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THE RELATIONSHIP BETWEEN TRANSFERENCE INTERVENTIONS AND THERAPEUTIC ALLIANCE IN A SINGLE CASE STUDY OF A 16-YEAR-OLD ADOLESCENT

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Aktarım Müdahaleleri ile Terapötik İttifak Arası İlişkinin 16 Yaşındaki Ergen Bir Vaka Üzerinde İncelenmesi

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ABSTRACT

Therapeutic alliance refers to the affective and collaborative aspects of a therapeutic relationship. There is abundance of research findings that indicate that positive therapeutic alliance is associated with positive treatment outcome. Another factor related with treatment effectiveness is the amount of transference interpretations utilized in treatment. Transference interpretations refers to any therapist intervention that points out transferential transactions that takes place in treatment. This study aims to explore the relationship between therapeutic alliance and transference interpretations. The data of this study is comprised 57 fully transcribed sessions of a 16-year-old adolescent patient from Turkey. Fifty-seven sessions were transcribed and coded separately. Therapeutic alliance was measured with the Therapy Process Observational Coding System - Alliance Scale (TPOCS-A). Transference interpretations were assessed and categorized based on Transference Work Scale (TWS). Furthermore, the relationship between therapeutic alliance and patient's active cooperative engagement was explored. Time-series analysis with Granger Causality test was utilized in order to see temporal relations between variables. Results of the study indicated that the therapist made category 2 and 3 transference interventions (e.g., the therapist's encouragement of the patient to discuss feelings and thoughts about the therapy and/or the therapist) only if the therapeutic alliance was strong enough. Moreover, strong therapeutic alliance predicted patient's active cooperative engagement. Findings and the clinical implications of the study were examined in detail.

Keywords: transference intervention, therapeutic alliance, transference work, adolescence, psychodynamic psychotherapy

ÖZET

Terapötik ittifak, terapötik ilişkinin duygusal ve işbirlikçi yönlerini ifade eder ve olumlu (pozitif) terapötik ittifak olumlu terapi sonuçlarıyla ilgilidir. Terapi etkinliği ile ilgili bir diğer faktör terapistin aktarımla ilgili yaptığı yorumların miktarıdır. Bu çalışma, terapötik ittifak ile aktarım yorumları arasındaki ilişkiyi incelemektedir. Çalışmanın verileri, 16 yaşındaki erkek bir ergen danışanın, tamamı kaydedilen 57 seanslık terapi sürecinden oluşmaktadır. 57 seans ayrı ayrı şifrelenmiş ve kaydedilmiştir. Terapötik ittifak, Therapy Process Observational Coding System - Alliance Scale (TPOCS-A) ile ölçülmüştür. Aktarım yorumları, Transference Work Scale (TWS) ile değerlendirilmiş ve sınıflandırılmıştır. Ayrıca TWS ergen danışanın etkin, işbirlikçi katılımını ve terapistin, danışanın hoş olmayan duygulardan kaçınma girişimini ne derece işaret ettiğini araştırmak için kullanılmıştır. Değişkenler arasındaki geçici (dönemsel) ilişkileri görmek için Zaman Serileri Analizi ile birlikte Granger Nedensellik Testi kullanılmıştır. Çalışmanın sonuçları, terapistin yalnızca terapötik ittifak yeteri kadar güçlü olduğunda kategori 2 ve 3 aktarım müdahaleleri uyguladığını (örneğin, terapistin danışanı terapi ve/veya terapist hakkındaki duygu ve düşüncelerini tartışması için cesaretlendirmesi) göstermiştir. Dahası, yeteri kadar güçlü bir terapötik ittifakın danışanın etkin işbirlikçi katılımıyla bağlantılı olduğu bulunmuştur. Çalışmanın bulguları ve klinik çıkarımları ayrıntılı bir şekilde incelenmiştir.

Anahtar Kelimeler: aktarım müdahalesi, terapötik ittifak, aktarım çalışması, ergenlik, psikodinamik psikoterapi

CHAPTER 1
INTRODUCTION

Relationships are created by two or more persons, each of whom brings unique characteristics and relationship patterns into those relations. Each individual contributes to the novel relationship based on his or her past. For this reason, any relationship other than the first one, which is likely to be an infant-mother relationship, includes remnants of previous relationships. Of particular importance is the understanding of what is brought by each individual to the relationship and how it influences the relationship, especially the therapeutic one. A therapeutic dyad includes two people, who bring their relationship patterns into the therapeutic context and impact each other's way of relating. Transference, as it applies, is related to what the patient brings to the treatment context from his or her past and present, and greatly helps therapists to understand the patient's relationship patterns.

The concept of transference has drawn a great deal of attention from a variety of psychotherapy approaches since Freud's first conceptualization of the concept, and has been regarded as one of the core active ingredients in psychoanalytic and psychodynamic psychotherapies (Strachey, 1934; Hoglend, Johansson, Marble, Petter, Bogwald & Amlo, 2007). In 1912, Freud wrote about the term transference and defined it as the patient's repressed historical past revived in the relationship with the therapist. After Freud, several theorists have expanded the concept and suggested new definitions, which created controversy about what it encompasses (DeFife, Hilsenroth, & Kuutman, 2015). A commonly accepted definition of transference was set forth as "a universal phenomenon in which aspects of important and formative relationships (such as with parents and siblings) are unconsciously ascribed to unrelated current relationships" (Levy, 2009, p. 191). In other words, transference is a process whereby the patient projects previous relationship templates, e.g., expectations, fears, behaviors, onto the person of the therapist.

Interpreting the transference in the therapeutic process is considered to be a central therapy tool in psychoanalytic psychotherapy (Ulberg et al., 2014). Freud discussed the interpretation of transference and how it is used clinically and during psychoanalysis first time in the case of Dora, an adolescent patient (Freud, 1905/1963). Although initially he considered transference as a resistance that is detrimental to the process of psychoanalysis, he later realized that transference is central and at the core of the analytic process (Mitchell & Black, 2016, Gay, 1988). Although transference analysis is essential to the treatment process (Piper et al., 1991), the research produced inconsistent results regarding the relationship between transference interventions and treatment outcomes. Transference interpretations have been found to be related to favorable outcome (Gabbard & Westen, 2003; Messer, 2013; Hoglend, Amlo, Marble, Bogwald, Sjaastad, & Heyerdahl, 2006), but the positive association between transference interpretations and treatment outcome varied as a function of both patient and patient-therapist relationship characteristics (Hoglend, 1993; Gabbard, Horwitz, Allen, Frieswyk, Newsom, Colson, & Coyne, 1994; Ryum, Stiles, Svartberg, & McCullough, 2010). Studies examining the relationship between transference interpretations and effectiveness of therapy among adolescents are scarce. In one randomized controlled trial (RCT) with adolescents who received a diagnosis of Major Depressive Disorder, researchers found that analysis of the transference had favorable effect on the depressive symptoms (Ulberg, Hummelen, Hersoug, Hoglend, & Dahl, 2021).

A relevant therapeutic concept that is closely related to transference is the therapeutic alliance. As is the case for transference, alliance concept first emerged in the writings of Freud. In 1912, he wrote about the “serious interest” and “sympathetic understanding” of the analyst toward the patient, which he thought facilitated the attachment of the patient toward the analyst. Initially, Freud conceptualized this relational bond between the analyst and the patient as one aspect of positive transference. However, in 1913, Freud saw that a positive relationship between patient and therapist may include aspects that are reality-based and is different from the

transference. This shift in the understanding transference phenomenon and separating it from the reality-based aspects of the therapeutic relationship gave birth to the concept of therapeutic alliance. Today, therapeutic alliance is an overarching term that encompasses several therapeutic relational processes including therapist's empathy, respect and compassion along with patient's motivation and positive expectations from treatment (Green, 2006). There are several studies examining the impact of the therapeutic alliance in psychotherapy process which reported positive associations between therapeutic alliance and favorable treatment outcome among adults (Horvath & Luborsky, 1993; Flückiger, Del Re, Wampold, & Horvath, 2018) and children (Shirk & Karver, 2003).

Regarding child psychotherapy, a recent meta-analysis consisting of 28 studies found small-to-medium positive effect size of therapeutic alliance on outcome (Karver, Nadai, Monahan, & Shirk, 2018). However, studies examining the relationship between therapeutic alliance and outcome among adolescents are limited (Halfon, Özsoy, & Cavdar, 2019). Furthermore, few research to date have examined the effects of transference interventions among adolescents (Ulberg et al., 2012; Ulberg, Hummelen, Hersoug, Midgley, Hoglend, & Dahl, 2021). Similarly, no study investigated the relationship between transference interpretations and alliance in psychodynamic psychotherapy with adolescent patients. The aim of this study was to fill this gap in the literature by investigating session-to-session associations between transference interpretations and therapeutic alliance in a single case of an adolescent patient. In the following sections, I will first discuss the concept of transference along with transference interpretations and their impact on treatment outcome. Following that I will discuss therapeutic alliance and how it is related to treatment outcome. Finally, I will talk about studies that investigated these two processes together in treatment.

1.1. TRANSFERENCE

1.1.1. Definition

Precursors of the concept of transference was first identified by Freud in 1888. He used the term “displaced energies” to indicate transferring of intense emotions formed within a particular relationship, e.g., mother-infant relationship, to a different person to whom those feelings originally do not belong. In *Studies of Hysteria* (Breuer & Freud, 1895), he defined it as a “false connection” referring to patient’s misperception of the analyst as someone for their past. Thus, he initially thought that transference was inappropriate, and saw it as an obstacle for analytic process. As he continued to develop the concept of transference, he called it “stereotype plates” which referred to the representations of others created by early interactions, and are sustained in other relationships. However, he later conceptualized transference as one of the significant components of the analytic process because it provided a direct observation of the childhood dynamics of the patient in the therapy room. In his revised vision of transference, defensive processes related to transference needed to be explored and resolved, and this was seen as the main task of psychoanalysis (Mitchell & Black, 2016).

After Freud, a number of theoreticians have developed and elaborated the concept of transference. For example, Klein (1952) emphasized the interactional aspects of the transference. She speculated that characteristics from which the transference components are derived are attributed and then attached to the analyst by the patient, that is, patient unconsciously urges the analyst to embrace those characteristics which belong to the original source. She also noted that acts of the patient elicit countertransference in the analyst. This way of elaborating the transference was different from what Freud had introduced, in that, contrary to Freud’s writings, Klein suggested that patient behaviors operate in a particular way to elicit specific behavioral patterns in the analyst (Levy & Scala, 2012).

Some theoreticians discussed transference within their own psychoanalytic frameworks. For example, Horney (1939) referred transference in the concept of "neurotic trends" which define one's personality and relationship patterns that are reenacted in novel relationships. Fairbairn (1958) conceptualized transference as the carryover of the object representations from past to current situations. Kohut (1971/2013) identified different types of transferences, e.g., the mirroring and idealizing transferences. Mirroring transference refers to the patient's attempt to see himself/herself in the therapist's eyes as precious and worthy of love, and idealizing transference is related to the patient's attempt to merge with the therapist, who the patient believes functions as calming and comforting parent (Baker & Baker, 1987). As seen in these definitions, all these psychoanalytic theoreticians conceptualized transference as the repetition of reactions and experiences toward significant others from earlier times in the present toward another person (Greenson, 2008).

1.1.2. Transference Interpretations

Transference interpretations links the patient's past relationships with his/her parents to the current relationship experiences including the therapeutic relationship (Levy, 2009). In other words, transference interpretations connect patient's relationship patterns formed in the relationship with significant others during childhood with the way they relate with others in current relationships which includes their therapist (Hoglend, 1993; Piper et al., 1991). More recent definitions of transference interventions are more inclusive, also focusing on any transaction that takes place in the here-and-now relationship of the therapeutic dyad as well as an examination of the link between repetitive relationship patterns in different contexts including treatment and with significant others in childhood (Hoglend, 2004; Ulber, Amlo, & Hoglend, 2014). In this study, transference interventions refer to this more inclusive conceptualization.

Regarding the use of transference interpretations, there has been controversy concerning the potential benefits of interpreting transference reactions in treatment (Ogrodniczuk & Piper, 1999; Gabbard, 1994). Freud, in 1912, strongly encouraged the use of transference interpretations. Even though at the beginning he suggested all types of transference needs to be interpreted, he later regarded positive transference as a reality-based part of the attachment-based relationship between analyst and the patient (which is later conceptualized as therapeutic alliance, and discussed in detail below). Strachey (1934) saw transference interpretations as "mutative" interpretations, pointing out their effectiveness in changing patient's way of relating, thus gave particular importance to transference interpretations in dynamic psychotherapy. These ideas gave way to subsequent research that aimed to examine the relationship between transference interpretations and treatment outcome. Using transference interpretations have been found to be related to increased insight (Gabbard & Westen, 2013; Messer, 2013), and better psychological functioning (Hoglend et al., 2006). However, there are studies which showed either no effect of transference interpretations or negative impact of it on the therapeutic process (Hoglend, 1993; Ulberg et al., 2021). This lead to controversy regarding its use in psychotherapy, when to use it, e.g., early or late in treatment, and what kind of patient groups benefit more from transference interpretations (Ryum et al., 2010; Connolly et al., 1999). For instance, Strachey (1934) pointed out that transference interpretations made at the beginning of treatment might lead to negative consequences such as dropouts. To the author' knowledge, the earliest research examining the relationship between transference interpretations and outcome was conducted by Malan, who found out that transference interpretations were related with favorable therapy outcome (Malan, 1976, as cited in Levy & Scala, 2012). However, this study was criticized on methodological grounds weakening its conclusions. Marziali (1984) found a favorable relationship between transference interpretations and outcome. Concerning the effect of the transference interpretations, it was found that there were no significant differences between transference and extratransference interpretations (i.e., interpretations that link the patient's experience

of individuals other than his/her parents to the patient's experience of the therapist) in brief dynamic psychotherapy (Piper, Debbane, Bienvenu, Carufel, & Garant, 1986). Patient response is an important variable that may moderate the relationship between transference interpretations and outcome. For instance, one study examining the influence of transference interpretations found that whether transference interpretations were followed by affective or defensive response by the patient was related to the outcome, thus highlighting the response of the patient in determining to what extent transference interpretations have a positive impact (McCullough, Winston, Farber, Porter, Pollack, Vingiano & Trujillo, 1991). This study extended our knowledge with the inclusion of the patients' response to transference interpretations, suggesting that not only the characteristics of the interpretations but also what kind of reactions it draws from the patient matter. The frequency of transference interpretations has been found to be related to the outcome as well (Høglend & Gabbard, 2012). Comparing the amount of the transference interpretations, Hoglend (1993) found that high frequency transference interpretations were associated with less positive outcome for patients with both high- and low-quality object relations at two-and-four years follow up. In a randomized controlled trial, patients with low quality object relations benefited more from low and moderate levels of transference interpretations (Hoglend et al., 2006). Another study found that transference interpretations were associated with treatment drop-out (Piper, Ogrodiczuk, Joyce, McCallum, Rosie, O'Kelly & Steinberg, 1999).

Other researchers examined moderator variables to better understand the link between transference interpretations and treatment outcome. For example, it was found out that patients with higher degree of interpersonal difficulties were influenced poorly by early transference interpretations, thus suggesting that therapists must take into account the patients' current interpersonal status and abstain from making early premature transference interpretations (Connolly, Crits-Christoph, Shappell, Barber, Luborsky, & Shaffer, 1999). Moreover, even though transference interpretations may have a negative effect on individuals with personality disorders and poor quality of object relations, it was proved to be efficacious, especially for people with borderline

personality disorder (Clarkin, Levy, Lenzenweger & Kernberg, 2007). Clarkin and colleagues (2007) compared three treatment styles (dialectic behavior therapy, transference-focused psychotherapy, and dynamic supportive treatment) and found out that transference-focused psychotherapy was associated with improvement in anger, impulsivity, and irritability for patients with a diagnosis of borderline personality disorder. In their transference-focused psychotherapy, they examined patient enactments in the here-and-now therapeutic relationship, which enabled patients to integrate previously split off affects and cognitions (Levy, Clarkin, Yeomans, & Scott, 2006).

The concept of therapeutic alliance was another variable examined to understand the link between transference interpretations and treatment outcome. One study from Ryum and colleagues (2010), who studied transference work, therapeutic alliance and their interaction in a sample of patients with personality disorders, found that higher focus on transference work with patients who were diagnosed with cluster C personality disorders and scored low on therapeutic alliance was associated with less favorable outcome. Results of this study demonstrated that patient characteristics and the context in which transference interpretations are given may moderate the impact of those interpretations. Transference interpretations, as a result, seem to be "high-risk" and also "high-gain" interventions as Gabbard and colleagues (1994) indicated. Whether transference interpretations may result in favorable or poorer outcome depends on the preceding alliance status between therapist and the patient. Further studies showed that there was an interaction between therapeutic alliance, quality of object relations and transference interpretations. For instance, in one study, weaker therapeutic alliance had a positive impact on clients with low quality object relations when therapists utilized transference interpretations, whereas, clients with high quality object relations and better therapeutic alliance were more poorly impacted by transference interpretations even though they benefited as much from the therapy (Hoglend, Hersoug, Bogwald, Amlo, Marble, Sorbye & Crits-Christoph, 2011). This finding, together with the previous ones may be understood in a way that low levels of

transference interpretations may be beneficial in the context of poor therapeutic alliance especially with patients who are low on the quality of object relations. In these studies, therapeutic alliance was examined as one factor that may moderate the relationship between transference interpretations and treatment outcome. The goal of the current study is to go beyond that by investigating its relation to transference interpretations within psychotherapy process. In other words, the aim is to analyze the link between transference interpretations and the therapeutic alliance, whether these two therapeutic processes have a direct impact on each other.

1.2. THERAPEUTIC ALLIANCE

1.2.1. Historical Overview

The concept of therapeutic alliance drew a great deal of attention from a variety of psychotherapeutic approaches since it is regarded as one of the most important non-technical parts of the therapeutic process (Hougaard, 1994). The evolution and ramification of the concept brought with it many controversies about what it encompasses and to what extent it is differentiated from the concept of transference (Horvath & Luborsky, 1993). Therapeutic alliance, helping alliance, working alliance, and treatment alliance are the terms used to label the alliance concept (Horvath & Luborsky, 1993). Like many other psychotherapeutic concepts, the origin of the concept of alliance has roots in the writings of Freud. In 1912, he wrote about the “serious interest” and “sympathetic understanding” provided by the analyst toward the patient, which facilitate the attachment to the analyst, referring to therapeutic alliance. Initially, Freud conceptualized the relational bond between therapist and patient as one aspect of positive transference, which he called unobjectionable positive transference, and he thought it needs to be interpreted as much as other forms of transference. Eventually, he revised this position as he observed that this positive relation between

patient and therapist may include aspects that are reality-based and is different from the transference.

Sterba (1934), who was the first person to describe the concept of “alliance” wrote about the alliance as reality-based aspect of the therapeutic relationship that enables the client to benefit from the therapist interventions. In his view, identification with the analyst paves the way for the formation of the alliance, and an emphasis on the collaboration between therapist and the client contributes to this process. For example, the use of “we” in psychotherapy process by the therapist contributes to the identification of the patient with the therapist. Zetzel (1956) was the first person to use the term “therapeutic alliance”, emphasizing the affective and social features of the therapeutic relationship as well as the active and positive stance of the therapist. She differentiated between alliance and transference, suggesting that reality-based aspect of the therapist-patient interaction enables the patient to observe and respond better to the therapist interventions. In this way, patient realizes what aspects are brought from past relationships and what aspects come from reality-based features in the here-and-now of the relationship. Similarly, Rogers (1957) emphasized that affective components of the therapeutic relationship are essential for treatment. He drew attention to the concept of “empathy,” the deep understanding of the patient by the therapist, and linked it to the positive relationship between them and successful treatment (Rogers, 1965).

In a similar vein, Greenson (1965) drew attention to the realistic and collaborative aspects of the patient-therapist relationship and presented the term “working alliance,” again differentiating it from the concept of transference. He stated further that the concept of the working alliance reflects the rational bond between client and analyst, thus enabling the analytic process to operate and the client to work in a goal-oriented manner in the therapeutic context. In essence, most psychoanalytic authors separate transference and alliance, however, there are still others who argue that all the components of the therapist-patient interactions have to do with the

transference issue and needs to be interpreted in a similar manner (Horvath & Luborsky, 1993; Brenner, 1979).

Bordin (1979) integrated several definitions and elaborations on the relationship between therapist and the patient in the concept of working alliance. Bordin's pantheoretical approach toward the alliance concept includes three components, namely goals, tasks and bonds. "Goals" component refers to the aims that the therapist and the patient have agreed upon. For example, psychoanalysis and psychodynamic treatments are based on the agreement that patient's thoughts, feelings and behaviors create disturbances and the goal is to make an amelioration of those disturbances. "Tasks" component refers to the necessities of the treatment process, for which therapist and the patient are responsible. The "bonds" component refers to the attachment and emotional bond between the therapist and the patient. After Bordin divided therapeutic alliance into different parts, he applied those aspects of the therapeutic alliance to a variety of psychotherapy modalities (Summers & Barber, 2003). The therapeutic alliance concept used in psychotherapy studies with adolescents and children emphasizes the collaboration and affection aspects in a therapeutic relationship as described by Bordin (1979).

1.2.2. Alliance Concept in Psychotherapy

Studies examining the relation between alliance and outcome revealed that therapeutic alliance is one of the significant aspects of the therapeutic process in relation to outcome (Priebe & McCabe, 2006). A number of psychotherapy outcomes have been identified and analyzed in a number of studies examining the effect of therapeutic alliance on outcome variables. In the meta-analytic study by Horvath and Symonds (1991), which comprised of twenty-four studies investigating the relations between therapeutic alliance and outcome, a moderate positive effect of alliance on outcome was found. Another meta-analytic study examining the significance of the therapeutic alliance in child and adolescent psychotherapy context found out that the

influence of positive therapeutic alliance was modest in explaining favorable treatment outcome (Shirk & Karver, 2003), which is similar to the recent investigation with adult patients (Flückiger et al., 2018).

1.2.3. Therapeutic Alliance in Youth Psychotherapy

Research with adolescent and child populations on therapeutic alliance fell behind the therapeutic alliance studies conducted with adults (Faw, Hogue, Johnson, Diamond, & Liddle, 2005). Building therapeutic alliance with children and adolescent clients early in treatment is important since they do not generally refer themselves for psychological treatment (Shirk & Karver, 2003). Furthermore, difficulty in establishing one aspect of the alliance, such as affective or collaborative dimension, may compromise the establishment of alliance at all (DiGiuseppe, Linscott, & Jilton, 1996). Moreover, quality of alliance of therapists with parents may be different from the quality of alliance with children and adolescents. The perception of the alliance by children and adolescents has more value in predicting outcome compared to perception of alliance by their parents (Green, 2006). Even though the importance of the alliance in child and adolescent treatment is established, there have not been a unifying model of alliance for these populations (Elvins & Green, 2008).

The significant role of the alliance in predicting therapy outcome was investigated in several research studies. A meta-analytic study by Shirk and Karver (2003) revealed that for children and adolescents, there were modest associations between the strength of the therapeutic alliance and the outcome. A more recent meta-analytic study analyzing 28 studies of child psychotherapy revealed a positive small-to-medium effect size of therapeutic alliance on outcome (Karver et al., 2018). A number of studies examining alliance-outcome relation took patient characteristics into consideration. Adolescents with externalizing difficulties have been found to have worse therapeutic alliance with their therapist (Ayotte, Lanctôt, & Tourigny, 2016). Furthermore, for adolescents with externalizing difficulties, there was a stronger

association between therapeutic alliance and outcome compared to adolescents with internalizing problems (Shirk & Karver, 2003). The reason behind this is that as the formation of therapeutic alliance is more difficult with adolescents with externalizing problems due to their difficulties with persons representing authority, the strength of the therapeutic relationship in that patient group predict favorable outcome better compared to adolescents with internalizing difficulties (Shirk & Karver, 2003).

Even though the critical role of therapeutic alliance on treatment outcome has been well understood, less is known about what predicts alliance formation in adolescent studies. Other than patient characteristics and type of problem they present, factors such as therapists' techniques and behaviors were less examined (Cirasola, Midgley, Fonagy, Martin, & IMPACT Consortium, 2021). Freud, in 1946, stressed the importance of giving great attention to the alliance-building behaviors in adolescent treatment, and emphasized that the analyst should follow the adolescent's lead on what topics to be focused. A recent study demonstrated that therapists exhibiting behaviors that promote rapport between them and their patients particularly at the beginning of psychotherapy as well as therapists giving attention to the adolescent's internal world are more likely to build better therapeutic alliance (Ovenstad, Ormhaug, Shirk, & Jensen, 2020). Moreover, the same study indicated that "rapport building" (giving attention to experiences and supporting adolescents) and "treatment socialization" (leading and directing attitude in the structuring of the session, explaining the type of treatment, stressing the collaborative aspects of therapy) are two of the specific therapist behaviors that enhance therapeutic alliance with adolescent patients (Ovenstad et al., 2020). Researchers comparing cognitive behavioral therapy (CBT) and nondirective supportive therapy in treatment of adolescent patients in terms of therapist behaviors that facilitate alliance found out that structuring the treatment and giving close attention to the adolescents' experiences are factors that enhance therapeutic alliance especially in CBT (Karver, Shirk, Handelsman, Fields, Crisp, Gudmundsen, & McMakin, 2008). Therapeutic alliance has been the focus of psychotherapy research across different therapy modalities (Cirasola et al., 2021;

Langer, McLeod, & Weisz, 2011), which points out its significant role on treatment effectiveness regardless of specific therapy approaches used.

1.3. PRESENT STUDY

In this study the aim was to investigate the relationship between transference interpretation and therapeutic alliance in a case of a single adolescent patient. To date, the relationship between transference interpretations and therapeutic alliance was analyzed only with adult patients (Piper et al., 1991; Piper et al., 1993; Piper et al., 1999; Ogrodniczuk, Piper, Joyce & McCallum, 1999; Bond, Banon, & Grenier, 1998; Gabbard et al., 1994). According to these studies there was a general agreement that high number of transference interpretations have a negative effect on outcome. Moreover, in previous studies, transference interpretations and therapeutic alliance between patients and therapists were generally measured intermittently at different points of the therapeutic process. They were generally naturalistic studies examining the correlation between variables, thus showing that there is a need for statistical procedures enabling researchers to make better assumptions about possible causal relationships. Current investigation assesses characteristics of transference interpretations and therapeutic alliance between therapist and the patient over the course of the treatment. Examining the therapeutic process session-to-session would enable us to make clearer and more meaningful inferences about the association between these variables. Moreover, session-by-session analysis of the therapeutic alliance was needed in order to see whether alliance between therapist and patient fluctuated across treatment sessions and to what extent it was influenced by the aspects of transference interpretations. In this regard, the association between different types of transference interpretations and therapeutic alliance will be explored. To the knowledge of this author, it will be the first study to examine the impact of different categories of transference interpretations in treatment context. Categorization of different types of transference interventions were based on Transference Work Scale

(TWS), a therapy process measure, developed by Ulberg et al. (2014). According to this scale, transference interpretations are differentiated based on whether the therapist only addressing the transactions between themselves and the patient, explore patient's thoughts and feelings about the therapist/therapy, or connecting different relationship patterns including traditional genetic interpretations. Different categories of interpretations include different aspects of the transference, and varying degree of relational interactions taking place in treatment. There are no studies at present that investigated the differential impact of different categories of transference interpretations in treatment. However, Ulberg and colleagues (2014) suggest that TWS can be used to assess if different transference interpretations have different effects on outcome. The details of this scale and different categories of transference interpretations are provided in more details in the method section.

The TWS involves multiple separate ratings on different categories of transference interpretations, timing and precision of interpretations, content and valence of the interpretations, and the response of the patient to these interpretations. Since the number of sessions analyzed in the current study did not allow for large number of items to be analyzed, most relevant items from this scale were selected. As a consequence, item number 19 which examines the extent of therapist's interventions that address patient's attempts to avoid certain topics in the session was selected. Finally, item number 25 which addresses the level of patient's active cooperative engagement in the session was chosen since it overlaps with the concept of therapeutic alliance. The goal was to cross validate the presence of therapeutic alliance by examining the relationship between therapeutic alliance and patient's active cooperative engagement.

Adolescents differ from adult populations in that aims and what will be achieved through therapy are generally determined by the referral source, which is usually not the adolescents themselves. This can lead to a conflictual atmosphere in treatment that may hinder the formation of a collaborative relationship (Everall & Paulson, 2002). Analyzing the therapist techniques in relation to adolescents' alliance quality with

therapist may have a value in increasing our understanding of the treatment process. Findings of the studies conducted with adults have generally been adapted and generalized to adolescents, without replicating and verifying the results for adolescents (DiGiuseppe et al., 1996). Therefore, it is necessary to conduct studies with adolescents in order to understand therapeutic processes specific to that population. Due to the scarce empirical investigation of transference interpretations and therapeutic alliance with this population, study hypotheses are formulated as exploratory questions. The current study aims to investigate:

1. the relationship between session-to-session frequency of transference interpretations and therapeutic alliance; more specifically, the relationship between different types of transference interpretations and therapeutic alliance,

2. the relationship between therapeutic alliance and therapist pointing out patient's attempt to avoid unpleasant emotions and thoughts in the sessions, and

3. to what extend the level of patient's active cooperative engagement in the sessions is associated with alliance scores.

CHAPTER 2
METHOD

2.1. DATA

The data of this study consists of 57 fully transcribed sessions of psychodynamic psychotherapy with a 16-year-old male adolescent who lived in Istanbul, Turkey. Sessions were recorded within the scope of research purposes in the Istanbul Bilgi University Psychological Counseling Center with the consent of the patient and his parents.

Client. Mr. K was a 16-year-old male adolescent who started psychodynamic psychotherapy with complaints of hyperactivity and attention problems, test anxiety, difficulty complying with school rules, emotion regulation problems, unstable mood, pessimism, lack of self-confidence, and difficulty making friends. Although Mr. K said the complaints started in the same year before the beginning of psychotherapy, his mother said Mr. K's complaints are long standing contradicting Mr. K's report. Mr. K was prescribed Risperdal for emotion regulation and anxiety problems while in kindergarten. He was later prescribed Ritalin and Concerta while in primary school due to the difficulties he experienced in complying with school rules. He used these medications until the third grade. Furthermore, Mr. K has history of brief psychotherapy in middle school reportedly for the complaints of food aversion and excessive sweating. At the beginning of psychotherapy, Mr. K was using Desyrel for his difficulties in sleeping, as reported by his mother.

Regarding family relationships, patient's mother reported that although Mr. K preferred to play with his mother rather than with his friends during preschool years, he did not experience difficulty leaving his mother to go to elementary school. She stated that she took on many responsibilities for Mr. K, such as tidying his room and checking his homework. According to her, she took on the task of parenting and the

father spent most of his time working outside the home. She reported that Mr. K's father refused to accept that Mr. K had psychological problems or that he needed individual psychotherapy. He thought these difficulties would disappear over time. For this reason, he did not attach importance to his child's difficulties.

When it comes to Mr. K's peer relationships, he had difficulty making friends and always had a hard time adapting to new relationships. It was especially difficult for him to admit unpleasant emotions and thoughts that were resulted from being rejected by his friends when he attempted to approach them. He frequently worried that his friends will ridicule him. He described himself as quick tempered but his anger faded quickly and he did not hold hard feelings for the people with whom he was angry. His family came from middle socio-economic background. He lives with his mother, father, and six-year-old sister. His mother was a housewife and his father was a bookmaker. There was no clue that he and his family practiced any religion.

In sessions, Mr. K usually made gestures and was generally laughing while talking about topics that seemed difficult for him. He was generally energetic and sometimes overexcited while talking. He was easily distracted, e.g., he would be distracted by the sounds coming from the next door or by the sight of a fly in the therapy room. He was observed that he rocked his body back and forth while talking.

At the beginning of the treatment process, Mr. K completed The Youth Self Report for Ages 11-18 (YSR 11-18) and his mother completed The Child Behavior Checklist for Ages 6-18 (CBCL 6-18). Row scores (Sum), T Scores, and Percentiles from these scales along with depression and anxiety scores are provided in Table 2.1.

Table 2.1

Row Scores, T Scores and Percentiles for CBCL and YSR at the Beginning of Therapy

CBCL	TC	IP	EP	SP	DP	AP
Row Score (Sum)	16	27	21	14	12	7
T Score	31	74	66	70	77	69
Percentile	3	>98	95	>97	>97	97
YSR	TC	IP	EP	PQ	DP	AP
Row Score (Sum)	20	20	19	19	8	5
T Score	43	66	62	48	65	58
Percentile	24	95	89	42	93	79

Notes. TC: Total Competence; IP: Internalizing Problems; EP: Externalizing Problems; SP: Stress Problems; DP: Depressive Problems; AP: Anxiety Problems; PQ: Positive Qualities

Therapist. Mr. K's therapist was a clinical psychology graduate student in her internship year at Istanbul Bilgi University. She practiced psychodynamic psychotherapy, and was supervised during the entire psychotherapy duration. The psychotherapy process with Mr. K continued until the end of the training process of the therapist in the graduate program. Thereafter, they continued the treatment process in another counseling center. The sessions in the current study covers the period during their work at the university counseling center.

Sessions. There are 57 psychotherapy sessions in this study. Session numbers 3, 6, 8, and 14 were not included in this study since they were family sessions. Because of the technical problems in recording, there are 7 missing sessions. Therefore, a total number of 57 sessions conducted between January 7, 2019 and June 25, 2020 were included in the analyses.

2.2. INSTRUMENTS

Therapy Process Observational Coding System-Alliance scale (TPOCS-A) was utilized in the current study to evaluate the quality of therapeutic alliance between therapist and patient (McLeod & Weisz, 2005). The scale consists of nine items measuring collaborative and affective aspects of the relationship between therapist and patient. After watching the videotapes, coders rated a nine-item scale considering the intensity and/or frequency of a specific item based on the relationship between the therapist and the patient. Nine items of the measure are as follows: "1) To what degree does the child experience therapist as supportive and understanding 2) To what degree does the child act in a hostile, defensive, or critical manner toward therapist 3) To what degree does the child demonstrate positive affect toward therapist 4) To what degree does the child share his experience with the therapist 5) To what degree does the child feel uncomfortable interacting with the therapist 6) To what degree do the child and therapist seem uncomfortable or anxious interacting with each other 7) To what degree does the child use skills learned in therapy to make changes outside of therapy 8) To what degree does the child do not comply with therapeutic tasks 9) To what degree do the child and therapist work equally on therapeutic tasks" (McLeod, 2005). The items are rated on a 6-point Likert scale ranging from 0 = *not at all* to 5 = *a great deal.* For the present study, Item 7 (child use therapeutic tasks to make changes outside the session) was excluded since in psychodynamic psychotherapy with children and adolescent therapist does not assign a task to the patient to implement outside the therapy session. The original TPOCS-A showed acceptable inter-rater reliability (ICC > 0.40*; M* = 0.59; SD = 0.10); and demonstrated excellent internal consistency (α = 0.95). Convergent validity of 0.53 has been found for the TPOCS-A measure when it was correlated with Therapeutic Alliance Scale for Children (TASC) a comparable alliance measure (McLeod & Weisz, 2005).

TPOCS-A was translated into Turkish by Özsoy (2018) for her thesis in consultation with Drs. McLeod and Halfon. The scoring manual of the measure was included and expanded with examples regarding psychodynamic psychotherapy for children. A total of 179 psychodynamic psychotherapy sessions from 49 children were coded by undergraduate psychology and clinical psychology graduate students in their training process. Coders obtained enough inter-rater reliability (ICC = 0.70). Thereafter, independent pairs double-coded 65 % of the sessions with the ICC of 0.70-1.

In the current study, the author and the other coders completed the same training and reliability process by coding pilot training videos. After obtaining enough inter-rater reliability scores which are above 0.80, other coders paired with the author and coded all the sessions. For the present study, mean scores of pair codings were used. Inter-rater reliabilities (ICC) ranged from .80 to 1 with the internal consistency of .63.

Transference Work Scale (TWS) was used in order to identify and categorize transference interpretations, and analyze the relationship between transference interventions and therapeutic alliance (Ulberg, Amlo, & Hoglend, 2014). Only relevant sub-components of TWS are used in the current study, and those will be explained in detail below. For a comprehensive description of the scale please refer to the manual as discussed by Ulberg and colleagues (2014) (See appendix A for TWS). Items in the "identification" component enable researchers to identify and categorize transference interventions. In TWS measure, transference interventions are categorized into five groups that are not supposed to be hierarchical (Ulberg et al., 2014).

The categories of TWS presented below have been directly adopted from Ulber et al., (2014, p. 2):

1) The therapist addressed transactions in the patient-therapist relationship (address transaction)

2) The therapist encouraged exploration of thoughts and feelings about the therapy and the therapist's style and behavior (thoughts and feelings about therapy).

3) The therapist encouraged patients to discuss how they believed the therapist might feel or think about them (beliefs about therapist).

4) The therapist included him-/herself explicitly in interpretive linking of dynamic elements (conflicts), direct manifestations of transference, and allusions to the transference (linking therapist to dynamic).

5) The therapist interpreted repetitive interpersonal patterns (including genetic interpretations) and linked these patterns to transactions between the patient and the therapist (repetitive interpersonal pattern).

The items concerning the content of the transference work analyze to what degree patient and therapist talk about specific themes in their speeches (i.e., "To what degree does the therapist refer to the patient's relation to others?", "To what degree does the therapist point out the patient's attempt to avoid themes in the session in order to control unpleasant emotions and thoughts"). In the current study, the latter item was used in the data analysis. Items concerning the "response of the patient" assess to what degree patient shows emotional involvement, reflective stance, and cooperative engagement in treatment. The last of these items was used to confirm the validity of TWS in relation to TPOCS-A. The items in the content and response components are rated on a 5-point Likert scale with the anchors of 0 = *not at all* and 4 = *high degree.* In the original study, for the "identification" of transference interventions, there was excellent inter-rater reliability with kappa values ranging from 0.77 to 1, and for the "categorization" of the transference interventions, there is good inter-rater reliability with kappa values ranging from .60 to .90 (Ulberg, Amlo, Critchfield, Marble, & Hoglend, 2014). Further, for the items in "content", "valence", and "response of the patient" parts of the measure, inter-rater reliabilities ranged from 0.31 to 0.98 (Ulberg et al., 2014). The TWS was translated into Turkish by the thesis advisor, and two doctoral level senior clinical psychologists reviewed the translated version for linguistic style and clinical content. Following this initial phase, a professional translator back-translated the scale into English. Based on back-translation, further revisions were made to the Turkish version. The Turkish version was previously used

by other authors who reported excellent inter-rater reliabilities (Sohtorik İlkmen & Halfon, 2019). In the present study, a doctoral-level clinical psychologist trained the author, and two master-level clinical psychologist who were not affiliated with Bilgi University. During this training a total of 10 sessions, which did not belong to the current case, were rated. Total amount of the training time was two months by meeting once a week for an hour. The ICC for TWS items ranged from .6 to 1.

2.3. PROCEDURE

For TPOCS-A, nine clinical psychology students (one of them is the author) with similar academic backgrounds at Istanbul Bilgi University clinical psychology graduate program received training to code the alliance measure. The author coded all of the videotaped sessions ($N = 57$) in pair with the other 8 clinical psychology students. For TWS, each of the available psychotherapy sessions was transcribed by a group of undergraduate psychology students. For the current study a two-stage coding process was conducted for TWS. In the first stage, the doctoral-level clinical psychologist identified whether there was any transference intervention in each of the sessions. Next, she determined the sequence number and category of the first transference intervention in each session. In the second phase of the coding process, the author rated all the other relevant items in TWS. Meanwhile, 20 % of the transcribed sessions selected with “random number generator” were rated by the other two master-level clinical psychologist to obtain inter-rater reliability.

2.4. DATA ANALYTIC STRATEGY

2.4.1. Quantitative Analysis

For the current study, time-series analysis was conducted to reveal temporal associations between frequency of different categories of transference interventions, therapist's emphasis on the patient's attempt to avoid unpleasant emotions and thoughts, patient's cooperative engagement, and therapeutic alliance throughout the treatment process. To see whether the sequential relationship between variables was present over the course of treatment, Granger Causality Test was used to see whether a specific variable in a time-series can predict future value of another variable for a certain time lag (Granger, 1969). Vector autoregressive analysis (VAR) with E-views 12 was used for conducting Granger Causality test. Before conducting time-series analysis, variables have to be stationary in order to meet an assumption of time-series analysis. "Augmented Dickey-Fuller" test (ADF, Dickey & Fuller, 1979) was conducted to reveal whether a variable has unit root or not. If a variable has a unit root, one can understand that variable is not stationary (Dickey & Fuller, 1979).

CHAPTER 3
RESULTS

3.1. DATA ANALYSIS

Descriptive statistics for transference intervention variables in treatment process are provided in Table 3.1.

Table 3.1

Descriptive Statistics for Transference Interventions and Therapeutic Alliance by Session in Treatment

Treatment Transference Related	*Mean*	*SD*	*Min.*	*Max.*	*Total Frequencies*
Frequency of C1	8.07	4.53	1	25	460
Frequency of C2	4.03	3.55	0	15	230
Frequency of C3	.24	.61	0	3	14
Frequency of C4	.07	.26	0	1	5
Frequency of C5	0	0	0	0	0
Response of Active Cooperative Engagement	2.54	.59	1	4	-
Content of TW - Unpleasant Emotions	1.50	.82	0	3	-
TA Related					
Therapeutic Alliance	26.72	2.96	17	32	-

Notes. C1: Category1; C2: Category2; C3: Category3; C4: Category4; C5: Category5; TA: Therapeutic Alliance; TW: Transference Work

Since the transference interventions belonging to category2 and category3 were related to similar aspects of the transference (e.g., therapist's exploration of how the patient feels about the therapist), I calculated their composite score by taking the sums of frequency of both category2 and category3 transference interventions. Moreover, since there was no transference intervention belonging to category5 and there was only one transference intervention belonging to category4 over the course of treatment, I excluded them from further analysis.

3.1.1. Granger Causality Test

Granger Causality tests were applied to the frequency of different categories of transference interventions, therapeutic alliance scores, patient's cooperative engagement, and the therapist's emphasis on the patient's attempt to avoid unpleasant emotions during the sessions over the course of treatment. Before conducting Granger Causality test, variables that would be analyzed need to be checked whether they are stationary or not. In order to see whether variables are stationary or not, Unit Root tests were conducted for all the variables. Augmented-Dickey Fuller Test (ADF) revealed that therapeutic alliance variable has a unit root. In other words, it was not stationary. Therefore, I converted all the variables into stationary through First Difference. Then, Augmented Dickey Fuller Test showed that therapeutic alliance variable was stationary ($t=-15.7249$ $p<0.01$). Table 3.2 indicated t-values and probability values of unit root tests for the variables.

Table 3.2

Statistical Values of Unit Root Test

Treatment Transference Related	t-Statistics	Prob.
Frequency of C1	-8.435598	0.0000
Frequency of C2	-8.900261	0.0000
Frequency of C3	-7.975630	0.0000
Frequency of C4	-6.689838	0.0000
Frequency of C5	-	-
Content of TW – Unpleasant Emotions	-5.953836	0.0000
Response of Active Cooperative Engagement	-7.036184	0.0000
Therapeutic Alliance Related	**t-Statistics**	**Prob.**
Therapeutic Alliance	-6.851445	0.0000

For further analysis, VAR was utilized to estimate optimal lag number for time series. Akaike Information Criteria (AIC) was utilized to estimate optimal lag number for the time series. Vector Autoregression Estimates revealed that 2-lag would be optimal for further analysis.

3.1.1.1. Hypothesis 1

According to Pairwise Granger Causality Test in time-lag 2, the therapeutic alliance strength between the patient and the therapist did not predict the frequency of transference interventions belonging to category1 ($F(2,53)=1.010$, $p>0.05$). Also, Pairwise Granger Causality Test in time-lag 2 showed that frequency of transference interventions belonging to category1 did not predict the changes in therapeutic alliance strength ($F(2,53)=0.86573$, $p>0.05$). In other words, when the therapeutic alliance

strengthens, this did not cause the therapist to use category1 transference interventions. In a similar way, when the frequency of category1 transference interventions changes, this did not predict the changes in therapeutic alliance strength. On the other hand, therapeutic alliance strength predicted the therapist's use of transference interventions concerning the relational aspects of the therapeutic dyad. In other words, when the therapeutic alliance strengthens, this caused the therapist to utilize more category2 and category3 transference interventions ($F(2,53)=3.30838$, $p<0.05$). However, the frequency of category2 and category3 transference interventions did not predict changes in therapeutic alliance strength ($F(2,53)=1.12569$, $p>0.05$).

3.1.1.2. Hypothesis 2

According to Pairwise Granger Causality Test in time-lag 2, changes in therapeutic alliance strength throughout treatment did not "granger caused" the extent to which the therapist pointed out the patient's attempt to avoid unpleasant emotions after the first transference interventions. ($F(2,53)=0.179$, $p >0.05$). Therefore, it was revealed that the therapist's focus on the patient's attempt to avoid unpleasant emotions that emerged during the treatment was not predictive of the therapeutic alliance strength between the patient and the therapist. In a similar way, Pairwise Granger Causality Test in time-lag 2 showed that the extent to which the therapist pointed out the patient's attempt to avoid unpleasant emotions after the first transference interventions did not predict changes in therapeutic alliance strength ($F(2,53)=0.17947$, $p>0.05$).

3.1.1.3. Hypothesis 3

According to Granger Causality Test in time-lag 2, the therapeutic alliance strength between the patient and the therapist predicted the cooperative engagement of the patient during psychotherapy ($F(2,53)=4.618$, $p<0.05$). In other words, when the therapeutic alliance strengthens, this caused the patient to show more active cooperative engagement. However, the cooperative engagement of the patient during psychotherapy did not predict changes in therapeutic alliance strength between the patient and the therapist ($F(2,53)=1.62402$, $p>0.05$).

CHAPTER 4
DISCUSSION

Given the importance of therapists' techniques for the treatment of adolescent patients (Cirasola et al., 2021), the aim of the present study was to explore the relationship between therapist's use of transference interpretations and therapeutic alliance strength. More specifically, the first aim of the study was to explore the relationship between the therapist's use of different categories of transference interpretations and the therapeutic alliance strength. Second goal was to explore the relationship between the therapeutic alliance strength measured by TPOCS-A and the extent to which the patient shows active cooperative engagement measured by TWS. These constructs measure similar processes in treatment. Examining the convergence of two different instruments measuring these constructs would provide support for construct validity of the coding systems used in the current study. The last objective of the study was to explore the relationship between the therapist's focus on the patient's attempt to avoid unpleasant emotions that emerged during the treatment process and the therapeutic alliance strength. When examining the treatment process, it was found that therapeutic alliance strength influenced the therapist's use of different categories of transference interventions. Of particular importance was the fact that the therapist utilized category2 (interpretations and/or explorations regarding the patient's thoughts and feelings about the therapist and treatment) and category3 transference interpretations (interpretations/explorations regarding the patient's beliefs about what the therapist thinks or feels about the patient) only if the therapeutic alliance was strong enough. The therapist's use of category1 transference interpretations was not influenced by the therapeutic alliance strength. Moreover, the therapeutic alliance strength predicted the patient's active cooperative engagement throughout the treatment process. However, it was found that there was no relationship between the therapeutic alliance strength and the extent to which the therapist pointed out the patient's attempt to avoid unpleasant emotions over the course of the treatment.

First and foremost, the present findings provide preliminary evidence for the utility of identifying different categories of transference interventions. Even though, there was no opportunity to examine category4 and category5 transference interpretations, the findings showed that different categories of transference interpretations had diverse relationship with the therapeutic alliance. This is the most significant contribution of the present study since no previous research has addressed this issue before. The therapist in the current study was a graduate student conducting psychodynamic psychotherapy under supervision. Making category4 and category5 transference interventions may have required the therapist to clearly examine the patient's relationship patterns formed in relationship with significant others during childhood with the way he related with the therapist. Moreover, perhaps the therapist may have thought that making category4 and category5 transference interventions may be more challenging compared to the other categories of transference interventions. For these reasons, the therapist may have experienced difficulty making category4 and category5 transference interventions. Furthermore, making category4 and category5 transference interventions may have required the therapist to examine closely the emotional status and readiness of the patient. The study showed that more experienced therapists are more likely to be able to recognize the emotional status of patients (Machoda, Beutler, & Greenberg, 1999). Perhaps recognizing the emotional status of the patient may have been more difficult for the therapist in the current study, which may have prevented her making category4 and category5 transference interventions. Future research needs to examine if this effect will be observed among categories of transference interpretations and other treatment variables including outcome. Since previous research on the link between the frequency of transference interventions and outcome produced inconsistent results, it would be interesting to examine if frequency of different categories of transference interpretations could explain different treatment outcomes.

An examination of the total frequencies of category1, category 2 and category3 transference interventions reveal that category1 transference interventions were used

with much frequency than others. While interpreting this finding the experience of the therapist has to be taken into account. The distribution of different categories of transference interventions probably would be different with a more experienced clinician. This needs to be examined in future research.

In order to contextualize the findings from the current data, it is important to understand the differences between different categories of transference interpretations. Category1 interpretations are simply any comment/inquiry regarding therapeutic interactions that may indicate transference reactions. According to Ulberg et al. (2014), these interventions prepare the patient for upcoming transference interpretations of higher categories. For instance, pointing out that the patient was late for the session or the patient has changed the topic at the present moment, are considered interventions that lays the groundwork for later genetic transference interpretations. On the other hand, category2 and category3 interventions addresses patient's thoughts and feelings about therapist/treatment directly. Even though these interventions are also considered preparatory by Ulberg et al. (2014), they go beyond category1 interventions by directly interpreting/exploring the relationship through these comments/questions. It is speculated that category2 and category3 interventions are more challenging since most patients find talking about the relationship directly very difficult. There is a need in the literature for further studies to investigate processes operating with different interpretations, and how they are related to change in treatment.

Previous research showed that a weak therapeutic alliance is associated with therapists utilizing more transference interventions in an attempt to handle the drop out of the patients (Piper et al., 1991). According to Piper and colleagues (1991), the reason behind the therapists' use of more transference interventions was the therapists' perception that there may have been a therapeutic impasse needed to be resolved, and transference interpretations may have been beneficial to resolve the resistance. However, in the present study, the results showed that the therapist used certain types of transference interventions when the therapeutic alliance was strong. More specifically, therapist pointed out and/or explored the thoughts and feelings of the

patient about the therapist and/or treatment when therapeutic alliance was high. Perhaps building the rapport opened up a channel for the therapist to encourage the patient to talk about how he might feel or think about the therapist and the treatment process. It is difficult to compare current findings with previous research results since most previous research defined transference interventions as genetic interpretations.

This study investigated the relationship between two essential treatment variables in the course of the treatment. Studying this relationship from session-to-session provides unique insights regarding the treatment process. Even though therapist's perception of the therapeutic alliance was not measured, the findings suggest that she consciously or unconsciously evaluated the level of therapeutic alliance and exerted her interventions accordingly. While she made category1 interventions regardless of the strength of the therapeutic alliance, she took it into account for categor2 and category3 interventions. Examining specific interactions from the current data may illuminate the relationship between therapeutic alliance and certain types of transference interpretations. Considering the adolescent patient of the present study, his strong interest in the therapist and willingness to be intimate with her might have enabled the therapist to perceive a strong therapeutic alliance, thus enabling her to make category2 and category3 transference interpretations.

In the example, the adolescent patient asked a personal question to the therapist at the beginning phase of the treatment process (Session 2)

P: I'll say, let's ask you, now. For instance, can you be rude to people who you love? I mean can you be offensive because you think it will be better for them?

T: Well, you want to find out this, how rude I might be for their sake? (C2 TI)

From a psychodynamic perspective, the question he asked may reflect his worry about whether the therapist likes him. Also, the patient may have wondered whether the therapist would be unkind if she did not like him. After the patient's question, the therapist made a category2 transference intervention. In this example, the therapist encouraged the patient to discuss his feelings and thoughts about the therapist. Such early transference interpretations may seem risky, but the therapist might have

evaluated the therapeutic alliance to be positive and decided to explore his comment to get a better understanding of his relational patterns.

In another example, in the middle phase of the treatment (Session 17), the patient reported to have searched for the therapist's name on "Instagram." Then, the patient told he wondered about the therapist's photos she used for her Instagram Profile, and he told he wondered whether the therapist had a boyfriend or not. Subsequently, the following transaction took place:

P: …I just wanted to see if you have one. Or how is it, what might you have shared etc. I do not know. I mean you might have posted about books, what you talk about. Are there only your own photos? I do not know. Perhaps you have posted wistful expressions or so (laughs). You may have a boyfriend or something, I do not know, I just wondered.

T: Well, what am I like? (C2 TI)

Here, the therapist invited the patient directly to discuss his thoughts about the therapist. Based on the current findings, the therapist might have thought that the therapeutic alliance between them was strong enough. This argument is consistent with research that suggests that therapists' use of specific techniques requires a strong enough therapeutic alliance (Everall & Paulson, 2002). Pine (1984) similarly argues that patients especially those with extreme difficulties might require a holding environment before their therapists made any interpretation. In other words, high levels of therapeutic alliance may provide a holding environment that is necessary to discuss relationship patterns. Moreover, the therapist's perception of strong therapeutic alliance may have implied that the patient was prepared affectively to hear the therapist's category2/3 transference interpretations, so enabling the therapist to make these comments confidently. It was also suggested that therapists' use of interpretations is more beneficial when they are offered to patients with enough emotional strength (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989). In the current study, the therapist may have needed to perceive the patient as emotionally prepared and strong enough to hear the encouragements of the therapist to discuss his feelings and thoughts

about the therapist. She may have inferred that the patient's perception of the therapist as understanding and his expression of positive emotions during sessions, which are stated in TPOCS-A measure and evaluated as an indication of a strong therapeutic alliance, may have been an indication of the patient's readiness to hear such interpretations.

In another example:

P: Whenever I came here, I saw you wear a skirt. I think this is what is expected, the weather is so hot, isn't it?

T: Yes. Here, you asked questions about me before, or questions that were related to my feelings and thoughts about you (C1 TI).

P: I did.

T: I saw this as your feeling close to me (C2 TI)

P: This is why I am here (laughs), I do not know.

The session unit mentioned above demonstrates the therapist's use of both category1 and category2 transference interpretations in the same unit. She first comments on patient's behavior in treatment preparing the patient for the upcoming relational comment. Piper and colleagues (1999) made a similar distinction between "transference relationship" versus "treatment relationship." "Transference relationship" is associated with the feelings and thoughts of the patient about the therapist, and the "treatment relationship" is related to the happenings in the treatment room between the therapeutic dyad. Furthermore, they suggested that the strength of therapeutic alliance is associated with therapist pointing out the transference relationship, but it is not related to the pointing out the treatment relationship. The current findings support this suggestion. That is, the therapist of the current study, did not consider the level of therapeutic alliance before pointing out the transactions without including the patient's thoughts and feelings about the therapist

Even though previous research on the relationship between therapeutic alliance and transference interpretations did not compare different categories of transference interpretations, they still provide support for current findings. For example, Ryum and

colleagues (2010) based on their findings suggested that transference interpretations should be used as an intervention if there is a strong therapeutic alliance. In a similar vein, Gabbard and colleagues (1994) suggested that transference interpretations that were made in the context of weak therapeutic alliance may have a detrimental effect on the outcome. They suggested that therapeutic alliance strength must be taken into consideration before making transference interventions, arguing that whether transference interpretations have a favorable or detrimental impact on outcome depends on the therapeutic alliance strength (Gabbard et al., 1994). The authors suggested that transference interventions should be made when the patient was emotionally prepared to tolerate strong emotions that would be elicited by the interpretations of the therapist.

The following example illustrates the use of category3 transference interpretation:

(Session 42)

P: Let's say, after I graduated from university, I meet you. What would you do?

T: You are exploring where you are in my life? (C3 TI)

P: Sometimes I wonder, I cannot help myself thinking something...

T: It seems there was a negative tone in your voice, it is like "Perhaps you do not want to see me" (C3 TI).

P: Maybe, it is not because I am a bad person. Perhaps you are busy, or you engage in something more valuable than me at that moment.

T: You mean I will ignore you? (C3 TI)

The extract shows how the therapist explores the patient's beliefs about what the therapist might feel or think about the patient. Both category2 and category3 transference interpretations are related to the patient's thoughts and feelings about the therapist with different emphasis. Consequently, we created a combined total score to measure the impact of these interpretations.

In contrast, there was no evidence of an association between the therapeutic alliance strength and the therapist's use of category1 transference interpretations in the

current study. Category1 transference interventions refer to any interpretation that points out the transactions in a therapeutic dyad, occurring in the "here and now" of the therapeutic relationship (Ulberg et al., 2014). An example of category1 transference intervention is given in the following example (session 31):

T: Now, you are talking about others' opinions about what you will do in the future. What do you want to do in the future? (C1 TI)

P: I have not decided yet. If I was successful at geography class, I would be admitted to psychology.

Here the therapist is pointing out the patient's behavior in the transaction. The differences between different categories of transference interpretations are evident in this example. The current findings indicate that the therapist's attempts to point out the happenings in the "here and now" of the relationship did not require a strong therapeutic alliance. As mentioned earlier, transference interventions should be treated differently from other interventions in that whether they have a favorable or negative impact depends on the previous strength of the therapeutic alliance (Gabbard et al., 1994). The present study contributed to previous literature by showing that different categories of transference interventions should be evaluated separately while considering the context in which they are implemented. This result is also a good indication of the possibility that strong therapeutic alliance is not always a requirement to implement such specific therapeutic techniques. Taken together, pointing out the thoughts and feelings of the patient about the therapist/therapy have been evaluated and treated differently by the therapist from mere pointing out the transactions in the "here and now."

It was also suggested that even though therapeutic alliance is a powerful therapeutic component, its influence on an outcome is not that profound (Safran & Muran, 2006). In other words, the increase in therapeutic alliance strength does not always a good indication of a parallel increase in its favorable effect on treatment process. For this reason, it is reasonable for the therapist not to wait for the building of a strong therapeutic alliance at least for category1 type of transference interpretations.

Another important finding in the current study was the positive relationship between therapeutic alliance and patient's active cooperative engagement measured by TWS. In other words, when therapeutic alliance was strong, it led the patient to show active cooperative engagement. The observer-rated tool (TPOCS-A) used in the current study measures both collaborative and emotional aspects of the therapeutic relationship (McLeod & Weisz, 2005). Therefore, besides the affective part of the therapeutic relationship, the patient's willingness to collaborate on the therapeutic tasks has also been taken into account while evaluating the therapeutic alliance. Research suggests that therapeutic alliance emerges as a function of both affective and collaborative components of the therapeutic relationship (Ogrodniczuk, Piper, Joyce, & McCallum, 2000). For this reason, it was expected that therapeutic alliance would be related with active cooperative engagement component of TWS. The results supported this assumption. This finding is significant in the sense that it provides support for the construct validity for the measures used to assess therapeutic alliance and transference interventions. In the same line, Everall and Paulson (2002) suggested that when the patient sees the therapist as a person who can be trusted and who supports the patient, the patient's active cooperative engagement on goals and tasks of the treatment increases. Moreover, when the patient experiences the therapist and the therapeutic process as emotionally positive, then they become more willing to accept therapeutic tasks and willing to show cooperative engagement (Everall & Paulson, 2002).

The participant of the present study was referred to treatment by his mother. The significance of forming a strong therapeutic alliance when patients are not self-referred was discussed before. For this reason, it may be especially important for this patient to achieve emotional security associated with the affective aspect of the therapeutic alliance before showing active cooperative engagement. In other words, a strong therapeutic alliance may be needed for active cooperative engagement, especially for adolescent patients who are not self-referred (Digiuseppe et al., 1996). Concerning the attitude of the adolescent patient, who has relational difficulties, it may

be especially important for this patient to feel safe and connected with the therapist before collaborating on therapeutic tasks.

Furthermore, according to the findings of Cirasola and colleagues (2021), in therapies (e.g., short term psychoanalytic psychotherapy) focusing on emotional expression, patients give particular importance to developing an emotional relationship with their therapists, which provides an opportunity for them to engage willingly in the therapeutic process. It may be assumed that a similar process has taken place for the adolescent patient in the current study; in other words, his willingness to feel connected and closer with the therapist may have paved the way building a strong therapeutic alliance, thus enabling him to cooperatively engage in his therapy focusing on his experiences and emotions.

Therapeutic alliance strength has not been found to be related to the degree to which the therapist pointed out the patient's attempt to avoid unpleasant emotions. This is not surprising given the similarity between this item and some of the category1 transference interpretations. In the current study, some of the category1 transference interpretations were utilized by the therapist to point out the patient's attempt to avoid unpleasant emotions. The following session unit (Session 27) demonstrates the therapist pointing out the patient's attempt to avoid unpleasant emotions.

T: How did we come to talking about Abdulhamit? (C1 TI)

P: Actually, we were talking about football teams. I mean I was talking about it (laughs). Let's make it correct, a little correction. I guess I love talking nonsense, at least right now. I am not talking about relevant things here.

T: Maybe you are trying to gain some time not to talk about other things (C1 TI).

P: Maybe. But I also doubt if I have something to talk about. I mean I do not know. So I do not feel like talking about it.

The extract above shows examples of the therapist making category1 interpretations by pointing out the patient's attempt to avoid unpleasant emotions. The therapist in the current study may have thought that pointing out the patient's attempt

to avoid unpleasant emotions may be an indication of the possibility that she understood the patient's difficulties in his life, which were difficult for him to explain during treatment. Moreover, perhaps she may have reasoned that pointing out the patient's avoidance of talking about particular subjects could be understood as the therapist's willingness to know much more about the patient. These possible thoughts of the therapist might have been an indication of the fact that a strong therapeutic alliance does not need to be required for the therapist to point out the patient's attempt to avoid unpleasant emotions. The therapist's pointing out the patient's avoidance of experiencing unpleasant emotions was probably beneficial for the patient. It was shown that the wellness of the patients increases when they began to talk about their emotions that are unpleasant for them (Kahn & Hessling, 2001).

Another example illustrating how the therapist points out the patient's attempt to avoid unpleasant emotions and experiences.

(Session 27)

P: But in fact I figure out nothing. I think blankly and just staring the chessboard. Here is the situation now. I cannot think of anything.

T: Yes, because we have just got to the complicated part. That is why you cannot think of anything. (C1 TI)

P: Yes (laughing)

The above extract also demonstrated the therapist pointing out the patient's attempt to avoid talking about a particular subject by a category1 interpretation.

Adolescent patients, who are especially self-referred to psychotherapy, may behave in a resistant manner, and the therapist's attempts to increase the patient's motivation to open up his feelings and experiences comfortably may help the patient to invest in treatment (Sommers-Flanagan, Richardson, & Sommers-Flanagan, 2010). Given that the current study was conducted with an adolescent patient, the same process would be provided by the therapist by pointing out the patient's attempt to avoid unpleasant emotions. This could be an indication of the possibility that a strong therapeutic alliance may not need to be a prerequisite for the therapist pointing out the

patient's avoidances, but rather the therapist's intervention pointing out the patient's avoidance may have a favorable effect on treatment process. It is sometimes difficult for teenagers to talk about their experiences in treatment process (Gensler, 2015). For this reason, it may be more beneficial for therapists to be interested in the experiences of teenagers, which may facilitate patients to talk about the experiences and difficult topics more comfortably. In the current study, the therapist may have showed her interest in the patient's life by pointing out the patient's attempt to avoid unpleasant emotions. In other words, the therapist's pointing out the patient's attempt to avoid unpleasant emotions may be an indication of her serious interest in his difficult experiences, which do not need a strong therapeutic alliance.

4.1. CLINICAL IMPLICATIONS

The results of the current study demonstrated that therapeutic alliance strength is an important therapeutic ingredient that exerts an influence on the therapists' attitudes in the therapeutic process. Firstly, the therapist's use of category2 and cateory3 transference interventions (e.g., the extent to which the therapist refers to the thoughts and feelings of the patient about the therapist and/or therapy) was predicted by the therapeutic alliance strength. It seems reasonable to argue that, if the therapeutic alliance is strong, then it creates a potential for the therapist to make interpretations and invited the patient to discuss their thoughts and feelings about the therapist and treatment. The clinical implication of this finding is that perhaps it is more preferable to take into account the level of therapeutic alliance while considering to discuss patients' thoughts and feelings about their therapists and treatment. Since directly discussing these aspects of the relationship can be difficult and challenging for the patients. Therefore, it may be more beneficial to establish a therapeutic bond and look for the signs of the patient's willingness to ally with the therapist before pointing out the perception of adolescent patients about the therapist and/or therapy. Secondly, the level of therapeutic alliance is associated with the level of patient's active cooperative

engagement. More specifically, high levels of therapeutic alliance predicted patient's active cooperative engagement. Of particular importance is the fact that adolescence is a stage in which being dependent on others and/or being an independent person are significant concerns (Digiuseppe et al., 1996). For this reason, while attempting to engage adolescent patients in tasks and goals of the treatment process, therapists should approach cautiously to this patient group. For example, therapists determining and imposing tasks and goals upon adolescents may contradict the necessities of their developmental stage. Therefore, before engaging adolescent patients in treatment, therapists should take the necessary steps to create an affective bond in the therapeutic dyad. Moreover, children and adolescents are generally not self-referred, causing them to come to the therapy in a resistant manner (Digiuseppe et al., 1996). Adolescents, especially those who are not self-referred may be resistant, and reluctant to collaborate with the therapist in sharing emotions and experiences. The therapist's pointing out the avoidance of unpleasant emotions may imply that she understands the patient's difficulty talking about the subject which he attempted to change. For this reason, a strong therapeutic alliance may not be necessary since it may be experienced by patients as the therapist's attempt to understand and engage the patient in treatment.

4.2. LIMITATIONS

Even though the current study measured the process variables longitudinally, it is important to highlight that the number of observations is limited. It would be preferable if the number of observations was higher. Moreover, there were eight missing sessions in the current study because of technical problems. Another limitation of the current study was that it was the forced termination of the treatment due to the therapist's graduating and finishing her clinical psychology training at Istanbul Bilgi University. For this reason, the current treatment process in this study cannot be seen as naturally terminated, which may have influenced the patient's and the therapist's attitudes toward the treatment process.

In the current study, Granger Causality test was utilized. Granger Causality test does not elicit the exact nature of causal relationships between variables but rather it shows the approximate causal relations between variables (Granger, 1969). Possible time lag associations other than the one used in the current study may have brought different relations and findings.

Even though transference interpretations are grouped into 5 different categories based on TWS manual, there were only a few category4 and no category5 transference interpretations in the current study. For this reason, no comparisons were possible between all different categories of transference interpretations. Given the nature of these interventions, it is not surprising that they were not utilized in treatment with an adolescent patient.

The current study is a case study where the generalizability of findings is limited. Nevertheless, the findings provide valuable insights about two important treatment process related constructs, and future studies can extend these findings by measuring them across larger number of participants.

Even though the TWS used in the current study has been translated into Turkish, its psychometric properties have not been examined within the Turkish culture. However, the scale was used by native Turkish speaker clinicians in their study (Sohtorik İlkmen & Halfon, 2019). In their study, they examined the relationship between the analyst's use of transference interpretations and the changes in the patient's insight and emotion expression over the course of long-term psychoanalysis. Findings of the study demonstrated that transference interpretations increased the patient's insightful attitude and exhibition of positive emotions. Even though they did not examine the reliability and validity of the scale with a Turkish sample, their study may legitimize the use of the scale by native Turkish speaker clinicians while coding the psychotherapy sessions in Turkish.

CONCLUSION

The current study attempted an in-depth exploration of the associations between different types of transference interpretations and therapeutic alliance. Furthermore, the relationship between therapeutic alliance and patient's active cooperative engagement was investigated. Finally, the link between therapeutic alliance and the extent to which the therapist pointed out the patient's attempt to avoid unpleasant emotions was explored. Findings showed that a strong therapeutic alliance facilitated the therapist's use of transference interpretations that explored/interpreted patient's thoughts/feelings about the therapist/therapy, but not those interventions that merely pointed out the transaction between them. Therapeutic alliance strength was not related to the extent to which the therapist pointed out the patient's attempt to avoid unpleasant emotions. Lastly, therapeutic alliance strength predicted the patient's active cooperative engagement.

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APPENDICES

Appendix A: Transference Work Scale (TWS)

Identification

1. Are there any transference interventions in the transcript from patient_____,session_____and segment_____? YES NO

If YES, answer the following questions:

2. What is the index number at the beginning of the Initial Transference Intervention (ITI)? _____

3. ITI is the first therapist-patient interaction in the transcript. YES NO

4. ITI is the last therapist-patient interaction in the transcript YES NO

5. What is the category of the ITI? _____

Timing –of the Initial Transference Intervention (ITI)

6. To what degree does the therapist's ITI connect naturally to the preceding clinical material, such as content and time, context, allusions to the transference, and other relevant issues?

0 1 2 3 4

7. How precise and striking is the therapist's ITI?

0 1 2 3 4

Category of the Transference Interventions (TI) in the Transference Work (TW

8. Does the TW include TI of category 1? YES NO

9. Does the TW include TI of category 2? YES NO

10. Does the TW include TI of category 3? YES NO

11. Does the TW include TI of category 4? YES NO

12. Does the TW include TI of category 5? YES NO

If more than one Transference Intervention (TI) in the Transference Work (TW), please score questions 13 and 14. If not, continue with question 15:

Timing –of the first Transference Intervention (TI) with the highest category score in the Transference Work (TW)

13. To what degree does the therapist's TI connect naturally to the preceding clinical material, such as content and time, context, allusions to the transference and other relevant issues?

0 1 2 3 4

14. How precise and striking is the therapist's TI?

0 1 2 3 4

Content in the Transference Work (TW)

15. To what degree does the therapist refer to the patient's relation to others?

0 1 2 3 4

16. To what degree does the patient refer to the patient's relation to others?

0 1 2 3 4

17. To what degree does the therapist refer to the patient's relation to parental figures?

0 1 2 3 4

18. To what degree does the patient refer to the patient's relation to parental figures?

0 1 2 3 4

19. To what degree does the therapist point out the patient's attempt to avoid themes in the session in order to control unpleasant emotions and thoughts?

0 1 2 3 4

20. To what degree does the therapist refer to the patient's symptoms?

0 1 2 3 4

21. To what degree does the patient refer to the patient's symptoms?

0 1 2 3 4

Valence – in the Transference Work (TW)

22. To what degree does the therapist make use of supportive interventions?

0 1 2 3 4

23. To what degree is the therapist challenging in the interventions?

0 1 2 3 4

Response – in the Transference Work (TW)

24. To what degree does the patient express associations and/or self reflections in the TW?

0 1 2 3 4

25. To what degree does the patient show active cooperative engagement?

0 1 2 3 4

26. Identify with the patient: What is the highest level of emotional involvement?

0 1 2 3 4

ETHICS BOARD APPROVAL

Ethics Board Approval is available in the printed version of this dissertation.