation independently. The immediate goal on the therapist's side is to keep the relevant theme alive and moving as well as focused.

Greenson (1960) states that:

To interpret means to make an unconscious phenomenon conscious. More precisely it means to make conscious the unconscious meaning, source, history, mode or cause of a given psychic event.... The procedures of clarification and interpretation are intimately interwoven.

Bibring (1954) classifies the supreme agent in the hierarchy of therapeutic principles to be insight through interpretation. A fine theoretical point is raised by Paul (1973) who discusses:

Interpretations are also criticisms  
 ....Interpretations are likely to hurt; they can be unwelcome news; they are often painful and humiliating.

The most important analytic technique is interpretation; all other interventions are subordinated to it both practically and theoretically. All analytic procedures are either preparation steps which lead to an interpretation or make an interpretation effective. Such is the case of substantive clarification interpretation which refers to placing the

issue being analyzed in sharp focus. The issue or the pattern of the problem in question has to be singled out, isolated and addressed. It makes the reasonable and conscious ego of the patient aware of something it had been oblivious to. In order to engage the patient's ego effectively in the treatment work, it is a fundamental requirement that what is to be interpreted must usually be demonstrated and clarified. For example, in order to interpret a resistance, the patient must be aware that a resistance is indeed at work. The therapist clarifies the painful affect which motivates a particular mode of resistance. The same procedure is followed in analyzing transference and defense-impulse phenomena.

The validity of interpretations is stressed by Kubie (1952) as the foundation of treatment. He welcomed research on this topic and recommended that evidence of the accuracy of interpretations be drawn from the patient's further free associations.

### Questions of Fact

In the present study, 'questions of fact' are defined as straightforward active factual information gathering interventions by the therapist. The questions were in the spirit of securing omitted data. Paul (1978) defines a question proper by its function, namely, to elicit information believed to have been omitted. He discusses a situation where the information question is of benefit. It is when the therapist has an interpretation in mind, but needs to secure additional information to be certain of accuracy. He takes strong objection to the interviewing format.

Questions can assist the therapist's efforts to understand the patient. Olinick (1954) discusses the judicious use of questions as an adjunct technical intervention. He speaks of how questioning ought to be simple and specific dealing with matters that can be easily validated. Kubie (1975) emphasizes the limited use of direct questions citing occasions when they are useful. Namely, to obtain precise information or when they act as a stimulus to further free associations. There is some evidence that inexperienced therapists display a tendency to ask more exploratory questions, which are made at the expense of interpretations. As a therapist gains in experience greater emphasis is placed upon interpretations. This characteristic is stated to differentiate reliably experienced from inexperienced therapists (Strupp, 1973).

### Empathic Statements

These statements are sensitive interventions. Expressed empathy has a function in analytic treatment. It is the creation of moments of "staying." It is a matter of the correct understanding of the patient's circumstance(s).

The Rogerian writers present research findings that high levels of therapist cognitive empathy are correlated significantly with patient improvement. Rogers (1957) advocates therapist characteristics of genuineness, empathy, and unconditional positive regard. Rogers (1961) emphasizes the capacity of the therapist both to perceive accurately what the patient is feeling and to communicate this awareness to the patient. Greenson (1967) states:

The ability to empathize is essential for psychological-mindedness and is dependent on the capacity for temporary and partial identification with others.

Kohut (1959) states that if analytic treatment is to remain a scientific discipline, it is imperative that the therapist maintain the capacity to oscillate between the use of empathy and intuition on the one hand and theoretical knowledge on the other hand. Psychoanalytic therapy makes contradictory demands on the therapist. The therapist listens with free-floating attention and uses his/her own conscious mind, empathy, intuition, introspection, and fantasy life as well as intellect, problem-solving skills and theoretical knowledge in weaving threads and arriving at an intervention.

#### Defense-Impulse

Anna Freud (1936) assumes a structural mode of id, ego and superego. She defines the unconscious as something that is actively barred from consciousness and it can be unconscious in either the id, the ego, or the superego. The ego is viewed as all those functions that are explicitly dealing with reality. The id is viewed as the source of drive energy consisting of two instincts or drives, namely, the sexual and the aggressive. The superego is viewed as a series of functions that are internalized, first, as direct commands to the child, and later as moral imperatives which operate as conscious.

Anna Freud views the ego as a very complex structure and more complex than the id. She speaks of the variety of

ego functions as being indefinite. The sum of the same psychosexual events end up in becoming different clinical phenomena as a result of defense mechanisms. Defense refers to processes which safeguard against danger and pain and it is to be contrasted to instinctual activities which seek pleasure and discharge. The function of defense is originally and basically an ego function. The adaptive function of defense permits the person to deal with reality. The defense mechanism itself is by definition always unconscious, but the patient may be aware of the secondary manifestation of the defensive process. The concept of defense entails two parts: a danger and a protecting agency. Defense refers to a variety of unconscious activities of the ego, but a distinction can be made between the unconscious, deep, automatic defense mechanisms and those which are closer to the patient's conscious ego. Defenses are operative in a fixed energy system and make use of counter-cathexis to keep the lid on the id. The economic approach to defense deals with how much energy is spent in containing and pushing down impulses. The dynamic concern focuses on what the defenses are erected against and where does the anxiety come from, for example, superego anxiety, objective anxiety, or fear of the strengths of the instincts. The structural concern is centered around what type of defense has become structuralized in defending against some particular conflict or anxiety. The genetic viewpoint is a historical one and it includes the points of fixation and is centered around and concerned with how well the patient has passed through the different stages

of psycho-sexual development.

The defense interpretations investigated in this research are categorized employing the defense mechanisms discussed by Anna Freud (1936). In her work she discusses the role of defense organization and illustrates fourteen defenses. The more primitive the place occupied by a particular defense in the hierarchy, the more closely it is related to repressed material and the less likely it is to become conscious. Examples of more primitive defenses are, undoing, denial, projection, displacement, reversal, turning against the self, repression, identification, and avoidance. Those defenses higher up on the scale operate more in accordance with secondary reality process; for example, intellectualization, isolation of affect, reaction formation, rationalization, and sublimation.

The fourteen defenses are defined as follows:

**Undoing.** This defense implies in adults a weak ego structure. It works to balance or to cancel out an unacceptable action, affect, or thought by a subsequent action, affect, or thought in contradictory terms. For example, the patient may in fantasy experience an aggressive impulse and then undo the impulse by acting 'real nice.' Undoing may also occur in behavior as when one attempts to nullify the effects of one action by a later action. Ego structure is weak because the impulse breaks through into expression.

**Denial.** This defense refers to the denial of an unpleasant or unwanted piece of external reality either by means of fantasy or behavior. The crucial question is how

often and to what degree is denial employed.

**Projection.** The defense mechanism of attributing impulses or affects arising within the person onto external objects or persons. Projection involves denial and introjection and operates without the patient's conscious awareness.

**Displacement.** This defense involves a purposeful unconscious shifting from one object to another in the intent and interest of solving a conflict. All defenses can be viewed as involving displacement. Scapegoating is an example of displacement.

**Reversal.** A form of displacement involving the transformation of one instinctual impulse into its opposite. For example, the patient who feels unacceptable loving feelings may instead find reason to be angry with or critical of the object of such affects. Reversal is a kind of reaction formation against affect which occurs developmentally early in life.

**Turning Against the Self.** A form of displacement involving the turning of an impulse directed towards someone else back against the self. For example, anger at externals is directed back to the self and depression ensues.

**Repression.** The feeling and the idea are split off with the idea being kept unconscious for a long period of time. The source of anxiety is internal. This defense needs only to be employed once and it can be the foundation for a symptom formation. For example, a sexual trauma is repressed with the anxiety being binded by a hysterical symptom.

Identification. A complex ego function which can also be defensive. As a defense there is identification with a loved object. Here the patient models themselves according to the characteristics of a significant loved object in an attempt to gain closeness and have the constant presence of this object. Anxiety due to separation is removed. Identification with a lost object works to negate loss of a valued object through taking on the characteristics of this object. Identification with the aggressor involves avoidance of anxiety by placing the aggression characteristic of a feared object within the self.

Avoidance. Refusal to encounter a perceived dangerous external situation. This can also involve an active turning away from conflict-laden thoughts, issues, objects, or experiences.

Intellectualization. This defense works to control affects and impulses through thinking them instead of experiencing them. It is a systematic overdoing of thinking deprived of its affect in order to ward off anxiety from an unacceptable impulse. The emphasis is on words and ideas.

Isolation of Affect. An intrapsychic separation of affect from content. Once separated the affect is displaced to a different, substitute thought. Compartmentalization is a specialized form of isolation in which there is a keeping apart of sets of ideas or affects from one another.

Reaction Formation. This defense involves the management of unacceptable impulses by permitting the expression of them in an exactly antithetical form, i.e., love=hate.

The superego will not permit the impulse into consciousness due to anxiety and conflict. Reaction formation secures the ego against the return of repressed impulses from within.

Rationalization. This defense involves giving a good reason but not the real reason for one's actions.

Sublimation. This defense involves the distortion and displacement of instinctual aim in conformity with higher social values. It presupposes the existence of the superego. For example, aggression is sublimated into productive work pursuits.

Defense mechanisms distort, falsify, or deny reality to varying degrees. These mechanisms operate for the most part unconsciously being utilized to reduce anxiety and conflict. Defense mechanisms become inappropriate when they begin to interfere with living and establishing normal relationships.

Colby (1951) states in his discussion of wish-defense interpretations:

...to interpret first the defense element of the wish-defense system....

He describes the therapist as empirically viewing and manipulating ego mechanisms, a mixture of impulse (wish) and defense. Paul (1973) agrees with Colby that it is good technique to interpret the defense prior to the impulse. The aim is to get the ego to renounce its pathogenic defenses or find more suitable ones. The old defensive maneuvers prove to be inadequate; new, different, or the absence of defense might permit some adequate instinctual outlet without guilt

or anxiety (Anna Freud, 1936).

### Resistance

Resistance is an operational concept. The resistances are repetitions of the defensive operations that the patient has used in their past life within the therapeutic situation. Psychoanalytic therapy is characterized by the systematic interpretation and analysis of resistances. It is the work of the therapist to untangle how the patient resists, what is being resisted, and why the resistance. The immediate cause of a resistance is the avoidance of some painful affect like guilt, anxiety, or shame. Underlying this motive will be discovered an instinctual impulse which has triggered the painful affect (Anna Freud, 1936).

A practical distinction is to differentiate the ego-syntonic resistances from the ego-alien ones. If a patient feels a resistance is alien, there is an opening to begin to interpret and analyze. If a resistance is ego syntonic, the patient may deny its existence or employ a second defense, such as, rationalization. As the working alliance develops, as the patient comes to identify with the therapist's working attitudes, the resistances can shift to an ego-alien defensive operation permitting analysis. The concept of resistance consists of three agencies; a danger, a force impelling to protect the irrational ego, and a force pushing toward taking a risk. Resistance is a manifestation of the defensive and distorting function of the ego. It is resistance which psychoanalytic technique attempts to initially interpret and analyze (Fenichel, 1945; Greenson, 1977).

The phenomenon of resistance is one of Freud's greatest discoveries and is one of the basic elements in psychoanalytic theory. Colby (1951) discusses resistance as a defense operating against the efforts of the therapy. It is always present in the treatment. In Freud's (1920) words:

Every step of the treatment is accompanied by resistance; every single thought, every mental act of the patient s, must pay toll to the resistance, and represents a compromise between the forces urging towards the cure and those gathered to oppose it.

Menninger and Holzman (1973) discuss resistance as developing in a certain rhythm or pattern that continues with fluctuations throughout the treatment. The therapist becomes familiar with its manifestations in each single treatment case.

Freud (1926) suggested five types of resistance. He listed resistance derived from unconscious fear; resistance from disappointed expectations in the treatment; secondary-gain resistance, repetition-compulsion resistance; and superego resistance.

Resistance derived from unconscious fear of repression resistance refers to the ego's tendency to control or hold back dangerous impulses by blocking them off from gaining expression.

Resistance from disappointed expectations in the treatment or transference resistance stemming from the therapist's posture of neutrality as well as from the abstinence from gratifying the regressive wishes of the patient. The texture of older relationships is revived with the therapist.

Secondary-gain resistance refers to the unwillingness of the ego to relinquish advantages that have arisen as a result of maladaptive behaviors.

Repetition-compulsion resistance stems from the id and refers to how even after the ego has decided to abandon its resistances there arise difficulties in undoing the repressions despite the advantages promised for abandoning resistances as per the three types of resistance listed above.

Superego resistance refers to a feeling of needing to be punished. Feeling a need to suffer which permits for the atonement of guilt feelings.

Clinically, resistance is seen in numerous forms, such as, detachment, flight, missed appointments. There is a tendency on the part of analytic therapists to refer to any social misbehavior as acting out resistance.

Paul (1978) discusses how resistance can manifest itself in the treatment situation whereby the patient promotes situations which test the therapist's consistency. Such tests belong in the category of acting-out and are best dealt with by the therapist delivering careful, sensitive, and diligent interpretations. Paul also states:

And it does take courage to be a psychotherapy patient - to struggle against the recalcitrant organization of one's character and experience, to withstand the pressures of one's life circumstances and history, and to grapple with the forces of resistance. It takes courage also to be a psychotherapist.

### Transference

A second element basic to psychoanalytic thought is

transference. Transference in Freud's writings was considered as a problem mainly as it affected treatment, and the dynamics of transference formation was treated only cursorily.

Freud (1912) clearly recognized, however, that transference went far beyond a mere treatment problem. He states emphatically that transference is confined neither to neurotic behavior, nor the analytic situation. He saw transference as a universal phenomenon applicable to all interpersonal situations, stating:

It is not the fact that the transference in psychoanalysis develops more intensely and immoderately than outside.... This peculiarity of the transference is not, therefore, to be placed to the account of psychoanalysis, but is to be ascribed to the neurosis itself.

Breuer and Freud (1895) began to develop the concept of transference. It is discussed as a disturbance of the therapist-patient relationship. It is only after he recognized it as an inevitable distortion that Freud used the word transference for the first time to describe the phenomenon.

Freud (1912,1915) used the term to conceptualize the array of feelings toward the therapist which were evoked by the psychoanalytic treatment technique. These feelings were considered to be inappropriate to the therapist as a person. They were seen by Freud to arise with a dual function, that of seeking gratification and that of resisting the analytic work. He viewed neurotics as having frustrated wishes which remain attached to early objects beyond which they have not

as yet matured. The lack of sufficient reality gratifications caused a build-up of tension within the person. This led to the immature wishes to become attached to the therapist in the transference in order to seek gratification. Freud also distinguished two types of transference, namely, positive and negative transference. The drive derivative of the positive transference, according to Freud, consisted of nonsexual affectionate feeling, whereas, the negative transference consisted of hostile wishes. In the transference the unconscious conflict came to be attached to the therapist. It is the positive drive derivative which Freud believed enabled the patient to align with the therapist and to work to overcome resistances to further analytic work. Freud also believed the transference to be a prototype of how the patient interacted with other people. It was deemed necessary that such an interpersonal prototype enter into the therapeutic relationship. Once this was accomplished there arose resistances within the patient as an attempt to ward off conscious recognition of the unconscious wishes. Instead, the patient attempts to obtain the early gratification(s) through acting out in the transference. Freud saw the therapist's task as having to frustrate such wishes in the patient, while also orienting the patient toward examining the urges and their roots. This was deemed necessary so that the patient may come to gain understanding and control over the unconscious wishes. This concept remained unchanged and central throughout Freud's further works which, in so many areas, show elaboration and modification. In

fact, in his last major work (1950), he states:

...the patient sees in his analyst the return-the reincarnation-of some important figure out of his childhood or past, and consequently transfers on to him feelings and reactions that undoubtedly applied to this model.

Further, in the works of many classical psychoanalytic writers, such as, Fenichel (1945) the concept of transference, is accepted as central today. Kohut (1968) discusses how during treatment with a narcissistic personality disorder (borderline syndrome) there develops a parallel or alternating simultaneous transference. While one may be more important than the other, this depends on the nature of the patient's particular problem. The two transferences alternate between the patient feeling that the therapist is all powerful and perfect (Idealizing Transference), while the other takes the form of the patient feeling they are themselves all powerful (Grandiose Self Transference). Guntrip (1968) states that the transference in the treatment of the schizoid patient does not occur easily but, when it does, it follows a sequence. In replacement therapy with schizoid patients the therapist must allow a near whole transference and a merging to develop.

Elaborations on the concept of transference contribute to a richer understanding of clinical methodology. Freud (1949) observed that:

...the patient never forgets again what he has experienced in the form of transference.

## Experimental Research

Experimental content analysis research in psychotherapy is a relatively recent technology.

Kiesler (1973) in his discussion on the discipline of content analysis states:

Historically, content analysis seems to have been, first and foremost, an attempt to make quantitative, objective, and publically replicable what had previously been qualitative, intuitive, and privately judgmental.

Berelson (1952) defined content analysis as a method for studying the content of communication in a systematic, objective, and quantitative fashion.

The following research discussion will focus on studies bearing on the hypotheses under investigation in this dissertation.

Harway, Dittman, Raush, Bordin, and Rigler (1955) developed a seven-point graphic rating scale of depth of interpretation and studied results obtained under various conditions of measurement. They used both naive and experienced judges to sort statements in the original scale development. They demonstrated the importance of giving this variable attention, for naive judges were significantly more variable and placed significantly more items at the deeper end of the scale than did experienced judges. In this experiment, sixteen raters evaluated four therapy interviews from different cases with different therapists in different settings increasing generality. The independent variables were the unit

of the interview (individual therapist response versus interview as a whole), method of presentation (typescript versus tape recording), and amount of information given or the context (therapist response in the context of the preceding interview material versus only the therapist's sequence of responses). The study was designed to systematically control or evaluate the influence of raters, interviews, and practice in the use of the scale. The scale was found to be able to differentiate among the interviews. The results obtained showed that it made no difference whether the material was presented in the form of a typescript or tape recording, the ratings of the depth of interpretation were based only upon the words spoken. Appraisal of context as a variable suggested that it is not necessary for a rater to possess knowledge of both the therapist and patient verbal activity, although variations in certain conditions of context led to changes in depth ratings.

Cutler, Bordin, Williams, and Rigler (1958) conducted a further study utilizing the Depth of Interpretation Scale considering the possibility that the generally low interjudge reliability of the scale would be improved by using judges who were more skilled and sensitive to the subtle aspects of the psychotherapeutic relationship. The four interviews were given for rating to four psychoanalysts and four analysts in training. The judges were able to distinguish between the interviews. The amount of contextual information and the method of presentation (typescript versus tape recording) had no effect. However, it was discovered with respect to

reliability that this group of judges agreed even less among each other than the group of psychologists who had done similar ratings in the prior study by Harway Et.al. (1955). Agreement was found to be higher within the analyst in training group when the information supplied was limited to only the therapist interventions.

Raush, Sperber, Rigler, Harway, Brodin, Dittman, and Hays (1956) conducted an investigation of the dimensions of depth of interpretation and attempted to determine if it is a unidimensional variable. Interpretation was defined as any therapist behavior that expressed the therapist's view of the emotions and motivations of the patient. Depth was defined in terms of the disparity between the therapist's expressed view and the patient's awareness. The greater the disparity the deeper the interpretation. Judges were inexperienced graduate psychologist-therapists at the University of Michigan. In the first study, ten judges were guided only by the definitions of interpretation and depth that were provided. Three dimensions were required to explain the results. When given a graphic rating scale, three judges had unidimensional judgments, but three dimensions were still needed to account for all the judgments. In a second study to determine if the improvement was due to the improved frame of reference furnished by the graphic scale or to prior practice, it was discovered that both helped. Depth of interpretation was one of three dimensions that were isolated. Subsequent studies are

referred to citing that depth of interpretation was a primary dimension. The other dimensions varied with the judges and stimuli utilized.

Fisher (1956) conducted a study testing the hypothesis that judgments of depth of interpretations are implicitly derived from estimates of their plausibility, with those that are more plausible rated as more shallow. Sixty therapist statements covering the entire range of depth were presented along with a fictitious case history to be rated on seven-point scales of depth and of plausibility from the patient's point of view. Ratings proved to be reliable and intercorrelated in the predicted direction. Fisher concluded that inferences regarding depth may be based upon similar cues used in drawing inferences about plausibility. Depth may be related to perceived rather than actual truth - content. If depth is a function of the patient's awareness, the author states, then, the same interpretation made late in therapy would be more plausible to the patient and not so deep as if it were given early in therapy.

Howe (1962) had forty-eight experienced psychiatrists rate sixty-two interpretative statements along one of five, seven-point scales. Judges rated the material for either depth, generality-specificity, potential for anxiety arousal in the patient, therapeutic skillfulness of response (judgment as to whether it would be helpful to the patient), or plausibility from the patient's point of view. Reliability for depth was  $r=.52$ , for specificity  $r=.30$ , for skillful-

ness  $r=.11$ , for anxiety arousal  $r=.29$ , and for implausibility  $r=.43$ . The intercorrelations of the mean ratings of depth, specificity, anxiety arousal, and implausibility were moderate to high, ranging from  $r=.45$  to  $.75$ . Ratings of skillfulness showed only chance departure from zero correlations with the other four. Fisher's (1956) findings on plausibility were substantiated. In the Howe study, statements rated as deep were also seen as implausible, specific, or sharply focused, and anxiety arousing. The judges viewed interpretations that are not too plausible to the patient or are not understood or accepted as being likely to arouse anxiety.

Dittman (1952) conducted a study whereby three judges rated typescripts of 965 therapist responses in thirty therapy sessions of a single patient on a number of variables including an interpretation continuum ranging from the superficial to deep. The judges were also asked to evaluate therapeutic movement from the patient's responses on a five-point scale. Progressive movement was discovered to be associated with therapist responses that were slightly deeper than pure reflection.

Speisman (1959) investigated verbal resistance as a function of depth of interpretation. Working from transcriptions of actual cases, teams of three raters judged depth of interpretation on the scales of Harway, et al. (1955). Interpretative responses were classified as superficial, moderate, or deep. Other raters judged resistance

with therapist statements deleted. The categories of exploration (positive) and opposition (negative) were used. In support of the hypothesis, both superficial and moderate interpretations were followed by more exploration and less opposition, taken to indicate lower resistance, than were deeper interpretations. More resistance was encountered to superficial than to moderate interpretations. Thus, deep interpretations evoked most resistance, moderate least, and superficial intermediate. Shifts from moderate to superficial levels were followed by increased resistance, and shifts from deep to moderate by lowered resistance. While the interpretations of the therapist had a systematic influence upon the patient responses, the contrary was not true. Speisman concluded that a moderate level of interpretation is most effective for maintaining minimum levels of resistance.

Frank and Sweetland (1962) conducted an investigation of types of client statements in response to therapist statements obtained from the first four hours of interviews of four Rogerian therapists with forty clients. Among the findings the investigators determined that therapist responses had a direct influence on client responses. Interpretation was followed by an increase in understanding and a decrease in statement of the problem. Clarification and cause-and-effect relational statements also led to an increase in understanding and insight. In contrast, the investigators report, direct questioning and forcing the topic resulted

in a decrease in insight and understanding as well as, increased statements about problems.

Paul and Gill (unpublished) have concentrated on studying the consequences of certain types of interpretation. The principal idea was to compare the effect of an interpretation which was deemed to be well-chosen and timely (good) in its content against one which was untimely (bad). The pair of interventions were deliberately produced. In most instances, the "badness" of an untimely interpretation lay only in the fact that it invited intellectualization. The order of the interpretations was unvaried; the timely interpretation always followed the untimely interpretation. The analyzand was a woman in her early thirties, of superior intelligence and verbal ability, who sought psychoanalytic treatment because of obsessional thoughts as well as a growing dissatisfaction with her patterns of emotional and social involvement. She accepted the invitation to enter treatment, four times a week, at a reduced fee with the understanding that the sessions would be recorded for the purposes of research. There were no other departures from the usual psychoanalytic technique. The main question under study was did the interpretations make a difference. Did they have a differential effect. The dependent variable selected for this patient was rate of speech disruptions and the clinical evaluation was directed at degree of "movement" or analytic work judged on a five-point scale. The results demonstrated the more timely interpretation segments showing

a significant decrease in speech disruption rate compared to the more untimely interpretation segments. The evaluation of analytic movement was made by the judges based partly at least on the rate of speech disruptions which they perceived while listening to the recordings to be related in some marginal way. It remains an unanswered question whether for this analyzand the speech disruption rate was an index of anxiety. In this research two groups of judges made determinations. One group consisted of graduate students in a clinical psychology training program, the other consisted of professional experienced psychoanalytic practitioners. In another phase, the two groups of judges were asked to judge the "goodness" of an interpretation. Judges listened to tape recordings of short segments of the patient's production followed by statements by the analyst, and then rated the "goodness" of each interpretation. There was a remarkable degree of agreement. It was also discovered that agreement among judges on the "goodness" of an interpretation was virtually as great when listening to a tape recording deleting the patient's prior statement. The conclusion drawn was that the judges were basing their judgments on what the analyst said, not on what the patient said. The authors suggest that there appears to be a conception of "good" timely interpretations which independent judges can agree upon.

Garduk and Haggard (1972) investigated the immediate effects on patients of psychoanalytic interpretations. A

specific hypothesis tested was that the verbal activity of patients differs in amount after an interpretation when compared to verbal activity after noninterpretations. The experimental sample consisted of experienced, skilled psychoanalysts, three males and one female. The patients were three females and one male diagnosed as psychoneurotic, above average in intelligence, and of middle-class socioeconomic status. The sample was selected from cases that had been extensively recorded by the Psychotherapy Project of the University of Illinois College of Medicine. Judgments were made by one psychoanalyst and two psychoanalytic Ph.D. psychologists. The interpretations were classified on a comprehensive-moderate-limited continuum. The orientation was psychoanalysis for two cases and psychoanalytically oriented psychotherapy for the remaining two treatment cases. Five minutes following each interpretation or noninterpretation constituted the "effect period" that was studied to determine the influence of the preceding intervention on the patient. The results showed a conspicuous difference between the mean length of interpretations ( $\bar{X}$  = 176 words) and that of noninterpretations ( $\bar{X}$  = 31.3 words): interpretations were, on the average, more than five times as long. Interpretations were found to consist of more words than do noninterpretations. Interpretations were not only longer than noninterpretations, they were less frequently phrased as questions. Only 15% of the interpretations in this study ended in an inquiry, whereas almost 42% of the noninterpretations were

stated in the interrogative. The interpretations tended to be declarations by the therapist even when they were presented tentatively or cautiously. The therapists did, however, show a tendency ( $p. < .10$ ) to interpret more after interpretations than after noninterpretations. The incidence of interpretations in effect periods was not high. Significant difference was found in patient response in that patients talked less after interpretations, and responded more slowly to interpretations than to noninterpretations. Patients were found to communicate less relatively factual, conscious-level material after interpretations than after noninterpretations. The comprehensive and moderate-limited interpretations were found to be not markedly different in regard to eliciting deeper-level material. The comprehensive interpretation were found to be more final than moderate-limited ones, and this suggests that they are less stimulating, less arousing. The authors conclude that the comprehensive interpretation is less effective than moderate-limited interpretations. Comprehensive interpretations were also less effective in eliciting material related to the transference. The major content findings in this research showed more affect, more understanding and insight, more defensive and oppositional associations, and more transference-related material after interpretations than after noninterpretations.

Kanfer, Phillips, Matarazzo, and Saslow (1960) investigated the comparative effects upon the duration of the inter-

viewee's utterances of interpretations as opposed to exploratory or information-seeking statements. The study was not done in the context of psychotherapy. Data were obtained from standard interviews with a group of nurses. The interviews were divided into three periods. During the first and third periods the interviewer made only exploratory and information seeking remarks, while twelve interpretations were made during the second period for experimental subjects. Exploratory statements were continued for control subjects. All interactions were recorded by the interaction chronograph. During the interpretation period the experimental subjects showed significantly lower mean duration of utterance while controls did not change over the three periods. The interpretation period was followed in the next period by a significantly higher mean duration of verbalizations. The authors speculated that interpretations might be considered as punishing, aversive stimuli, and therefore lead to reduced verbal output. Another explanation was offered to the effect that exploratory questions could, by their nature, call for more extended verbalizations whereas interpretations call for a simple yes or no answer. This may have been an artifact brought about by the interrogative manner in which interpretations were worded in this investigation. For example, the interviewer asked, "Do you think that... (interpretation)?" It was suggested that interpretations worded as statements rather than questions might well stimulate different patient verbal outputs.

The present research is a replication in part of research reported by Colby (1961). The subjects in this study were four male college students without complaint in a controlled experimental interview situation seen four times a week for three weeks in thirty-minute sessions. The subject lay on a couch with the experimenter behind him and was asked to free associate. In this connection, Colby compared the "amplifying power" (increase in free association) of questions with that of interpretations offered in casual terms such as, "You felt this way because of..." and interrogatives (questions asked by the experimenter) such as, "Do your parents object to the marriage?" In the Colby study the experimenter's statements were systematically varied and restricted to either questions or interpretations referring to immediate antecedents. The subject's response unit following the experimenter's statement was scored for presence or absence of the personage or topic indicated in the input. Colby found that 'causal correlative inputs' (that is, interpretations) resulted in significantly greater amounts of amplifying power (increase in free association) and a greater percentage of references to relevant topics and persons.

## CHAPTER II

## METHOD

SubjectsTherapists

Five clinical psychology Ph.D. graduate students at the same level in formal training at The Graduate School and University Center of the City University of New York and one Ph.D. Psychologist with clinical training, three males and three females.

All of the therapists were Caucasian with the exception of one Black female. Three males and two females were in personal psychotherapy. Average age was 29 years.

Patients

Four males and three females. The patient subjects were diagnosed as schizoid, depressed, and borderline personalities by the therapists under advisement of psychotherapy supervisors.

The patient sample is as follows:

- One Hispanic female college student
- One Black married housewife
- One Black female pre law college student
- One Caucasian male Masters student
- One Caucasian male Navy veteran college student
- One Caucasian male Navy veteran college professor
- One Caucasian male musician

Type of Therapy

Individual therapy, face to face analytically oriented. The patient determined the subject matter of the session hour. One session per week was the minimum, average two sessions per week.

### Duration of the Therapy

Minimum nine months, average two years.

### Type of Sampling

The subjects were culled from volunteers with twenty-four psychologists at different levels of training being approached. Ten volunteers produced twenty session tapes. For the purpose of this study fourteen single therapy session tapes were utilized with the determination being the quality of the tape from start to finish. These tapes were supervision tapes prepared prior to the formulation of the hypotheses to be tested in this research and before any inclination that they would be used for research purposes.

The sample was randomly drawn from previously terminated therapies and the fourteen sessions were as follows:

One beginning phase of therapy (first month)  
 Eleven middle phase of therapy (nine to eleven months)  
 Two ending phase of therapy (twenty two months)

The hypotheses tested in this investigation involved each subject serving as their own control in lieu of a control group. The interventions vary and the patients' verbal output is the dependent variable under the different conditions. This experimental design has been employed in psychotherapy research (Meltzoff and Kornreich, 1970). The principal advantages of own-control designs is reduced error and the elimination of the need of obtaining equivalent samples.

## PROCEDURE

### Part I

The fourteen session-tapes were transcribed into verbatim typescripts. Two independent raters were trained to score the protocols. Rater training was complete upon achieving one hundred percent passing grade on the testing sessions. The task involved placing the therapist segments into one of five categories reflecting type of intervention. See Appendix A for rater instructions, testing, and training session protocols. The training and testing protocols were constructed from the experimenter's old handwritten session notes which were not part of the sample tapes utilized in this investigation.

### Clinical Sophistication of Judges

Classification in this study was done initially by two fourth year pre-internship Ph.D. clinical psychology graduate students in training at The Graduate School and University Center of the City University of New York. These two raters, one male and one female, judged the protocols in the first part of this investigation. Their orientation was analytical. In the second part of this investigation again two raters judged the protocols. The male analytic pre-internship rater remained and a second male in training in the clinical psychology program at The Graduate School and University Center of the City University of New York joined the study. This new rater was two years post-internship and his orientation was behavioristic. All

three raters were currently treating their own patients. Interjudge reliability clearly exceeded chance beyond the 0.05 level of significance. In practice this involved an interjudge agreement of 75 percent or above on each of the various tasks. For example, agreement on the initial five categories of therapist inputs was 80% while agreement on the four major classes of interpretation was 90%.

## Part II

Once trained, the two raters were first instructed to judge independently all of the protocols placing the therapist segments into the prescribed definitional categories, as well as tabulating the amplifying power index of these therapist inputs. See Appendix B for instructions.

## Scoring

The unit of scoring the amplifying power index was the sentence. Each of the patient's sentences following one of five definitional classes of therapist inputs was scored on a lined tally sheet for the presence (1) or the absence (0) of the topic indicated in the input. Ratings of therapist inquiries were made from the typescript protocols with preceding and antecedent patient responses intact. Those patient sentences pertaining to the topic were scored as tallies, those which did not pertain to the topic, as blanks. The response set consisted of all patient topical sentences following the therapist input up to the occurrence of five empty non-topical sentences (which were not counted). The size of the set was determined as a function of a sentence and word count on a lined tally

sheet of those patient sentences pertaining to the topic in the therapist input.

The size of the response set and the percentage of tallies in the set were used as a measure of the amplifying power of the input. This scoring system and arbitrary endpoint of five empty sentences has been employed experimentally in previous research (Colby, 1961).

### Part III

Once all the response protocols were scored, the experimenter acted as a referee bringing the two raters together to discuss and reconcile differences. During the reconciliation session, the raters were asked to further judge those segments rated as miscellaneous so as to place them into various subcategories. The raters were provided with a list of subcategories. See Appendix C for instructions and rating categories.

### Part IV

The two raters were then trained to judge the therapist interpretative inputs. The task involved placing each of the therapist interpretations, both formal and those of motive, into one of the four categories. The definitions are as follows:

#### 1. Resistance

Statements made by the therapist indicating the patient's overt or covert opposition to the therapeutic process. For example, "It seems as though on the one hand you agree that what I say is valid but you do not seem to

derive any help from this." Also, statements made by the therapist such as, "It sounds like you feel that you do not need therapy anymore; but you do, because there appear to be a number of unanswered questions that you still have."

## 2. Clarification

Statements made by the therapist to crystallize (or define) the patient's thoughts and feelings around a particular subject, to focus the patient's attention on something requiring further investigation and interpretation, to sort out a theme from apparently diversified material, or to summarize the understanding thus far achieved. They may take the form of questions, mild imperatives, or simplified restatements (Colby, 1951). For example, "You are really very unaccepting of your own feelings. You want them all to be different and you can not accept what you want to feel."

## 3. Defense-Impulse

Statements aiming at interpretation or pointing up a defense, such as, "Are you aware of a wish not to think about..." (avoidance). Also, "I wonder if you suspect that your over-reacting and putting the blame too much on other people" (externalization of blame). The statements were scored utilizing the fourteen defenses outlined by Ann Freud (1966).

## 4. Transference

A whole series of psychological experiences is revived as applying to the person of the therapist at the

present moment. Statements such as, "I wonder if you're concerned about impressing me" as well as, "So you naturally think that I, too, like your past figures, will disappoint you." See Appendix D for testing and training session instructions and protocol.

#### Part V

Once the interpretative inputs were judged, the experimenter acted as a referee bringing the two raters together to discuss and reconcile differences.

#### DATA ANALYSES

The index of verbal activity, the number of words in each remark by the patient was used as the measure of amplifying power (increase in relevant free association) in this investigation. It was also deemed of value to analyze the index of the therapist verbal activity as well as to compute a difference score consisting of the total number of words spoken by the patient over and above the total number of words in the preceding therapist input.

Data from this study was key punched and analyzed via computer at The Graduate School and University Center of the City University of New York employing (Nie, et al, 1975) programs from the statistical package for the social sciences (S.P.S.S.).

## CHAPTER III

## RESULTS

The intent of this investigation was to determine the relative amplifying powers of several different types of therapist inquiries in actual therapy sessions, in an attempt to establish guidelines for therapist effectiveness. Amplifying power, for the purposes of this research, was defined as the patient's relevant free association to the topic indicated in the previous therapist input exclusive of switching to a new topic, silence, or reintroduction of a previous topic.

Hypothesis 1A and Hypothesis 1B were not independent. Hypothesis 1A predicted that interpretations, both formal and of motive (variant of interpretation), have greater amplifying power on relevant free association than do empathic statements, or questions of fact. This was not confirmed.

Hypothesis 1B, a sub-hypothesis, predicted that questions of motive (variant of an interpretation), have greater amplifying power than empathic statements or questions of fact. This was not confirmed.

Hypothesis 2 predicted that formal interpretations have greater amplifying power than the variant of interpretation, questions of motive. This was not confirmed.

The .05 significance level was used to test hypotheses throughout this dissertation, but .01 and .001 significance levels are reported for the use of readers who prefer to

refer to them.

Table 1 presents the basic results of this investigation, with each patient-therapist dyad represented as a line of the table, and each type of intervention (questions of fact, empathic statements, questions of motive, formal interpretations, and the miscellaneous category) as a major column of the table. Each of the five major columns is divided into sub-columns for the N (number of patient-therapist inter changes for that dyad and type of intervention). Table 1 displays a difference score reflecting the total number of words amplified by the patient over and above the total number of words in the therapist's preceding input according to type. The raw data was comprised of pair wise (patient-therapist) segments of information. Each segment consisted of three raw data units as follows: number of therapist's words; number of relevant patient words; status=type of input (questions of fact, empathic statements, questions of motive, formal interpretations, and the miscellaneous category). This difference score column was derived by subtracting for each dyad the total number of words amplified by the patient in excess of the amount of words in the therapist's input in a given segment. This score could on occasion be negative as well as positive.

The median Table 1 reads as follows: the first patient-therapist dyad included a female patient and a female therapist. This therapist made 36 statements of fact, having a median length of 5.5 words. The patient's response is indi-

cated by a median of 15.0 relevant words. The total number of words amplified by the patient over and above the total number of words in the therapist's preceeding input here, in this example, questions of fact, yielded a P-T difference score median of 9.0 words. This therapist made 3 empathic statements with a median of 7.0. The patient's median relevant response was 33.0 words with a difference score of 25.0 words. This therapist in the first dyad, asked 25 questions of motive which yielded a median of 9.0 words. The patient's median relevant amplification was 71.0 words with a difference score (P-T) median of 42.0 words. This same therapist made 3 formal interpretations with a median of 9.0 words. The patient's median relevant response was 8.0 words with a median difference score (P-T) of -5.0 words. Finally, this therapist in the first dyad made 46 statements which were judged to be miscellaneous with a median of 8.5 words. The patient's response yielded a median of 32.0 words with a (P-T) difference score median of 23.0 words.

At the bottom of Table 1 are presented the total medians, grand mean, and standard deviations for the total set of raw data from which the column entries were derived. The overall median for any sub-column, in other words, is based on the raw total number (EN) of patient-therapist interactions for that major column, not on the 7 medians presented in the sub-columns.

Because the data were not normally distributed and

Table 1  
MEDIANs

DYAD	SEX P T	FACT				EMPATHIC				MOTIVE				INTERPRETATION				MISCELLANEOUS			
		N	T	P	P-T	N	T	P	P-T	N	T	P	P-T	N	T	P	P-T	N	T	P	P-T
1	F F	36	5.5	15.0	9.0	3	7.0	33.0	25.0	25	9.0	71.0	42.0	3	9.0	8.0	-5.0	46	8.5	32.0	23.0
2	M M	59	4.5	14.0	9.0	3	8.0	27.0	23.0	79	6.5	9.5	3.0	26	20.5	7.5	-11.5	122	5.5	7.5	2.5
3	M M	21	8.0	7.0	1.0	3	14.0	30.0	12.0	80	10.0	20.5	8.5	36	19.5	13.0	-3.5	69	10.5	12.0	1.5
4	F M	10	6.5	43.0	36.5	3	11.0	4.0	-6.0	12	4.0	86.5	72.0	14	17.5	63.0	34.5	20	6.5	37.5	28.0
5	F M	9	8.0	41.0	33.0	7	6.0	48.0	44.0	55	10.0	40.0	31.0	32	23.0	19.5	3.5	54	6.0	17.5	9.0
6	F F	20	6.5	21.5	16.5	1	11.0	138.0	127.0	33	7.0	41.0	33.0	27	10.5	33.0	18.0	82	4.5	23.5	17.0
7	M F	1	5.0	0.0	-5.0	-	---	---	---	10	8.5	18.0	8.0	42	28.5	28.0	2.5	32	10.5	15.5	-2.5
TOTALS																					
MEDIAN		156	6.0	15.0	9.0	20	7.0	27.5	14.5	294	8.0	25.0	13.5	180	19.5	24.0	2.0	425	6.5	15.3	5.2
MEAN			7.2	38.3	31.1		9.3	46.4	37.1		11.8	49.0	37.2		26.3	53.9	27.6		12.5	37.9	25.4
S.D.			5.8	79.1	79.1		6.9	61.9	61.2		11.2	73.7	74.1		20.6	111.8	113.6		19.1	66.7	70.2

note. n = number of interventions  
 T = therapist  
 f = patient  
 f-T = patient minus therapist difference score

were extremely skewed due to occasional long utterances by a patient, they were analyzed utilizing the Mann-Whitney U tests, with z transformations for estimation of significance. The Mann-Whitney U's were based on the raw data. The z scores for therapist, patient, and difference, corrected for any ties in ranking, derived from the Mann-Whitney U tests are presented in Table 2. Tests were done among all the different inquiry types displayed in Table 1 as well as contrasting each type with the miscellaneous category.

It can be seen for column 1 of Table 2 that the therapist utters more words when delivering an interpretation, both formal and question of motive (variant of an interpretation) than when asking a question of fact. This is seen in all of the dyads presented in Table 1 with the exception of dyad #4. However, formal interpretations, questions of motive and empathic statements are not discriminably different in terms of therapist verbal activity. Also, questions of fact do not differ from empathic statements with respect to therapist verbal activity.

It is observed that the patient amplification is greatest with respect to empathic statements. This is seen especially in dyad #6. Patient amplification is higher for questions of motive when contrasted with formal interpretations. This is seen in all of the dyads with the exception of dyad #7. The least amount of patient amplification is observed to follow a question of fact as evidenced in

Table 2

## Summary of Analyses of Mann-Whitney U Tests

<u>Type of Input</u>	<u>Therapist</u>	<u>Patient</u>	<u>P-T Differ</u>
Questions of Fact vs. Empathic Statements	<sup>1</sup> z=-0.96	z=-1.49	z=-0.67
Questions of Fact vs. Questions of Motive	z=-3.24**	z=-4.96***	z=-1.35
Questions of Fact vs. Formal Interpretations	z=-2.34*	z=-12.49***	z=+3.04**
Empathic Statements vs. Questions of Motive	z=-0.28	z=+0.80	z=-0.21
Empathic Statements vs. Formal Interpretations	z=-0.07	z=+5.05***	z=+2.05*
Questions of Motive vs. Formal Interpretations	z=-0.66	z=+10.41**	z=+4.43***
Questions of Fact vs. Miscellaneous	z=-0.97	z=-0.38	z=+1.39
Empathic Statements vs. Miscellaneous	z=+0.86	z=+0.71	z=+1.23
Questions of Motive vs. Miscellaneous	z=+3.55***	z=+3.84***	z=+3.18**
Formal Interpretations vs. Miscellaneous	z=+11.26***	z=+2.48*	z=-2.42*

\*=.05

\*\*=.01

\*\*\*=.001

<sup>1</sup> Note: The table reads as follows: when the central tendency for the right hand contrast was larger than the left hand contrast, the z scores are indicated with a negative sign.

dyad #3. When the types of inquiries were contrasted each with the miscellaneous category, formal interpretations and questions of motive were observed to be significantly different with patient amplification being greater after a question of motive followed by formal interpretations. It was also seen that where questions of fact and empathic statements were concerned, they were found to be not discriminably different from the miscellaneous category.

The second part of this investigation involved the relationship between four major classes of therapist interpretive inquiry and the resultant patient amplification.

Hypothesis 3 predicted substantive clarification interpretations have greater amplifying power than transference, defense-impulse, or resistance interpretations. This was not confirmed.

Hypothesis 4 predicted transference interpretations have greater amplifying power than defense-impulse or resistance interpretations. This was not confirmed.

Hypothesis 5 predicted defense-impulse interpretations have greater amplifying power than resistance interpretations. This was not confirmed.

The data analyzed was drawn exclusively from formal interpretations and questions of motive. Table 3 presents the raw score number of therapist interpretive inputs across the four major categories of classification.

Table 4 presents the median results of the amplification word count scores drawn exclusively from formal in-

terpretations and questions of motive across the four major classes of therapist interpretive inquiry. This table describes the therapist-patient dyads separately, as well as the difference score (P-T) reflected in the total number of words amplified by the patient over and above the total number of words in the therapist's preceeding input according to type. Also, presented is the total median, the grand mean, and standard deviation.

The data in this second part of this investigation were also extremely skewed and it was analyzed utilizing the Mann-Whitney U tests, with z transformations for testing significance. The z scores for therapist, patient, and difference, corrected for any ties in rankings, derived from the Mann-Whitney U tests are presented in Table 5. The tests were among the four major classifications displayed in Table 4 as well as, contrasting each classification with the miscellaneous category.

It is observed from Table 4 that therapist verbal activity is greatest when delivering a defense-impulse or resistance interpretation. The least amount of therapist utterance is found in the transference interpretation class. This is shown in dyads #5 and #7. It is also seen that all four major classifications differ significantly from the miscellaneous category in terms of the therapist having more verbal activity when delivering an interpretation.

With respect to patient amplification, there were no significant differences in Tables 4 and 5. When each of

Table 3  
Interpretive Inputs

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	<u>Questions of Motive</u>	<u>Formal Inter- pretations</u>	<u>Total</u>
Resistance	17	22	39
Substantive Clarification	244	105	349
Defense-Impulse	8	32	40
Transference	<u>25</u>	<u>21</u>	<u>46</u>
Totals	294	180	474

Table 4

DYAD	N	SUBSTANTIVE CLARIFICATION			TRANSPERENCE				DEFENSE-IMPULSE				RESISTANCE				
		T	P	P-T Differ	N	T	P	P-T Differ	N	T	P	P-T Differ	N	T	P	P-T Differ	
1	FF	27	9.0	50.0	37.0	1	3.0	71.0	68.0	0	-	-	-----	0	-	-	-----
2	MM	98	8.5	9.0	1.0	2	5.0	15.0	10.0	1	20.0	14.0	-6.0	4	15.5	26.0	10.5
3	MM	83	11.5	18.0	4.0	28	13.5	14.0	2.5	2	14.5	19.0	4.5	3	19.0	11.0	4.0
4	FM	14	9.5	75.5	59.5	4	11.0	188.0	166.5	0	----	----	-----	8	20.5	53.5	29.5
5	FM	45	12.0	39.5	30.0	10	10.0	25.0	14.5	17	27.0	19.0	-5.0	15	21.0	98.0	58.0
6	FF	57	8.0	41.0	25.5	0	----	----	-----	3	19.0	33.0	2.0	0	----	----	-----
7	MF	25	18.0	24.5	6.5	1	12.0	28.0	16.0	17	40.0	32.0	2.0	9	28.0	28.0	12.0

Totals  
349

46

40

39

Median	11.0	24.0	10.0	12.5	21.0	6.5	27.5	25.5	-2.0	21.0	37.0	12.0
Mean	14.4	48.0	33.6	16.3	45.0	28.7	34.7	67.2	32.5	26.8	66.8	40.0
S.D.	13.0	92.2	93.1	13.3	68.0	71.2	29.4	104.7	107.6	21.4	74.9	78.2

Table 5

## Summary of Analyses of Mann-Whitney U Tests

<u>Type of Input</u>	<u>Therapist</u>	<u>Patient</u>	<u>P-T Differ</u>
Resistance vs. De- fense-Impulse	<sup>1</sup> z=+4.05***	z=-1.86	z=-0.16
Resistance vs. Sub- stantive Clarification	z=+0.97	z=-0.60	z=-1.23
Resistance vs. Transference	z=+2.30*	z=+1.61	z=+0.61
Defense-Impulse vs. Substantive Clarifica- tion	z=+4.74***	z=+0.97	z=-2.01*
Defense-Impulse vs. Transference	z=+1.11	z=+0.27	z=-0.94
Substantive Clarifica- tion vs. Transference	z=-3.10**	z=+0.84	z=+1.03
Resistance vs. Miscel- laneous	z=+5.54***	z=+3.08**	z=+0.72
Defense-Impulse vs. Miscellaneous	z=+6.20***	z=+3.17**	z=-1.55
Substantive Clarifica- tion vs. Miscellaneous	z=+6.17***	z=+2.37*	z=+1.59
Transference vs. Miscellaneous	z=+3.69***	z=+1.38	z=+0.16

\*=.05

\*\*=.01

\*\*\*=.001

<sup>1</sup> Note: The table reads as follows: when the central tendency for the right hand contrast was larger than the left hand contrast, the z scores are indicated with a negative sign.

the four major classifications were contrasted with the miscellaneous category, all were found to be statistically significant with the exception of the transference class in terms of patient amplification.

Mann-Whitney U tests were done comparing each of the four major classifications (resistance, defense-impulse, substantive clarification, and transference with formal interpretations versus questions of motive). The data are presented in Table 6.

It was found that more substantive clarification therapist inquiries were cast as questions of motive. Questions of motive were also found to be statistically significant in the classes of resistance, defense-impulse, and transference in terms of therapist verbal activity. The difference score however, points up more therapist verbal activity when delivering a substantive clarification formal interpretation.

Table 7 presents the Mann-Whitney U tests z scores corrected for any ties in ranking for therapist, patient, and difference score broken down for the four major classifications divided into formal interpretations or questions of motive.

It is seen that therapist verbal activity is greater when delivering formal interpretations in the following order: substantive clarification, defense-impulse, resistance, and transference. Substantive clarification and resistance questions of motive were also statistically significant but indicative of less therapist verbal activity

Table 6

## Summary of Analyses of Mann-Whitney U Tests

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<u>Type of Input</u>	<u>Therapist</u>	<u>Patient</u>	<u>P-T Differ</u>
Questions of Motive vs. Formal Inter- pretations Resistance	z=3.32*** M<I	z=0.34	z=1.19
Substantive Clarifica- tion	z=8.02*** M<I	z=1.62	z=4.25*** M>I
Defense-Impulse	z=2.49* M<I	z=0.39	z=0.76
Transference	z=2.28* M<I	z=0.56	z=0.15

\* = .05

\*\* = .01

\*\*\* = .001

when contrasted with formal interpretations.

It is seen with respect to patient amplification that therapist inquiries cast as substantive clarification questions of motive were most powerful. Patient amplification was also found to be statistically significant with respect to formal defense-impulse and resistance interpretations as well as, resistance questions of motive.

It is noteworthy that in the case of formal substantive clarification interpretations with the greatest overall therapist verbal activity it is seen to elicit the least amount of patient amplification.

Table 7

## Summary of Analyses of Mann-Whitney U Tests

<u>Type of Input</u>	<u>Therapist</u>	<u>Patient</u>	<u>P-T Differ</u>
Resistance (Questions of Motive)	z=1.98*	z=2.18*	z=1.40
Resistance (Formal Interpretations)	z=5.79***	z=2.27*	z=0.24
Substantive Clarification (Questions of Motive)	z=3.06**	z=3.61***	z=3.37***
Substantive Clarification (Formal Interpretation)	z=8.42***	z=0.79	z=-2.36*
Defense-Impulse (Questions of Motive)	z=0.96	z=0.65	z=0.40
Defense-Impulse (Formal Interpretation)	z=6.49***	z=2.35*	z=1.59
Transference (Questions of Motive)	z=1.57	z=0.75	z=0.01
Transference (Formal Interpretation)	z=3.89***	z=1.27	z=0.25

\* = .05

\*\* = .01

\*\*\* = .001

## CHAPTER IV.

## DISCUSSION

Patient Amplification

It was found that patient amplification (relevant free association) is greatest with respect to empathic statements. When compared with formal interpretations, patient amplification is greater for questions of motive (variant of interpretation). The least amount of patient amplification is observed to follow a question of fact. When the types of inquiries, i.e., formal interpretations, questions of motive, questions of fact, and empathic statements, were contrasted with the miscellaneous category it was found that formal interpretations and questions of motive were significantly different. Questions of fact and empathic statements were found to be not discriminably different from the miscellaneous category.

The second part of this investigation involved the relationship between the four major classes of therapist interpretive inquiry as follows: substantive clarification, defense-impulse, resistance, and transference. The only discriminably different significance was found between the defense-impulse response difference score and the substantive clarification class. When each of the four major interpretive classifications were contrasted with the miscellaneous category all except transference interpretations were found to be statistically significant in the negative direction in terms of patient amplification.

Therapist inquiries cast as substantive clarification questions of motive were most powerful. Patient amplification was also found to be statistically greater after formal defense-impulse and resistance interpretations as well as after resistance questions of motive than defense-impulse questions of motive or inquiries in the transference and substantive clarification classes.

Formal substantive clarification interpretations with the greatest overall therapist verbal activity were found to elicit the least amount of patient amplification.

#### Therapist Verbal Activity

It was found that the therapist utters more words when delivering an interpretation, (both formal and questions of motive) than when asking a question of fact. However, formal interpretations, questions of motive and empathic statements are not discriminably different in terms of therapist verbal activity.

The greatest amount of therapist verbal activity was found when delivering a defense-impulse or resistance interpretation. The least amount of therapist verbal activity was found in the transference interpretation class.

All four major interpretive classifications, i.e., substantive clarification, defense-impulse, resistance, and transference, differ significantly from the miscellaneous category in terms of the therapist having more verbal activity when delivering an interpretation.

A majority of substantive clarification therapist inquiries were cast as questions of motive. Questions of

motive were also found to be statistically greater in the classes of resistance, defense-impulse, and transference in terms of therapist verbal activity. The difference score points up more therapist verbal activity when delivering a substantive clarification formal interpretation, which elicited the least amount of patient amplification.

Therapist verbal activity was greater when delivering formal interpretations in the following order: substantive clarification, defense-impulse, resistance, and transference. Substantive clarification and resistance questions of motive were also statistically significant relative to defense-impulse and transference questions of motive but indicative of less therapist verbal activity when contrasted with formal interpretations.

#### Relation to Previous Studies

The results of the present study are reported utilizing the median measure of central tendency. The median is preferred here to the mean because there existed a few very long utterances which would have moved the mean excessively and give a distorted view.

The results of the present study are not consistent with those of earlier out of the therapeutic process studies investigating the comparative effects of various inquiry techniques (Kanfer, et al., 1960; Colby, 1961). For example, Kanfer, et al. (1960) reported, utilizing data from standard research interviews modeled after clinical interaction with a group of nurses, subjects showing sig-

nificantly lower mean duration of utterance following an interpretation. Exploratory questions in the Kanfer, et al. (1960) study elicited more extended verbalizations.

The present results also differ from the findings of Colby (1961). Colby's was an experimentally controlled interview situation involving four male college student subjects without psychiatric complaint. The subjects were seen four times a week for three weeks in thirty-minute sessions. Colby found that interpretations resulted in significantly greater amounts of amplifying power than questions. Colby reports his findings using the mean measure of central tendency. Colby is also reported to have scored his own data, which indicates a methodological imperfection.

The results of the present study differ from many earlier studies (Kanfer, et al., 1960; Colby, 1961) in that the data which consisted of verbatim supervision tapes of actual therapy sessions were prepared prior to any notion of their use in this dissertation research. The results therefore, are not affected by experimenter expectancy wherein the experimenter normally knows the hypothesis being tested and can hardly help but have some opinion as to the probable (or desired) outcome while collecting the data. The role of being a subject without psychiatric complaint in an experiment differs from being an actual patient with psychiatric complaint in ongoing treatment. A subject who, deliberately or not, is trying to act so as to support what he or she guesses to be the

experimenter's preferred outcome is doing something quite different from simply reacting to the independent variable as it would occur in a non-experimental therapy situation.

Also, the issue of interventions is relevant in that those utilized under experimental conditions may be more neutral, intellectualized, superficial or intriguing to the subject rather than being salient content at appropriate moments in the therapy in order to facilitate the therapeutic process.

However, the present study, in large part, confirms a finding obtained by Garduk and Haggard (1972), one of the in-treatment studies employing verbatim tapes. Like the present study, Garduk and Haggard found therapist interpretations consisted of more words than do noninterpretations.

In the present study, empathic statements (N=20) delivered by the therapist elicited the greatest amount of patient amplification. These statements were formulated, articulating a preconscious inference regarding the patient's experience. A speculation could be made as to the accuracy of these therapist empathic statements judging from the amount of relevant patient amplification.

The second most powerful inquiry in terms of patient amplification in the therapeutic process in this study was therapist questions of motive (N=294). These were interpretations delivered by the therapist in the form of a question. Beginning therapists must often undergo consid-

erable emotional re-education as well as intensive technical training. A typical concern of a beginning therapist is to promote the opportunity for the patient's verbal expression of clinical material. Another major concern of effective beginning therapists is to engage the patient in a therapeutic relationship that is direct, genuine, intense as well as a verbal-cognitive discourse. This is seen in this study's sample of therapists who utilized questions of motive delivering a "borderline" interpretation implying just a little more than the patient said. One could speculate that this tendency arises out of the therapist's inexperience and anxiety may have intervened promoting a natural tendency to ask questions. It may also reflect a judgment made by the therapist that this particular type of intervention provides in some instances ego support, orientation, and relatedness to the patient. For example, a majority of the substantive clarification inquiries were cast by the therapists as questions of motive (N=244).

Those interventions delivered by the therapist managing the resistance were effective in terms of relevant patient amplification with the formal resistance interpretations (N=22) being more powerful than resistance questions of motive (N=17). This may reflect the experience of psychoanalytical training which stresses the instruction that resistance is ever present and is the focus of the therapist's interpretive endeavors.

The therapists in this study also delivered a majority

of defense-impulse inquiries cast as formal interpretations (N=32) compared with defense-impulse questions of motive (N=8). These interventions were effective also in eliciting relevant patient amplification. This can also be reflective of supervision and training instruction that it is good technique to interpret defense prior to impulse articulated with an interpretation. One could speculate here that a patient engages in psychotherapy which is a unique relationship in order to explore and attempt to gain understanding concerning inner and outer realities. Patients it appears in this study, despite the ever present resistance, expect to be given interpretations regarding their defenses in terms of how they behave and experience events. A testimony to the ongoing therapeutic alliance lies in the acceptance of such therapist formulations and the subsequent relevant patient amplification. These therapist interventions tactfully articulated and timely delivered safeguard the integrity of the therapeutic process.

It is of interest that the least amount of patient amplification was in response to a therapist question of fact (N=156) which appeared to elicit non-extended verbalizations in most instances.

Also, noteworthy was the finding in this study demonstrating the least amount of patient amplification to be in response to an inquiry in the transference class (N=46). This may be a function of inexperienced therapists attempting to examine the many types of projections placed on

them by the patient which are a blend not only of the achievement of object relationships in early childhood, parental images and the patient's own idealized self-image. In addition, transference is also a function of the capacity for a patient to have a unique type of therapeutic relationship with the therapist which in some instances takes time to develop depending upon the quality of object relationships.

However, the present study, in large part, confirms a finding obtained by Garduk and Haggard (1972), one of the in-treatment studies employing verbatim tapes. Like the present dissertation, Garduk and Haggard found therapist interpretations consisted of more words than do noninterpretations.

#### Limitations

It is apparent from the data presented in this dissertation that there were both variations and consistencies within the therapist sample. One limitation in this present research is that it examined therapists in training for the most part, with only one therapist being in clinical practice. Strupp (1973) discusses how the principal technical differences between experienced and inexperienced therapists concern interpretations, explorations, and passive rejections. Explorations in the form of questions appear to be a sign of inexperience while interpretative statements being the hallmark of intensive psychotherapy are considered suggestive of experience and professionalism.

Another consideration in this study is the diagnostic evaluation of the psychotherapy patient sample. The patients were diagnosed as being a non-psychotic population consisting of borderline, schizoid and depressed types.

#### Suggestions for Further Research

Findings specific to depth of interpretation emerged in this research with the therapist's formal interpretation of resistance and defense-impulse being powerful in terms of patient amplification. Further research on this present data perhaps utilizing the depth of interpretation scale exploring the interpretations, both formal and those of motive, would be of interest. The present data could also be scored with respect to analytic movement (Gill and Paul, unpublished paper).

Research needs to be conducted in the context of psychotherapy utilizing verbatim tapes studying the specific issue of accuracy of interpretation. Such a study might reveal a relationship between accurate interpretations and empathy.

Quantitative research on the patient's transference response is slight. This phenomena needs to be assessed.

Research designed to study the effect played by the therapist sex and perceived authoritativeness is lacking. Most studies are not designed with these variables being prominent.

## APPENDIX A

TESTING AND TRAINING SESSION PROTOCOLS FOR STUDY 1

### Instructions

The raters at the onset were given three (3) training sessions and were asked to judge whether the therapist input fell into one (1) of four (4) classes: formal interpretation, question of motive (a variant of an interpretation), question of fact, and empathic statement. Upon completion of the training sessions the raters were provided with immediate feedback as to correctness. They then proceeded to the testing session where they achieved one hundred percent correctness. At this point, the raters were asked to make similar judgments on the research data (see Appendix B page 88 for additional rating instructions).

#### Rules for the Word Count:

Count the number of words in each remark by the therapist and the patient. Each segment is to have two (2) totals, i.e., one (1) for the T and one (1) for the P.

The rules for the word count are as follows: contractions count as two (2) words; meaningless vocalizations count as one (1) word; if enough of a word has been enunciated to be understood, it is to be counted; and repeated or stuttered words are to be counted the number of times they occurred.

Do not count the words in those sentences that you judge to be empty.

## TRAINING SESSION A

P: It has been a strange two days. I don't know where to begin. A lot of things have been happening to me. The relationship is more messed up than ever before. She says I'm so damn narcissistic and selfish and so involved with myself that she can't stand me anymore.

1. T: uhm

P: I feel that the whole relationship is beyond us and I'm at the point where I can't accept all this nagging and the complaining any longer. I think we are both too self involved.

2. T: Do you think your anger is related to feelings that you may have about making a commitment?

P: I used to believe that I was the type of guy who could drift through life kind of above the normal hassles and every day affairs. A kind of young mystic or whatever who never actually had to get involved with anyone too deeply but you really can't live up to your fantasies.

3. T: It seems that your anger may be related to demands being made on you to satisfy some of your wife's needs.

P: She is so dependent upon me and she is always asking me for support and compliance and to more involvement with her and then she can turn around and come off as so independent.

4. T: You both appear to have problems giving to one another.

P: How true or else how can it be that she says the almost exact same things I say and has the same exact complaints and sees everything the opposite. That is, if I see the situation as her not giving to me, she sees it as me not giving to her. If I see the situation as her acting selfish, she would see it as my being selfish. I know I have a lot of changes to do in the way I relate to people but there is something wrong with me alright but can I find out what it is and face up to it.

5. T: I can understand that this is scary.

P: I can deal with it. I saw my life as being stable for so long and all of a sudden it just falls apart. I feel this should have been over with already and why is it going on again. An endless cycle of finding yourself and losing yourself. I feel so old and yet I am terribly young again. I am again questioning what am I doing in this relationship and in my life. The time is going by so quickly.

6. T: How long have you been in this relationship?

P: One year and two months.

7. T: uhm

P: I do try to commit myself but it seems that whenever I get back into the situation it just falls apart. But you have to see that her grievances about

me are so basically about me and they are not about certain things that I do but they are about me and my attitude, my way of being, my way of relating and whether I act or I don't act just doesn't matter any more.

T: We'll stop here for today.

## CORRECT RESPONSES FOR TRAINING SESSION A

- Segment 1.       Miscellaneous
- Segment 2.       Question of Motive (variant of interpretation)
- Segment 3.       Interpretation
- Segment 4.       Interpretation
- Segment 5.       Empathic Statement
- Segment 6.       Question of Fact
- Segment 7.       Miscellaneous

## TRAINING SESSION B

P: I feel so badly over crying so much here on Monday.

1. T: Perhaps your crying in the last session was because you're finding beginning the therapy so frightening.

P: I don't know if I can talk to you. I don't know if I can trust you or if you can really understand my problems.

2. T: I wonder if you're concerned that I am going to say something that is going to be hurtful to you?

P: Like maybe that's it also. I'm scared to know what's bothering me but I know something is bothering me. And I never expected the whole situation to be like this with me doing all the talking.

3. T: mm uhm

P: I have problems with groups of people and I expect that they will go to reject me in the final analysis but I also realize that I am insecure but the feelings do persist. I am a very insecure person and very neurotic.

4. T: What does neurotic mean to you?

P: I am always afraid and insecure when there is nothing to be concerned with. This I believe is neurotic. I stay up at night and lose sleep if my day is too much for me to take. If my boss is in a bad mood I think it is because I have done something. If

my husband isn't around I have great anxiety that something awful has happened to him. My fears are neurotic and now I am here with a stronger feeling telling a stranger my problems.

5. T: I can see this is painful for you.

P: I don't know what to say except I am in a panic. My marriage is suffering from my emotional turmoil. My husband is sending me here. I am a wreck. I am always uptight and our whole marriage is coming apart. He is fed up with my nervous condition.

6. T: How long have you been married?

P: Three years.

7. T: What is your husband's occupation?

P: Nuclear engineer. He is on a federal contract with private industry and is also a senior faculty member at Embry-Riddle Aeronautical University.

8. T: uhm

P: I need reassurance. I am a person who needs a lot of attention when I am nervous. And lately I am always nervous about something either at home or at work.

9. T: Can you give me an example?

P: If my layouts are not perfect I go into a fit of shaking and crying. I am good at design but to see me come apart you'd think I was incompetent. The slightest hint of criticism sends me into a rage.

10. T: How do you understand this?

P: I don't really. I feel so tense. I feel so embarrassed and self-conscious. I feel so inadequate and it looks on the surface like a paradox as I have a lot of responsibility at work and have things going for me. I am so dependent. Dependent on my husband and on everyone else. Everyone around me.

T: We'll stop here for today.

## CORRECT RESPONSES FOR TRAINING SESSION B

- Segment 1. Interpretation
- Segment 2. Question of Motive (variant of interpretation)
- Segment 3. Miscellaneous
- Segment 4. Question of Motive (variant of interpretation)
- Segment 5. Empathic Statement
- Segment 6. Question of Fact
- Segment 7. Question of Fact
- Segment 8. Miscellaneous
- Segment 9. Question of Fact
- Segment 10. Question of Motive (variant of interpretation)

## TRAINING SESSION C

P: Maybe it is something emotional in its basis but the ENT specialist did find it necessary to give me antibiotics. I was down with a high fever and I can't have this cold anymore. It is getting me so down.

1. T: It could be a coincidence but I've noticed that this cold developed after you phoned up Larry.

P: It was very upsetting to find him so unresponsive but I do see myself at fault for not allowing that relationship to develop. I phoned him up Monday evening.

2. T: When did the cold develop?

P: Late the same Monday night. I was so depressed and disappointed after talking to him. I know it was my fault to begin with as I was too scared to get really close to him and I still find it hard to really understand. The way I acted.

3. T: Do you think you felt vulnerable and needed to protect yourself?

P: I really liked him and some how this made me feel even more insecure and unsure of myself as a person. I saw him as much more worldly a person than anyother man I have known. He had his own apartment which was nicely furnished. He was self-supporting having a good job as a public health administrator. He took me to nice places and was considerate and interesting. I felt so unsure of myself as a person and

I'm only a nursing student. What would he see in me.

4. T: This was scary.

P: I was always scared that I could not measure up and begin to compete with the other females that he has known who have their own apartments and who do not live in a dorm and who are working and doing interesting things with their lives.

5. T: You seem to need to see yourself as an unworthy person who does not have much to offer.

P: I don't know why I would have such a need to put myself down so much. I lack any real confidence in myself and this maybe the reason why I run away. Sometimes when someone is giving me attention and is caring I find myself pulling back from them and feeling really frightened. I have really never been a winner and I have lost out on everything all along so far especially where my sister is concerned. I just couldn't stand being a loser again. I don't see me as a winner. I lose all the time and maybe this one time I've set it up and I admit to this but I lack the confidence in myself to see me as winning anything let alone this man preferring me over the other females who have maybe more.

T: We have to stop for today.

## CORRECT RESPONSES FOR TRAINING SESSION C

- Segment 1. Interpretation
- Segment 2. Question of Fact
- Segment 3. Question of Motive (variant of interpretation)
- Segment 4. Empathic Statement
- Segment 5. Interpretation

## TESTING SESSION

P: I believe that I am losing all my friends. They still bother with me but I think down under it all, I am losing their friendship.

1. T: I wonder how you understand these feelings of losing friends?

P: I am a bother and I am bothered with too many problems. I talk to people about my problems and I later find that I feel like a bother. I am always talking to my girlfriends who live upstairs and I am dependent on them to be there for me to speak to. You see, I think I am worthless as a person and a plain bore.

2. T: This must be very painful.

P: Yes. I often cry by myself. I feel that I complain and demand too much from my friends and this may cause them to give me up some day. I am a third wheel when I accept their invitations as they are mostly dating or coupled.

3. T: You seem to need to see yourself as an unlovable person.

P: I have many such fears which make me depressed. I fear very strongly that I will end up unmarried for life and that people will say behind my back things like, how come an attractive woman like that is not married. I know of such a woman who is very attractive and in her fourties who is single and who is known to

have emotional problems of some sort or other.

4. T: uhm

P: I have emotional problems too. I get very uptight and afraid of the man before the date. I have no problem getting the date but the evening usually is a drag as I am nervous and do dumb things like drop my handbag, step on his foot, and spill drinks and the men don't bother to call me back again.

5. T: How old are you?

P: Twenty six. I'm an old maid at age twenty six. I have bouts of anxiety over being left behind.

6. T: uhm

P: I don't know what to say, I sometimes become very paranoid for no real good reason and then I have a hard time reading reality and knowing what is going on inside of me. I don't know what triggers off such feelings to begin with and then I have so many conflicting opinions about myself as a person. I both like and dislike myself from day to day for no good reason. I am also the type of person who puts her foot in her mouth and is always saying the wrong thing at the wrong time to people.

T: We'll have to stop for today.

## CORRECT RESPONSES FOR TESTING SESSION

- Segment 1. Question of Motive (variant of interpretation)
- Segment 2. Empathic Statement
- Segment 3. Interpretation
- Segment 4. Miscellaneous
- Segment 5. Question of Fact
- Segment 6. Miscellaneous

APPENDIX B  
DEFINITIONS AND INSTRUCTIONS FOR STUDY 1

## INSTRUCTIONS

### Definitions

The four (4) classes of therapist inputs are as follows:

#### Formal Interpretation.

Malan (1962), "an interpretation is defined as an intervention in which the therapist suggests or implies an emotional content in the patient over and above what the patient has already openly stated...." For example, "I believe your anger is related to feelings you may have about your father."

#### Question of Fact.

A probe used to obtain a specific piece of information. For example, "what day did this happen on?"

#### Question of Motive.

A variant of an interpretative intervention. Malan (1962), "...interpretations can be in the form of a question. An example of a 'borderline' interpretation, implying just a little more than the patient said, which is also in the form of a question." For example, "do you think your anger is related to feelings you may have about your father?"

#### Empathic Statement.

This can be described by the following example, "I can understand (or appreciate) ...is difficult for you."

#### Miscellaneous.

Meaningless vocalizations such as, "uhm; mm; um, etc." as well as, those inputs which do not fall into one of the above stated four (4) classes.

## Part I

Once you have determined which of the classes the therapist input falls into you then go on to read the patient's sentences following this input. Using the lined tally sheet, score the patient's sentences in each segment for the presence (1) or absence (0) of the topic indicated in the input. Those sentences pertaining to the topic are to be scored as tallies (1), those which do not pertain to the topic in the therapist input, scored as blanks (0).

Those which can not be scored are to be placed in the miscellaneous category.

## Part II

Now you have to determine the size of the response set. Here the unit of scoring is the sentence. Count each one of the patient sentences following the therapist input up to the occurrence of five (5) empty sentences.

## Part III

### Rules for the Word Count.

Count the number of words in each remark by the therapist and the patient. Each segment is to have two (2) totals, i.e., one (1) for the T and one (1) for the P.

Contractions count as two (2) words; meaningless vocalizations count as one (1) word; if enough of a word has been enunciated to be understood, it is to be counted; and repeated or stuttered words are to be counted the number of times they occurred.

Do not count the words in those sentences that you judge to be empty.

APPENDIX C  
INSTRUCTIONS FOR STUDY 1

InstructionsMiscellaneous Category:

Judge those segments rated as miscellaneous so as to place them into various sub categories as follows:

Reflective	= R	Clarification	= C
Directive	= D	Suggestion	= S
Confrontation	= Con	Advice	= A
Education	= Ed	Verification	= V
Business	= B	Reassurance	= Re
Uhm; mm; um	= ✓		

APPENDIX D  
INSTRUCTIONS AND TRAINING PROTOCOL FOR STUDY 2

### Instructions

The raters at the onset of this second phase were given one (1) training session along with the definitions and were asked to judge whether the therapist interpretative inputs fell into one (1) of four (4) clinical categories: clarification, defense-impulse, resistance, or transference. Upon completion of the training session, the raters were provided with immediate feedback as to correctness with one hundred per cent achievement. At this point the raters were asked to make the same judgments on the research data (see page 98 for additional rating instructions).

## INSTRUCTIONS

Definitions

The four (4) classes of therapist interpretative inputs are as follows:

Resistance.

Statements made by the therapist indicating the patient's overt or covert opposition to the therapeutic process. For example, "It seems as though on the one hand you agree that what I say is valid but you do not seem to derive any help from this." Also, statements made by the therapist such as, "It sounds like you feel that you do not need therapy anymore but you do because there appears to be a number of unanswered questions that you still have."

Clarification.

Statements made by the therapist to crystallize (or define) the patient's thoughts and feelings around a particular subject, to focus the patient's attention on something requiring further investigation and interpretation, to sort out a theme from apparently diversified material, or to summarize the understanding thus far achieved. They may take the form of questions, mild imperatives, or simplified restatements (Colby, 1951). For example, "You are really very unaccepting of your own feelings. You want them all to be different and you can not accept what you want to feel."

Defense-Impulse.

Statements aiming at interpretation or pointing up a de-

fense, such as, "Are you aware of a wish not to think about..." (avoidance). Also, "I wonder if you suspect that your over-reacting and putting the blame too much on other people" (externalization of blame). The fourteen (14) defenses dealt with exclusively in Anna Freud's The Ego and the Mechanisms of Defense (1966).

Transference.

A whole series of psychological experiences is revived as applying to the person of the therapist at the present moment. Statements, such as, "I wonder if you're concerned about impressing me" as well as, "So you naturally think that I too like your past figures will disappoint you."

### Instructions

Those interpretative inputs that are judged to be in the category - Defense-Impulse - ought to be scored according to the fourteen (14) defenses outlined in Anna Freud's The Ego and the Mechanisms of Defense (1966).

#### Classification

Avoidance  
denial  
rationalization  
projection  
repression  
isolation  
undoing  
introjection  
identification  
turning against the self  
reversal  
sublimation  
regression  
reaction formation

Interpretation  
Training Session

P: It's so you won't know. The boy doesn't make any difference, and the girl was so involved that I would rather not go into it.

1. T: I think you are trying to keep things vague and to avoid your specific feelings, and your sense of involvement in them by not giving people's names here.

P: I was so jealous of her. I felt that she was so favored by my mother and even by my friends. And yet she felt so sorry for me! She's so meek and harmless. I feel so sorry for her now because her life is ruined. Why would I want to hurt her? Except that I used to be so jealous of her.

2. T: What did you mean when you said her life is ruined?

P: But this is the absolute core of me.

3. T: So all the more reason to ask why you should keep it out of the therapy.

P: It always happens to me. It's just like with my mother. No, it's really not. I saw through Robert the whole time! They would always say, "trust me!" and yet, they always used me. Both he and my mother, they were such idiots. I want to let myself go with you! That whole deal with Robert was like reliving the whole thing with my mother. He was trying to destroy me with the breast! It was like he was saying, "come and suck," and then, damn! He threw me away as if he were destroying me. I can't trust anyone! And yet

I know that I can with you. But mother and Robert keep coming to mind and it shakes me up! How can Robert be so unadjusted? I have such an urge to cut my wrists whenever I think of him. I think of the blood! It's like he was a nail and he was driving it into me. I bled and bled! He was trying to bring me out and I held back and I could not trust him. It was just like with my mother. He wasn't capable of handling my feelings! And yet he wanted them! But he just wasn't capable. I wonder if this is all reality? It makes me sick to my stomach! Suddenly my hand feels numb! Oh, you can't do this to me! I want to trust you and put myself into you and say, "Here I am, the raw horrible me," but I hate you and I can't stand you. I know that I'm weak, but I've managed somehow up to now.

4. T: So the issue seems to be, am I strong enough to tolerate and accept you and all of your feelings, or am I like Robert and mother, and in that sense, weak and unable to do this.

## CORRECT RESPONSES FOR THE INTERPRETATION TRAINING SESSION

Segment 1.        Defense-Impulse

Segment 2.        Clarification

Segment 3.        Resistance

Segment 4.        Transference

## APPENDIX E

VERBATIM EXCERPTS FROM TYPESCRIPTS OF PSYCHOTHERAPY SESSIONS

FORMAL INTERPRETATION

T: Well, I keep having this feeling that you are thinking of yourself like a thing that doesn't change and you are going to have all this understanding out here like your knowledge of Spanish. And if you don't want to speak Spanish then you won't and if you don't want to change, then you won't. I'm afraid life isn't like that.

T: Yea, but you generally find something. What the pauses mean I guess is that we have run into some sort of impasse. Um that you talk about something as much as you want to or that you have something else you want to talk to and and haven't or you didn't know how to stop the one thing and start the other.

T: Well, anyway, what it suggests is a change of attitude since you have been so serious up until now and now you are much more um (pause) more human. Yea, more human and I'm wondering about that.

T: It is as if you felt that someone was criticizing you or that you would be criticized.

T: And what I hear when you say that is a judgment. That there's something wrong about staying where you are and are you comfortable with that or you shouldn't do it and that there is no choice.

T: And it's very possible that you guessed right and it is also possible that there is something else going on.

T: It seems to me that you've been the one to to feel that anger is particularly difficult to deal with.

T: But I sense a kind of ambivalence about that and on the one hand you kind of like staying where you are and your not too sure that you want to change things and you also are um discontent with things.

T: Well, what you are saying is that your mother comes out there and looks at you and doesn't say anything many times and then you feel that you are under a critical eye.

T: Well, you may experience that your mother feels that you are not doing the best, you are not doing a very good job.

QUESTION OF MOTIVE  
(A VARIANT OF AN INTERPRETATION)

T: Do you think it is like a wish to have a strong man? A strong man to lean on, you know? Maybe what you felt you didn't have?

T: What does masochist mean to you?

T: I'm trying to understand, are you implying that you are leaving therapy because Barbara wants you to?

T: I'm trying to understand how you mean that?

T: And I wonder how comfortable that is? That realization?

T: What would happen if you got angry?

T: Do you think it has any relation to the first thing? Or any relation to your facial expression or are you just presenting a list of complaints?

T: Have you thought of any way if you wanted to make it work that you could do anything now?

T: Yea, I'm saying, your feeling that your mother is out there watching you and rather critically though she's not saying anything?

T: Are there any other people that you would like to prove it to?

T: Well, what for example might you say that you feel so anxious about?

T: Do you realize what you just did?

A QUESTION OF FACT

T: Not before then? Not before six months?

T: Your mother told her that you feel bad about it?

T: What do you mean, they are not tax deductible?

T: Do you have definite plans? Do you have definite plans to start teaching in September?

T: I don't know even how that works. What do you usually do just improvise?

T: Was he very angry when he left home?

T: Can you tell me the details of one of those situations?

T: September of next year?

T: Have you spoken to Derek?

T: mm I thought you had some sort of arrangement with a commercial group?

EMPATHIC STATEMENT

T: That must have been disappointing?

T: You seem to be in great pain.

T: That must hurt you a great deal.

T: No, I can appreciate that.

T: That must have hurt you an awful lot?

T: You are paying a high price.

T: It's difficult but you are doing it.

T: I would imagine that you would have to count to ten a lot of times when you try to reach this hospital. It is a pretty hard place to get through to sometimes.

T: I guess you could never really tell whether if they were making excuses or whether they were really busy. Mmm

T: I don't mean to be critical but you are very sensitive to this.

APPENDIX F  
VERBATIM EXCERPTS FROM TYPESCRIPTS OF  
THERAPIST INTERPRETATIVE INPUTS

RESISTANCE

T: I said, that it seems that the therapy is making you afraid because it is leaving you on your own and you are beginning to doubt and question yourself and your actions.

T: You would find the things that you wouldn't want to change to talk about rather than the things that are distressing you that you want to change.

T: So, you very often haven't seen the point of really coming and meeting with me once a week except maybe to have me as a monitor.

T: And you are coming to doubt yourself. To question yourself.

T: Maybe your only allowing a very small part of yourself to be in the situation like right now and the rest of yourself your hiding or your putting out of the room in some way.

T: Is it that or is it possibly ah not denying that it is a financial burden of some sort, there is something about going to a private therapist, there really is, it adds some form of commitment that I think the V.A. does not provide and I wonder if you are referring to that?

T: Well, you keep saying things like well anyway which makes it very hard for me to answer. Which makes it very hard for you to look into yourself and see what's going on because you want an outside answer and you brush away everything that doesn't fit with what you already believe. So how much are you going to find out?

T: I wonder, does the V.A. in some ways represent to you the image of the old clothes, the West Side, and going to private therapy, feel like you are taking steps to wear your new clothes.

CLARIFICATION

T: You are both probably very hurt at each other.

T: What does that mean to you, the people you love you always hurt?

T: It does seem though that on the one hand you seem to be a little excited about the therapy and on the other hand a little frightened by it also.

T: Feeling that way causes you unhappiness.

T: It strikes me that you would have a great fear that you would fall apart if you got a divorce.

T: Then there is an expectation that you are going to get hurt and some kind of action brings hurt.

T: Yea. How does that make you feel though? Since we have different memories about what happened.

T: How do you feel about that? I take it it comes as something of a surprise.

T: What could anyone have done if you had said, well, I don't see the need for that and I refuse and I won't come.

T: So not only did you feel that she was talking directly to you but it made you angry that she should judge you that way.

T: I think it all has to do with different ways that you feel that you will not expose.

T: It gets mixed in with alot of feelings that just don't seem appropriate.

T: Maybe that's not it, maybe your not trying to forget something, maybe you just have alot of interfering feelings.

T: How do you know? You are not even sure if you should be angry at it or not and you are so sure about he saying that. Something made you angry and you automatically assume that it's a misperception on your part. How do you know, maybe he genuinely said it in a way that is insulting. You can't tell the difference anymore, really.

T: You attributed the repulsion once because she carried around all these sores which you felt that you could in some way catch. But, yet you still feel somewhat repulsed when any one would come close to you either physically or verbally.

T: It could have been handled differently but on the other hand given the limits that they presented to you and the way you handled it, and this is not meant as a criticism, if anything it is meant as a way of showing you that sometimes you can create situations that make you feel hurt.

DEFENSE-IMPULSE

T: And you are just the opposite of what your mother does. (Identification)

T: You are hiding from yourself and you are hiding from people. (Avoidance)

T: I don't mean that. If you are all involved with yourself and thinking about other people observing you and as long as your direction is directed out to other people and when you are not concerned about other people viewing you then you feel comfortable. (Repression)

T: The anger that you feel never gets expressed because you turn it back on yourself and say ah that there's something wrong with me. (Turning Against Self)

T: You are laughing like crazy and I wouldn't know you are feeling uneasy. (Denial)

T: Not to deny what you are saying but I do think your focusing on externals and I think as you know these things are symbolic about your own feelings about yourself. The west side image or the east side image and in some way you are trying to come to grips with it and trying to reconcile it. (Projection)

T: Well, I think there is a relationship but I had a feeling that you thought you were presenting a list of complaints but I think there is a very clear relationship. In each one of those situations some feelings are going on that you will not let yourself be aware of. You will not let yourself show in each one of those situations and it's only later or when you are isolated or when there is no

longer another person involved that you can reflect back on some of those feelings that were being expressed and you say--what me! Because it's so distant.

(Isolation of Affect)

T: You know what amazes me about you that as old as you are and after all this time you just throw your hands up about yourself (patient laughs) I don't know there must be just something about me, don't ask me it's just my face. It's not any important part of me or anything. There's just something about me and you take it very easily.

(Denial)

T: That's your way to deal with a situation about which you have feelings. You might not be angry with her, you might like her and that might be too much for you. I don't know what goes into that shell of yours. You throw that shell up whenever you have strong feelings.

(Isolation of Affect)

T: The whole thing is made up. You have no idea what they are seeing and you are working on all kinds of assumptions of what they are seeing and you are not even checking any of it out.

(Projection)

T: Yea, if you were all intellect and nothing else then you would have no problems but you are not you are a whole person so your feelings get in the way. Well, not in the way, that's a bad way of expressing it. Well, your feelings get in the way, they get expressed indirectly and you are not aware of it at this point because you have made

yourself unaware of your feelings.

(Isolation of Affect)

TRANSFERENCE

T: And, also perhaps the fact you had asked and expected something of me and I really didn't meet that expectation. I have a feeling that maybe you felt that I was deliberately being nasty.

T: Well, there are quite a few areas in which that appears to be unresolved and I think there are quite a few areas that you have opened up. But, when you say something about a successor to me and I wonder how you feel about where you have come in therapy with me and how you feel about beginning with another therapist.

T: Yea, but you mentioned safety and I wondered how you felt here? Have you felt safe here telling me all the things about yourself?

T: It's for my study. But, I wonder again if maybe you feel you cannot trust me.

T: And so you don't have a chance to do what you want to do and to get your wishes met at home and here too.

T: You seem to be looking for a reaction from me.

T: You seem to be expecting to be criticized and taking many things that I say as criticism and it is the talking also about what happened last week with this instance where you might have been angry or gotten angry and I think you may expect me to criticize you.

T: Well, you haven't asked directly for it but then it does seem to be something that you want and in some ways for me to direct, to direct you.

T: The way you are frightened about therapy is the way you are frightened about life and it appears also to be about persons getting close to you.

T: It does seem that you have been wanting to provoke me into telling you what to do.

T: I'm not fighting with you but you may be fighting with me.

T: I wonder if maybe last week wasn't ah my saying that I would not be able to give you ah a change in the time in the schedule, if that was one of those occasions when you thought that I was deliberately trying to get you angry or testing you.

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