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HOW THE PATIENT'S PLAN RELATES TO THE CONCEPT OF TRANSFERENCE

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Inconsistent findings in previous studies of interpretations have resulted from the confounding of categories of interpretations with accuracy of interpretations. This study adds two new patient process measures (Insight and Referential Activity) to our original study (Fretter, 1984; Silberschatz, Fretter, & Curtis, 1986) and consistently demonstrates that accuracy (as measured by Plan Compatibility) is a significant predictor of three patients' immediate progress in brief dynamic psychotherapy, whereas category (transference versus nontransference) is not. The theoretical concept of transference is translated into the concept of the Plan. Finally, a clinical case taken from the empirical study is presented to illustrate our theoretical point that the power of the Plan lies in its case-specific ability to address multiple aspects of the patient's many transferences whether or not they are directed explicitly toward the therapist.

The concept of the patient's Plan derives from a psychodynamic theory of therapy developed by Weiss (1986) and empirically studied by Weiss, Sampson, and the Mount Zion Psychotherapy Research Group (1986). Weiss proposes that psychopathology stems from unconscious pathogenic beliefs of danger if the patient were to pursue certain important developmental goals. These pathogenic beliefs are irrational, painful, and based on childhood experiences. According to Weiss, the patient enters therapy with a Plan that is a flexible strategy for testing these pathogenic beliefs in relation to the therapist in the hope of disconfirming them and using the therapist's interpretations to acquire insight into them. The patient will benefit from interpretations that are compatible with the patient's Plan, thereby disconfirming the pathogenic beliefs that serve as obstacles to the attainment of the patient's goals.

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Parts of this paper were given in two presentations at the 19th Annual Meeting of the Society for Psychotherapy Research, Santa Fe, New Mexico (June 1988): "The Plan—Better than Transference?—or a Measure of Transference?" and "The Immediate Effects of Interpretations on Referential Activity as a Measure of Three Patients' Progress."

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The Plan has proven to be a powerful instrument for both research and clinical purposes, for although the Plan resides within the patient, it can be inferred by clinicians trained in the theory. This feature allows the Plan to be used not only by therapists treating patients but also by outside clinicians interested in objectively investigating the process and outcome of recorded psychotherapies of any theoretical orientation. By following closely the verbatim transcripts of the earliest therapy sessions, trained clinical judges can reliably infer what the patient's goals are for treatment, what pathogenic beliefs are obstructing the attainment of those goals, how the patient will likely test the therapist to disconfirm these beliefs, and what insights might be useful for that particular patient. Used in this way, as a research tool, the Plan can then be applied to completed psychotherapies of many theoretical orientations and is in no way limited to the theory from which it derives.

In this article we describe how we used the Plan as a research tool to study the immediate effects of therapists' interpretations (transference and nontransference) on three patients' progress in brief, psychodynamic therapy. The Plan provided a case-specific method for evaluating what had, until recently, been unmeasurable in psychotherapy research—the quality, accuracy, or suitability of therapist interventions. The Plan provided us with a standard—a ruler—against which the therapist's interventions could be compared to evaluate the goodness-of-fit of each intervention for each particular patient. Recently, researchers from other theoretical orientations have focused on developing their own instruments for including the variable of accuracy of interpretations (Crits-Christoph, Cooper, & Luborsky, 1988; Crits-Christoph, Luborsky, Dahl, Popp, Mellon, & Mark, 1988); some have focused on the categories of interpretations (Piper, Azim, Joyce, & McCallum, 1991; Piper, Debbane, Bienvenu, de Carufel, & Garant, 1986; Piper, Debbane, de Carufel, & Bienvenu, 1987); some have investigated both (Fried, Crits-Christoph, & Luborsky, 1992; Crits-Christoph, Demorest, & Connolly, 1990; Horowitz, 1987; 1991; Luborsky & Crits-Christoph, 1990; Luborsky, Crits-Christoph, & Mellon, 1986; Perry, 1989; Perry, Luborsky, Silberschatz, & Popp, 1989; Strupp & Binder, 1984).

BACKGROUND

Although the interpretation and the transference interpretation have maintained central positions within the psychoanalytic theory of therapy since Freud's first clinical observations, until recently the few empirical studies of their effects on the patient in treatment yielded inconsistent and contradictory results (Bergman, 1951; Butler, 1988; Claiborn, 1982; Dittman, 1952; Garduk & Haggard, 1972; Hill, Carter, & O'Farrell, 1983; Malan, 1963; 1976; Marziali, 1984; McCullough, 1988; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). The common methodological problem shared by these studies was a failure to assess the goodness-of-fit between the therapist's interpretations and the patient's particular problems. Unable to reach agreement on the psychodynamic formulations that might measure this critical variable (Seitz, 1966), these previous researchers studied categories or types of interventions that could be measured, such as noninterpretations, interpretations, transference interpretations. Rather than focusing on the quality (or goodness-of-fit) or suitability of the interventions, these studies focused on quantities: Some counted frequencies of the various categories and some focused on depth of interpretations; but because none included the vital variable of suitability, they constantly confounded the suitability of the interpretations with these other categories.

In our earlier study (Fretter, 1984; Silberschatz, Fretter, Curtis, 1986) of the verbatim transcripts of three patients treated in brief psychodynamic therapy, we solved this problem by using the Patient's Plan Diagnosis (the Plan) as a case-specific measure of the suitability of therapist interpretations for the particular problems of each particular patient. By incorporating this measure of case-specific suitability of interpretations while investigating the immediate effects on the patient of a central category of interpretation (transference versus nontransference), we were able to distinguish the relative contributions of these previously confounded variables.

The results showed across all three cases that although suitability of interpretations (Plan Compatibility) was consistently able to account for significant variations in immediate patient progress, category of interpretations (transference versus nontransference) was unable to account for any significant variation in such progress. Contrary to what might have been expected based on the theoretical centrality of the transference interpretation in brief (Davanloo, 1978; Malan, 1963; 1976; Marziali, 1984; Sifneos, 1979), as well as long-term psychodynamic therapy, there were no significant differences in immediate patient progress following transference versus nontransference interpretations. In contrast, across all three cases, patients progressed significantly following interpretations that were compatible with the Plan and decreased significantly in progress following interpretations that were incompatible with the Plan. Furthermore, some data suggested that therapies with a higher proportion of plan-compatible interpretations might yield better treatment outcomes, because each case reflected either an excellent, good, or poor outcome and each of these cases respectively contained a proportional number of plan-compatible interpretations.

In this article we present new results of two additional patient progress measures that were applied to the data from the original study. Furthermore, we discuss the clinical implications of our findings regarding the relative power of plan-compatible interpretations and transference interpretations to contribute to patient progress. Our discussion addresses the important issue of how the patient's Plan actually relates to the concept of transference. We will show how the concept of Plan Compatibility is far from irrelevant to the psychoanalytic concept of transference. Instead, the Plan can be viewed as a highly sensitive, individually tailored formulation for addressing multiple aspects of the patient's transferences in a more comprehensive and, at the same time, more articulate way than other descriptions of transference.

METHOD

SUBJECTS

Patients. This study was conducted ex post facto on the verbatim transcripts of three audio-recorded psychotherapies randomly selected from the larger Brief Therapy Research Project at Mount Zion Hospital and Medical Center (N.I.M.H. Grant #35230). All potential patients were screened by an independent evaluator who accepted adult patients with (1) a history of positive interpersonal relationships; (2) no evidence of psychosis, organic brain syndrome, or mental deficiency; and (3) no evidence of serious substance abuse or suicidal or homicidal potential.

Pre- and posttherapy assessments were made for each patient based on standard psychotherapy outcome measures that included the patients' own ratings of changes as well as ratings by the therapist and the independent evaluator. Based on these

measures, the three patients selected for this study reflected a range of treatment outcomes from excellent to good to poor. On the basis of clinical intake interviews and self-report measures, each of these patients was diagnosed as suffering from chronic, neurotic depression, or dysthymic disorder (Diagnostic and Statistical Manual of Mental Disorders, DSM-III, American Psychiatric Association, 1980).

Therapists. The therapists participating in the project were experienced (at least three years of private practice) psychologists and psychiatrists with a general "psychodynamic orientation." They had also received specialized training in brief psychodynamic therapy. Patients were assigned to therapists on a random basis and there was no attempt to match patient and therapist.

Prior to treatment, the therapists knew nothing of the patients except that they had been accepted for brief therapy (16 weekly sessions). The therapists had no access to any formulations of the patients' Plans. The therapists were unaware of what we were studying, and they conducted the therapies as they would normally carry them out. The research was done directly from the verbatim transcripts of the completed cases only after the therapies were finished.

OVERVIEW OF PROCEDURE

In our study of the immediate effects of interpretations on patients' progress we first investigated the extent to which the category of interpretation would account for the patients' immediate progress. Since the transference interpretation is reputed to be the most mutative of all interpretations, we selected the transference versus nontransference category for this study. In our second analysis we combined all the interpretations without regard to the transference or nontransference category and assessed the degree to which the quality, suitability, or the Plan Compatibility of the interpretation was related to the patients' immediate progress.

To measure these variables, three separate sets of independent clinical judges evaluated the verbatim data and provided all the clinical ratings used in the study. The first set of judges identified all transference and nontransference interpretations by reading the entire verbatim transcript of each case. Then all transference interpretations plus the nontransference comparison interpretations were isolated from the transcript and presented in random order to the second set of independent clinical judges for rating the suitability of these interpretations. This second set of judges utilized the Plan that was devised for each of the three cases. The third set of judges evaluated the patients' immediate progress following interpretations. Segments of patient speech, both preceding (baseline) and following (effect) the selected interpretations were isolated from the transcript and presented in random order to the patient progress judges. In the original study, judges rated these segments using the Experiencing Scale (EXP; Klein, Mathieu, Gendlin, & Kiesler, 1970). In the present study two separate groups of judges applied new patient process scales.

MEASURES

IDENTIFYING TRANSFERENCE INTERPRETATIONS

All therapist interventions were categorized according to the typology devised by Malan (1963; 1976; see also Marziali, 1984; Marziali & Sullivan, 1980). Four

clinical psychology graduate students applied the typology to the complete verbatim transcript of each therapy. Every therapist intervention (i.e., any therapist comment) was categorized as an interpretation or a noninterpretation (N) depending upon whether or not it added an emotional content above and beyond what the patient had already said. All interpretations were then categorized as either transference or nontransference according to the person toward whom the interpretation was directed. The transference category (T) included all interpretations about the patients' feelings about the therapist or the therapy. The nontransference categories included interpretations about the parent or sibling (P), a significant other (O), or the patients' feelings about themselves (U). All transference interpretations and the most frequently occurring category of nontransference interpretations in each case were studied.

In addition to categorizing interpretations, these judges also indicated briefly for each transference and comparison interpretation the context necessary for evaluating the suitability of the interpretations when these would be presented in a random order to Plan Compatibility judges.

ASSESSING PLAN COMPATIBILITY

Assessing Plan Compatibility requires clinical judges to (1) study the Plan formulation for each particular patient and (2) rate each selected interpretation from that particular case on the Plan Compatibility of Intervention Scale (PCIS; Caston, 1980). Each patient's particular Plan is used as a standard against which the therapist's interpretations can be compared in order to determine the Plan Compatibility of each interpretation on the PCIS. The PCIS is a 7-point Likert scale ranging from -3 (strongly antiplan) to $+3$ (strongly proplan) with 0 as the midpoint containing both pro and antiplan aspects.

The Plan Compatibility judges were experienced psychologists and psychiatrists who were trained in our theoretical model. For each case, four to six judges received a Plan formulation, all the selected interpretations, and a copy of the PCIS. The selected interpretations were isolated from the transcript and randomized so that the judges could evaluate how compatible the interpretations were with the Plan without being biased by the patients' responses to the interpretations. The context necessary for this task was included with each interpretation.

Plan formulations were prepared for each of the three cases by a team of five experienced clinicians using the transcripts of the intake interview plus the first two sessions of each treatment as part of a prior study determining the reliabilities of dynamic case formulations (Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Rosenberg, Silberschatz, Curtis, Sampson, & Weiss, 1986). In the Discussion below, we present excerpts from the "Linda" Plan (Case 2) to demonstrate the clinical complexity of this instrument as well as to illustrate how the patient's Plan relates to the concept of transference.

MEASURING PATIENTS' IMMEDIATE RESPONSES TO INTERPRETATION

Immediate patient progress was measured by applying the two new process scales to the preinterpretation (baseline) and postinterpretation (effect) segments of patient speech. Before applying these scales, all segments of patients' speech were isolated from the transcript and randomized for presentation to the clinical judges. Thus the judges were blind to where the segments occurred in the therapy, to what

the interpretation was, and to whether the segment was baseline or effect. Segments consisted of as much patient speech as possible before another interpretation by the therapist and averaged 3 to 5 minutes in length.

The Morgan (1977) Patient Insight Scale. Morgan's (1977) Patient Insight Scale measures the degree of insight in each of seven types of behavior drawn from psychoanalytic and other literature. The construction of the scale was influenced by Reid and Finesinger's (1952) definition of emotional insight and has been used as a measure of patient process in treatment (Morgan, 1977; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). Each segment of patient speech is scored on seven scales that reflect that the patient can recognize (1) relevant ideas, affects, or behaviors; (2) habitual patterns of behavior; (3) playing an active rather than passive role; (4) connections between problems; (5) repressed thoughts, feelings, or impulses; (6) cause and effect, learning from experience; and (7) that psychological experience is cumulative. Broitman (1985) revised the scale by adding an eighth scale called Global Insight, which was scored for each segment following the previous scales.

The Referential Activity (RA) Scale. RA is a linguistic measure that has demonstrated usefulness in predicting outcome variables from patients' early memories reported prior to treatment (Von Korff, 1987). Another study found higher RA levels in analytic sessions classified as "work" as opposed to "resistance" sessions (Dahl, 1972; Bucci, 1988).

The scale is derived from the dual code theory of mental representations (Bucci, 1989). According to this model, which is based on formulations from cognitive psychology (Bower, 1970; Paivio, 1971; 1978), experience registers in the mind in two different formats: nonverbal and verbal. The two separate systems are connected by a complex system of referential links. RA is defined as activity of the system of referential connections between the verbal and nonverbal representations; the latter include imagery in all sense modalities, perception, emotion, and somatic experience. The referential connections are bidirectional, thereby permitting both the translation of experience into words by the speaker and the translation of words back to experience in the listener's mind. From this perspective, the goal of psychotherapy is to reach the experiential and emotional structures of the nonverbal system: The effectiveness of therapy depends upon the operation of the referential connections that link the words spoken in the session to the nonverbal emotional structures. Facilitating the referential process should facilitate change in the nonverbal schemata, which is what is meant by structural change (Bucci, 1985).

The basic measures of RA are scales that rate the linguistic qualities of Sensory Concreteness, Specificity, Clarity, and Imagery of speech, because these qualities have been found to be operational indicators reflecting connection to imagery and emotional structures (Paivio, 1971, 1986). These dimensions are all interpreted as manifestations of the same underlying dimension: the closeness of the connections between language and the nonverbal representational system. Each dimension is rated on a scale of 0–10 and a global score represents the mean rating of all the dimensions combined. Language that is high on these dimensions is rich in concrete sensory detail and has a quality of immediacy, as if the speaker is reliving the experience in imagination; such language makes the experience come alive for the listener as well as the reader. Language that is low on these dimensions will sound abstract, general, and vague, lacking in specific and concrete detail, and will fail to evoke imagery in the listener (Bucci, 1985).

TRAINING AND INTERRATER RELIABILITIES

Broitman (1985) trained nine experienced, psychodynamically oriented clinicians to apply the revised Morgan Insight Scale to the original training segments utilized by Morgan (1977). Subsequently, judges received specialized training applying the scales to segments from brief dynamic psychotherapies. Broitman (1985) obtained excellent interjudge reliabilities on all three cases for this study with means of the nine judges ratings (coefficient alpha) ranging from .81 to .95. The interitem correlations among the scales ranged from .82 to .98. The interitem correlations among Global Insight and all other items ranged from .88 to .98. Since this Global Insight appeared to capture so much of the information in the other scales, it was used for all data analyses.

Bucci trained three psychology graduate students as described in the manual of Instructions for Scoring RA in Transcripts of Spoken Narrative Texts (Bucci, 1987). Interjudge reliabilities for the Global RA scores on all three cases were good with measures of the means of the three judges ratings (coefficient alpha) ranging from .65 to .75.

The reliabilities for all scales used in the original study were excellent and were reported elsewhere (Fretter, 1984; Silberschatz, Fretter, & Curtis, 1986).

RESULTS

EFFECTS OF TRANSFERENCE AND NONTRANSFERENCE INTERPRETATIONS ON IMMEDIATE PATIENT PROGRESS

To assess the relationship between the category of interpretation and the patients' immediate progress, *t* tests were conducted for transference and nontransference interpretations with the residualized gain scores on the Insight Scale and RA Scale. For residualized Insight, on one case (Case 2) there were no significant differences between the patient's progress following transference versus nontransference interpretations; on two cases (Case 1 and 3), the patient showed greater improvement following nontransference rather than transference interpretations. For residualized RA, on two cases (Case 1 and 3) there were no significant differences in the patients' progress following transference versus nontransference interpretations; on one case (Case 2) again the patient showed greater improvement following nontransference rather than transference interpretations. Thus, transference interpretations did not further the patients' immediate progress more than nontransference interpretations. Although Case 1 and 3 showed slight improvement after nontransference interpretations on the Insight Scale, these findings were not demonstrated on the same segments rated on RA; likewise, although Case 2 showed slight improvement after nontransference interpretations on RA, these findings were not demonstrated on the same segments rated on Insight. Due to such inconsistencies, no general statement can be made from these data about the effectiveness of nontransference interpretations.

The above analyses did not, however, distinguish between suitable (plan-compatible) and unsuitable (plan-incompatible) transference interpretations. To take into account the possibility that suitable transference interpretations would be more effective than suitable nontransference interpretations, we selected only those transference and nontransference interpretations that received a rating of +1 or

more on the PCIS (i.e., interpretations rated mildly to strongly plan-compatible). We repeated the *t* tests comparing patients’ progress on the two scales following suitable transference versus suitable nontransference interpretations. On both scales, across all three cases, patients’ showed no significant differences in either residualized Insight or residualized RA following suitable transference versus suitable nontransference interpretations. The results therefore showed that suitable transference interpretations did not further immediate patient progress more than suitable nontransference interpretations.

EFFECTS OF PLAN COMPATIBILITY ON PATIENT PROGRESS

To assess the relationship between suitability of interpretations and the patients’ immediate progress, we combined all interpretations without regard to category and correlated the PCIS scores with the residualized Insight and RA scores for each case. Across all three cases, on both scales, our hypothesis was confirmed: Suitability (Plan Compatibility) of therapists’ interpretations predicted immediate patient progress, and category (transference versus nontransference) did not. Although the transference category of interpretations was unable to account for significant variations in patients’ immediate progress, Plan Compatibility consistently correlated positively and significantly with variations in all three patients’ progress on Insight as well as RA (see Table 1). Following plan-compatible interpretations, all three patients showed increases in progress on Insight and RA; whereas following plan-incompatible interpretations, all three patients showed decreases in progress on Insight and RA. These new findings confirmed the findings of our previous study (Fretter, 1984; Silberschatz, Fretter, & Curtis, 1986) using the Experiencing Scale. We then compared these dependent variables across all three cases to see if they were all measuring the same processes in the patient. Table 2 shows that although there is *some* overlap on the Insight and Experiencing Scales, RA is clearly measuring a different process. All scales, however, consistently correlate positively and significantly with Plan Compatibility, which further validates the Plan concept.

DISCUSSION

The results of the current study have confirmed the original study showing that although Plan Compatibility accounts for significant proportions of variance in immediate patient progress, the transference category is unable to account for any

Table 1. Correlations Between Plan Compatibility and Residualized Insight and RA

	Case 1 (n=66)	Case 2 (n=76)	Case 3 (n=66)
Insight	.45**	.32*	.35*
RA	.25*	.32*	.34*

*p<.05, two-tailed.
**p<.01, two-tailed.

Table 2. Correlations among Dependent Variable Scales

	Case 1 (n=124)		Case 2 (n=154)		Case 3 (n=180)	
	EXP	RA	EXP	RA	EXP	RA
Insight	.79**	.22*	.59**	.32*	.66**	.23*
RA	.21*		.17*		.09	

*p<.05, two-tailed.

**p<.01, two-tailed.

significant variation in such progress. What are the clinical implications of these findings regarding the relative power of plan-compatible interpretations and transference interpretations to contribute to the progress of the patient? Are we implying that the concept of transference is irrelevant to the Plan and therefore to the patients' progress? Adamantly no.

Although the findings presented here *do* challenge the technical idea that an explicit and exclusive focus on the transference relationship with the therapist is uniquely powerful, they *do not* challenge the importance of the concept of transference in therapy. At least in these brief therapy studies, transference interpretations alone did not lead to patient progress, whereas Plan Compatibility alone did consistently lead to immediate progress. The real power of the Plan concept derives directly from the fact that the Plan incorporates within it *all* the patient's central pathogenic transferences, rather than only those aimed explicitly toward the relationship with the therapist.

Below we illustrate the power of the "Linda" Plan to address articulately *all* aspects of the patient's transferences whether or not they are directed explicitly toward the therapist. First we present Freud's definitions of transference, then we compare this definition to the concept of the Plan and present our clinical illustration from empirical data to demonstrate the power of the Plan to incorporate the central pathogenic transferences related to the patient's progress.

Freud's 1912 paper describes transference as a pattern of relating, an attitude derived from the past, a way of approaching new people with "libidinal anticipatory ideas:"

Each individual through the combined operation of his innate disposition and the influences brought to bear on him during his early years, has acquired a specific method of his own in his conduct of his erotic life. . . . This produces what might be described as a stereotype plate (or several such), which is constantly repeated—constantly reprinted afresh—in the course of the person's life. (p. 100)

The patient forms a "psychical series" of these stereotype plates, which can represent the "father imago," "mother imago," "brother imago," or a combination. The transference is made up not only of "conscious anticipatory ideas" but also of those that are unconscious.

Freud further describes that these transference plates are repeated in all relationships, not just the relationship with the analyst. "It is not a fact that transference emerges with greater intensity and lack of restraint during psychoanalysis than

outside it" (Freud, 1912, p. 101). Freud viewed transference repetitions in relationships outside analysis as occurring with equal intensity and "extending to nothing less than mental bondage." And finally he describes the characteristics of transference as "attributed not to psycho-analysis but to neurosis itself" (Freud, 1912, p. 101).

The concept of the patients' Plan relates directly to Freud's notions of conscious and unconscious "anticipatory ideas" that derive from traumatic childhood experiences and are constantly repeated in new relationships throughout a person's life. In Weiss' (1986) concept of the Plan, these transferred "attitudes" and "ideas" are defined as pathogenic beliefs that are derived from traumatic childhood experiences and cause psychopathology. The patient comes to therapy with a Plan to test these pathogenic beliefs in relation to the therapist in the hope of disconfirming them. The Plan concept certainly encompasses a focus on the relationship with the therapist in that *all* pathogenic beliefs are tested in relation to the therapist. However, the Plan concept goes even further to specify how these "transferred" pathogenic beliefs are repeated in any of the patient's relevant relationships. Each Plan consists of the presenting problem and the background followed by the following sections: (1) GOALS describe the conscious or unconscious developmental achievements the patient has been obstructed from reaching. (2) OBSTRUCTIONS represent the "transferred" pathogenic beliefs that prevent the patient from achieving the goals due to "irrational generalizations about conditions of danger and safety that are drawn from repressed memories of actual traumatic experiences" (Bush, 1986, p. 65). (3) TESTS represent the many possible ways the patient may attempt to disconfirm these "transferred" pathogenic beliefs through experiences in relation to the therapist; and (4) INSIGHTS represent some of the relevant interpretations about the pathogenic beliefs and their origins that will enable the patient to overcome these obstacles to the attainment of important goals.

To illustrate further how the Plan relates to the concept of transference, we now present excerpts of a Plan from this study, the "Linda" Plan (Case 2).

Excerpts Edited from the "Linda" Plan (Case 2)

Presenting Problem: Linda is a 58-year-old, Caucasian female who works as an executive secretary. Her husband was forced to retire from his job as an engineer because of high blood pressure brought on by stress. Since his retirement he has become "nervous," "nit-picking," critical, and unhappy. Linda also reports feeling increasingly nervous and pressured; she feels these emotions of her husband's have "rubbed off" onto her. She has been experiencing increased difficulty in writing and concentrating. She drew a parallel between these problems and similar ones her sister has experienced. She also worries that arthritis could force her to retire early from her job, which has always provided her with feelings of competence, success, and enjoyment. She frets that her nervousness and difficulty concentrating could render her unable to adjust well to her own retirement. She also worries that she is indecisive and overly dependent on others' approval. She claims her husband encouraged her to be dependent upon him, and now she wants to regain her independence. "I want to stand on my own feet without hurting him."

Background: Linda is the younger of two daughters. Her father was a successful physician who had many friends and kept an active social life. Linda's mother devoted herself to her husband and worked in his office in

addition to attending to the family. "She (mother) put him (father) up front and put herself in the background, and when I think of her she has always been very much in the background." In the last few years of his life, when her father became ill, Linda's mother gave up everything to care for him. She had been an accomplished singer; but when her husband became ill she swore never to sing again—indeed she never did.

Linda's sister has had a long history of emotional and physical problems: She was a sickly child, did poorly in school, had few friends, and as an adult has been diagnosed schizophrenic. Linda has always been uncomfortable that she was more capable and successful than her sister, and has always felt overly responsible and in need of caring for her. Linda said her father "had a tendency of putting me up on a pedestal all the time, which I was always fighting." Although her mother was always in the "background," her father had higher expectations for Linda. Linda felt especially badly when her father compared her favorably to her sister, and when he told her she was stronger and brighter than her sister and that he liked her better than her sister. These heightened Linda's feelings of responsibility for her sister's situation and she fought this by "feeling inadequate" and unworthy.

Plan Formulation: We infer that Linda suffers from a type of "survivor guilt" that stems from her discomfort as a child about being better off than either her sister or her mother. As a child, she developed the unconscious belief that her successes came at the expense of her mother and sister and represented a betrayal of them. Thus, she felt she should not allow herself to have more than or feel better off than her sister or mother. Her husband's illness has provoked a resurgence of these feelings, because Linda feels guilty about being better off than he is. As long as he was healthy and working, Linda was able to allow herself some independence and self-fulfillment through her job. However, this equilibrium was shattered by her husband's disability. She is now in danger of needing to give up everything—much as her mother gave up her singing when Linda's father became ill. In a situation reminiscent of her relationship with her sister, Linda feels guilty about being better off and more capable than her husband. As with her sister, she has felt intense responsibility to care for her husband and has assumed some of his symptoms in an obvious identification with the victim. Thus, like her husband, she feels tense. Similarly, she worries about needing to take an early retirement because of poor health and questions her ability to adjust well to such a retirement.

(For brevity, we provide a single example each from the long lists of operationalized goals, obstructions, tests, and insights that help judges evaluate each interpretation.)

Goals: To allow herself to function well at work and maintain her job (instead of retiring early).

Obstructions: She unconsciously believes that her strengths make those less fortunate than her look weaker and thereby hurt or humiliate them. She believes she should not allow herself to function more competently than others and that she should deny or give up her own capabilities.

Tests: She may test to see if the therapist links her strengths or successes with her husband's weaknesses in order to disconfirm the idea that her strengths could hurt her husband as she felt they hurt her sister.

Insights: One salient insight she might want to achieve is that many of her current symptoms (nervousness, poor concentration, concern about early retirement) are based on an unconscious identification with her disabled husband, which serves as a defense against her guilt for being more capable than he is at the present time.

These excerpts demonstrate that the Plan can be viewed as a case-specific description of how Linda's pathogenic beliefs that derive from traumatic childhood relationships are repeated in her current relationships. The pathogenic beliefs are the determinants of her central pathogenic transferences. Interpretations that are compatible with this Plan will be interpretations that enable Linda to disconfirm her pathogenic beliefs. At one point in the therapy, after she has talked about not attending a concert for fear of hurting her husband who could not attend, she talks about her extreme feelings of guilt and responsibility for her schizophrenic sister. When the therapist addresses the fact that Linda is holding herself back by feeling unduly responsible for her husband's illness in the same way that she held herself back as a child and felt responsible for her sister's condition, the interpretation is rated as highly plan-compatible and the patient showed immediate progress. We view such an interpretation as addressing multiple relevant aspects of the patient's "transferred" pathogenic beliefs in a plan-compatible way as they are being tested in the therapy.

Malan's (1976) interpretation typology, however, categorized this interpretation as nontransference—an OP, because it referred to her significant other (O) and her sibling (P). Transference interpretations were limited to those that referred to the patient's feelings about the therapist or the therapy. Our empirical findings show the patient benefitted from interpretations that disconfirmed pathogenic beliefs transferred onto the significant others in her life just as much as the therapist. Thus, the Plan is able to encompass a wider and more varied view of transference than a focus exclusively on the relationship between patient and therapist.

This more encompassing conception of transference has been discussed by psychoanalytic authors (e.g. Gill, 1982; Stone, 1967; Strachey, 1969), though these authors still promote the primacy of the transference relationship with the therapist. Gill (1982) discusses the importance of addressing transference both inside and outside the therapy situation as he cites Freud's (1916–1917) general definition of transference as "new editions of the old conflicts" (Gill, 1982, p. 49). The reason Freud saw it as desirable for the transference to be addressed within the therapy is that there it is always within reach of our intervention (Freud, 1914, p. 154). However, transference is expressed in a patient's relationship with significant others, friends, spouses, bosses, employees, and so on. The Plan concept enables the therapist to address, on a case-specific basis, *all* pathogenic beliefs that are "transferred" to a variety of significant relationships, *including but not exclusive to the relationship with the therapist*.

Even though more encompassing views of the transference are discussed by psychoanalytic authors, most eventually return to the centrality of the more narrowly defined transference interpretation. Gill (1982) states, "I conclude that while extra-transference interpretations play a role . . . priority, in both time and importance, should go to transference interpretations" (pp. 125–126). The findings from the present study, which confirm findings from the original study, suggest that priority both in time and importance should go to disconfirming all "transferred" pathogenic beliefs that are directed toward significant people in the patient's world

as they appear during treatment, rather than to an exclusive emphasis on explicit interpretations of the relationship between patient and therapist.

Further research is required to extend the generalizability of the present findings. Although further research on more brief therapy cases is necessary, replications on long-term psychotherapies are even more important since transference interpretations made over the course of time may vary greatly from those made in a brief treatment.

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