AN INVESTIGATION OF TRANSFERIENCE
USING REPERTORY GRID TECHNIQUE

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SUMMARY

A review of the clinical literature on transference indicates that considerable controversy exists over the meaning of the term. Its relationship to another, more recently defined therapeutic variable - the treatment alliance - is discussed, and it is suggested that much of the disagreement as to the nature of transference stems from its confusion with the concept of treatment alliance.

Relatively few empirical studies are to be found on the subject of transference, a fact which may be due to the failure of psychoanalytic theorists to state their hypotheses in a clearly testable manner. However, two recent studies have attempted its investigation with the use of repertory grid technique (Sechrest, 1965; Crisp, 1964, 1965, 1966). It is concluded that these writers were making the incorrect assumption that transference reactions are to be found in all patients at any point in therapy, or indeed in individuals not in therapy at all.

The aim of the present investigation was to study the phenomenon further by comparing a psychiatric assessment of transference with a psychological measure derived from repertory grid testing, and to re-examine the findings of Crisp and Sechrest. A number of psychiatrists were asked to specify patients in whom they considered a definite transference relationship was occurring. Attention was concentrated on two particular aspects of the transference phenomenon - the 'evaluative' component (i.e. the extent to which the patient expresses positive or negative feelings towards the therapist) and the 'figural' component (i.e. the extent to which the therapist is identified with a specific figure from the patient's life situation).

Six psychiatrists and ten patients took part in the study. The psychiatrists were provided with a rating form on which to assess the transference situation. A repertory grid test was applied to the patients, from which transference measures were derived. The psychiatric and patient ratings were then compared. Both measures were re-applied two weeks later to assess whether any changes in
transference had taken place, and to evaluate the stability of the repertory grid during this period.

The results were as follows:

1) The repertory grid test proved to be highly stable (in terms of structure and content of the first principal component) over the two week period.

2) Analysis of the psychiatric rating scale indicated that therapists tended to propose 'real' or 'ideal' parents as transference figures.

3) A comparison of the psychiatric and patient 'evaluative' scales showed that, while both tended to be positive and stable between test and retest, they were not significantly correlated. Some evidence was obtained to suggest that the therapists were successful in predicting the direction of small changes in the patients' evaluation of them.

4) There was no relationship between the transference figure which the therapist proposed and the position of that figure (relative to the therapist) on the patient's repertory grid. Furthermore, no evidence was obtained for the Freudian hypothesis that the therapist was likely to be identified with the patient's father or mother.

5) Repertory grid test results indicated that patients tended to see the therapist as similar to 'ideal father', 'ideal self' and 'G.Rs in general', and as dissimilar to negative figures in their lives. These findings provided some support for both Crisp's and Sechrest's studies.

The extent to which repertory grid tests can provide an adequate measure of the transference phenomenon is discussed. It is also suggested that the concept of transference may have little usefulness as a therapeutic variable in non-analytic settings, and alternative measures of the patient-therapist relationship are proposed.
INTRODUCTION

A. The Freudian View of Transference

The term 'transference' first made its appearance in Freud's 'Studies on Hysteria' in 1895. It was described in relation to his psychotherapeutic technique of eliciting verbal associations from his patients. This technique, free association, was intended to provide the patient with a link between his present symptoms on the one hand and his past experiences on the other. Freud observed that, during the course of treatment, changes often developed in the patient's attitude to the physician. These changes, which involved strong emotional components, could cause an interruption in the process of free association, often resulting in substantial obstacles to treatment. Thus, he wrote that, "... the patient is frightened at finding that she is transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis. This is a frequent and indeed in some analyses a regular occurrence. Transference on to the physician takes place through a false connection." (1895) This 'false connection', made by the patient, tended to occur between a person who was the object of earlier (usually sexual) wishes and the doctor. The transference of these wishes onto the analyst was an unconscious one, insofar as the patient experienced them not as something belonging to the past, but as new events. In this connection, Freud remarked on the propensity of patients for developing erotic attachments towards their doctors. At this point in time, Freud was only aware of the negative aspects of the phenomenon. It was necessary to make the transference conscious to the patient, to demonstrate that it was an obstacle to treatment, and to trace its origin in the therapeutic hour.

By 1905, however, Freud had come to recognise the importance of transference and its potential usefulness as a therapeutic tool. In 'A Case of Hysteria', Freud described how his young, hysterical patient 'Dora' broke off treatment with him after three months. Only subsequently was he able to attribute his therapeutic failure with Dora to his misinterpretation of the 'transference'. Freud had been unaware
of the patient's transference on to him of feelings towards an important figure in her past. He wrote: - "In this way the transference took me unawares, and because of the unknown quality in me which reminded Dora of Herr K., she took her revenge upon me as she believed herself to have been deceived and deserted by him. Thus she acted out an essential part of her recollections and phantasies instead of producing it in the treatment." In this paper, Freud put the question: - "What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment." (1905)

By now, the main characteristics of transference reactions had developed. They were to be seen as the experiencing of feelings towards a person which do not necessarily befit that person and which actually apply to another. Essentially, a person in the present is reacted to as though he were a person in the past. The people who are the original sources of transference reactions are the meaningful and significant people of early childhood, usually the parents. (Freud, 1912) Freud stressed that "psychoanalytic treatment does not create transferences, it merely brings them to light." Within the psychoanalytic setting, however, transference reactions offered the analyst an invaluable opportunity to explore the inaccessible past and the unconscious. It was important to note that the patient tends to repeat the past, rather than to remember it. "... the repetition is always a resistance in regard to the function of memory. However, by repeating, by re-enacting the past, the patient does make it possible for the past to enter into the treatment situation. Transference repetitions bring into the analysis material which is otherwise inaccessible. If properly handled, the analysis of transference will lead to memories, reconstructions and insight, and an eventual cessation of the repetition." (Freud, 1912)
Why should transference reactions take place at all? Freud (1912) wrote: - "Instinctual frustrations and inhibitions cause the neurotic to seek belated opportunities for satisfaction." Thus, by re-enacting past relationships in the present, the patient seeks gratification where before there was only frustration.

By 1912, Freud had attempted some classification of the transference reactions. While recognising that all transference phenomena are essentially ambivalent in nature, he divided the general concept of transference into transference of positive feelings and transference of negative feelings. The positive transference referred to the different forms of sexual longing, as well as liking, loving, and respecting the analyst. The negative transference implied some variety of aggression in the shape of anger, dislike, hate, or contempt towards the analyst. Freud further divided positive transferences into transference of friendly and affectionate feelings, of which the patient was aware, and transferences which represented the return, possibly in distorted form, of childhood erotic relationships, which were largely unconscious. It was considered that positive transferences of the latter sort, together with negative transferences, could develop into resistance to treatment. The friendly and affectionate component of the positive transference was described as representing "the vehicle of success in psychoanalysis." (Freud, 1912) As Sandler (1970) has recently pointed out: - "The essential distinction made by Freud at this time was between the patient's capacity to establish a friendly rapport and attachment to the doctor on the one hand, and the emergence within the framework of the treatment, of revived feelings and attitudes which could become an obstacle to therapeutic progress. . . . the fact that Freud used the term 'transference' for both these aspects of the relationship has been a source of confusion in subsequent literature." This topic will be discussed further in the next section.

By 1914, Freud had further developed the concept of transference. In the paper, 'Remembering, Repeating and Working-Through', he introduced the notion of 'transference neurosis'. The term was used to describe a regular occurrence in the transference reactions of a patient undergoing psychoanalytic treatment. During the course of analysis, Freud observed,
the patient's interests became increasingly more focussed on the person of the analyst. He wrote:— "We regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his (the patient's) ordinary neurosis by a 'transference neurosis' of which he can be cured by the therapeutic work." 'Transference neurosis' was, therefore, the term used to define the clinically induced neurosis of the present. In the working out of the transference neurosis, the patient gradually learned to deal with the same emotional conflicts which he could not master in the past, and which he had, therefore, repressed and excluded from consciousness.

It is unfortunate that the term 'transference neurosis' was to gain a second meaning. In 1916, Freud divided psychiatric disorders into two groups, on the basis of whether or not a patient could develop and maintain a relatively cohesive set of transference reactions and still function in the analysis and in the external world. Patients with a 'transference neurosis' could do this, while those with a 'narcissistic neurosis' could not. Under the heading of 'transference neurosis' came hysterics, phobics and obsessive-compulsives. The term 'narcissistic neurosis' was intended to comprise patients with functional psychoses. The analysable patient was required to have an ego capable of temporarily regressing to transference reactions, but this regression had to be partial and reversible so that the patient could be treated analytically and still live in the real world. The schizophrenic or manic-depressive patient was considered incapable of doing this.

From its original conception as an obstacle to treatment, transference came to be viewed by Freud as "a factor of undreamt of importance." (1938) Techniques of psychoanalysis were developed whereby the phenomenon would be maximised. In 1912, Freud developed 'The Rule of the Mirror'. The aim of the analyst became the mirroring of the patient's thoughts, feelings and behaviour. By letting the patient know as little as possible about the therapist, it was expected that he would fill in the blank spaces with his own fantasies. 'The Rule of Abstinence', developed in 1915, proposed that:— "Analytic treatment should be carried through, as far as is possible, under
privation - in a state of abstinence." (Freud, 1919) Freud maintained that the patient's symptoms, which drove him into treatment, consisted in part of warded-off instincts seeking satisfaction. In analysis, prolonged frustration should induce the patient to regress, so that his entire neurosis would be re-experienced in the transference, as the transference neurosis. However, allowing symptom-substitute gratifications of any size would deprive the patient of his neurotic suffering and his motivations to continue treatment. By the abstinence rule, Freud was trying to prevent his patients from making a premature 'flight into health'.

Thus, psychoanalysis became distinguished as a therapy, by the way in which it promoted the development of the transference reactions and by its attempts to systematically analyse transference phenomena.
B. Developments and Modifications of the Concept of Transference

Since Freud's original definition of transference, numerous attempts have been made to refine and expand the concept, both within psychoanalytic circles and without.

In recent years, psychiatry and other medical disciplines have been paying increasing attention to the relationship between the patient and the doctor, and the concept of transference has frequently been applied rather loosely as a synonym for relationship in general, in this setting. However, as Sandler (1970) has pointed out in a recent review of psychoanalytic concepts, "a distinction has always been made within clinical psychoanalysis between transference 'proper' and another aspect of the patient's relation to the doctor which has been referred to in recent years as the 'therapeutic alliance', 'working alliance' or 'treatment alliance'."

It is this other aspect of the patient's relation to the doctor which Freud touched on in 1912, when he subdivided the positive transferences into 'the friendly and affectionate aspects of transference' which help the therapeutic work and 'the erotic transferences' which may hinder it. Although he maintained the importance of this distinction, the fact that he retained the term 'transference' for both these aspects of the relationship has doubtless caused a blurring of the concept and a certain amount of confusion among subsequent writers.

At the same time, there have been numerous attempts to maintain and clarify the distinction. Sterba (1934, 1940), in two papers, emphasised the need for the psychoanalyst to bring about a separation within the patient of those elements which are focussed on reality and those which are not. The former allow the patient to identify with the aims of the doctor, a process regarded by Sterba as essential for successful analytic treatment. In the same context, Fenichel, in 1941, wrote of a 'reasonable' aspect of the patient, and what he called a 'rational transference'. Somewhat later, Zetzel (1956) coined the term 'therapeutic alliance', and thus achieved a more complete separation of the two kinds of relationship. More recently, Greenson (1967) has
employed the concept of a 'working alliance' to define the "relatively non-neurotic, rational rapport" which the patient has with his analyst. The label 'working alliance' was selected because the term emphasises its outstanding function; it centres on the patient's ability to work in the analytic situation. Greenson has maintained that it can be seen at its clearest when a patient is in the throes of an intense transference neurosis, and yet can still maintain an effective working relationship with the analyst. The core of the working alliance is formed "by the patient's motivation to overcome his illness, his sense of helplessness, his conscious and rational willingness to co-operate, and his ability to follow the instructions and insights of the analyst."

In tracing this concept through the literature, it becomes clear that the 'rational transference' (Fenichel, 1941), 'therapeutic alliance' (Zetzel, 1956), 'working alliance' (Greenson, 1965) and 'treatment alliance' (Sandler, 1970) all have in common an emphasis on a relatively non-neurotic, rational and helpful relationship between patient and therapist.

However, Greenson has pointed out that the differentiation between transference reactions and working alliance is not an absolute one, since the working alliance may contain elements of the infantile neurosis which will eventually require analysis. In this context, he writes that, "the awareness of neurotic suffering also compels the patient to establish a relationship with the analyst. On a conscious and rational level the therapist offers a realistic hope of alleviating the neurotic misery. However, the patient's helplessness in regard to his suffering mobilises early longings for an omnipotent parent. The working alliance has both a rational and an irrational component." (1967)

Nevertheless, there appears to be a strong case for distinguishing the concept of 'working alliance' from other aspects of the patient's relationship to his doctor which are not sufficient in themselves to form a successful basis for psychoanalytic treatment. Sandler has suggested that, in the future, it may be necessary to obtain some assessment of a patient's capacity to form a treatment alliance with his physician. Particularly with psychotic patients, "the assessment,
during the initial period of doctor-patient interaction, of the
patient's capacity for forming a treatment alliance must have
diagnostic significance with regard to the severity of the disorder,
and prognostic significance where the prognosis is related to the
method of treatment." Greenson has indicated that a patient must
develop both a 'transference - proper' and a 'working alliance' with
the therapist in order to be analysable, and it is certainly true that
Freud's refusal to treat psychotic patients stemmed partly from his
belief that they were unable to develop an adequate working alliance
with the analyst.

It should be pointed out that not all psychoanalytic writers
accept the necessity of a treatment alliance as a prerequisite for
psychoanalytic treatment. Instead, some have tended to widen the
corpus of transference far beyond its original definition. This
trend is seen, for example, in the technique of Melanie Klein and her
followers. (Klein et al., 1952) In her method, all communications by
and behaviour of the patient in treatment tend to be conceptualised
and interpreted as transference of postulated attitudes and feelings.
The Kleinian School, therefore, relies almost entirely on transference
interpretations to the exclusion of everything else. The trend
similarly found its expression in the followers of James Strachey (1934),
who suggested that the only effective interpretations in psychoanalytic
treatment were transference interpretations. In consequence,
Strachey's followers chose to formulate as many of their interpretations
as possible in transference terms, in order to increase the effective-
ness of their interventions. It seems that this wide use of the
'transference' concept, in which all communications and behaviour within
the psychoanalytic setting are regarded as transference, can only render
the term relatively meaningless - at least if it is to be extended
outside psychoanalytic treatment.

To return for a moment to the narrower sense of the term as the
experiencing of feelings towards the therapist which are not
appropriate to him, and which actually apply to another, Freud had
proposed that the objects who were the original sources of the
transference reaction were the important people of a child's early
years, - as a rule, the father or mother. Thus, a practical method for designating a particular type of transference phenomenon is to label it according to the object relationship from early childhood to which it owes its origin. In this way, we may speak of a father transference, a mother transference, a brother transference, and so on. It was expected that, during the course of analysis, the object relationship determining the transference reaction would change as the analytic work progressed. For example, a patient might begin analysis with a predominantly father transference which could slowly change to a mother transference. Greenson has suggested that transference reactions may also be derived from later figures and even current figures, but that analysis will reveal that these later objects are secondary, and were themselves evolved from the primary, early childhood figures.

Another common means of classifying transference phenomena is to label them as predominantly positive or negative, and this was Freud's favourite means of designation. As was mentioned previously, the positive transference usually comprised loving and sexual feelings, the negative transference hostile and aggressive feelings. Some psychoanalytic writers have pointed to another aspect of the positive transference - the idealisation of the therapist, in which he is seen as perfect or supremely capable. In this context, Greenacre (1966) has suggested that certain elements of a child's early life, if exaggerated, "may favour an over-idealisation of the analyst or of analysis to a degree that is not helpful and may become rigidly binding and tenacious." Such idealisations can cover underlying hostile feelings and may break down (often quite dramatically) if the patient feels disappointed or if hostile feelings become too strong. At the root of such idealisations is the natural ambivalence felt towards parents in childhood. In patients prone to idealisation, it appears that hostile feelings in childhood were either found to be intolerable, or not tolerated by the parents, with the result that repression of such feelings occurred, and instead an anxious over-attachment or over-evaluation of the parents was formed. Greenson, too, has written
of the idealised transference reaction:- "These are patients who can maintain for years on end a stubborn positive idealised transference for their analyst. This transference reaction is ego-syntonic and yields to analysis only with difficulty. In part it is hard to demonstrate the underlying hostility because these patients are skilful in finding auxiliary transference figures onto whom to displace their hatred. . . . . If one persists in analysing the idealised transference as a resistance and gives no neurotic transference gratifications, ultimately the idealisation breaks down. Then one can see the enormous rage and hatred in the patient as well as the paranoid suspiciousness." (1967)

Clearly, both these methods of labelling the transference - on the one hand, according to the object relationship from which it originated, and on the other, according to the predominant feelings experienced - can be combined, and one may then speak of a 'positive father transference', a 'negative mother transference', and so on.

While some writers have extended the concept within the psychoanalytic situation, others have taken the view that transference should be regarded as a general psychological phenomenon. Greenson, for example, has indicated that for a reaction to be considered transference it must have two characteristics: it must be a repetition of the past, and it must be inappropriate to the present. Sandler (1970) has pointed out that "such a definition appears to include more than Freud had originally intended: for example, it would include habitual types of reacting to other persons which have become part of the patient's character - e.g. a tendency to be afraid of authority. This is quite different from the conception of transference as the development, during the process of the psychoanalytic work, of feelings which were not apparent at the beginning of the treatment, but which emerged as a consequence of the condition of treatment." Sandler's criticism is not completely warranted, since Greenson has himself specified this particular form of reaction, and has labelled it a 'generalised transference reaction'. He writes:- "The patient's transference behaviour toward the analyst is usually quite distinct from his behaviour toward most of the people in his outside life except for those few who are
similar transference figures. Transference reactions are ordinarily specific and circumscribed. By Generalised Transference Reactions is meant a form of transference phenomenon which differs from all other previous forms precisely in being unspecific and uncircumscribed. Here the patient reacts to the analyst as he reacts to many or most of the people in his life. The transference behaviour is not distinctive, but typical and habitual." (1967) This form of transference had earlier been designated by Wilhelm Reich (1928) as 'character transference'. In other words, they are reactions which have become character traits of the individual manifesting them. According to Greenson, they are so deeply rooted in the patient's character structure and so well rationalised that they are difficult to make the subject of analysis. It is evident that this type of character trait will be found not only in the patient undergoing analysis, but in the majority of normal individuals.

Accepting the proposition that transference is a general psychological phenomenon one may ask whether there are any particular types of people who are more likely to arouse transference reactions than others. Greenson (1967), for example, has indicated that "transference reactions are more apt to occur in later life toward people who perform a special function which originally was carried out by the parents. Thus, lovers, leaders, authorities, physicians, teachers, performers and celebrities are particularly prone to activate transference responses. Furthermore, transference reactions can also occur to animals, to inanimate objects and to institutions, and here, too, analysis will demonstrate that they are derived from the important people in early childhood."

The concept of 'institutional transference' has, in fact, gained increasing attention in recent years. Within a psychiatric context, Goldsmith (1970) has described it as "the variable which figures most prominently in the recovery of some patients." In 1953, Reider had described a group of patients in whom the transference was to the clinic and not to their therapists, and had implied that the therapist can be but the incidental agent in the treatment of some patients. Harris, too, has stated that, in certain cases "... the clinic has become
invested with parent-like qualities furnishing them (the patients) with emotional support." (1966) This emotional attachment to the institution tends to be accompanied by a concomitant detachment from particular individuals who constitute the institution (Saperstein, 1967). Thus, some patients demonstrate a definite inability to enter into an intense relationship with an individual therapist. These patients come to the clinic or institution, but not to the doctor. Prominent among such patients may be "schizoid people who are unable to tolerate the vulnerability which is associated with a close personal relationship, but may have an immense need for narcissistic supplies which can only be safely obtained from institutions." (Goldstein, 1970) This particular application of the transference concept would seem to be capable of generalisation to include transference reactions to various types of institutions, e.g. universities, prisons, etc., on the part of normal as well as psychiatric populations. Goldsmith (1970), for example, has discussed the development of institutional transference reactions on the part of psychiatric residents.

The tendency towards broadening the concept of transference outwith the psychoanalytic situation has a basis in Freud's own work. In 1905, for example, he stated that: "All people have transference reactions: the analytic situation only facilitates their development and utilises them for interpretation and reconstruction." Again, in 1912, he wrote: "It is not a fact that transference emerges with greater intensity during psychoanalysis than outside it. In institutions in which nerve patients are treated non-analytically, we can observe transference occurring with the greatest intensity." Such comments were among his repeated references to the fact that the phenomena which could be observed in psychoanalytic treatment could also be observed outside it.

In summary, a number of divergent trends have occurred with respect to the concept of transference. For instance, some writers, notably among the Kleinian School, have widened the concept to encompass all patient-therapist relations. Others, perhaps feeling that the concept has become too nebulous, have attempted to distinguish
various types of relationship between patient and doctor, of which transference is only one. The notion of 'treatment alliance' has been developed in this context. Attempts have also been made to classify the various transference reactions, e.g. on the basis of the predominant feelings towards the therapist (whether positive or negative), or on the basis of the object relationships from which the transference originated (e.g. father transference, mother transference, etc.). Other categories of transference reactions have also been formulated, among which are the 'idealised transference' and the 'generalised transference reaction'. A further trend, originating in Freud's own comments, has been towards regarding transference as a general psychological phenomenon, rather than a purely psychiatric concept.
C. Review of the Experimental Literature on Transference

In view of the recent upsurge of interest in the experimental study of doctor-patient variables in therapy (Goldstein and Dean, 1966), it is perhaps surprising that relatively little experimental evidence has accumulated on transference which is one of the earliest mentioned therapeutic variables. In part, this finding is undoubtedly due to the fact that transference has been essentially a psychoanalytic concept, and psychoanalytic theorists and practitioners have tended to be reluctant to subject their technique to scientific observation (Glover, 1952). At the same time, the very complexity of the variable has probably made it an unattractive subject for experimentation. Furthermore, there seem to be few experimental techniques available to explore the concept, particularly in view of the fact that most writers are agreed that transference relates to unconscious processes in the individuals demonstrating it. The appearance of Personal Construct Theory (Kelly, 1955) on the psychological scene, however, has enabled certain investigators to explore the topic. As Bannister (1966) has pointed out, repertory grid techniques do not involve a direct report, and therefore do not preclude the operation of unconscious tendencies.

In 1962, Sechrest studied the Freudian notion of transference using repertory grid technique. In particular, he explored the hypothesis that the patient in psychotherapy would liken the therapist to his father or mother, or at least someone from his early family situation. Sechrest's subjects were 35 patients (12 men and 23 women) who were receiving some form of interview therapy which their therapist was willing to call psychotherapy (in 17 cases of the supportive type, in 18 cases of the interpretive type). Eleven male therapists were involved. The patients were tested at the beginning of therapy and again six weeks later. The measure used was an adaptation of Kelly's Role Construct Repertory Test. In this test, the subject was asked to fill out a role title list with the names of 16 persons known to him, in addition to his own name. The 16 persons included family
figures, spouse, liked schoolteacher, minister, etc., and, in addition, the patient's therapist. From the 17 names thus obtained, the subject was then given three names at a time, and asked to indicate ways in which two of the persons were alike, and different from the third person. In this way a number of bi-polar constructs were elicited. After having given each construct and its opposite (contrast), the subject was asked to go over the remaining 14 names on the role title list and check the individuals who had the characteristic which formed the construct.

'Stimulus equivalents' of the therapist (degrees to which he elicited the same test response as each one of the 16 persons on the role title list) were obtained by counting the constructs attributed to him which he shared with any of the other 16 persons. Thus, if both therapist and father were checked as being 'tolerant', or if neither was checked, father would receive one point towards equivalence to the therapist. The equivalence score was the total number of points. Because subjects varied in the number of constructs they provided, the raw scores were converted to within-subject ranks before analysis. The person least like the therapist was given a rank of 1, the next a rank of 2, and so on. Data consisted of stimulus equivalence ranks for the therapist in the initial test period, and retest period, and changes between the two. Results indicated that 1. at both points in therapy, the therapist was most likely to be described as similar to the physician, then the minister, then the liked teacher. He was far less likely to be described as similar to either parent, self, a brother, etc. 2. All other persons listed by each patient on his role title list were then categorised as similar or not similar to the therapist in terms of sex, age, and occupational status. Mean person-therapist similarity scores were then determined for each patient for the two groups of persons: those similar to the therapist in age, sex or occupation; and those not similar. Analyses, for both test and retest occasions, revealed that the therapists were described as similar to those persons whom they did in fact resemble in sex, age and occupational status. 3. To determine changes in therapist description from the early to the late
therapy period, scores for initial similarity of a person to the therapist were subtracted from later similarity scores. Results showed that, across all the persons, the therapist description did not change between first and second testing.

Sechrest concluded that the Freudian transference hypothesis was not supported. He attempted to forestall criticisms of his measurement of transference in patients at the beginning of treatment by quoting Freud's remarks that the phenomenon is evident almost immediately in therapy. It seems possible that Sechrest, like many previous writers, has been confused by Freud's varied use of the term to describe a) that aspect of the positive transference which "is present . . . from the beginning of treatment" and which is different in quality from b) the erotic transferences which arise during the course of treatment. As has been discussed in the previous section, the former can be regarded as a component of the treatment alliance. It seems feasible to suggest, therefore, that Sechrest's study provides a measure of 'treatment alliance' rather than of 'transference proper'.

In a series of studies, again using Repertory Grid Technique, Crisp has investigated certain aspects of transference. His first study, in 1964, concentrated on one area of transference, namely, the hypothesised identification of the doctor with an 'ideal father' by the dependent patient. This particular 'transference' attitude of patients towards both general practitioners and psychiatrists was examined in three sub-studies: 1) by comparing two groups differing by social class: 2) in a group of psychoneurotic patients: 3) in three patients in a continuing therapeutic relationship, during which changes of attitude could regularly be assessed. Crisp developed a form of Repertory Grid Technique for the purposes of the study. His investigation, therefore, "embodied an attempt to demonstrate, by the testing of predictions, the validity of the technique for assessing the patient's attitudes to the doctor and the changes which can occur in these attitudes." The grid technique was one in which the subject was required to select as elements twenty people whom he knew well. Ten of the twenty people were of obligatory type. They included father; mother; spouse; self; a frightening person; a good friend;
an authoritarian person; a disliked person; plus the words 'ideal father' and 'ideal mother'. The other 10 elements were people of the subject's own choosing. The subject was then asked to pick out 10 from the 20 who, in his opinion, most conformed to each one of 36 different constructs. These 36 constructs were selected by Crisp as being important, on the basis of clinical experience, in most patients' construing of doctors. Thirty-three of the constructs were related to common needs and personality traits, e.g. conscientious, impulsive, reliable, etc. The remaining 3 key constructs were whole-person constructs:- a) 'ideal, dependable father' b) 'my G.P.' c)'the psychiatrist' (or, where the test was applied to patients, the name of the psychiatrist about to treat them).

The method of scoring was one whereby 'matching scores' were calculated between each of the 3 whole-person key constructs and all the other constructs. Differences could then be scored between the 3 key figures by comparing their matching scores on each construct. The sum of these comparative scores in each case represented a measure of the extent to which the individual's construing of 'ideal, dependable father' diverged from his construing of the two doctor figures. This total score, Crisp termed the 'transference score'. A low 'transference score' was intended to represent positive transference, i.e. when the subject regarded the 'ideal, dependable father' and the doctor figures in the same light, and a high 'transference score' a negative transference.

In the first of three sub-studies, Crisp applied the measure to two groups differing by social class, to assess whether differences in their hypothesised 'transference' attitudes to doctors could be demonstrated by this method. The two groups consisted of 10 normal, social-class I individuals, and 10 normal, social-class III individuals. Based on "an admixture of personal clinical judgment and sociological data and hypotheses" Crisp predicted that:- 1) the class III group would construe 'the psychiatrist' as less close to 'ideal, dependable father' than would the class I group: 2) the class III group would construe their 'G.P.' as closer to 'ideal, dependable father' than the class I group: 3) the social-class III group would construe their
'G.P.' more closely than 'the psychiatrist' to 'ideal, dependable father', and the class I group might do the reverse. Results confirmed the first two predictions and partly confirmed the third.

In Crisp's second sub-study, his repertory grid measure was applied to a group of psychoneurotic patients. The intention was to discover whether hypothesised differences of the 'transference' attitude to doctors between this group and the preceding groups of 'normal' individuals could be demonstrated by this measure. The group of neurotic patients comprised two sub-groups. Five patients with monosymptomatic phobias were out-patients who had seen a specific psychiatrist once with a view to having behaviour therapy. The other five, suffering from neurotic depression, were in-patients who had been seen once by a specific psychiatrist with a view to commencing psychotherapy. The predicted differences between the 'transference scores' of the neurotic group and the normal groups were based on a number of hypotheses. For example, neurotic patients were thought to be likely to enter into a greater 'transference' relationship with the doctor than other patients. Since this group of neurotic patients had come to doctors for help, it was likely that their 'transference' feelings would be positive. Similarly, Crisp hypothesised that the patients' transference attitudes to their G.P.'s might be influenced not only by the fact that their G.P.'s had referred them to a specialist but also that, in so doing, they had demonstrated their own relative inability to continue helping the patients. On the basis of these hypotheses, Crisp predicted that:

a) the neurotic group would construe both the G.P. and the specific psychiatrist more closely to the 'ideal, dependable father' than the normal group: b) they would construe the specific psychiatrist more closely to the 'ideal, dependable father' than their G.P.'s. Results substantiated the first prediction with regard to the specific psychiatrist, but not the G.P. The second prediction was not confirmed.

In the third sub-study, the measure was applied to the study of the 'transference' aspects of a continuing doctor-patient relationship in individual patients undergoing treatment. The intention was to discover whether the measure would prove to be sensitive to trends and
shifts in the 'transference' relationship as evaluated clinically. Three neurotic patients, referred for behaviour therapy, were studied in this way. During the treatment period the patients were seen by Crisp at regular intervals independently of the behaviour therapist. On these occasions, the patients were assessed clinically and by means of a rating scale in relation to their specific symptom under treatment and their total psychiatric state. A decision was made on each occasion about the current state of the 'transference' relationship with the therapist. The decision was based on a number of psycho-dynamic propositions: - a) the initial attitude to the therapist would be favourable; this was based on the fact that these were neurotic patients, keen to have treatment: b) so long as the therapist attended to and relieved the specific symptom and provided no other symptom developed, the 'initial' transference would become increasingly positive: c) if, during behaviour therapy, other symptoms developed which were incapacitating, and if the therapist did not attend to these, then a less 'positive transference' would ensue. Once the initial clinical assessment had been made, subsequent assessments were always compared with the preceding assessment. On the basis of this, a prediction was made on each occasion concerning the nature of the grid 'transference score' that would emerge. The prediction was only concerned with the relationship of this score to the preceding one, i.e. whether it would be a larger or smaller 'transference score'. Thus, an assessment that the (clinical) transference was more positive than at the time of the previous assessment led to a prediction that the 'transference score' would be lower than on the previous occasion, and vice versa. The patient was then immediately tested on the grid. Results indicated that, of a total of 14 applications of the test to these 3 patients, the prediction was correct 13 times.

On the basis of these three studies, Crisp concluded that his repertory grid measure appeared to be an accurate one in that predictions of the results were almost invariably correct.

In 1965, Crisp and Moldofsky reported a psychosomatic study of writer's cramp, in which 'transference attitudes' to the therapist were again measured using repertory grid technique. Crisp once more
attempted to measure that aspect of transference which contained an attitude of 'idealisation' of the doctor on the part of the patient. He also proposed that the doctor-patient relationship may come to contain other elements as it progresses. For instance, "if the doctor is non-authoritarian, attentive to the patient, of appropriate sex and perhaps age, a conscious or subconscious homosexual or heterosexual transference may develop." In order to investigate these two aspects of the 'transference' relationship, Crisp employed the whole-figure constructs: - 'ideal, dependable parent', 'best sexual partner' and 'Doctor . . .' (the therapist treating the patient). The original 36 constructs employed in the grid were reduced to the 20 most significant ones of the previous study. Otherwise, the form of the grid and the method of scoring were similar to those adopted by Crisp in 1964.

Seven patients were treated by a combined behavioural and psychotherapeutic approach along with a programme of re-education in writing - all three techniques being carried out by the same therapist. The clinical state of the patients was monitored by means of weekly interviews together with a patient symptom self-rating technique (Crisp, 1964). In addition, the 'transference' measure was applied after an initial interview with the therapist, and regularly thereafter. In spite of a lack of any statistical analysis of the data, Crisp concluded that a number of trends could be observed. For instance, he commented that the three treatment procedures were inevitably inter-related since the existence of a strong 'positive transference' in the general therapeutic situation was found to facilitate true relaxation (during the behaviour therapy part of the treatment). He further observed that: - "In most cases, 'transference' as measured by 'transference scores' seemed to bear a fairly direct relationship to clinical change despite the existence of other uncontrollable 'stress' variables in the life situation which might also be expected to influence the clinical state. Often an increase in 'positive transference' as observed and measured preceded clinical improvement."

In a more recent study (1966), Crisp explored further the findings of his previous investigations. This study comprised an attempt to
examine some of the alleged relevant variables in behaviour therapy of which the 'transference' relationship has been considered to be one. Fifty-four patients suffering from a psychoneurotic illness, often with phobic symptoms, were made the subject of the study. The 'transference' measure was, once more, the one derived from the repertory grid technique used in the 1965 study. The ongoing clinical state of the patient was scored in terms of the specific symptom under treatment and the general status of anxiety and depression. This score was arrived at by having the patient sort appropriate cards to describe his or her present state. An independent psychiatric assessment was also made on each occasion. It was never found to differ from the patient's self-rating in determining direction of clinical change since the previous assessment. Data analysis was again based on visual interpretation of 'charted' scores. The most general finding was "that there appear to be some overall relationships between 'transference' and clinical course." Thus, wrote Crisp, "the major clinical changes during treatment are often associated with or occasionally preceded by appropriate changes in 'transference'." More specifically, where the clinical state remained unchanged, 'transference' remained unchanged at the end of treatment; where the clinical state was improved, 'transference' was also more positive at the end of the treatment. The finding that, in some cases, 'transference' changes precede changes in clinical state is an interesting one in the setting of behaviour therapy. Some behaviour therapists are agreed that they have occasionally encountered therapeutic relationships in which their patients appeared to become intensely dependent upon them and that this has seemed to have an impact on the outcome of treatment (Cooper, 1963; Meyer and Gelder, 1963). However, there is a general consensus of opinion that 'transference', in the psychoanalytic sense of the word, has no impact on behaviour therapy. Eysenck (1963), for example, has erected an alternative theoretical concept, based on learning theory, in an attempt to explain the phenomenon. He proposes that the patient who is responding well in the treatment situation (for whatever reason) would be expected to generalise the gratifying source of improvement on to the therapist, and thereby develop a pleasurable relationship
with him. According to this theory, symptom changes would be expected to precede 'transference' changes. No experimental support is quoted for this position.

Some differences between the male and female groups of patients emerged in Crisp's study. In the group of female patients initial 'transference scores' in both the 'ideal' and the 'sexual' areas bore a predicted direct relationship to symptom state at the end of treatment, i.e. low 'transference scores' at the beginning of treatment a more positive 'transference' at that time more successful outcome. Crisp interpreted this to mean that "female neurotic patients who liked the therapist from all points of view, even after they had only had fleeting contact with him, did best in the immediate treatment situation. Thus, in this group, 'sexual' and 'dependency transference' appeared to bear a close relationship to each other so that, both separately and summated as 'transference scores', they showed the same relationship to clinical change." These findings did not hold true for the male group of patients. In some cases, although the patient recovered well symptomatically, he also had an initial high 'transference score' i.e. a negative transference.

However, the general finding of a relationship between 'transference' attitude and clinical progress is in agreement with a previous finding by Knowles and Lucas (1962) using a direct questionnaire method. They had hypothesised that "the impact of the doctor on the patient can be such as to modify or worsen the disease, depending to some degree on the meaning the patient has learned about certain or all help-giving situations in the past. To the extent that doctors and therapy have come to stand for relief of distress, the patient's response is likely to be favourable." On the basis of this hypothesis it was predicted that patients who had acquired favourable attitudes to doctors and medical treatment would respond better to treatment than those less favourably disposed. Using a sample of university students under treatment for "disabling fatigue without clear physical cause," Knowles and Lucas obtained results to support their predictions.

Crisp has suggested that his technique has certain advantages
over the direct questionnaire method. For instance, in Crisp's technique "it seems that the individual is unaware that his or her attitude to doctors is being measured; it therefore becomes possible to measure less conscious attitudes which involve taboo areas of emotional expression, such as hostility and sexuality." (1965)

Several points may be made about this series of studies which Crisp and his colleagues have carried out. In the first instance, the relationship of Crisp's 'transference' measures, to the various clinical views on the nature of transference (discussed in the previous section) is a complicated one. Just what is the basis of Crisp's use of the 'ideal, dependable father' construct in the measurement of transference? He regards it as being based on the theory which proposes that "idealisation, a fundamentally unrealistic attitude, is first necessarily developed in relation to earlier authoritarian figures, usually the father and/or mother in the subject's childhood. It is then subsequently 'transferred' to other such figures (including doctors) whenever they are encountered." (1964) Thus far the attitude is seen to be an unrealistic one based on neurotic defence mechanisms elaborated towards the parents in childhood. This conception of the 'idealised transference' is in agreement with the clinical observations of Greenson and Greenacre, set out in the previous section. Having identified this aspect of transference as a neurotic attitude, it becomes reasonable to expect differences between normal and neurotic individuals. However, it is not clear how it can be made the basis of a distinction between normal social-class I individuals and normal social-class III individuals. Why should social-class I normals be more likely to adopt this neurotic attitude, involved in identifying the psychiatrist with an 'ideal, dependable father'? The sociological data on which Crisp relies for his predictions - e.g. Hollingshead and Redlich's (1958) findings that their social-class I groups were "more prepared to accept psychiatric advice than the lower groups and tended to regard the psychiatrist as socially equal or inferior to themselves" - may indeed suggest that class I groups are more favourably disposed to psychiatrists, but does not suggest that they are more likely to construe psychiatrists as 'ideal, dependable fathers'.
It seems possible, therefore, that subjects may have based their decisions on the general 'evaluative' aspects of the construct (i.e. liking or disliking) rather than on the 'figural' component. Crisp's change in definition of the construct from 'ideal, dependable father' (1964) to 'ideal, dependable parent' (1965) further inclines one to ask how important the figural component is.

The inclusion of a measure of the 'sexual aspect of transference' in 1965 further complicates the issue. Crisp maintained that the 'idealised transference' and the 'sexual transference' separately and together were a measure of 'positive transference' and that positive transference tended to be associated with clinical improvement. While psychoanalytic writers are generally agreed that idealised and sexual attitudes towards the therapist can be included under the term 'positive transference', these attitudes are conceived of as potential sources of resistance to treatment. It seems particularly feasible in the case of male patients with a male therapist that a 'sexual transference' towards the therapist will not be directly related to clinical progress. This fact may partly account for Crisp's findings of differences between male and female patients in the relationship between their 'transference attitudes' and clinical improvement.

Another divergence of Crisp's measure from the traditional view of transference as an essentially unconscious, neurotic attitude arising in the course of treatment, has been his application of the technique to normal individuals with no psychiatric contact and to patients at the beginning of behaviour therapy. In fact, he has suggested that his measure is tapping that "complex of feelings that the patient may initially experience towards the doctor" and which "is sometimes termed the 'superficial and positive transference'" (1964). He continues: - "The patient's initial expectation of that authoritarian figure, the doctor, on cultural and realistic grounds, is frequently that he will fulfil the idealised authoritarian role more fully than most such figures. This initial positive attitude may be reinforced, after the first meeting, by the doctor's obvious care and attention and by any real therapeutic gain." Such comments suggest that Crisp's measure is not tapping solely the unconscious neurotic
transference attitude described by psychoanalytic writers, but that it is probably exploring a combination of the realistic and cultural attitudes with which a patient initially construes his doctor and the more unrealistic and neurotic feelings which originate in early parent-child interactions.

Finally, a recent article by Watson (1970) has some relevance to this review. The main aim of Watson's study was to obtain a measure of therapist-patient understanding using repertory grid technique. Watson applied a standard repertory grid to a patient on four occasions over a period of eight months, and he himself filled in four grids at the same time as he thought the patient would complete them. Relevant to the present discussion is the finding that the patient's own grids were highly consistent over the four test occasions, and that there was no great change in the patient's construing of the therapist, which remained positive and idealised.

In summary, the studies reviewed in this section have attempted to measure aspects of the psychoanalytic concept of transference. Sechrest, for example, investigated the Freudian view that transference involves the expression of attitudes towards the therapist which are repetitions of parent-child attitudes. He found no support for this view and instead proposed that "the goodness or pleasantness of the relationship between the therapist and the patient" be used as a concept in the place of transference. Crisp, investigating an alternative psychoanalytic notion that the doctor is construed as an 'ideal, dependable father' has provided evidence that such an attitude may be related to changes in the clinical state of the patient. It has been suggested that these writers have not solely been measuring the psychoanalytic conception of transference. By using their repertory grid measures with individuals at the beginning of treatment or, indeed, not in therapy at all, it seems possible that they have been studying an admixture of the neurotic and unrealistic attitudes which are an aspect of 'transference proper' and the more realistic and partly culturally-determined feelings which may be subsumed under the concept of 'treatment alliance'.
AIMS

Previous empirical studies of transference appear to be based on an assumption that transference attitudes towards doctors are to be found in all patients undergoing therapy (and even in individuals not under treatment) and, furthermore, that they can be investigated at any point in therapy. In the case of Crisp's studies this assumption seems quite feasible since 'transference' was seen to include attitudes to doctors in general. It is reasonable to assume that individuals - both normal and neurotic - are able to express opinions of doctors in general, as well as to develop attitudes and feelings towards specific doctors. This is not to say that all patients develop 'transference' attitudes in therapy, if by these we mean inappropriate and unrealistic attitudes derived from childhood relationships. Sechrest, for example, appears to have interpreted Freudian Theory to mean that all patients in therapy identify their doctors with parental (or other childhood) figures. This is not in fact the case. Transference attitudes, in the psychoanalytic sense of the word, appear to vary considerably with regard to point of onset, intensity, duration, rate of change, etc. (Greenson, 1967). The essential feature (according to psychoanalysts) is that, for psychoanalysis to be successful, transference attitudes must develop at some point in therapy and be appropriately interpreted by the analyst.

It is also noteworthy that none of the studies was carried out in a psychoanalytic setting. Sechrest used a setting of brief psychotherapy - either interpretative or supportive. Crisp used the context of behaviour therapy. While psychoanalysts are generally agreed that 'transference' phenomena will appear in all therapeutic settings, they would also agree that they are particularly fostered in a psychoanalytic context.

A further point concerns the observation that none of the previous studies had required the therapist to assess the nature of the transference. The status of the concept for present-day psychiatrists, practising brief psychotherapy, is in fact rather unclear. It seems
important to ask whether they still employ the transference concept and, if so, whether it is used in the Freudian sense. Clinical impressions suggest that psychiatrists do still use the term, but that they vary with regard to the meaning which they attach to it. For example, some psychiatrists appear to use it in a general evaluative manner – i.e. the terms 'positive' and 'negative' transference are used to describe the patient's feelings for the therapist, whether appropriate or not. Others seem to imply the expression of inappropriate attitudes, involving some form of identification of the therapist with individuals in the patient's life. It is clear, too, that psychiatrists differ in their opinions about the rate at which transference attitudes change. Some appear to think that the phenomenon remains stable for weeks at a time; others, that it varies from session to session, and even within sessions. It is not clear whether opinions concerning the 'rate of change' are related to the actual definition of the term which is employed.

The aim of the present study, therefore, was to approach the phenomenon from the psychiatrist's point of view. Psychiatrists were asked to specify patients in whom, they considered, some form of transference situation had developed. These patients were then made the object of a comparison between the psychiatrist's assessment of transference and a psychological measure of transference.

It was decided to base the psychological measure of transference on a form of repertory grid test. The main advantages of this test, for present purposes, seem to be, firstly, that it does not involve a direct report on the part of the patient of his feelings towards the therapist – as in questionnaire techniques. Secondly, the measurement of the patient's attitudes and feelings is based on his perceptions of past and present important figures in his life. As such, the test is particularly appropriate for the study of a phenomenon which is thought to be a) largely unconscious and b) derived from an individual's perceptions of such figures. The adoption of repertory grid technique had the added advantage of enabling the investigator to compare present findings with those of past studies, in particular those of Crisp and
Based on the review of the clinical and empirical literature, it was decided to concentrate on three potential aspects of transference:

1) The patient feels and expresses a variety of emotions towards the therapist. These are likely to be complex in nature but, at any one time, will be predominantly positive or negative. This 'evaluative' component may be largely rational and non-neurotic (forming part of the treatment alliance), or it may be mainly inappropriate and based on neurotic mechanisms (forming an aspect of 'transference'). Alternatively, it may be a combination of the two concepts.

2) At any one point in therapy the patient may identify the therapist with a specific real person from his or her past (or present) life, e.g. father, mother, spouse. This component derives from Freud's proposal that parent-child relations are at the basis of the transference phenomenon. In line with Greenson's comments on 'secondary' transference figures, it was proposed that, in some cases, identification might occur to figures in the patient's present life situation.

3) The patient may identify the therapist with some 'ideal' figure, e.g. an 'ideal father'. This proposal is based on clinical observations by Greenson and Greenacre that, in some cases, idealisation of the therapist occurs, and on Crisp's use of the construct 'ideal, dependable father' in his measurement of transference.

The aim was to investigate these three aspects of transference in patients in whom psychiatrists had indicated the presence of some form of transference attitude. A short questionnaire intended to tap these aspects of transference was presented to psychiatrists (see Appendix). A repertory grid test was devised to enable measurement in the specified patients of these aspects of transference. In this way, it was hoped that a comparison could be made between the psychiatrists' assessment of transference, and an assessment derived
from patients' repertory grid tests.

No study is available on the validity or reliability of psychiatric definitions of transference, so that, in the present investigation, the psychiatrists' assessments could in no way be accepted as the criterion measure against which to test the validity of the present repertory grid measure. In like manner, the repertory grid test developed for this study could not be assumed to provide either a valid or reliable estimate of transference. The basic technique of the test has been shown to provide a reliable and valid measure for various purposes (Bannister, 1960). However, as Bonarius (1965) has pointed out, "although the basic technique may be both reliable and valid, with each new analysis of the reptest, its reliability and validity should be controlled anew." It has been seen that Crisp's study was concerned with examining the validity of the reptest with respect to his particular measure of transference. The test was always applied, therefore, in the light of predictions concerning the results. In the present study, it was considered that agreement between the psychiatric assessment and the repertory grid measure would provide evidence for convergent validity i.e. the validity obtained when different measures of the same variable, arrived at independently, correlate with one another. Lack of agreement between the two measures would mean that no conclusions could be drawn about the validity of either measure of transference, other than that they are not measuring the same variable i.e. they are unlikely both to be valid.

At the same time the opportunity was taken to examine further the findings of Crisp and Sechrest by including in the repertory grid measure their proposed 'transference figures'.

It has already been mentioned that psychiatrists appear to vary in their opinions about the rate of change of transference phenomena - some considering that it fluctuates over relatively short time intervals, others believing it to be a reasonably stable phenomenon. In order to obtain some information about this aspect of transference, it was proposed to apply the measure on two separate occasions.
A time interval, between test and retest, of two weeks was chosen for the following reasons:

1) It had been decided to conduct this study in the two wards of the Professorial Unit at the Royal Edinburgh Hospital. This Unit receives acute psychiatric cases, of predominantly neurotic diagnosis, and practises brief psychotherapy, individual and group, within an analytic framework. It was noted that the average length of stay in this Unit was three months (based on Ward I Statistics for 1969-70). In view of this relatively short (average) admission period, and allowing for the possibility that psychiatrists would only provide patients who had been in treatment for some time, a test-retest interval of two weeks seemed a reasonable period in which to investigate any changes of transference.

2) As Bonarius has indicated (above), any new application of repertory grid technique should incorporate some assessment of its reliability. In this study, it was also necessary to be able to distinguish 'real' transference changes from a) random fluctuations in grid technique or b) overall changes in the patient's construct system. A test-retest interval of two weeks seemed a suitable period for the assessment of the reliability of the grid measure.

Certain comments require to be made about the reliability of repertory grid measures. Bonarius (1965) has pointed out that:

"In a theory where movement and change is one of the basic assumptions an instrument with a perfect test-retest reliability would present an awkward contradiction. On the other hand, a certain stability must be postulated should change occur. It makes sense, therefore, to search for the consistent aspects of the Reptest."

Various grid measures have, in fact, been subjected to tests of reliability. Early repertory test studies focussed on examining the consistency of elicited constructs (Hunt, 1951: Fjeld and Landfield, 1961) and of elements (Pedersen, 1958: Mitsos, 1958). Factor analytic techniques, such as J.V.Kelly's non-parametric factor analysis (1962), provide both figure (i.e. element) and construct factors, which can also be submitted to tests of consistency. Pedersen (1958),
applying the grid test to normal subjects with a test-retest interval of one week examined the factorial consistency of his results. The consistency of the factorial content of the first figure factor i.e. the loadings of the figures on that factor, was calculated by means of a test-retest Pearson correlation for each of 27 subjects. The average correlation was 0.85. For the factorial content of the first construct factor Pedersen found an average test-retest correlation of 0.83. More recently, Watson (1970) examined the consistency of a single patient's repertory grid results over a period of eight months. Four grids obtained from the patient during psychotherapeutic treatment were shown to have 'indices of consistency' (i.e. overall correlation between two of the patient's grids) ranging from 0.73 to 0.84. Such results suggest that repertory grids have certain quite stable features in terms of various matrix pattern measurements.

While it is reasonable to assume that the aim of psychotherapy, in Kelly's terminology, is to induce changes in the patient's construct system, a period of two weeks is a relatively short time interval in which to expect any major changes to occur. It was, therefore, predicted that relatively stable results would be obtained from the repeated grid test application.

The main aims of the present study were, therefore:--

1) to compare a repertory grid measure of transference with a psychiatric assessment of transference in a small sample of patients.

2) to assess the overall stability of the repertory grid measure during a two week test-retest interval.

3) to investigate any changes in transference, as assessed by the psychiatrist and by the repertory grid test.

4) to obtain further information concerning the transference measures of Crisp and Sechrest.
METHOD

1. **Design of Study**

In the Professorial Unit of the Royal Edinburgh Hospital, where the study was carried out, individual and group psychotherapy, based on analytic principles, form the mainstay of the treatment programme. Where appropriate, drug and behaviour therapies are also employed. Each patient is assigned to a psychiatrist on the Unit. The patient then has almost daily contact with his therapist in the group therapy sessions, and sees him for individual psychotherapy on average twice a week.

A number of psychiatrists practising in the Professorial Unit were asked to supply the names of patients under treatment with them (at the time of the investigation) with whom, in the psychiatrists' opinion, some form of transference situation which they could specify was occurring. They were then provided with a short psychiatric rating form and asked to complete the parts they considered appropriate for each patient. Since some psychiatrists had suggested that transference was a phenomenon which fluctuated, possibly from one session to another, it was emphasised that the psychiatrist should limit his opinions to the current transference situation. Immediately after the assessment form was returned by the psychiatrist the patient was interviewed and the repertory grid measure obtained. Psychiatrists were not always able to complete the forms immediately they were given them and sometimes requested time to consider the transference situation. These psychiatrists were asked to return the forms as soon as they were completed. Experience indicated that the forms were not, in fact, always returned immediately after completion, with the result that the original intention of interviewing patients directly after the psychiatric assessment was not possible in one or two cases. In view of the fact that the repertory grid measures were subsequently shown to be very stable over the two week test period, it seems unlikely that the delay in returning the assessment forms affected the comparisons of results to any great extent.
Two weeks later, the psychiatrists were again asked to fill in another assessment form for each patient. They were once more requested to express their opinions on the current transference situation with the patient. Each patient was then re-tested with the repertory grid measure.
2. Subjects

a) The Psychiatrists

Six therapists took part in the present study - five staff psychiatrists and one clinical assistant. The staff psychiatrists were all male - four being of Registrar Grade and one a Senior Registrar. The clinical assistant was female, and attached to the Unit to gain psychiatric experience. Although the majority of these therapists were relatively junior in terms of amount of psychiatric experience, they did the major portion of the therapy on the Unit. All had indicated familiarity with the concept of 'transference'.

b) The Patients

Ten patients took part in the present investigation - five males and five females. It will be recalled that the selection of these patients was based on the psychiatrists' decision about the existence of a transference situation between patient and therapist. The patients were not intended, therefore, to form a random sample of patients admitted to the Professorial Unit. They may possibly be considered representative of those patients in whom therapists can specify the existence of transference attitudes.

The mean age of the sample was 24.5 years (age range 19 - 34 years). Two of the patients were still in hospital at the end of this investigation. The length of stay of the ten patients, therefore, ranged from 58 days to 240 + days. The expectation that psychiatrists would only provide patients who had been in hospital for some time was borne out by the fact that no patient was included who had been in the Unit for less than three weeks. The average length of stay at the time of first testing was, in fact, 66 days. In view of this finding, and the doctors' own statements that they could not assess transference in patients who were relatively new to them, it is reasonable to assume that they were using the term to describe attitudes which arise during the course of therapy and not
simply to describe the patients' initial attitudes to the therapist.

Nine of the ten patients were diagnosed as having a psycho-neurotic illness. Five of the nine cases were classified as having 'anxiety' neuroses, three as having 'depressive' neuroses, and one as having an 'obsessional' neurosis. The tenth patient was diagnosed as having an 'endogenous depression with reactive features'.

It has recently become the policy of the Professorial Unit to diagnose patients in terms of 'personality disorder' as well as psychiatric illness. All ten patients were classified as having some form of personality disorder. These included four diagnoses of 'over-dependent' personality, two of 'schizoid' personality, one of 'obsessoid' personality, one of 'hysterical' personality and two of 'sociopathic' personality (one 'passive' and one 'aggressive').
3. Measuring Instruments

a) The Psychiatric Rating Form

In devising this form it was originally intended to make the questions as open-ended as possible, in order to allow for the fullest possible range of psychiatric opinions on transference. However, further consideration suggested that such an aim would produce results which, though potentially interesting, would be difficult to analyse and might make comparison with the repertory grid measure impossible. The form used was, therefore, devised with the dual aim of providing the essential material for comparison with the grid measure and of allowing psychiatrists to add any further opinions they wished to make about the 'transference' situation.

The questions posed concerned - 1) the psychiatrist's perception of the patient's feelings towards him. A 7 - point scale, ranging from 'extremely positive' to 'extremely negative' was adopted. This was intended to allow for a wide range of opinion and to provide a measure comparable to the 7 - point rating scale employed in the repertory grid measure: 2) the psychiatrist's assessment of a transference 'figure'. Therapists were asked to specify the name(s) of any figure or figures with whom they considered the patient might be identifying them. It was made clear to the therapists that they were only to fill in those parts of the assessment form which they considered appropriate at that particular point in therapy. Thus, for example, they might not consider that the patient was identifying them with any particular person from his or her past (or present) life.

The assessment form is presented in Appendix A.

b) The Repertory Grid Test

In devising the grid test for the present study consideration had to be given to the variety of designs available with their attendant advantages and drawbacks. For example, a decision had to be made about whether to provide constructs or to elicit them (constructs being defined here as the parameters on which persons
important to the patient are to be judged). Although Crisp used
the former procedure in his investigation, a number of problems arise
when constructs are supplied by the experimenter. As Bannister and
Mair (1968) have pointed out, "any assurance that the constructs are
a meaningful part of the subject's repertoire is forfeited, and some
of the grid matrix variance will inevitably reflect a degree of
failure by the subject to translate them into his own terms." At
the same time it must be granted that, in certain experimental or
clinical investigations, some use of supplied constructs may be
necessary. For example, the investigator may be mainly interested
in how the subject uses constructs in the general areas of sex or
aggression and in how such constructs relate to others within his
system. Since no specific hypothesis was involved in the present
study, and since concern was mainly with relationships between elements,
rather than constructs, it was not considered necessary to include
supplied constructs in the repertory grids. Instead, an attempt was
made to preserve the important ideas in construct theory as set out
in the individuality corollary* and, at the same time, to incorporate
sufficient structure into the test procedure to allow the aims of the
study to be satisfactorily investigated.

The repertory grid measure developed for the present study was
based on Kelly's Role Construct Repertory Test (1955). Following
Kelly's method, each subject was presented with a role title list
containing a number of different roles. The subjects were then
provided with cards and asked to write down the names of adult persons
in their environment who fitted each role. The selection by the

* The individuality corollary states that "persons differ from each
other in their construction of events." In practical terms, this
corollary implies that in order for a repertory grid test to be
personally meaningful, constructs should be elicited from each
individual, and in such a way as to adequately sample that
individual's construct system.
investigator of the role titles depended on two factors. Firstly, the list had to sample a sufficiently wide range of people likely to be important in any person's life and secondly, it had to include those figures commonly thought to be at the basis of the 'transference' situation. The inclusion of parental figures, for example, can be assumed to be based on both these factors. In line with Freudian Theory that authority figures are likely to be the originators of transference reactions, other authority figures, such as teachers and bosses, were also included in the Role Title List. The list was as follows:-

1) Mother
2) Father
3) Spouse or opposite sex friend
4) Brother nearest own age, or someone who has been like a brother
5) Sister nearest own age, or someone who has been like a sister
6) Someone who has been like a mother to you
7) Someone who has been like a father to you
8) Boss, under whom you worked and whom you liked
9) Boss, under whom you worked and with whom you found it hard to get along
10) Someone with whom you worked who was easy to get along with
11) Someone with whom you worked who was hard to understand
12) Someone who has had a big influence on your life
13) Someone of the opposite sex to whom you have been attracted
14) A friend who let you down
15) A teacher whom you liked
16) A teacher whom you disliked

The names (elements) which the subject provided from this list were used to elicit constructs. The triadic method of construct elicitation
was employed. The subject was presented with three of the elements and asked -
"In what important way are two of these figures alike and, at the same
time, different from the third?"
This aspect or construct dimension was written down in bipolar form.
The 'likeness' which the subject provides is called the construct pole; its opposite - the contrast pole. This procedure was repeated until a sufficient number of construct dimensions had been elicited. As far as was possible the presentation of triads was standardised over the ten subjects and care was taken to ensure that all the elements were adequately sampled. In general, triads were presented until the subjects were unable to provide a new construct dimension for any one of three successive triads.

When each subject had completed his construct list, he was asked for each construct dimension in turn -
"Which do you think it is generally better to be?" e.g. "Is it generally better to be outgoing or withdrawn?"
- to indicate which pole was positively evaluated. The intention was to devise for each subject a general evaluative scale from all his constructs. This scale was to be made the basis of the measurement of the 'evaluative' component of transference (described in the previous section) and was to be compared with the psychiatrist's assessment of the 'evaluative' transference component. If a patient could not specify which pole was preferable, for any one construct dimension, then a further construct was to be elicited in place of this one. In only one case was a subject actually unable to specify his preference for a single construct dimension. This construct was subsequently excluded from the list.

Two further elements - 'self' and 'therapist' (i.e. the name of each patient's own therapist) were then included in the list of elements.
Subjects were presented with a 7-point scale and it was explained to them that they were to rate all the elements on each of the construct dimensions. This rating technique was chosen in preference to the more easily used split-half method, since it allowed subjects to make greater discriminations between elements and made possible a more satisfactory
comparison with the 7-point evaluative scale used in the psychiatric rating form. It was ensured that each subject understood the meaning of the scale by translating the numbers into verbal terms when necessary. Thus, points 1 and 7 were extreme positions and implied that a person rated in these positions had either 'very little' or 'very much' of the characteristic in question. The mid-point of 4 was to be used if a person was judged to be 'average' on a particular construct, or if the construct did not really apply to the person at all. This second usage of the mid-point was intended to tackle the 'range of convenience' problem since it was possible that some elements would lie outside the range of convenience of a particular construct. In order to minimise response sets, the position of the preferred pole was varied during rating i.e. on some occasions it was at the '1' end of the scale, on others at the '7' end. For the statistical analysis, ratings were subsequently transformed so that the preferred pole of the construct dimension lay at the upper end of the scale (points 5 to 7).

After the elements had been rated subjects were introduced to a second set of elements. These elements comprised 'ideal' and 'stereotype' figures. The inclusion of ideal figures was based on the references in the psychoanalytic literature to idealisation of the therapist and on the use made by Crisp, in his own investigations, of the concept 'ideal, dependable father'. In order to allow for the possibility that psychiatrists might specify an ideal figure as the transference figure on the first or second assessment occasions, and to test Crisp's hypothesis, the following ideal elements were included - 'ideal father', 'ideal mother', 'ideal spouse' and 'ideal self'.

The opportunity was also taken to investigate further the alternative findings of Sechrest that the therapist was most likely to be described as being similar to the family doctor, the minister or the teacher. Three 'stereotype' figures were included in the grid. They were - 'What ministers are like in general', 'What family doctors are like in general' and 'What teachers are like in general'. It was ensured that subjects understood the meanings of these elements and
they were then asked to rate the 'ideal' and 'stereotype' figures on the constructs they had provided, using the 7 - point scale. The separation of elements into two groups was made because it seemed likely that patients would become confused if they were asked to rate all the real, ideal and stereotype figures at one time.

The present grid differs from that employed by Crisp, not only in its use of elicited rather than provided constructs, but also in its use of 'therapist' and 'ideal' figures as elements rather than as constructs. It may be remembered that Crisp used 'the psychiatrist', 'ideal, dependable father' and 'best sexual partner' as whole-figure constructs, which he then matched with other (psychological trait type) constructs. The decision not to adopt this procedure was based on Bannister and Mair's (1968) comments that such a usage probably involves certain risky assumptions. As Mair (1967) has pointed out, "Subjects can hardly handle such whole-figure constructs in any total sense and must break them down to the idea of 'like my father' in respect of dimension X, or 'like I am in character' as far as dimension Y is concerned." Thus, any relationship scores between this type of whole-figure construct and other constructs may be difficult to interpret. At the same time, Crisp's procedure seems to be more successful in avoiding the need to ask directly for specific information about the key figures and as such probably makes more allowance for the operation of unconscious transference attitudes on the patient's part than does the present procedure.

All patients were able to comply with test instructions and co-operated quite readily despite the fact that the initial test session lasted on average for 2½ hours.

The grid measure was re-administered to patients two weeks later. On this occasion, they were only required to rate the same two groups of elements on the previously elicited set of constructs. Subjects were told to "rate the people as you feel about them now. Do not try to remember how you rated them last time." This second test session lasted approximately 40 minutes.
4. Analysis of the Repertory Grid Measure

The twenty repertory grid tests obtained from the ten subjects in this study were subjected to the Principal Component Analysis which has been made available by Slater (1964). A number of measures can be obtained from this analysis. They include:-

1) **Relationships between constructs** - expressed in terms of correlations.

2) **Distances between elements** - the distance between two people in the construct space is an indication of their similarity or dissimilarity over the whole range of constructs used. This value is expressed in the grid analysis in terms of 'the unit of expected distance', calculated in such a way that elements rated at random would be separated by one such unit.

Ryle and Lunghi (1968) have suggested various interpretations of 'element distance' scores. For example, the perception of self or ideal self as similar to another may provide evidence of identification: perception of similarity between the spouse and a parent may suggest the influence of oedipal factors in mate selection, etc.

3) **Principal component analysis** - this analysis extracts the mathematical components underlying all the relationships expressed within the grid. These components are extracted according to the amount of variance contributed by them, from the largest to the smallest. The analysis is carried out entirely without reference to the verbal labels of the constructs. Thus, for example, there is no rotation of components to achieve 'psychological meaning' as in many factor analytic techniques. It is the degree of association between constructs and elements which is explicitly examined (Bannister, 1965). The mathematical components can, however, be identified in terms of the positive and negative loadings on them of both constructs and elements. One can map out the dispersion of elements in terms of any two components. The constructs which have high loadings (positive and negative) on these components serve to indicate the meaning of
the discriminations being made.

The 'distances between elements' analysis and the principal component analysis were the two measures derived from the programme which were employed in the present study. The 'figural' aspect of transference i.e. the degree of identification between the therapist and other specific figures in the grid, was measured with the use of the 'distances between elements' analysis. The principal component analysis was used to assess the reliability of certain structural and figural properties of the grid.
RESULTS

1. Psychiatric Assessment Form

From the psychiatric assessment form, the following information was extracted:

(i) therapists' self-ratings on the 7-point evaluative scale. The first and second test occasions were considered separately. The mean 'evaluative' scores of 5 (first occasion) and 5.3 (second occasion) suggest that the therapists perceived their patients as having predominantly positive feelings for them.

(ii) therapists' proposed 'transference' figures - first and second occasions considered separately. Results are presented in Table I.

<table>
<thead>
<tr>
<th>TABLE I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Transference Figures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex of Therapist</th>
<th>Sex of Patient</th>
<th>First Test Occasion</th>
<th>Second Test Occasion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Male</td>
<td>Father</td>
<td>Ideal father</td>
</tr>
<tr>
<td>&quot; &quot;</td>
<td>Female</td>
<td>Father</td>
<td>Father</td>
</tr>
<tr>
<td>&quot; &quot;</td>
<td>&quot;</td>
<td>Father</td>
<td>Mother and father</td>
</tr>
<tr>
<td>&quot; &quot;</td>
<td>Male</td>
<td>Mother and father</td>
<td>Mother</td>
</tr>
<tr>
<td>Female</td>
<td>&quot;</td>
<td>Ideal mother</td>
<td>Ideal mother</td>
</tr>
<tr>
<td>&quot;</td>
<td>&quot;</td>
<td>Ideal mother</td>
<td>Ideal mother</td>
</tr>
<tr>
<td>&quot;</td>
<td>Female</td>
<td>Ideal mother</td>
<td>Ideal father</td>
</tr>
<tr>
<td>&quot;</td>
<td>&quot;</td>
<td>Teacher-figure</td>
<td>Ideal father</td>
</tr>
<tr>
<td>&quot;</td>
<td>&quot;</td>
<td>Ideal father</td>
<td>Ideal father</td>
</tr>
<tr>
<td>&quot;</td>
<td>Male</td>
<td>Father and uncle</td>
<td>Father, uncle and ideal father</td>
</tr>
</tbody>
</table>

As may be seen from the table, all the therapists were able to
specify transference figures on the first test occasion, and nine out of the ten did so on the second occasion as well. In some cases more than one figure was proposed. It is noteworthy that in 19 out of the 20 assessments, the therapists specified as transference figures either 'real' or 'ideal' parental figures.

(iii) psychiatrists' additional comments on the 'transference situation'

All the psychiatrists were able to provide additional comments as well as the basic information requested in the assessment form. While these comments were not subjected to any form of quantitative analysis, they provide some interesting additional information to the psychiatric assessments and highlight certain uses of the 'transference' concept.

The dual aspects of dependency and sexual feelings, which Crisp used as the basis of his (1965) transference measure, are exemplified in the comments of a male therapist treating a 23 year old phobic woman of hysterical personality. He writes: - "Though the patient identifies me with her father, now deceased, she also has sexual feelings towards me. She would like her husband to be in the same supportive role as I am in at present." While this therapist specifies 'father' as the transference figure, he also apparently feels that he is being placed in the role of an 'ideal spouse'.

The combined sexual and dependency aspects are again seen in the case of a 22 year old female student diagnosed as having a reactive depression. The therapist comments, "during interviews her basic attitude, whatever she is discussing, is one of quiet passivity and over-dependence." A few weeks prior to the assessment there had been a "florid expression of dependent and sexual wishes; she wished to sit at my feet, not in the chair opposite, and to touch my knee while talking; she wanted to prolong interviews." This patient is reported by the therapist as coming from a constrictive family, where she had been particularly cosseted and over-protected by father. The therapist indicated that he was being identified with the patient's father. At re-assessment, two weeks later, the therapist proposed both parents as
transference figures: "Both parents have been over-protective and restrictive, and she (the patient) has been overly dependent on them. All these features seem to be repeating themselves in her relationship to me." This last statement recalls Freud's assertion that transference involves the repetition of past attitudes, rather than the remembering of them.

The over-idealisation component of transference, about which Greenson and Greenacre have written, can be seen in the comments of a male therapist treating a 21 year old obsessional neurotic man: "He has an over-estimation of me at present, presumably seeing me as the sort of accepting person he would have liked his father to have been." The transference figure specified by the therapist was 'ideal father'.

On the one occasion, where a (female) therapist was unable to specify a 'transference' figure for her male anxiety neurotic patient, she suggested the existence of - "a positive transference, only in the sense that he likes and trusts me and does not fear being overwhelmed or smothered by me, as he does by most women." Such a comment is suggestive of the rational, non-neurotic feelings which form part of the treatment alliance and which Freud included under the term 'positive transference'.

Other comments by the therapists include references to the circumstances which led them to postulate a particular transference figure. An example is seen in the case of a 25 year old male patient with chronic anxiety and a schizoid personality who had formed an attachment to a nurse on the ward. The therapist had to explain to the patient that the nurse was due to leave the ward (a routine change). The therapist writes: "He saw me as a depriving, calculating person who had 'set up' a situation so that he became involved with her, then deliberately contrived to let him down. This I took to be a paranoid distortion in the transference situation." The therapist saw himself as being identified with the patient's father and mother who were thought to be "depriving, not understanding, not caring and all his (the patient's) relationships are affected by his distortions."
The ambivalence of the patient's feelings towards the psychiatrist are seen in the further comment: - "Against this clearly expressed hostility must be set his other statement that he likes me." It is quite possible that we have here an example of Greenson's assertion that "the working alliance is seen at its clearest when a patient is in the throes of an intense transference neurosis, and yet can still maintain an effective working relationship with the analyst."

In defining the present transference situation, some therapists commented on changes in the patients' attitudes which had occurred prior to the assessment. Two references to the effects of therapeutic abreactions on patients' feelings suggest that this may be a potentially interesting area in which to examine patient-therapist attitudes. Commenting on a 20 year old female patient with phobic anxiety, her therapist writes that "the transference became markedly negative for a short while, after a series of abreactions revealed the extent of denied aggression. The patient was then able to express a desire to be violent towards me." By the time of the assessment the patient's aggressive feelings had become displaced from the therapist. He writes: - "Her anger is not specifically directed towards me since this would be too conflicting with her image of me as 'the one who makes her better'." The proposed transference figure in this case was an "ideal authority figure e.g. schoolteacher." By the second assessment, the therapist saw himself in the role of an 'ideal father'. "She sees me now as someone to depend on for help and someone who is able to fulfil some of her needs to be cared for; with a less punitive aspect than previously."

In the second case, in which the female therapist had conducted an abreaction with a 21 year old male patient, diagnosed as an anxiety neurotic with a (passive) sociopathic personality disorder, she suggested that the patient was identifying her with an 'ideal mother figure'. At the same time, she felt that a change might be occurring to a 'sexual-type transference'. This patient, who was apparently conscious of having identified the therapist with a mother-figure, spontaneously remarked during testing that since he now saw the
therapist as a sexually attractive figure, he could no longer envisage her in the role of a mother.
Finally, on one assessment occasion, a male therapist indicated that his 34 year old female patient with endogenous depression was identifying him with an 'ideal mother'. Accepting Freud's proposition that attitudes and feelings towards both parents are re-expressed in the transference situation, it is reasonable to expect that transference reactions to the parent of the opposite sex to the therapist, can occur.
2. Repertory Grid Test

(i) Number of Elements and Constructs

Subjects varied in the number of elements and constructs they were able to provide from the role title list. Some subjects were unable to specify figures for all the roles, others felt it necessary to give more than one figure for some of the roles. Over the group of 10 subjects the number of elements which each patient was able to provide varied from 12 to 19 (mean = 14.7). Similarly, subjects differed in the ease with which they were able to supply constructs and the number of elicited constructs varied from 9 to 18 (mean = 12.9).

Kelly (1955) and subsequent writers have stressed the necessity for adequate sampling of an individual's elements and constructs. Although an explicit attempt was made to obtain adequate samples from all patients in the present study, the possibility remains that this may have been unsuccessful and that the different numbers of constructs and elements affected the structure of the construct space. It was, therefore, decided to compare the number of elements and constructs elicited from each subject with the amount of variance extracted from each grid by the first principal component, assuming the latter to be a representation in statistical terms of the major part of the construct space. If the underlying structure of the grid is closely related to the number of elements or constructs which a subject provides, then it would seem to be crucial to ensure that methods of representative sampling are developed.

The relationship between the number of elements and constructs and the percentage variance of the first principal component for each subject was investigated by means of the Spearman Rank Correlation Coefficient: $r_s$ (Siegel, 1956). Where appropriate a correction for tied scores was made. The significance of the obtained $r_s$ was tested by the formula for Student's $t$. (The statistical methods and formulae employed in this section are presented in Appendix B.) Results are shown in Table 2.
TABLE 2

Correlations (Spearman's $r_s$) between number of elements, number of constructs and percentage variance extracted by first principal component on 2 test occasions

<table>
<thead>
<tr>
<th>Source*</th>
<th>First occasion</th>
<th>p</th>
<th>Second occasion</th>
<th>p**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of constructs vs. First component</td>
<td>-0.15</td>
<td>N.S.</td>
<td>-0.05</td>
<td>N.S.</td>
</tr>
<tr>
<td>Number of elements vs. First component</td>
<td>0.56</td>
<td>N.S.</td>
<td>0.46</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

*A rank of 1 is given to the subject with the smallest number of constructs and elements, and a rank of 1 to the subject with the smallest percentage variance on the first principal component.

**2-tailed values of $p$ shown.

These results indicate that there is no relationship between the number of elements and constructs which the subjects provide and the percentage variance of the first principal component. This justifies the use of the percentage variance as a general measure of grid structure despite the different numbers of constructs and elements occurring in different cases.

(ii) Consistency of the Repertory Grid Test

The largest component of the grids of the 10 subjects accounted for between 33.43% and 74.52% of the matrix variance on the first test
occasion. The mean percentage was 56.3%. On the second test occasion, the first principal component accounted for between 34.32% and 78.51% of the variance (mean = 58.2%).

The 'structural' consistency of the first principal component was assessed by means of a test-retest rank-order correlation of the percentages over the 10 subjects.

<table>
<thead>
<tr>
<th>TABLE 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correlation (Spearman's $r_s$) between percentages of first principal component on first and second test occasions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>$r_s$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage first component - test/retest</td>
<td>0.98</td>
<td>&lt; .001</td>
</tr>
</tbody>
</table>

These results indicate a high 'structural' consistency in the grids from first to second test occasion.

It is clear, however, that despite this significant correlation, it tells us little about the content reliability of the first principal component. In order to examine the consistency of content, therefore, the construct and element loadings on the first principal component of each subject's grid were subjected to a rank-order correlation. Thus, for example, the construct loadings on the first component were ranked from the highest positive to the highest negative for test and retest occasions, and a Spearman $r_s$ calculated between these 2 rank orders for each one of the 10 subjects. Results are presented in Table 4.
TABLE 4

Correlations (Spearman's $r_s$) of construct and element loadings on first component between first and second test occasions

<table>
<thead>
<tr>
<th>Subject</th>
<th>Construct loadings</th>
<th>Element loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.96</td>
<td>0.95</td>
</tr>
<tr>
<td>2</td>
<td>0.85</td>
<td>0.89</td>
</tr>
<tr>
<td>3</td>
<td>0.71</td>
<td>0.78</td>
</tr>
<tr>
<td>4</td>
<td>0.94</td>
<td>0.97</td>
</tr>
<tr>
<td>5</td>
<td>0.92</td>
<td>0.85</td>
</tr>
<tr>
<td>6</td>
<td>0.62</td>
<td>0.95</td>
</tr>
<tr>
<td>7</td>
<td>0.89</td>
<td>0.92</td>
</tr>
<tr>
<td>8</td>
<td>0.99</td>
<td>0.94</td>
</tr>
<tr>
<td>9</td>
<td>0.90</td>
<td>0.93</td>
</tr>
<tr>
<td>10</td>
<td>0.89</td>
<td>0.94</td>
</tr>
</tbody>
</table>

| Mean    | 0.87              | 0.91             |

In view of the varying numbers of constructs and elements between subjects, significance levels were not calculated for these results. However, it can be seen that the test-retest correlations for both element and construct loadings on the first principal component are uniformly high.
3. Relationship between the Psychiatric Assessment and the Repertory Grid Measure

(i) The 'evaluative' aspect of transference

It will be recalled that an evaluative scale was derived from each patient's grid by having him indicate, for every construct dimension, which pole was preferable. For the analysis, the preferred pole was allotted to the upper end of the 7-point rating scale. The average rating of any element on a subject's list of constructs was thus (operationally) defined as that element's evaluative rating i.e. construct ratings for any element were summed and divided by the total number of constructs. In this way, an element with an average rating of 5, 6 or 7 would be regarded as being positively evaluated by the subject.

The mean evaluative rating of psychiatrists by the patients on the repertory grid scale was 5.98 on the first test occasion, and 5.97 on the second occasion. This tendency by patients towards positive evaluation of the therapists is in agreement with the therapists' own perceptions that patients were showing predominantly positive feelings towards them (reported in Section 1 (i) of 'Results').

The relationship between the therapist's self-rating (on his evaluative scale) and the patient's rating of the therapist (on the repertory grid test) was assessed by means of Spearman's rank correlation coefficient. A correlation coefficient was obtained for 1) the first test occasion: 2) second test occasion and 3) changes between occasions 1 and 2, i.e. difference scores were worked out between test and retest on the psychiatrist's rating scale and the patient's rating scale, and these differences were rank ordered. Results are shown in Table 5.
TABLE 5

Relationship (Spearman's $r_s$) between psychiatrists' and patients' 'evaluative transference' scales

<table>
<thead>
<tr>
<th>Source</th>
<th>$r_s$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>First test occasion</td>
<td>0.44</td>
<td>N.S.</td>
</tr>
<tr>
<td>Second test occasion</td>
<td>0.28</td>
<td>N.S.</td>
</tr>
<tr>
<td>Change between 1 and 2</td>
<td>0.90</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

These results show that while the trend is in the expected direction, there was no significant agreement between the psychiatric assessment of the evaluative transference and the repertory grid measure. A significant relationship did, however, obtain in the difference scores between test and retest.

(ii) The 'figural' aspect of transference

The relationship between the psychiatrists' proposed transference figure (see Table I) and the transference figure obtained from each patient's grid was examined. In the case of the grid test the transference figure was operationally defined as the figure (i.e. element) with the smallest distance from the 'therapist element'. This figure will be the one most closely identified with the therapist of all the figures included in the grid.

Subjects had varied in the number of elements they were able to provide. In particular, they were not all able to supply fitting names for the role titles: - 'someone who has been like a mother to you',
'someone who has been like a father to you', 'a friend who let you down' and 'an attractive member of the opposite sex'. The data for these 4 figures were, therefore, averaged. The composite is referred to as 'peripheral persons'. In the few cases in which subjects had provided more than one name for any role title (and had maintained that they were equally important), the data were again averaged. Including the group of elements provided by the investigator, the final total number of elements for all subjects was 21, excluding the 'therapist element'. These elements were then ranked in terms of their distance from the therapist on each patient's grid. The element closest to the therapist was given a rank of 1, the next closest a rank of 2, and so on.

The relationship between psychiatrists' transference figure and grid transference figure was calculated by means of the Binomial Test, (Siegel, 1956). This test provides a measure of the expected probability of finding any one of a number of scores in a specific position: in this case, the expected probability of finding the psychiatrist's transference figure to be the 'figure closest to therapist' on the patient's grid. Some therapists had specified more than one transference figure e.g. mother and father. These cases were omitted from this comparison. Results are presented in Table 6.

**TABLE 6**

Relationship between psychiatric transference figure and repertory grid transference figure. (Binomial Test)

<table>
<thead>
<tr>
<th>Psychiatric figure vs. grid figure</th>
<th>( \frac{X}{N} )</th>
<th>Binomial Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>First test occasion</td>
<td>( \frac{1}{8} )</td>
<td>( p &gt; 0.32 )</td>
</tr>
<tr>
<td>Second test occasion</td>
<td>( \frac{1}{7} )</td>
<td>( p &gt; 0.28 )</td>
</tr>
</tbody>
</table>

Psychiatrists had proposed a single transference figure in 8 out of 10 cases on the first test occasion, and in 7 out of 9 cases on the second occasion (see Table I).
It can be seen that there is no significant relationship between the psychiatric transference figure and the repertory grid transference figure on either first or second test occasion.

To expect the therapist's proposed figure to be the closest figure to the therapist on the patient's grid is probably a rather stringent measure of patient-therapist agreement. It was, therefore, decided to investigate whether any significant association obtained between the therapists' transference figures and the patients' grid test results. Table 7 shows the rank position of the therapist's transference figure on his patient's repertory grid.

<table>
<thead>
<tr>
<th>First Occasion</th>
<th>Second Occasion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist's transference figure</td>
<td>Patient's ranking of therapist's figure</td>
</tr>
<tr>
<td>1 Father</td>
<td>8</td>
</tr>
<tr>
<td>2 Father</td>
<td>9</td>
</tr>
<tr>
<td>3 Father</td>
<td>18</td>
</tr>
<tr>
<td>4 Mother and father</td>
<td>10</td>
</tr>
<tr>
<td>5 Ideal mother</td>
<td>10</td>
</tr>
<tr>
<td>6 Ideal mother</td>
<td>3</td>
</tr>
<tr>
<td>7 Ideal mother</td>
<td>1</td>
</tr>
<tr>
<td>8 Teacher-figure</td>
<td>2.5</td>
</tr>
<tr>
<td>9 Ideal father</td>
<td>12.5</td>
</tr>
<tr>
<td>10 Father and uncle</td>
<td>13</td>
</tr>
</tbody>
</table>

In case 1 (first test occasion), for example, the therapist proposes father as the transference figure. On his repertory grid test, the patient ranks father as 8th closest figure to the therapist. It
should be noted that the maximum possible rank number is 21, i.e. a figure with such a rank would be furthest from the therapist of all the repertory grid figures. In those cases in which therapists proposed more than one transference figure, e.g. mother and father, the average rank was calculated.

The Kolmogorov-Smirnov One-sample Test was applied to determine whether the obtained set of ranked scores differed from a theoretical distribution of scores. Results are shown in Table 8.

**TABLE 8**

<table>
<thead>
<tr>
<th>Relationship between psychiatrists' transference figures and repertory grid test results (Kolmogorov-Smirnov Test)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients' ratings of therapists transference figures</strong></td>
</tr>
<tr>
<td>First test occasion</td>
</tr>
<tr>
<td>Second test occasion</td>
</tr>
</tbody>
</table>

Results show that the psychiatrists' transference figures were not ranked any more closely to the therapist on the patients' repertory grids than would be expected by chance.
4. Assessment of Changes in Transference

(i) Evaluative-scale changes

The significance of changes in the psychiatric 'evaluative' scale and in the repertory grid 'evaluative' scale between first and second test occasions was assessed by means of the Wilcoxon Matched-pairs Signed-ranks Test (Siegel, 1956). Results are shown in Table 9.

<table>
<thead>
<tr>
<th>Test-retest comparisons</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric ratings</td>
<td>12.5</td>
<td>N.S.</td>
</tr>
<tr>
<td>Repertory grid ratings</td>
<td>26</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

It can be seen that there are no significant changes in the psychiatrists' perception of the patients' feelings towards them between first and second testing, and similarly the patients themselves do not change significantly in their evaluative ratings of psychiatrists, between the 2 test occasions.

(ii) Figural Changes

a) Psychiatric assessment

No statistical test of changes in the 'figural' aspect of transference could be applied since there was no specific set of persons from which psychiatrists had chosen their transference figures.
However, reference to Table I shows that in 3 out of the 10 cases there was no change in transference figure from first to second occasion. In most other cases, changes involved the replacement of a single parental figure by both parental figures, or of a real parent e.g. 'father' by an ideal parent e.g. 'ideal father'. In the majority of cases, the figures proposed on both test occasions were either 'real' or 'ideal' parental figures.

b) Repertory grid

The investigation of changes in the position of the 'therapist' element relative to all other repertory grid elements between test and retest is reported in the next section.
5. Investigation of Crisp's and Sechrest's findings

The extent to which any one element (e.g. Crisp's 'ideal father') or any particular type of element (e.g. Sechrest's teacher, G.P., minister) was ranked significantly closer to the therapist than all other elements was investigated by means of a Friedman Two-way Analysis of Variance (Siegel, 1956).

The data consisted of within-subject ranks of the 'element distances' from therapist for a) first test occasion b) second test occasion and c) changes between the two occasions. Results are presented in Table 10.

<table>
<thead>
<tr>
<th>Source</th>
<th>$\chi^2$</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>First test occasion</td>
<td>66</td>
<td>20</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Second test occasion</td>
<td>84.22</td>
<td>20</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Changes between occasions 1 and 2</td>
<td>19.84</td>
<td>20</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

These results indicate that certain elements are rated significantly closer to (or more distant from) the therapist compared with other elements on both test occasions. There is, however, no significant difference between elements in their amount of change relative to the therapist, between first and second testing.

The mean ranks of all elements in terms of their distance from the therapist element, and the mean ranks of element changes between first and second testing are presented for inspection in Table 11.
<table>
<thead>
<tr>
<th>Elements</th>
<th>Mean ranks on first test occasion</th>
<th>Mean ranks on second test occasion</th>
<th>Mean ranks of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Mother</td>
<td>12.8</td>
<td>13.3</td>
<td>11.5</td>
</tr>
<tr>
<td>2 Father</td>
<td>13.9</td>
<td>13.2</td>
<td>11.1</td>
</tr>
<tr>
<td>3 Spouse/opp.sex friend</td>
<td>10.75</td>
<td>12.55</td>
<td>12</td>
</tr>
<tr>
<td>4 Brother</td>
<td>10.5</td>
<td>10.05</td>
<td>8.05</td>
</tr>
<tr>
<td>5 Sister</td>
<td>12.05</td>
<td>10.75</td>
<td>8.3</td>
</tr>
<tr>
<td>6 Liked boss</td>
<td>8.75</td>
<td>8.4</td>
<td>8.2</td>
</tr>
<tr>
<td>7 Disliked boss</td>
<td>15.85</td>
<td>16.1</td>
<td>9.45</td>
</tr>
<tr>
<td>8 Influential person</td>
<td>13.5</td>
<td>14.4</td>
<td>11.85</td>
</tr>
<tr>
<td>9 Liked workmate</td>
<td>7.85</td>
<td>7.2</td>
<td>11.85</td>
</tr>
<tr>
<td>10 Disliked workmate</td>
<td>17.65</td>
<td>17.15</td>
<td>10.45</td>
</tr>
<tr>
<td>11 Liked teacher</td>
<td>7.15</td>
<td>7.1</td>
<td>8.15</td>
</tr>
<tr>
<td>12 Disliked teacher</td>
<td>19.2</td>
<td>18.6</td>
<td>11.75</td>
</tr>
<tr>
<td>13 Self</td>
<td>11.4</td>
<td>12.3</td>
<td>10.9</td>
</tr>
<tr>
<td>14 Ideal mother</td>
<td>7.8</td>
<td>6.25</td>
<td>13</td>
</tr>
<tr>
<td>15 Ideal father</td>
<td>4.7</td>
<td>4.3</td>
<td>11.1</td>
</tr>
<tr>
<td>16 Ideal spouse</td>
<td>7.45</td>
<td>7.35</td>
<td>14.85</td>
</tr>
<tr>
<td>17 Ideal self</td>
<td>6.1</td>
<td>7.35</td>
<td>9.75</td>
</tr>
<tr>
<td>18 Teachers in general</td>
<td>11.95</td>
<td>12.9</td>
<td>14.3</td>
</tr>
<tr>
<td>19 Ministers in general</td>
<td>10.5</td>
<td>10.45</td>
<td>11.35</td>
</tr>
<tr>
<td>20 G.P.'s in general</td>
<td>6.8</td>
<td>6.45</td>
<td>9.1</td>
</tr>
<tr>
<td>21 Peripheral persons</td>
<td>14.35</td>
<td>15.05</td>
<td>13.8</td>
</tr>
</tbody>
</table>

* Low rank indicates that element is close to therapist.
In order to investigate which elements are significantly close to or distant from the therapist element the Kolmogorov-Smirnov Test was applied to all the elements. Results are shown in Table 12.

### TABLE 12

Kolmogorov-Smirnov Test applied to all elements for both test occasions

<table>
<thead>
<tr>
<th>Elements</th>
<th>First test</th>
<th></th>
<th>Second test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D</td>
<td>p</td>
<td>D</td>
<td>p</td>
</tr>
<tr>
<td>1  Mother</td>
<td>0.21</td>
<td>N.S.</td>
<td>0.29</td>
<td>N.S.</td>
</tr>
<tr>
<td>2  Father</td>
<td>0.27</td>
<td>&quot;</td>
<td>0.29</td>
<td>&quot;</td>
</tr>
<tr>
<td>3  Spouse/opp.sex friend</td>
<td>0.13</td>
<td>&quot;</td>
<td>0.17</td>
<td>&quot;</td>
</tr>
<tr>
<td>4  Brother</td>
<td>0.29</td>
<td>&quot;</td>
<td>0.24</td>
<td>&quot;</td>
</tr>
<tr>
<td>5  Sister</td>
<td>0.23</td>
<td>&quot;</td>
<td>0.11</td>
<td>&quot;</td>
</tr>
<tr>
<td>6  Liked boss</td>
<td>0.23</td>
<td>&quot;</td>
<td>0.31</td>
<td>&quot;</td>
</tr>
<tr>
<td>7  Disliked boss</td>
<td>0.42</td>
<td>&lt; .05</td>
<td>0.46</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>8  Influential person</td>
<td>0.22</td>
<td>N.S.</td>
<td>0.26</td>
<td>N.S.</td>
</tr>
<tr>
<td>9  Liked workmate</td>
<td>0.29</td>
<td>&quot;</td>
<td>0.32</td>
<td>&quot;</td>
</tr>
<tr>
<td>10 Disliked workmate</td>
<td>0.66</td>
<td>&lt; .01</td>
<td>0.51</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>11 Liked teacher</td>
<td>0.37</td>
<td>N.S.</td>
<td>0.37</td>
<td>N.S.</td>
</tr>
<tr>
<td>12 Disliked teacher</td>
<td>0.66</td>
<td>&lt; .01</td>
<td>0.57</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>13 Self</td>
<td>0.22</td>
<td>N.S.</td>
<td>0.19</td>
<td>N.S.</td>
</tr>
<tr>
<td>14 Ideal mother</td>
<td>0.38</td>
<td>&quot;</td>
<td>0.38</td>
<td>&quot;</td>
</tr>
<tr>
<td>15 Ideal father</td>
<td>0.51</td>
<td>&lt; .01</td>
<td>0.57</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>16 Ideal spouse</td>
<td>0.37</td>
<td>N.S.</td>
<td>0.28</td>
<td>N.S.</td>
</tr>
<tr>
<td>17 Ideal self</td>
<td>0.41</td>
<td>&lt; .05</td>
<td>0.43</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>18 Teachers in general</td>
<td>0.23</td>
<td>N.S.</td>
<td>0.28</td>
<td>N.S.</td>
</tr>
<tr>
<td>19 Ministers in general</td>
<td>0.29</td>
<td>&quot;</td>
<td>0.13</td>
<td>&quot;</td>
</tr>
<tr>
<td>20 G.P.'s in general</td>
<td>0.42</td>
<td>&lt; .05</td>
<td>0.42</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>21 Peripheral persons</td>
<td>0.33</td>
<td>N.S.</td>
<td>0.27</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

It can be seen that therapists were most likely to be described as
similar to 'ideal father' then 'C.P.'s in general' and 'ideal self' on both test occasions. They were also likely to be described as dissimilar to the 'disliked teacher', the 'disliked workmate' and the 'disliked boss'.
DISCUSSION

1. Psychiatric Assessment Form

The psychiatrists taking part in the present study were not required to give their own definitions of transference. However, there are a number of reasons which suggest that they were using the term mainly in a psychoanalytic sense rather than simply in the sense of implying a positive or negative relationship between patient and therapist. Firstly, they tended to provide only those patients who had been in therapy for several weeks. This would seem to imply that the psychiatrists considered the transference phenomenon to arise during the course of therapy rather than to be present at its beginning. Secondly, all therapists were able to specify a transference figure on at least one test occasion, and, in addition, these figures were predominantly 'real' or 'ideal' parental figures. This latter finding is in line with Freud's own assertion that transference reactions were most likely to involve parental figures. Furthermore, the therapists' own comments (see section 1 (iii) of RESULTS) frequently reiterate the clinical writings of psychoanalysts that transference is an inappropriate reaction to the psychiatrist involving the repetition rather than the remembering of past relationships.

At the same time, the view is often put forward in clinical descriptions that transference reactions fluctuate fairly rapidly during therapy. It was, therefore, interesting to note that no significant changes occurred in the psychiatric 'evaluative' scale between first and second test occasions. It is, of course, quite possible that considerable changes had occurred during the two week interval between test and retest, and it would be necessary to obtain more frequent psychiatric assessments (for example, after each therapeutic session) before this possibility could be excluded. It is also feasible that the relatively global assessment of 'positive' or 'negative' feelings ignored the components which contributed to these all-inclusive terms. Changes in the components would not necessarily
have affected the overall assessment.

A more likely explanation for the test-retest stability of evaluative ratings is that these ratings were not simply measuring positive or negative transference reactions but were also assessing the more 'rational, non-neurotic rapport' between patient and therapist which is a component of the treatment alliance. While transference attitudes may fluctuate quite rapidly, this other type of relationship is probably fairly stable during therapy.

Results have shown that the therapists tended to perceive their patients as having predominantly positive feelings towards them (in terms of 'evaluative scale' means). There are at least two possible reasons for this. On the one hand, therapists may only have made available those patients with whom they had a good relationship. This possibility seems unlikely. Impressions suggested that, in fact, the therapists either provided all the patients who were in therapy with them at the time of the study or that they provided patients who had been in hospital for some time. New patients were therefore excluded. On the other hand it may be that in brief psychotherapy an explicit attempt is made to maintain positive relationships between patient and therapist. Such a practice would be opposed to Freud's assertion that negative transference reactions must develop at some point in psychoanalysis if improvement is to occur.

2. Repertory Grid Test

Certain features of repertory grid methodology were investigated in the present study.

In devising the grid measure, it was decided to concentrate on the 'personal' aspect of the technique rather than attempt to standardise the grid for all subjects by providing elements and constructs. The adoption of this approach meant that subjects varied in the number of constructs and elements they were able to provide. The subsequent analysis (Table 2, RESULTS) showed that the procedure
employed was quite adequate for obtaining a valid assessment of the major portion of the subjects' construct space. At the same time, the practice of allowing subjects to supply varying numbers of constructs and elements made group comparisons of results quite difficult. In order to carry out certain statistical analyses, such as the Binomial Test, it was necessary to combine categories of elements in some cases in order to equate total element numbers over the 10 subjects. Such a practice undoubtedly led to some loss of information in certain grids. Against this must be considered the possibility of rendering the task less meaningful for subjects by including supplied constructs and elements.

The first principal component accounted for an average of 56% and 58% of grid matrix variance for first and second test occasions respectively. Ryle and Lunghi (1968) have reported that the first component usually accounts for 30 - 40% of all the variance in a grid. The percentages obtained in the present study appear therefore to be unusually high. In the absence of information about the particular types of grid test involved in Ryle and Lunghi's report, and about the samples employed, discussion of this discrepancy can only be speculative. At first sight, however, it seems possible that the explicit aim of obtaining a preferential pole for each construct of a subject's grid may have inflated the total percentage of the first component. Osgood, Suci and Tannenbaum (1957) demonstrated, for example, that the largest factor underlying a person's semantic space is an evaluative one. In practice, it seems unlikely that this was the case. It may be recalled, for example, that only one subject was unable to specify a preference, and for only one construct dimension. It seems reasonable to conclude with Bonarius (1965), therefore, that most of a person's constructs have an evaluative aspect. The possibility of subjects developing a response set when rating elements was also guarded against by varying the position of the positive pole on the 7-point rating scale.

Alternatively, one might speculate that the high percentage of
the first principal component is a measure of the 'unidimensional' or 'monolithic' nature of the neurotic patient's construct system (Bannister, 1960: Norris, Jones and Norris, 1970). Jones (1954) and subsequent writers (Flynn, 1959: Campbell, 1960) have used the explanatory power of the first Reptest factor as a measure of cognitive complexity. Jones, for example, found support for the hypothesis that neuropsychiatric subjects are characterised by a simpler cognitive structure than normal subjects. In like manner, it seems feasible to postulate that the higher the percentage of the first principal component the more simple or unidimensional the individual's construct system.

In view of the fact that the first principal component accounted for such a large proportion of the total variance of patients' grids, it was considered reasonable to assess the stability of the grid in terms of the test-retest reliability of this component. While it remains true to say that "there is no such thing as the reliability of the grid" (Bannister and Mair, 1968), it has been shown that certain grid properties have quite stable features. The present findings that the first principal component gives a stable measure of grid structure, regardless of the number of constructs and elements, and that it gives a stable measure of grid content, compare favourably with previous investigations of grid reliability. Pedersen (1958), for example, reported a one week test-retest correlation of the factorial content of the first figure factor of 0.85, and a test-retest correlation of 0.83 for the first construct factor. Results from the present investigation, showing a mean test-retest correlation of 0.91 for element loadings on the first principal component and a correlation of 0.87 for construct loadings on the first component, are highly comparable with those of Pedersen.
3. Relationship between the Psychiatric Assessment and the Repertory Grid Measure

It has already been stated (see AIMS section) that failure to obtain a correlation between the two measures could allow no conclusions to be drawn about the validity of either measure, other than to suggest that they are unlikely to be assessing the same variable.

Results have shown that the mean ratings for both the psychiatric and patient evaluative scales tended to be high. However, a rank-order correlation between the two ratings failed to reach significance on either test occasion. A number of explanations could account for this finding. Firstly, a comparison was made between the therapist's evaluative scale, which was a direct measure, and an indirect assessment of the patient's evaluation of the therapist. This latter measure was obtained by summing the therapist's ratings on each patient's set of constructs. The possibility exists that this was an inadequate measure of patient feeling. In order to assess which pole of each construct dimension was positively evaluated, for example, the patient was asked which pole was preferable in general. Such a procedure does not take account of the extent to which preference may depend on the type of element under assessment. For example, a patient rating the therapist on the construct 'deep - outgoing' may consider it better for the majority of people to be outgoing, but at the same time feel that a psychiatrist should be 'deep'. In an investigation of the Semantic Differential, Knapper and Warr (1965) found that the meaning of a scale depended on the concept being judged - that hard, for example, meant one thing when a person was being judged and another when inanimate objects were being considered. Presly, too, (1969) has shown that scale intercorrelations vary according to the types of concept being rated.

Another possible explanation for the failure to obtain a significant correlation between the two evaluative scales lies in the type of construct which patients tended to provide on the grid test.
The constructs elicited from subjects were predominantly of the 'psychological trait' variety, e.g. 'sincere - hypocritical', 'conscientious - lazy', 'stable - neurotic', etc. Constructs reflecting more fleeting emotional characteristics, such as angry, hostile, cheerful, etc. were rarely obtained. It seems likely that 'psychological trait' type constructs change rather gradually in therapy compared with 'emotional' constructs. The failure to obtain a significant correlation between the two evaluative scales may have been due to the fact that both were employing different types of constructs. At the same time, although therapists may have been basing their ratings on 'emotional' type constructs, it is noteworthy that there was still no significant change in their ratings between test and retest.

A third possibility is that individual differences between raters may have contributed to the lack of correlation between the rating scales. With the small size of sample in the present investigation it was obviously impossible to investigate the extent to which subjects, in either the patient or therapist sample, differed in their rating policy. Such an explanation might, however, account for the fact that, although there was no direct relationship between the scales, a significant correlation was obtained between the test-retest difference scores on both scales.

The high difference score correlation is, in fact, made rather spurious by the finding that both scales showed no significant changes between the first and second test occasions. The ranking procedure may have inflated relatively small differences between test-retest scores. At a superficial level, however, the high correlation suggests that psychiatrists are successful in detecting the direction of small changes in their patients' feelings towards them.

Results indicated that there was no relationship between the psychiatric transference figure and the 'distance score' of that figure from the therapist on the patients' repertory grids. Several factors may have contributed to this result. It may be recalled that the
statistical analysis of transference figures was not based on all 10 cases. Those cases in which therapists specified more than one transference figure were excluded from the data to which the Binomial Test was applied. Similarly, in the investigation of the distribution of therapists' transference figures on the 10 repertory grids (Kolmogorov-Smirnov Test), the practice was adopted of averaging the 'element distance' ranks in those cases where therapists had specified more than one figure. It has already been suggested (above) that such a procedure involves some loss of information from patients' grids. Presumably, psychiatrists who proposed two or more transference figures meant that their patients reacted to them as if they had some of the traits of each of these figures e.g. some 'maternal' traits and some 'paternal' traits. The practice of averaging the total 'element distance' scores of these figures to obtain a composite score, probably had the effect of negating these 'partial' identifications.

The lack of agreement between psychiatric and grid transference figures may, alternatively, lie in the fact that psychiatrists were left free to specify their own figures. In other words, there was no set of persons from which they could make their choice. It has already been suggested that their choices were partially based on their knowledge of Freudian Theory and on the type of figure which this theory hypothesises is most likely to be involved in transference reactions. Had psychiatrists been provided with the same set of figures as the patients, they might have found other persons with whom they were more closely identified.

Inspection of Table 7 in fact shows that there was relatively good agreement with repertory grid results in those cases in which therapists specified 'ideal' transference figures, since such figures tended to be ranked close to the therapist on patients' grids. Lack of agreement occurred where they proposed 'real' parents as the transference figures.
4 Investigation of Crisp's and Sechrest's Findings

Grid results provided no support for the traditional Freudian hypothesis that the therapist is most closely identified with the patient's father or mother. The Friedman analysis of variance has shown that there was no significant tendency for real parental figures to be ranked closer to the therapist than other figures over the 10 subjects. These findings bear out the results of Sechrest's study and have an added advantage in that the present study had selected patients in whom therapists considered a definite transference relationship was occurring. Sechrest's study was apparently based on the assumption that transference reactions are to be found in all patients at any point in therapy.

The analysis of variance showed that there was a tendency for certain elements to be ranked significantly close to or distant from the therapist element over the 10 grids. Those ranked close to the therapist included 'ideal father', 'ideal self' and 'G.P.'s in general'. Elements ranked significantly distant from the therapist were 'disliked boss', 'disliked workmate' and 'disliked teacher' (i.e. wholly negative figures).

The finding that the 'ideal father' element was ranked closest to the therapist of all the grid figures provides support for Crisp's assertion that the doctor is often seen in the role of an ideal father. It may be recalled that Crisp saw this as a 'transference' reaction based on a neurotic defense mechanism on the patient's part. Idealisation of the therapist may in fact be viewed in two possible lights. On the one hand, it can be interpreted as an attitude engendered in a helpless patient who sees his doctor as the main source of relief from distress. The doctor may subsequently become endowed with qualities of omnipotence. Greenson (1967), for example, has referred to the patient's need to see the therapist as omnipotent and regards this as a component of the 'working alliance' rather than of transference proper. On the other hand, idealisation can be conceptualised as a true transference reaction which operates to defend the patient against hostile feelings towards the therapist.
It was suggested in the 'Review of the Experimental Literature' that Crisp's application of the 'ideal father' construct was more in keeping with its interpretation as a component of the treatment alliance than of transference proper. It seems quite reasonable to envisage idealisation of the therapist simply as an aspect of 'liking' for him. Obviously no definite conclusions can be drawn about the meaning of the patients' tendency to idealise the therapist. However, if it is in fact a defense against aggression, then one would expect that with progress in therapy a stage should eventually be reached where idealisation breaks down and hostility manifests itself.

The additional finding that patients identified the therapist with a stereotype family doctor figure partly replicates Sechrest's own findings that therapists were most frequently identified with doctors, teachers or ministers. In a discussion of Sechrest's study, Bannister (1966) has suggested that his findings might be extended "by checking in the first place whether the patient views model figures of the family doctor, minister, teacher-type favourably, and this might be an index of the way in which he will ultimately respond to the attentions of the therapist as such." It seems reasonable to expect that if psychiatrists are closely identified with 'doctors in general' and if the latter are positively evaluated, then psychiatrists will be also. The opposite need not necessarily be true, however. In the present investigation, for example, one female patient reported intense negative attitudes towards general practitioners but highly evaluated her own therapist (and was also perceived by the therapist as having positive feelings towards him). Various possible explanations for this type of reaction could be found. It may be, for example, that the distress of mental illness forces the patient to develop a positive attitude towards his potential helper, or, alternatively, that the close one-to-one relationship existing in psychotherapy enables the patient to distinguish the psychiatrist from other doctor figures with whom he is less likely to develop a close relationship.

If there is an initial tendency for patients to identify the
psychiatrist with their impressions of doctor-figures in general, then it does indeed become important to know whether the patient has a positive or negative attitude towards such figures. In this way, the psychiatrist would be able to decide whether it was appropriate to foster the identification or, if this was thought to be a potential threat to therapeutic progress, whether he should encourage the patient to distinguish him from other doctor figures.

Thus far, discussion of the failure to obtain support for the Freudian transference hypothesis has concentrated on specific points of methodology in the present study. A number of more general comments also seem relevant. One possible explanation for the failure lies in the nature of psychotherapy being practised to-day. It has already been pointed out that neither Crisp nor Sechrest used a psychoanalytic setting for their investigations. A similar criticism may be made of the present study, although an attempt was made to use a therapeutic setting which had been developed within a psychoanalytic framework. Szpilka and Knobel (1968) have pointed out some of the essential features of brief psychotherapy. "Short-term psychotherapy differs from psychoanalysis in that - 1) regression is not encouraged, but rather the relationship is maintained at an adult level by communicating corrective information and 2) transference is used only when it does not become the axis of treatment, thus avoiding 'transference neurosis'." Zavitzianos (1967) has also commented that in dynamic psychotherapy transference does not assume the form of a 'transference neurosis'. It seems likely that the identification of the therapist with a specific figure from the patient's past life is a feature of the 'transference neurosis' whereby the patient repeats with the psychiatrist all the original features of the neurosis in transference form. In other words, the psychiatrist becomes identified with those figures who were central to the development of the illness. Where transference reactions have not developed into the fully-fledged transference neurosis, it is reasonable to assume that any identification of therapist with figures in the patient's life will only be
partial, and possibly not analysable by the type of measurement which can be derived from a repertory grid test.

A second and related argument concerns the susceptibility of the transference concept to any form of psychological measurement.

It is reasonable to assume that our perceptions of new persons generally involve an attempt to categorise these persons in terms of some previously acquired system. Information from Social Psychology on processes of person perception and the development of stereotypes supports such a notion. Stated in another way, most new people whom we meet in adult life are likely to be identified to a greater or lesser extent with past figures in our lives. The development by individuals of a personal construct system seems to be an important means of enabling us to make this classification process possible. Freud has suggested that the tendency to identify new persons with past childhood figures is particularly strong in the neurotic, and this tendency is seen at its optimum in the transference reactions of therapy. The actual nature of the identification in therapy is unclear however. Greenson (1967), for example, has stressed the 'as if' quality of transference phenomena. Thus, while the patient may react emotionally to the therapist in the same manner as he once reacted to parental figures in childhood, he is nevertheless able to distinguish the therapist as an individual in his own right at an intellectual level. His reactions, therefore, have an 'as if' quality in which identification of the psychiatrist with parents is restricted to a certain level of communication. This explanation takes account of the fact that transference phenomena are regarded by psychoanalysts as being largely unconscious. It becomes questionable whether any psychological task involving intellectual judgment on the patient's part can provide an adequate assessment of the transference phenomenon.

Finally, the possibility does exist that transference reactions were likely to be diffuse since both individual and group therapies were involved in the treatment programme of the present patient sample.
In consequence they may have occurred to persons other than the patient's own therapist. An example of such an occurrence was seen in the statement of a male therapist (P.49) that his patient had displaced her aggressive feelings from him since they were too conflicting with her perception of him as "the one who makes her better." Obviously displacement of transference reactions can occur in psychoanalysis as well. Greenson cites as one example the case of students undergoing a training analysis who may find it necessary to displace their negative attitudes onto other psychiatrists rather than experience the anxiety of expressing aggressive feelings towards a supervising analyst. At the same time, substitutes are more easily available in a group therapy setting than in the predominantly one-to-one psychoanalytic situation.

It is clear that no experimental study (including the present investigation) has provided satisfactory measurement of the Freudian transference hypothesis. None of the studies has adequately attempted an investigation of the phenomenon within a psychoanalytic setting where, most writers are agreed, transference reactions are seen at their clearest. The fact remains that the concept has been extended outwith that setting, and that it is used to describe features of the patient-therapist relationship in various forms of therapy. It therefore becomes important to ask whether the concept is sufficiently well defined to allow its use as a measurable therapeutic variable in these settings. It has already been seen that even psychoanalytic writers are not in agreement about the definition of transference. It seems fair to say that the confusion over the meaning of the term in subsequent experimental studies is an inevitable result of the fact that psychoanalysts' "hypotheses are not stated in a form which can be tested in a scientifically valid way."(Sutherland, 1952).

As Curran and Mallinson (1944) so aptly state (in a different context):- "The discussion of any topic is handicapped so long as there are doubts and disagreements as to what is being discussed." Added to the confusion over meaning is the observation that in brief psychotherapy,
where rational communication between patient and therapist is emphasised, any transference reactions which do appear will be experienced in much diluted form. It is, therefore, tentatively suggested that the transference concept does little to advance our knowledge of patient-therapist variables in non-analytic therapeutic settings, and that it might be more useful to concentrate on some of the features which various writers have suggested contribute to the concept e.g. that transference involves inappropriate and irrational attitudes, and that such reactions arise during the course of therapy as opposed to attitudes existing previous to the onset of treatment.

**Implications for Future Research.**

In the development of the transference concept, the term 'treatment alliance' came to be used to contrast the non-neurotic rational rapport which the patient forms with the therapist against the more inappropriate and unrealistic attitudes which contribute to the transference concept. It has been suggested that past investigators, while purporting to measure transference proper, have really been looking at the treatment alliance. Crisp, for example, speaks of the patient's "therapeutic potential", and Sechrest of "the pleasantness of the patient-therapist relationship." Such comments recall Sandler's (1970) suggestion that "it is useful for the referring physician to come to some decision about the patient's capacity and motivation to develop an enduring treatment alliance which could support the treatment process." It would seem useful, therefore, to investigate the attitudes to doctors which the patient brings into therapy, and to relate them to other therapeutic variables such as length of stay, outcome, and so on. Crisp, for example, showed that patients' initial attitudes to doctors were related to symptom changes in behaviour therapy. The relationship might also be investigated in other types of therapy. If, as Sechrest's work and the present results suggest, the therapist tends to be identified with the general practitioner, it would obviously be useful to assess the patient's
attitudes towards this type of figure.

It would also be interesting to know under what conditions the patient's initial attitudes to doctors change. What new attitudes emerge as a consequence of being in therapy? As Knowles and Lucas (1962) have pointed out: "We recognise that attitudes to doctors and treatment are likely to be complex and that the reaction to an individual practitioner may be at variance with a patient's evaluation of a wider range of doctors with whom he has been in contact. Such reactions are likely to be of importance."

If the irrational and inappropriate feelings and emotions of the patient towards the psychiatrist (which partly define the transference concept) are not measurable by psychological techniques such as repertory grids, then measurement might usefully be made by content analysis of therapeutic interviews. Furthermore, the relationship of such emotions to other more appropriate and realistic attitudes might be examined. Are there certain points in therapy at which the proportion of inappropriate reactions will be high? What, for example, is the relationship of patient-therapist attitudes before and after therapeutic abstractions? Are patients more likely to express unrealistic (transference) emotions immediately after abstractions? Other important points in therapy such as a change of therapists, absence of the therapist due to vacation or illness, might also be investigated.
APPENDIX A

The Psychiatric Assessment Form
Doctor:

Ward No.:

Date of Assessment:

Patient:

1) Please assess, in your own terms, the present transference situation with this patient -

2) How would you rate the patient's feelings for you at the present time? Are they mainly positive or negative? Please rate on the scale provided -

   negative 1 2 3 4 5 6 7 positive

3) Is the patient identifying you with a particular figure in his/her past or present life e.g. father, spouse, etc.?
   Name the figure:

4) Is the patient identifying you with some 'ideal' figure e.g. an 'ideal' brother, uncle, etc.?
   Name the figure:

5) Please make any further comments you wish about the present transference situation.
APPENDIX B

Further notes on the statistical methods employed
The Binomial Test was applied to determine the probability of finding the therapist's transference to be the figure closest to the therapist on the patient's grid (Table 6).

The probability of obtaining \( x \) objects in one category and \( N-x \) objects in the other category is given by:

\[
p(x) = \binom{N}{x} p^x q^{N-x}
\]

where \( p = \) proportion of cases expected in one of the categories
\( q = 1-p = \) proportion of cases expected in the other category.

In the present investigation, \( p = \frac{1}{21} \)

\[
q = \frac{20}{21}
\]

\( x = \) no. of times therapist's transference figure was the closest element to therapist on the patient's grid.

\( N = \) total no. of cases.

In some cases therapists had specified more than one transference figure e.g. mother and father. This meant that the proportion of cases expected in either of the categories varied over the ten subjects. In other words, the probability of any one of 21 figures being closest to the therapist is \( \frac{1}{21} \). The probability of any 2 out of 21 figures being closest to the therapist is \( \frac{2}{21} \), and so on.

For this reason comparisons were limited to the cases in which psychiatrists had specified only one transference figure.

The Kolmogorov-Smirnov One-sample Test was applied on two occasions - 1) to test whether the distribution of the therapists' transference figures on the patients' repertory grids was significantly different from that which would be expected on the basis of chance. (Table 8). 2) to assess which of the 21 repertory grid elements were significantly related to the therapist element over the 10 subjects. (Table 12).
The test involves a comparison between the distribution of the obtained ranked (distance) scores and a theoretical rectangular distribution.

The formula for the Kolmogorov-Smirnov Test is given by: 
\[
D = \text{maximum} \left| F_0(X) - S_N(X) \right|
\]

where \( F_0(X) \) is a specified cumulative distribution under \( H_0 \) - where \( H_0 \) (in the present investigation) is that each of the 21 rank positions would receive \( \frac{1}{21} \) of the choices.

\( S_N(X) \) is the cumulative distribution of the observed choices of the total number of subjects.

The Friedman Two-way Analysis of Variance was applied to determine whether any element on the patients' repertory grids was significantly related to the therapist element.

When the number of rows / or columns is not too small, \( \chi^2 \) is distributed approximately as chi square with \( df = k-1 \), when

\[
\chi^2 = \frac{12}{NK(k+1)} \sum_{j=1}^{k} \frac{(R_j)^2}{N(k+1)} - 3N(k+1)
\]

where \( N \) = number of rows.
\( k \) = number of columns.
\( R_j \) = sum of ranks in jth. column.

\[
\sum_{j=1}^{k}
\]

directs one to sum the squares of the sums of ranks over all k conditions.

In the present application of the test (Table 10):-

\( N = \) number of subjects = 10
\( k = \) various conditions = 21

The Friedman test determines whether it is likely that the different columns of ranks (samples) came from the same population (Siegel, 1956).
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