Concentration and Correspondence of Transference Interpretations in Short-Term Psychotherapy

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This article provides a review of research on the relationship between aspects of transference interpretation and outcome in dynamic psychotherapy. It also presents the results of a recently completed study that focused on 2 aspects of transference interpretations, concentration and correspondence. Significant relationships between each of these 2 aspects and both therapeutic alliance and outcome were found, as well as an interaction effect for outcome. The relationships differed as a function of the patient personality characteristic known as quality of object relations. The results concerning correspondence were consistent with those of previous studies that investigated the correctness of interpretations. The overall findings suggest that (a) variation in technique may make a difference in brief dynamic therapy and (b) variation and impact of technique may have been masked in some previous studies and reviews.

One of the central and distinguishing technical features of psychoanalytically oriented psychotherapy (subsequently referred to as dynamic therapy) is the interpretation of transference. By interpretation, we refer to the actual statements made by the therapist to the patient in an attempt to enhance the patient's understanding of his or her experiences. This is related to, but distinct from, the therapist's internal process of understanding the patient. In general, the intent of interpretation is to produce an alteration in the patient's intrapsychic conflicts to permit improved functioning (Brenner, 1976). Transference interpretations focus on the patient's reactions to the therapist. They may be, but are not necessarily, linked to the patient's reactions to other important people. This article provides a review of research that has examined the relationship between aspects of transference interpretation and outcome in dynamic therapy. In addition, the results of a study of time-limited therapy that was recently completed in our center is presented.

The investigation of the impact of transference interpretation is an important area in the field of psychotherapy process research. A general problem in this field, which was highlighted by Garfield (1990), is a deficiency of replication and cross-validation of findings; this involves both a scarcity of replication attempts and inconsistent results when replications have been attempted. In recent years, however, some lines of convergence regarding the impact of interpretation have emerged in studies conducted in independent settings. Our article highlights that convergence.

During the past 20 years, increasing importance has been attributed to relationship factors (e.g., therapeutic alliance), compared with technique factors (e.g., interpretation), in explaining the results of psychotherapy. Several types of research findings have been cited to support this position. First, well-known reviews of psychotherapy outcome research of both the box score (Luborsky, Singer, & Luborsky, 1975) and meta-analytic (Smith, Glass, & Miller, 1980) varieties and certain carefully conducted individual studies (Strupp & Hadley, 1979) have reported general success for psychotherapy regardless of the type or, presumably, the technique used. Second, other reviews (Horvath & Symonds, 1991; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988) have identified significant relationships between the patient-therapist alliance and favorable outcome in many studies. Third, as indicated earlier, there has been a deficiency of methodologically strong studies, which have been replicated and cross-validated, that have demonstrated that variation in technique makes a difference. In light of the existing evidence, the burden of proof rests with those who believe in the importance of technique. That is a reasonable conclusion and a challenge.

Yet the evidence used to discount the importance of technique is not without its shortcomings. Box score reviews have reported similar benefits for different therapies; however, small sample sizes and corresponding low statistical power in many of the studies, as well as methodological weaknesses, represent compelling alternative explanations for the nonsignificant findings. The findings for meta-analytic reviews have been based on the extensive averaging of several components. For each measure, each patient's outcome score was averaged with other patients' scores to create an effect size. Then, effect sizes were averaged across measures and across studies to test general hypotheses. In the process of averaging, it is likely that variability caused by other factors (e.g., therapist technique) was obscured. For certain individual studies, the investigators reported considerable variability of outcome among the patients. The tendency...
has been to attribute such variability to patient characteristics (Strupp, 1980). The role of technique, which is often interdependent with patient characteristics, has remained in the background. This may partly be due to the fact that patient characteristics are often easier to measure than technique. Clearly, most of the outcome studies reviewed have not carefully assessed the nature and range of the techniques used.

In studies that have demonstrated significant associations between alliance and outcome, many researchers have relied on patient self-report measures for both types of variables. This raises the possibility that the measures of alliance may, in part, represent early reports of outcome. If so, significant associations should not be surprising. Despite that ambiguity, few would disagree with the notion that a strong alliance is important to the work and outcome of psychotherapy. Similarly, few would argue with the idea that technique and alliance are interdependent and that both should be used in predicting outcome. The position advocated in this article is not that technique has a more important impact on outcome than such factors as patient characteristics and alliance but that technique should not be prematurely rejected as an important variable. What appears to be lacking in the literature is an accumulation of studies with large sample sizes that include careful assessment of technique and outcome, with adequate ranges where other potentially confounding variables (e.g., therapist experience) have been controlled. Also needed are studies that consider the interaction of technique with such factors as patient characteristics and alliance. Some of the studies reviewed in this article meet these conditions.

What the literature provides is an enumeration of a large number of aspects of interpretations that may have an impact on the outcome of dynamic therapy (Sandler, Dare, & Holder, 1971). They include content (e.g., conflictual components), persons (e.g., therapist), correctness (e.g., correspondence with a central conflict), unconscious material, timing, sequencing, linkage, and dosage. Most of these aspects have been offered by clinicians in the context of providing practical guidelines for effective technique (Hammer, 1968; Menninger, 1958; Paul, 1963). Whereas some aspects such as dosage are quantitative in nature, others such as correctness, timing, and sequencing refer to the quality of interpretations. Few aspects have been carefully investigated in clinical outcome studies. This article focuses on only a limited set of aspects. They include the quantitative aspect of dosage and the qualitative aspect of correctness, or in our research, what we have preferred to label as concentration and correspondence, respectively. By studying transference interpretations, we have also chosen to focus on the person of the therapist.

**Transference Interpretation**

Because transference interpretation has been regarded as a hallmark of the technique of dynamic therapy, both the terms transference and interpretation have received considerable attention in the literature. Unfortunately, they have assumed a variety of meanings over the years. In regard to transference, there has been disagreement about what it encompasses and whether additional concepts such as therapeutic alliance or real relationship are required to account for the patient's reaction to the therapist (Ehrenreich, 1989). Similarly, the literature on interpretation suggests a number of possible definitions. Some seem to reflect stages in the evolution of psychoanalytic theory. Rather than contradicting one another, however, they represent complementary perspectives. For example, from the topographical point of view, an interpretation makes the unconscious conscious. From the dynamic point of view, an interpretation makes reference to the components of intrapsychic conflict. Clinicians are able to use both of these definitions to guide their practice, but researchers encounter considerable problems in attempting to use both. That has been our experience because of the difficulty of distinguishing what was conscious from what was unconscious. To achieve a reliable operational definition while maintaining clinical meaningfulness, we adopted the dynamic point of view. In our research, an interpretation was defined as the therapist's reference to the components of intrapsychic conflict.

Although a variety of definitions of transference and interpretation have been provided, there is consensus that the exploration of the patient's transference reaction to the therapist is a unique opportunity for insight and psychic change. Because the transference reaction occurs in the present, the extent to which it is inappropriate can be explored in a situation that is immediate and compelling. Recognition of the importance of transference was originally made by Freud (1912/1958) and later elaborated by Strachey (1934), who outlined a process in which transference interpretations are capable of reversing the patient's "neurotic vicious circle." This involves the patient making a distinction between the analyst and early influential figures. The importance of linking the patient's reactions to the therapist and reactions to parental figures was later emphasized by Malan (1976b) in the area of short-term therapy. Gill (1982) has also written extensively about the importance of transference interpretations, but with a different technical emphasis. He advocates that priority be given to exploring the here-and-now transference reaction to the therapist rather than linking the reaction to its original sources. A similar position has been taken by Strupp and Binder (1984) in regard to short-term therapy.

Because transference interpretation has been regarded as a particularly powerful technique, many who have investigated it have assumed that it would be possible to detect a direct relationship between the use of transference interpretation and the outcome of treatment. In their process-and-outcome model of psychotherapy, Orlinsky and Howard (1986) postulated several intervening variables between therapist interventions and treatment outcome, which they referred to as macro-outcome. The variables included other events during the session (therapy process), events after each session (postsession outcome), and events in the patient's life between sessions (micro-outcome). Their model and review of the literature suggested that the detection of a strong direct relationship between transference interpretation and treatment outcome would be difficult.

**Review of Research Investigating Dosage of Transference Interpretations**

Economic and other practical factors have been influential in sustaining interest in short-term dynamic therapy. Enthusi-
asm about innovations in technique is also evident in the writings of many of the proponents of short-term therapy during the 1970s (Davanloo, 1978; Malan, 1976a; Mann, 1973; Sifneos, 1976). One innovative feature involves the early and active interpretation of transference. An early attempt to provide research justification for this approach was made by Malan (1976b). In a sample of 22 brief-therapy patients, Malan correlated the proportion of transference interpretations relative to all interpretations with the outcome of the treatment. Although that correlation was nonsignificant, he reported finding a significant correlation between the proportion of transference and parental linking (T/P) interpretations and outcome. T/P interpretations indicate the similarity between the patient's reactions to the therapist and the patient's previous reactions to his or her parents. This was an intriguing finding, but its validity remained in question because of serious methodological problems with the study. Marziali and Sullivan (1980) overcame one of the problems (lack of rater blindness) by rerating Malan's data. They did not report findings concerning the relationship between simple (patient-therapist, nonlinked) transference interpretations and outcome but did report confirming the significant relationship between T/P interpretations and outcome.

Marziali (1984) subsequently attempted to replicate Malan's findings in an independent study of 25 patients in brief (20-session) therapy. The study overcame many of the methodological weaknesses of the earlier study. The data were derived from audio recordings, raters were blind to outcome, and data analyses were controlled for pretherapy patient differences. Four main types of outcome variables were included (patient global outcome rating, therapist global outcome rating, patient symptom index and independent assessor dynamic outcome ratings). For simple transference interpretations, no significant correlations were found; as for T/P interpretations, a significant correlation was found for one of the four outcome variables, the dynamic change ratings, which Marziali highlighted as replicating Malan's (1976b) findings. However, because raw frequency rather than proportion of T/P linking was used, it is possible that interpretation was confounded with such variables as the activity or the involvement of the therapist.

Another opportunity to test relationships between transference interpretations and outcome in short-term individual therapy came from a comparative outcome study that W. E. Piper and his colleagues conducted in Montreal (Piper, Debbane, Bienvenu, & Garant, 1984). In one of the conditions of the study, 21 patients were treated with an average of 23 sessions of individual therapy. A reliable system for categorizing interpretations, the Therapist Intervention Rating System (TIRS; Piper, Debbane, de Carufel, & Bienvenu, 1987) was applied to audio recordings of the sessions. According to the TIRS, an interpretation makes reference to one or more dynamic components. A dynamic component is one part of a patient's conflict that exerts an internal force on another aspect of the patient (e.g., wish, anxiety, or defense). The TIRS also assesses the type of object (person) included in the intervention. Proportions of transference and T/P interpretations, as well as interpretations that included reference to other types of persons and linkings, were correlated with many outcome variables from several different sources (Piper, Debbane, Bienvenu, de Carufel, & Garant, 1986). An inverse relationship between simple transference interpretations and improvement in sexual adjustment was found at posttherapy. For T/P interpretations, a direct relationship with overall usefulness as rated by therapist was found at posttherapy, and an inverse relationship with improvement in relationships with friends was found at follow-up. Overall, however, only a few significant correlations were found relative to the total that had been calculated.

The studies reviewed thus far have provided no evidence of a direct relationship between the dosage of simple transference interpretations and favorable outcome, and only weak evidence for such a relationship between T/P interpretations and favorable outcome. Piper et al. (1986) even suggested that inverse relationships may exist for certain outcome variables. To be fair, however, we also note that the sample sizes were small, the dosages of T/P interpretations were low, and variation may have been limited, all of which would have worked against the detection of significant differences. In contrast, the next study (Piper et al., 1991), which was conducted in our center, involved a large sample and a considerable range in dosage of transference interpretations.

The database for the dosage study (Piper, Azim, Joyce, & McCallum, 1991) came from a controlled clinical trial of time-limited, short-term individual psychotherapy that involved the random assignment of 125 patients to immediate treatment or delayed treatment (wait-list) conditions (Piper, Azim, McCallum, & Joyce, 1990). Garfield (1990) has argued that it is wise to establish the efficacy of treatment before expending effort in studying process variables. The clinical trial clearly demonstrated the efficacy of the treatment. The dosage study was based on a sample of 64 of the 86 therapy completers that was well balanced on several variables. The TIRS was used to reliably rate over 22,500 interventions from the sessions of the 64 patients. An intervention was defined as a therapist statement that occurred between patient statements or silences of 30 s or longer. Interventions ranged from brief facilitative remarks to complex statements. The average number of interventions, interpretations, and transference interpretations per session were 44, 11, and 5, respectively.

The transference interpretation dosage variable, which we labeled concentration, was a proportion defined as the frequency of transference interpretations divided by the total number of interventions. A large set of outcome variables was reduced to three factors (general symptoms and dysfunction, individualized objectives, and social-sexual adjustment) by means of a principal-components analysis. Two additional types of variables were measured, a patient characteristic that we have labeled quality of object relations (QOR; Azim, Piper, Segal, Nixon, & Duncan, 1991) and therapeutic alliance. QOR was defined as a person's internal enduring tendency to establish certain types of relationships, ranging from primitive to mature. Therapeutic alliance was defined as the nature of the working relationship between the patient and therapist. Three alliance factors (patient-rated impression, therapist-rated immediate impression, and therapist-rated reflective impression) were derived from a principal-components analysis of ratings of six items that were made by the patient and therapist after each session or each third of therapy.

Table 1 presents correlations between concentration and alliance and between concentration and outcome measured at
posttherapy and at 6-month follow-up. The square of concentration was used in the analyses because curvilinear rather than linear relationships best represented the patterns. The strongest findings involved the high QOR patients. Concentration was significantly (or near significantly) and inversely related to all but two of the therapeutic alliance and outcome factors. None of the correlations for low QOR patients were significant. Because the study was naturalistic rather than experimental in design, more than one causal explanation of the significant correlations is plausible. With regard to alliance, a high concentration of transference interpretations could have weakened the alliance with subsequent negative effects on outcome, a weak alliance could have prompted a high concentration from the therapist, or both could have occurred. Further examination of session material provided evidence that was consistent with both explanations. It was also clear that continuation of a high concentration of transference interpretations could have weakened the alliance with subsequent negative effects on outcome, a weak alliance could have prompted a high concentration from the therapist, or both could have occurred.

**Table I**

<table>
<thead>
<tr>
<th>Sample, r, and n</th>
<th>Therapeutic alliance factors</th>
<th>Posttherapy outcome factors</th>
<th>Follow-up outcome factors</th>
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**Note.** The square of concentration of transference interpretations was used in the correlations. For therapeutic alliance, Factor I = patient-rated impression, Factor II = therapist-rated immediate impression, and Factor III = therapist-rated reflective impression. For outcome, Factor I = general symptoms and dysfunction, Factor II = individualized objectives, and Factor III = social-sexual adjustment. High outcome scores are undesirable. QOR = quality of object relations.

*p < .10. **p < .05. ***p < .01. ****p < .001.

**Review of Research Investigating Correctness of Transference Interpretations**

**Correctness,** among other terms, has been used to refer to the degree to which an interpretation “fits” or “is relevant to” a formulation about the patient. Formulations have typically included the components of recurrent conflicts and maladaptive outcomes in the patient’s life. Other terms that have been used rather than correctness are focality, congruence, suitability, compatibility, accuracy, and correspondence. For practical reasons concerning the need to use time efficiently, there has been a good deal of interest among advocates of time-limited therapy in constructing focused formulations to which interpretations can be addressed. French (1958) was among the first to write about the patient’s “nuclear conflict” and the need for the therapist to address it by means of interpretation. Similarly, Malan (1976a) emphasized the importance of interpreting the patient’s “basic neurotic conflict.” Some proponents of brief therapy have suggested interpreting particular conflict areas such as oedipal issues (Sifneos, 1976) or separation issues (Mann, 1973), whereas others have advocated focusing on the interpersonal aspects of conflict regardless of the specific content area (Strupp & Binder, 1984). Perhaps the first attempt to quantitatively measure correctness can be credited to Luborsky, who developed a rating method for assessing the degree to which the therapist responded to the patient’s main communication (Auerbach & Luborsky, 1968).

Research investigating the correlates of correctness began with Malan’s (1976a) examination of the concept of focality. There have been two meanings associated with this concept that should be distinguished because they have often been confused in the literature. The first meaning concerns focality as a patient characteristic. As such, it is not a representation of correctness of interpretations, because it refers only to the degree to which the patient’s problem can be conceptualized in terms of a focal conflict. Malan (1976a) and others, such as
Sifneos (1976) believe that focality of conflict is an important patient selection criterion for brief therapy. However, when Malan correlated ratings of focality with outcome in his study of 22 patients, the result was nonsignificant. Similar nonsignificant results for focality as a patient predictor were found in two additional studies (Husby, Dahl, Heiberg, Olafsen, & Weisoth, 1985; Piper, de Carufel, & Szkrumelak, 1985). Thus, the evidence to date has indicated that the usefulness of focality as a selection criterion is questionable.

The second meaning concerns focality as a technical variable, which constitutes a representation of correctness. In Malan's terms, it refers to the extent to which the therapist sticks to a single theme or focus for his or her interpretations. Ratings of this variable were significantly correlated with outcome in his study. While Malan's work represents an important beginning in the area of correctness research, the methodology that he used was crude by today's standards. For example, his measure of focality was a global rating applied to a written summary of an entire therapy session. Such ratings are susceptible to other global qualities that characterize "good" and "bad" sessions. In addition, no reliability data were provided for the measure. In contrast, the measures of correctness in the subsequent studies we review were more complex (i.e. comprised several components) and were applied to each of the therapist's interpretations. Considerable efforts were made to establish their reliabilities.

The first of these measures was developed by the Mount Zion Psychotherapy Research Group in San Francisco. The rationale for their measure, as well as the theory associated with the therapy that they provide, is presented in a book by Weiss, Sampson, and the Mount Zion Psychotherapy Research Group (1986). According to the theory, a patient has unconscious pathogenic beliefs that serve to perpetuate symptomatology and maladaptive behavior. The origins of these beliefs are usually attributed to traumatic childhood experiences. It is also assumed that a patient in therapy attempts to test his or her beliefs through interaction with the therapist. Although the patient would like to better understand and disconfirm his beliefs, he or she runs the risk of confirming them. The patient's strategy for disconfirmation is called his or her plan. It is the therapist's task to discover the plan and pass the tests that are presented. To increase the likelihood that this is achieved, the therapist should generate a written plan formulation. The formulation includes four components (patient goals, pathogenic beliefs, tests, and insights). The Mount Zion Group has demonstrated that the components of the plan can be judged reliably (Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Rosenberg, Silberschatz, Curtis, Sampson, & Weiss, 1986). According to these investigators, an interpretation is "correct," or to use their terminology, "suitable," if it is compatible with the patient's plan (i.e., if it passes the test). However, from a consideration of some of the examples that they provide (Silberschatz, Curtis, & Nathans, 1989), it is not entirely clear whether an interpretation to be rated as suitable must strictly pass the test or whether, at times, it might only have to sensitively address the conflicts indicated in the plan formulation.

Silberschatz, Fretter, and Curtis (1986) used their measure to study the relationship between suitability of interpretation and immediate patient productivity. The latter was measured by the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1970) for 3 patients in brief therapy. Following Malan (1976a), an interpretation was defined as an intervention in which the therapist suggested or implied an emotional content in the patient beyond what the patient had already said. A transference interpretation made reference to the patient's feelings about the therapist or the therapy. For all 3 patients, a significant direct relationship between suitability and experiencing was found. For 2 of the patients, no significant relationship between the use of transference interpretations and experiencing was found, but for the third patient, a significant inverse relationship emerged. The investigators also provided anecdotal data that suggested that suitability was positively related to treatment outcome. They believed that their study supported the importance of suitability but were also clear in acknowledging the need to replicate their findings with a larger sample of patients and therapists.

The second of the measures was developed by investigators from the Department of Psychiatry at the University of Pennsylvania in Philadelphia. They defined accuracy of interpretation as the degree of congruence between the content of the patient's Core Conflictual Relationship Theme (CCRT) (Luborsky & Crits-Christoph, 1990) and the content of the therapist's interpretation. The CCRT is a representation of the patient's central relationship patterns. It is derived from narrative episodes provided by the patient concerning his or her relationships. Such narratives are frequently presented in assessment interviews and early therapy sessions. A CCRT specifies three components: the patient's main wishes, needs, or intentions toward other persons; the responses of other persons; and the responses of the self. The process of constructing a CCRT involves several steps. An independent judge reviews some of the patient's narratives and then, through a process of formulation and reformulation, arrives at a specification of the three components. Adequate reliability for the formulations has been demonstrated (Crits-Christoph, Luborsky, Dahl, Popp, Mellon, & Mark, 1988).

Crits-Christoph, Cooper, and Luborsky (1988) used their measure to study the relationship between accuracy of interpretation and therapy outcome for 43 patients in moderate-length (approximately 1 year) therapy. The ratings for accuracy were based on two early-in-treatment sessions. An interpretation was defined as (a) explaining possible reasons for a patient's thoughts, feelings, or behavior; (b) alluding to similarities between the patient's present circumstances and other life experiences; or (c) both. In this study, transference interpretations were not distinguished from nontransference interpretations. Two composite outcome variables were constructed. One was a residual gain score derived from adjustment ratings provided by the patient and a clinical observer, and the other was a rated-benefit score based on ratings by the patient and the therapist. The two were highly correlated. The investigators found a significant direct relationship between accuracy (reflecting two combined CCRT components, wish and response from others) and treatment outcome. The relationship held even when therapeutic alliance and errors in technique variables were partialled out. Crits-Christoph et al. concluded that the results were consistent with the principle that correctly addressing the patient's pattern of wishes and responses of others is an effective tech-
Edmonton Correspondence of Transference Interpretation Study

The third of the measures was developed in our research center. As indicated earlier, after investigating the relationships between the concentration (proportion) of transference interpretations and both therapeutic alliance and treatment outcome, we sought to investigate correctness. We wanted to know whether the two variables were confounded, but we were also interested in studying the relationship between correctness, either as a single variable or in interaction with concentration, and both therapeutic alliance and treatment outcome. We did not have plan formulations or CCRT formulations for the patients from which we could derive a measure of correctness, but we did have a psychodynamic formulation that had been constructed by each patient’s therapist after the first two therapy sessions. The therapist had described a repetitive conflict for the patient that involved similar maladaptive outcomes and similar objects (types of people).

The derivation of an accuracy score involved several steps. From each formulation, which was in the form of a narrative, A. S. Joyce extracted information about five topics: (a) patient wishes and needs, (b) patient anxieties and fears, (c) patient defensive processes, (d) patient maladaptive outcomes, and (e) objects. The reliability of this process of extraction was checked by having an independent judge perform the process with 12 cases. A third judge rated the agreement between the two extractions for each of the five areas. Agreement across the five areas averaged 86% (range, 75%–92%). We defined correctness, which we preferred to call correspondence, as the degree of correspondence between the content of the interpretation and the content of the therapist’s formulation (Joyce, 1991). An independent judge rated the degree of correspondence using a 3-point rating scale (1 = no, 2 = moderate, and 3 = strong) with half-point ratings permitted. In our study, we were interested in the correspondence of transference interpretations. Because the therapist as object was not included in the therapist’s formulation, the degree of correspondence for transference interpretations focused only on the first four areas of the formulation. The object (person) of the therapist could take the role of any relationship pattern explained in the formulation.

The information extracted from one of the therapist’s formulations and actual examples of high and low correspondence transference interpretations from the therapy of the patient, a 28-year-old woman, are provided.

Wishes: 1. Wishes to be dependent on others, have others care for her and make decisions for her and thereby show their love for her.
2. Wishes for mother to show her love.

Anxieties: 1. Terrified of involvement as she becomes over-involved—consumed by it to the exclusion of any other activity.
2. Afraid she’ll be punished by someone for her over-attachment because she has taken that person away from others who need them, i.e. fearful of reprisal from others.

Defensive processes:
1. Has brought her life to a standstill; doing very little dating, work, school, or other activity—little involvement in normal activities.
2. Becomes over-involved with others to the exclusion of other relationships or activities.

Maladaptive outcomes:
1. Feeling depressed, nonproductive and uninvolved.
2. Crying
3. Repeatedly feeling disappointed by significant others.

Objects:
1. Mother
2. Father
3. Boyfriends
4. Bosses
5. Male siblings
6. “Mother substitutes,” others.

Interpretation 1. “It makes a great deal of sense. You have been looking for someone all your life to tell you how to do things, and if it’s right or wrong. I’m no different. In fact, it’s very clear that you wish for someone to do it as you wanted your mother to do things for you, which she did not.” This interpretation received the maximal correspondence rating of 3 because of the strong correspondence to the wish in the formulation.

Interpretation 2. “It’s very terrifying for you to even hear me say that your father’s wishes for you and your mother’s wishes for you were contradictory.” This interpretation received the minimal correspondence rating of 1 because of the lack of correspondence between the fears identified in the interpretation and the formulation.

Correspondence ratings were made for the same set of transference interpretations that were in the concentration study. The sample included 2,381 transference interpretations from approximately 22,500 interventions that had been made during 8 of the 20 therapy sessions for each of the 64 patients. To investigate rater reliability, a second judge independently rated correspondence for all transference interpretations for 16 randomly selected patients—a quarter of the sample. An intraclass correlation coefficient (ICC; 2, 1) was calculated for each of the 16 patients. The average ICC was .60 (SD = .21; range, .10–.96), which indicated moderate reliability. One factor that worked against a higher ICC was a large number of “no correspondence” ratings, 60% for the first judge and 72% for the second. Even with this basement effect, reliability was reasonable. The average correspondence rating for all transference interpretations was 1.46 (SD = .25; range, 1.0–3.0).

We first examined the relationship between concentration and correspondence. Pearson product–moment correlation coefficients for the two variables were low and nonsignificant for high-QOR patients, r(30) = .10, low-QOR patients, r(30) = .21, and all 64 patients, r(62) = .14, which indicated considerable independence. Thus, concentration was not confounded by correspondence in the previous study. That alleviated our concern that the interpretations given in high concentration had perhaps been of low correspondence. The independence also facilitated the multivariate analyses that are reported below.

Before conducting the multivariate analyses, we conducted a
set of univariate correlations between correspondence and alliance and between correspondence and outcome measured at posttherapy and at 6-month follow-up. The results are reported in Table 2. For concentration findings, the results differed for high- and low-QOR patients. For low-QOR patients, significant inverse relationships with the patient- and therapist-rated reflective alliance factors were found. In addition, a significant inverse relationship with favorable outcome regarding individualized objectives was found at follow-up. For high-QOR patients, no significant relationships with the alliance or posttherapy outcome factors were found. However, a significant direct relationship with favorable outcome regarding general symptoms and dysfunction was found at follow-up.

The inverse relationships between correspondence and both alliance and follow-up outcome for low-QOR patients represented new findings. Again, because of their correlational nature, the findings are open to more than one explanation. Low-QOR patients, who report a history of relatively nongratifying relationships, may be more in need of forming a gratifying relationship with the therapist than exploring their pattern of nongratifying relationships in therapy. Accordingly, high correspondence by emphasizing similarities between past abusive relationships and the current transference could weaken the alliance. Alternatively, a weak alliance could elicit high correspondence by the therapist in an effort to encourage work. In regard to follow-up outcome, high-QOR patients, in contrast to low-QOR patients, may continue to recognize and work through transference projections beyond the therapy sessions because of their ability to incorporate the analytic function of the therapist during therapy. For the low-QOR patients, consideration of the therapist as another nongratifying object may render them feeling criticized, rejected, or abandoned during and after therapy, which contributes to a poorer outcome. Thus, it is perhaps most beneficial for high-QOR patients to use the therapeutic relationship to appreciate their not all relationships need to be abusive. These explanations are, of course, tentative and in need of future verification.

Next, a series of hierarchical, multiple-regression analyses were conducted. For each analysis, the independent variables were concentration, correspondence, and the interaction (product) of the two single variables, with the dependent variable being one of the alliance, posttherapy outcome, or follow-up outcome factors. The analyses were conducted separately for high-QOR and low-QOR patients. The analyses, which were clearly exploratory in nature, allowed us to determine several things: (a) whether either single variable (correspondence) was a significant predictor, (b) whether the other single variable significantly improved the prediction, and (c) whether the interaction (product) significantly improved the prediction after the effects of the single variables had been accounted for.

For all of the therapeutic alliance factors and the posttherapy outcome factors, the multiple regression analyses did not provide any new information. Univariate (i.e., single variable) predictions were not significantly enhanced by addition of the second single variable or by addition of the interaction product. That was also true for the follow-up outcome factors in the case of the low-QOR patients. In contrast, new information was obtained for the first follow-up outcome factor (general symptoms and dysfunction) in the case of high-QOR patients. The regression results are presented in Table 3. At Step 1, correspondence accounted for 15% of the variance; at Step 2, concentration accounted for an additional 18%, and at Step 3, the interaction product accounted for an additional 10%, for a total of 43% of the variance, which is substantial.

Methods for examining the interaction of continuous variables in regression analyses as described by Cohen and Cohen (1983) and by Aiken and West (1991) were used to interpret the results. Figure 1 illustrates the pattern. As the level of concentration decreased, correspondence changed from having a negative effect to having a positive effect on outcome. The slope of the regression line for low concentration significantly differed.

Table 2
Correlations Between Correspondence of Transference Interpretations and Therapeutic Alliance Factors, Posttherapy Outcome Factors, and Follow-Up Outcome Factors

<table>
<thead>
<tr>
<th>Sample, r, and n</th>
<th>Therapeutic alliance factors</th>
<th>Posttherapy outcome factors</th>
<th>Follow-up outcome factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>III</td>
</tr>
<tr>
<td>High QOR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r</td>
<td>.08</td>
<td>-.21</td>
<td>-.13</td>
</tr>
<tr>
<td>n</td>
<td>32</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Low QOR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r</td>
<td>-.37**</td>
<td>-.04</td>
<td>-.37**</td>
</tr>
<tr>
<td>n</td>
<td>32</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r</td>
<td>-.10</td>
<td>-.14</td>
<td>-.23*</td>
</tr>
<tr>
<td>n</td>
<td>64</td>
<td>64</td>
<td>64</td>
</tr>
</tbody>
</table>

Note. For therapeutic alliance, Factor I = patient-related impression, Factor II = therapist-rated immediate impression, and Factor III = therapist-rated reflective impression. For outcome, Factor I = general symptoms and dysfunction, Factor II = individualized objectives, and Factor III = social-sexual adjustment. High outcome scores are undesirable. QOR = quality of object relations.

* p < .10. ** p < .05.
The findings suggest that, in the interest of interpersonal functioning (Piper, Azim, Joyce, McCallum, Nixon, & Segal, 1991), better predictor of alliance and outcome than measures of reality variable, which represents the quality of the patient's life-time pattern of relationships, has previously been shown to be a distinct concept, each of which is significantly related to certain forms of therapeutic alliance and treatment outcome. The study also indicated that the relationships differed according to whether patients were low or high on QOR. This personality variable, which represents the quality of the patient's lifelong pattern of relationships, has previously been shown to be a better predictor of alliance and outcome than measures of recent interpersonal functioning (Piper, Azim, Joyce, McCallum, Nixon, & Segal, 1991).

The clinical implications of our findings must remain tentative at this stage. The findings suggest that, in the interest of enhancing favorable outcome in brief therapy, therapists might consider providing low concentrations of highly correspondent transference interpretations to high-QOR patients and avoiding highly correspondent transference interpretations to low-QOR patients. However, as we have noted, our studies have focused on only a limited set of variables that characterize therapist interventions. Concentration and correspondence are but two representations of the quantity and quality of interpretations. An interpretation of high correspondence may also be of low quality on other criteria such as timing or sequencing. The context in which interpretations are provided is extremely important, a point that clinicians have made for many years and an area that psychotherapy process researchers have begun to investigate. Future work in this area should provide an even stronger predictive model.

In reference to all of the studies reviewed, there appears to be greater convergence of findings for the variable correctness. The more recent studies have provided data from three independent settings (San Francisco, California; Philadelphia, Pennsylvania; and Edmonton, Canada) that indicate a direct relationship between correctness and favorable process or outcome for certain types of patients. These findings are consistent with those previously reported by Malan (1976a). The convergence is more representative of cross-validation than replication because the definitions and measures of correctness have varied.

An important difference between our measure and those of others is the use of the therapist rather than a team of independent assessors to generate the patient formulation. Given that it is the therapist who actually makes the interpretations, we believe that our method has an advantage in terms of clinical applicability.

Whether our measure has an advantage in regard to predictive validity remains to be demonstrated. Future research that compares the validity of the different concepts and measures would be useful. Another worthwhile topic for future research concerns the advisability of changing the patient's formulation and the corresponding focus of interpretations as therapy progresses.

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Table 3
Multiple Regression Results for Follow-Up Outcome Factor I (General Symptomatology and Dysfunction) for Patients With High Quality of Object Relations

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>R</th>
<th>R²</th>
<th>Overall F ratio</th>
<th>Partial F ratio for the added variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correspondence</td>
<td>.39</td>
<td>.15</td>
<td>4.52*</td>
<td></td>
</tr>
<tr>
<td>Concentration</td>
<td>.57</td>
<td>.33</td>
<td>5.86**</td>
<td>6.26*</td>
</tr>
<tr>
<td>Interaction product</td>
<td>.66</td>
<td>.43</td>
<td>5.84**</td>
<td>4.22**</td>
</tr>
</tbody>
</table>

Note. The relationship between favorable outcome on Factor I and correspondence was direct, whereas the relationship between favorable outcome on Factor I and concentration was inverse. * p < .05. ** p < .01.

from 0 (p < .01), the slope of the regression line for average concentration almost significantly differed from 0 (p < .06), but the slope of the regression line for high concentration did not. Thus, the best follow-up outcome was associated with low concentration and high correspondence. For correspondence (or what can generally be regarded as correctness in transference interpretations) to have a favorable effect, a less concentrated use of transference interpretations may be required. Although intriguing, because of the number of variables and regression analyses, the significant results must be interpreted with caution and regarded as tentative until replicated.

Discussion

In the course of reviewing clinical investigations of the relationship between the use of transference interpretations and outcome in dynamic therapy, several impressions have emerged. In general, few studies have been conducted, particularly those with large samples, large ranges for the variables, and controls for possible confounding factors. The studies that have been conducted have tended to focus on short-term rather than long-term dynamic therapy. In regard to design, the studies have been correlational rather than experimental, which has increased the number of potential explanations for the findings. In addition, the impact of other variables (e.g., patient characteristics) has been identified as important. Finally, more recent studies are considerably stronger than earlier studies in regard to methodology.

From the more recent studies, two characteristics of transference interpretations have been highlighted—dosage and correctness. The results of our present study suggest that the two are distinct concepts, each of which is significantly related to certain forms of therapeutic alliance and treatment outcome. The study also indicated that the relationships differed according to whether patients were low or high on QOR. This personality variable, which represents the quality of the patient's lifelong pattern of relationships, has previously been shown to be a better predictor of alliance and outcome than measures of recent interpersonal functioning (Piper, Azim, Joyce, McCallum, Nixon, & Segal, 1991).

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Figure 1. Interaction of correspondence and concentration for follow-up Factor I.
ceeds. Hatcher, Huebner, & Zakin (1986) have provided data that indicate that formulations do change during time-limited therapy. The implication for research concerning correctness is that the criterion for correctness should change as therapy progresses. In more intensive psychotherapy, particularly psychoanalysis, such a strategy would seem to be even more imperative.

Overall, we believe that the findings reviewed indicate that variation in technique may make a difference in brief dynamic therapy. It is likely that variability in technique and its effects have been masked in some previous studies and reviews. Thus, the effects of appropriate technique and inappropriate technique may have cancelled each other out. In addition to the technical characteristics highlighted in this article, there are others (e.g., timing and sequencing) that are of potential theoretical and practical importance that have not been carefully investigated in any large-scale studies. If studied, they too will need to be examined in the context of other potentially interacting variables.

References


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