The Assessment of Transference by the CCRT Method

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1. Introduction

Ever since Freud introduced the concept of transference after the turn of the century (Freud 1912b), psychoanalytic clinicians have formulated it and reformulated it during the treatment of their patients. In their clinical writings they have attended to it even more than to the other two clinical factors that are considered curative, the therapeutic alliance and the internalization of the gains (Luborsky 1984). Despite its clinical centrality there has been no well researched operational measures of it on the basis of psychoanalytic sessions. It was only ten years ago that the advent of the CCRT measure (Luborsky 1977) began to fill that void. Now, in this volume are three of the most prominent current attempts to represent the transference: the CCRT, the PERT (Gill and Hoffman 1982b), and FRAME structures (Dahl, this volume; Teller and Dahl 1981a, 1986).

In this chapter we describe how the measure was discovered, how it works, an example from the Specimen Hour, its reliability and validity and future plans for it.

Fifteen years ago, in order to develop such a measure, Luborsky joined a group of clinical researchers who met once a week for several years – the Analytic Research Group of the Institute of the Pennsylvania Hospital. Although we made some progress and developed a measure of *amount* of transference (Luborsky et al. 1973), the group finally gave up the search and disbanded because their ultimate aim had been to discover a measure of the *content* of the transference, not just a measure of amount of transference.

Then several years ago Luborsky stumbled upon a content measure while occupied with what appeared to him to be another task. It happened in this way. After the helping alliance measure (Luborsky 1976) had been constructed he was exploring the question of how the helping alliance relationship measure might fit into a measure of the general relationship pattern. He looked into this question in much the way he had proceeded with the helping alliance measure. He read and re-read psychotherapy sessions and then reviewed what he had been attending to in forming a concept of the general relationship pattern. First he saw he was giving special attention to the narratives of interactions between the patient and other people ("relationship episodes") not only early episodes in relationship with the parents but current episodes in the relationship with the therapist. Relationship episodes are spontaneously told narratives found in almost all sessions. They are about other people, typically the father, mother, brother, sister, friends, bosses, and the therapist. He also noticed that his understanding of the relationship pattern within the narratives consisted of understanding these components: the patient's main wishes, needs or intentions toward the other person in the narrative, the responses of the other person, and the responses of the self. His inferences about the basic relationship pattern were primarily determined by the types of these components with the highest frequency across the relationship episodes. In fact, the combination of these highest frequency types of components constituted the main relationship pattern, the "Core Conflictual Relationship Theme" (CCRT). It was only later that experiences with the CCRT led him to realize that he had hit upon on an operational definition of the transference.

The method appears to have common elements with the TAT's scoring method and such appearances are not entirely deceiving. Some of the categories of the two are similar; for example, the wishes are similar and the expected responses from others is similar; it is called "Press" in the TAT. But there are major differences. In the CCRT, (1) the narratives are presented by the patient or subject as real narratives not fantasies, and (2) the principal inferences are about the few most recurrent organizing themes or mental schemas, not as in the TAT about a large array of all kinds of themes. In fact, the CCRT may belong to a family of conceptualizations of relationship patterns which includes Tomkin's (1979) concept of a nuclear script, Meichenbaum and Gilmore's (1984) concept of core organizing principle and similar concepts reviewed by Singer (1984). Despite the similarities in terms of concepts, the CCRT method is the most advanced in terms of representing a guided clinical judgment system for evaluating the transference

concept, with some evidence for reliability and validity as described below (Luborsky et al. 1985 and Luborsky et al. 1986).

2. The CCRT Procedures

The CCRT measure is described in detail in a guide to the method (unpublished but available upon request, Luborsky 1986)[1]. The first step in the method is to identify the relationship episodes in the session. This is typically done by independent judges before the transcripts are given to the CCRT judges. A minimum of eight relationship episodes are usually used as a basis for scoring the CCRT.

The CCRT judge reads the relationship episodes in the transcript and identifies the types of each of the three components in each episode:

a) the patient's main wishes, needs, or intentions toward the other person,
b) the expected or actual responses of the other person; and
c) the responses of the self.

The CCRT represents the types of components with the highest frequency across the sample of relationship episodes.

The judge first identifies the wishes, responses from others and from the self in each of the RE's and from these makes a preliminary CCRT formulation (steps 1 and 2) and then the same judge re-identifies and re-formulates (steps 1' and 2'):

Step 1: Identify the types of wishes (W), responses from others (RO), and response from self (RS) in each relationship episode (RE).

Step 2: Formulate a preliminary CCRT based on the highest frequencies of each of the types of each component.

Step 1': Re-identify, where needed, the types of W, RO, and RS based on the step 2.

Step 2': Re-formulate, where needed, based on the recount of all W, RO, RS in step 1'.

[1]In the meantime a German version has been published by Luborsky (in Luborsky and Kächele 1988)

The CCRT judges work independently of each other. Judges are trained by first reading the CCRT guide and trying several practice cases, receiving feedback from the research team about their performance after each one. Although we have preferred to use experienced clinicians as judges, some graduate students have also performed well as judges because the task does not require that the judge be committed to a particular school of therapy and clinical understanding is more crucial than clinical experience.

3. Examples from the Specimen Hour

Two experienced independent CCRT judges evaluated the CCRT for the Specimen Hour. Before they applied their CCRT scoring 11 relationship episodes had been independently identified in this session. For purposes of simplifying this presentation the 11 relationship episodes were abbreviated so that they could all be shown in Figure 1. The two CCRT judges showed good agreement with each other on their CCRT formulations. Their combined formulation is briefly summarized at the center of the outer ring of 11 episodes. The wish that appears most frequently in these episodes is the wish to be assertive in the sense of wanting to exert control, to be dominant and to be better than the other person. The next most frequent wish is the wish for reassurance. The wish for reassurance is typically associated with the episodically uncontrolled expression of her most frequent wish for control or dominance of others. The other person is expected to or actually responds negatively – the other person dominates, controls, disapproves and does not reassure. The negative responses from the self include: feeling an absence of control over herself, self blame, annoyance, anger, upsetness – with the last three of these being the most frequent.

The CCRT approach can be applied by trained CCRT judges as it was in the example just given, or it can be applied more informally by the therapist during the course of the session. The therapist must decide when the CCRT components are close to being experienced and when it is desirable technically to interpret them.

4. Reliability of the CCRT (Agreement among Judges)

Even in the first trials of the CCRT method (Luborsky 1977) considerable agreement among judges was found. In Levine and Luborsky (1981) 16 graduate psychology students judges individually scored the

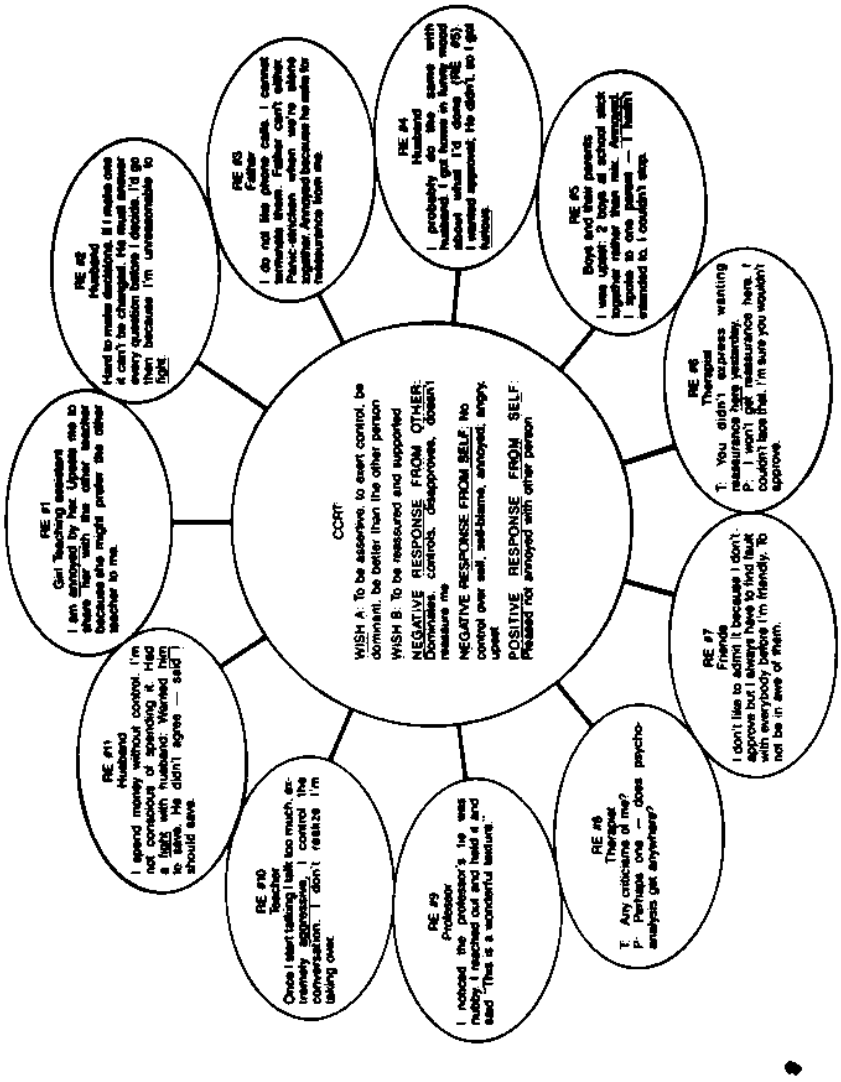

Figure 1 RE's and CCRT for Specimen Hour

CCRT for one patient (Mr. B.N.). When the scoring of each of these judges was compared with composite scoring of research judges (who also individually scored the CCRT) good agreement was found (average correlation of .88). Furthermore, agreement was shown by the method of "mismatched cases" – agreement was greater when the components to be

compared were drawn from the Mr. B. N. case itself rather than from two other purposely mismatched cases.

A larger reliability study was carried out on eight patients each scored by three independent judges (Luborsky et al. 1985; Luborsky et al. 1986). Determining agreement involved the use of a second set of two judges who compared the CCRT formulations of each of the three CCRT judges by the method of paired comparisons and were asked to indicate whether the formulations were basically similar or different. Formulations were judged to be similar if words with similar meanings (e.g. "anxious" and "afraid") were used by the different CCRT judges. This task showed good interjudge agreement (96%). We then calculated how often the three CCRT judges came up with similar formulations across the eight cases. The data revealed that on the wish component the three CCRT judges had similar formulations 75% of the time (6 out of 8); two of the three judges had similar formulations 100% of the time. For the negative response from other, 63% of the time the three judges arrived at similar formulations, while two out of the three judges arrived at similar formulations 88% of the time. For the negative response from self, the three judges reached similar formulations 38% of the time, while two of the three reached similar formulations 88% of the time. We should emphasize that for good reliability to be achieved judges should be well-trained in the use of the method (by following the manual and comparing their work with our set of practice cases). A much larger study is near completion which shows good levels of agreement (Crits-Christoph et al., in preparation)

5. Validity

Two kinds of validity were tried. An example of the most usual type, which is the correlation of the measure at hand with a more standard measure, will be presented first.

Validity (1): CCRT "improvement" versus standard improvement measures.

To assess the validity of the CCRT we related it to other measures. Using data from the study of eight patients (Luborsky et al. 1986), we hypothesized that change in the CCRT from early to late in treatment should be related to independent measures of the outcome of treatment. The measure of change in CCRT was the difference score between the early-in-treatment pervasiveness of each CCRT component (i.e., the

percentages of relationship episodes that contained each main wish, negative response from self, negative response from other, positive response from self, and positive response from other) and the late-in-treatment pervasiveness of the same CCRT components. Two independent outcome measures were selected as criteria, one from the perspective of the patient, the Hopkins Symptom Checklist total score, and one from the perspective of an external clinical judge, the Health-Sickness Rating Scale (Luborsky 1975). Both measures were obtained at the beginning of treatment and at termination. Change in the pervasiveness of the main negative R was significantly correlated with change in Health-Sickness Rating Scale, $r = -.81$, $p < .05$, as was change on the main wish, $r = -.73$, $p < .05$. Change in the main positive RO was significantly correlated with change on the Symptom Checklist, $r = -.79$, $p < .05$. The direction of all of these correlations was as expected: increase in the frequency of positive components or decrease in negative components of the CCRT was associated with more favorable outcomes. A study by Baguet, Gerin, Sali and Marie-Cardine (1984) has also shown a relationship between change on the CCRT and change on the Health-Sickness Rating Scale.

Another kind of validity also has been explored. It is validity defined as meaningful relationships of the CCRT to other phenomena:

Validity (2): Correspondence of the CCRT with Freud's Observations of Transference:

A more indirect way of examining the validity of the CCRT is to compare its results with nine observations Freud (1912b) made about transference. This comparison is based on a study of eight patients' psychotherapy sessions (Luborsky et al. 1985; Luborsky et al. 1986). Each patient's CCRT was scored by three independent judges on a minimum of ten RE's drawn from two sessions early in treatment and by three different independent judges on ten RE's from two sessions late in treatment (about one year later). Each of Freud's nine observations were translated into operational definitions and these were examined for the degree to which they applied to the CCRT results. At this point Freud's observations will only be briefly listed; details can be found in Luborsky et al. (1985, 1986): (1) each patient has one transference pattern; (2) each patient has a special form of transference pattern; (3) the pattern applies to "the conduct of his erotic life;" (4) the transference pattern is composed of a portion that is kept out of awareness and a portion that is in awareness; (5) the pattern "is constantly repeated – constantly reprinted afresh – in the course of the person's life;" (6) the pattern "is certainly not entirely insusceptible to change;" (7) the relationship with the ther-

pist in the course of treatment becomes like the general transference pattern; (8) the transference pattern derives from the "combined operation of his innate disposition with the influences brought to bear on him during his early years;" (9) the transference is evident both inside and outside of the treatment. We were able to make an operational definition for most of these and found that for them the CCRT findings and the operational definition of Freud's observation appear to be consistent.

6. Plans

A high priority for further development of the CCRT is more studies of reliability, validity, and comparisons with other measures. Much of this will be accomplished through analysis of a sample of 43 patients from the Penn Psychotherapy Study. Within the next three years we hope to publish a definitive guide to the method and to the research using the method. These are the specifically planned studies to be carried out during this period:

1. Further Reliability Studies: These studies will be based on the 43 cases each evaluated by three judges. We have found that the paired comparison method is a way to deal with providing a quantified estimate of the similarity of the scoring of the judges with each other. Since the categories used for each patient are tailor-made descriptions to fit each patient, a paired comparison system of judgment of these descriptions by independent judges judging degrees of similarity is a first approximate solution to the need to provide a quantified reliability estimate.

2. More Simplified and Reliable CCRT-Scoring Methods: Since the usual CCRT scoring is by tailor-made categories for each patient and such categories not only are time consuming to score but they engender problems in reliability, we have been refining a set of uniform pre-set categories. We intend to compare the usual CCRT tailor-made scoring with a combination scoring in which the judge first does the usual CCRT scoring and then consults the pre-set category list and translates each of the CCRT categories into the best-fitting pre-set category. The combination system seems to us to be a prudent one to achieve the scoring of the pre-set categories. In the next stage of this research we will venture to try an unassisted system. CCRT judges will select the most applicable categories from the pre-set category list without having first done their own tailor-made categories. We do not expect the results of the direct-use-of-pre-set-categories to be as reliable as the results of the combination system, but we will see.

For the pre-set category list (Edition #1) we used a normative sample of 16 cases: 8 from the Penn Psychotherapy project and 8 from other research centers. The set of categories in the Edition #1 is built on an empirical basis, i.e., it is an assemblage of the categories that best describe the core theme components in the RE's of our sample of 16 patients. Edition #2 to be developed in the same way in the next two years will be on a normative sample of 60 cases.

The principles for selecting the categories and organizing them are as follows: (1) the categories chosen are those that most frequently appear in the 16 cases in the normative set. (2) The categories are the ones that are most readily discriminable from each other, that is, they are fairly clearly non-overlapping. (3) The adjectives used within each category are fairly synonymous. (4) The words selected for the categories in each of the three types of component lists are the same wherever possible e.g. wish: "not be dominated;" response from other: "dominates;" response from self: "feels dominated."

Our plan is to have two independent judges apply Edition #1 to the set of 43 cases drawn from the Penn Psychotherapy project. We will then evaluate the agreement in the ways described above.

Based on the application of the combination system in three cases we have some impressions of the findings: (1) The translation of the tailor-made categories into the pre-set categories could usually be readily done. (2) The tailor-made categories tend to capture more completely the special flavor of the category as it applies to the particular patient. (3) The pre-set category system is convenient and relatively rapid to use as compared with the tailor-made system and is an obvious asset for simplifying the job of assessing interjudge agreement.

3. Further Validity Studies: Our plan is to apply both kinds of validity studies in the enlarged sample (N = 43) to permit (1) the comparison of change in the CCRT vs change in the health-sickness rating scale (as described earlier) and (2) the comparison of Freud's observations and about transference with the CCRT findings.

4. Further Comparison of the CCRT Measure with Other Measures: The measure that potentially has most in common with the CCRT is the Patient's Experience of the Relationship with the Therapist method (PERT) (Gill and Hoffman 1982b; Hoffman and Gill, this volume). This guided clinical judgment method uses transcripts of psychotherapy sessions and offers guidelines for the frequency of

communications regarding the patient's manifest experience of the relationship with the therapist as well as presumed implicit references to the experience. It has two main divisions: (1) experiences of the relationship that are manifestly about the relationship with the therapist and (2) experiences of the relationship that are not manifestly about the relationship with the therapist and have no specific designation. A comparison of the two methods is underway in which the PERT method and the CCRT method are being applied to the same sessions.

5. Further Simplified Assessment Methods: A questionnaire method for establishing general relationship patterns has been developed by Horowitz et al. (1983) which should be compared with the CCRT. It includes interpersonal behaviors mentioned as problems in psychiatric interviews; it is an "inventory of interpersonal problems" (IIP). The questionnaire has good internal consistency and test-retest reliability. We will evaluate 20 patients by both the IIP and the CCRT. We do not expect the IIP to tap into the transference pattern as clearly as the CCRT but the proposed study offers chance to see the strengths and liabilities of the two methods.