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Who Am I to You? Using Function Words as a Measure of Transference

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by

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

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There is a gap in our understanding of transference resolution as an aspect of therapeutic process and its relation to changes in language. My hypotheses can contribute to this area by identifying whether there are detectible changes in pronoun use in a psychoanalysis that are related to the resolution of transference. Data: The de-identified transcripts of a young agoraphobic housewife in a four time a week then two time a week psychoanalysis from the 1970s. Method: The Linguistic Inquiry and Word Count software will be used to measure structural changes in language that may reflect intrapsychic changes in the speech patterns of a psychoanalytic patient. First, I will attempt to measure if there are changes in the patient's flexible use of language. I will next verify that the patient's self-reference as measured by pronoun use changes. Then other linguistic behavior associated with pronoun change will be identified. Finally, I will qualitatively explore if there is a relationship between proposed language change and transference. Findings: Self-reference in terms of LIWC "I" use showed major change from High I use in the first half of the analysis when compared to the second half. LIWC language categories found to be associated with High I sessions were high affect, high "you," high negation, high present and future tense, high verbs, and low "we," low conjunctions, and low prepositions. Low I sessions tended to have high "we" scores, high "they" scores, high conjunctions, and low "you" scores, and low negation scores. When compared, the major differences between High I and Low I

sessions was found in the difference in pronoun use, where Low I sessions tended to be high "we/they" sessions and High I sessions tended to be high "you" sessions. For the qualitative analysis, sessions with High "I/you" scores tended to be interpreted as transference by the analyst, while high "we/they" scores tended to be interpreted by the analyst or patient as identification.

Key Words: psychoanalysis, transference, LIWC, pronouns, functions words, self-reference, textual analysis, therapy process research

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Chapter 1: Introduction, Review of the Literature, and Hypotheses

I. Introduction

Campbell and Pennebaker's (2003) content analysis of essays written by students and prisoners about traumatic incidents in order to study health improvements found that looking at language content, such as what the person wrote, was not predicative of improved health outcomes as measured by infirmary visits after diagnosis of illness. However, the authors found that the more that people changed their writing styles, the "how" of what they wrote rather than "what" they wrote, the more likely they were to visit the infirmary after diagnosis of an illness. The authors constructed a "styles measure," made up of particles and function words consisting of prepositions, conjunctions, articles, auxiliary verbs, and pronouns, in order to measure these writing styles. They hypothesized that these function words can serve to help identify relationships between the speaker, other individuals, and objects. They used Language Semantic Analysis (LSA), a program that "computes coefficients of similarity between any two text samples in a reliable and multidimensional way (p. 60)" in order to analyze the students' and prisoners' essays. Specifically, they found that the lower the similarity rating of the essays in pronoun and particle use, the more likely the person was to visit the infirmary. That is, the more the essay style changed, the more likely they were to have improved health outcomes.

The authors argued that coming to terms with a traumatic experience, especially a social trauma, was linked to changing thinking about oneself in relation to others and that this change in thinking can be measured by the change in function word usage. They write, "The LSA analyses have starkly demonstrated that different clusters of pronouns describe different social realities or different lenses through which our participants saw their worlds (Campbell and

Pennebaker, 2003, p. 64)." The authors believe that using this paradigm could have important implications for clinical research.

Psychoanalysis has a long history of thinking of "oneself in relation to others (Campbell and Pennebaker, 2003, p. 64)" and many authors would call this social lens "object relations" and its clinical manifestation "transference" (Freud, 1912). Transference is defined by Freud (1912) as the unconscious repetition of infantile relationships "transferred" onto the analyst and contemporary relationships. More recent investigators have called this and similar phenomena internal working models of attachment (Bowlby, 1969), representations of interactions that have been generalized (Stern, 1985), emotional schemas (Bucci, 1997) and cyclical psychodynamics (Wachtel, 2008). Part of the goal of an analysis is to bring these repetitions to the conscious awareness of the patient. Many analytic thinkers conceptualize this relationship between self, other, and reality in terms of pronouns (Lacan, 1954; Winnicott, 1958; Kernberg, 1987; Butler, 2003; Ogden, 2001).

Based on the implicit linking of pronouns and transference by the above authors, this thesis will examine whether pronoun and function word usage could be a way to measure therapeutic process. Utilizing Pennebaker and Campbell's (2003) method, I will examine the therapeutic process in a psychoanalytic therapy focused on transference interpretations. I argue that mental health status is correlated with the linguistic style, as measured by pronoun usage and function word use. Next, I will examine if there are other linguistic categories that are associated with those changes. Finally, a qualitative examination of the session material will be used to ascertain if there is a relationship between transference and the hypothesized changes in language structure.

The Linguistic Inquiry and Word Count Software as developed by Pennebaker, Booth, and Francis (2007) will be used to count pronouns and function words in order to measure structural changes within the analysis. This software will be applied to select sessions from the database containing the complete transcripts containing the full analysis of A2, a Midwestern housewife in a psychoanalysis, focused primarily on transference interpretations. The literature review will examine the theoretical and empirical work that has informed the development of my hypotheses. First, the theory of the resolution of transference as a constructive treatment goal will be examined in order to demonstrate that transference could be used as a potential measure of therapeutic process in the analysis of A2. In the second section, the work of researchers that have argued for linguistic structure to be used to examine therapeutic process will be examined. The literature review indicates that there is a gap in our understanding of looking at the process of transference resolution as an aspect of therapeutic process in an analytic treatment as it relates to function word use. My hypotheses can contribute to this area by identifying whether function word usage in an analysis is related to the resolution of the transference.

Transference: A History of the Concept and Role in Treatment

In this section, I will go over a very brief history of the term transference, how it has evolved, and briefly cover some of the current thinking around the term. Though countertransference will be touched on, other aspects of the transference such as the therapeutic alliance and other potential mechanisms of therapeutic change will not be reviewed as it is outside the purview of this paper. Controversies around the accuracy, frequency, or timing of a transference interpretation will be examined in the empirical literature section. The section will focus on the transference as it relates to psychopathology and the changes in theory that have

developed over the history of the term, organized by Harry Smith's (2003) terms for broad and narrow views of the transference.

Freud's attitude towards transference fluctuated through-out his theory, and different thinkers have focused on these different moments of fluctuation to extrapolate different positions in regards to transference. Freud (1895) first mentions transference in the analysis of Anna O. in her reaction to Breur, noting that it is a situation where the patient places wishes and feelings from a previous object onto the physician. Transference as we know it today was described in order to explain the failure of Freud's treatment of Dora (1905):

> What are transferences? They are new editions or facsimiles of the tendencies and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, 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 physician at the present moment. (p.106)

At first, Freud placed his idea of transference as a resistance to treatment following his adherence to a "resistance analysis" (Strachey, 1934). Freud's focus of the work of analysis was to make the "unconscious conscious" (Strachey, 1934, p. 67), and to induce the patient to remember repressed memories that were acted out in symptoms. As Freud's theory developed, the goal of this type of analysis began to change in focus from remembering the traumatic event to analyzing the resistance to remembering the traumatic event that fixated the patient in a certain psychosexual developmental stage (Hamilton, 1992). Transference was seen at this time as part of that resistance (Strachey, 1934).

As his theory developed, Freud (1916) would argue at times that resolving the transference was the key goal of treatment, where "the transference, which, whether affectionate or hostile, seemed in every case to constitute the greatest threat to the treatment, becomes its best tool (p. 496)." A year later Freud, (1917) would state:

> The decisive part of the work is achieved by creating in the patient's relation to the doctor in the 'transference' new editions of the old conflicts; in these the patient would like to behave in the same way as he did in the past, while we, by summoning up every available mental force [in the patient], compel him to come to a fresh decision. Thus the transference becomes the battlefield on which all the mutually struggling forces should meet one another. (p. 454)

Rather than transference serving to undermine the treatment, the facilitation of the "transference neurosis," where libido is cathected on the person of the analyst, and those infantile over stimulations or understimulations that lead to the onset of neurosis is now worked through with the positive alliance of the ego (positive transference). This working through becomes an avenue to a new resolution to the old conflicts in the "actual and immediate situation" with the analyst (Strachey, 1934, p. 68). Henry Smith (2003) argues that from Freud's original hypothesis, there emerged two different schools of thought in North American thinking about transference, and which he terms the narrow view and the broad view. Ego psychology, as developed from Freud's structural model and Anna Freud's description of "defense analysis" (1936) would come to dominate the North American scene up until the 1970's, and represents the origins of the more narrow view (Smith, 2003).

Anna Freud (1936) in her development of what would become ego psychology, and in her continuation of one interpretation of Freud's theories, represents the origins of the narrow view of transference (Smith, 2003). In Ego psychology, interpreting the id impulses of Classical analysis become less important than the transference of defenses related to keeping those impulses from the ego's awareness (A. Freud, 1936). It is not the impulses themselves, but the defenses against those impulses that then become the primary goal of analysis. The development of the "transference neurosis" (Gill, 1954) is the goal of treatment in this formulation, and defenses against the transference neurosis developing are themselves interpreted. As it came to dominate the North American scene, Gill (1954) sums up the therapeutic action of American ego

psychoanalysis: "Psychoanalysis is that technique which, employed by a neutral analyst, results in the development of a regressive transference neurosis and the ultimate resolution of this neurosis by interpretation alone (p. 774)." The analyst presents a "blank slate" so that the analyst's personality does not interfere with the development of the transference. Countertransference in this model is "essentially a contaminant, distracting and potentially dangerous" (Mitchell, 1993, p. 145). However, this is a far more narrow view than something closer to a middle ground that Strachey (1934) proposed.

Strachey (1934) outlines the structure of the therapeutic action of transference and the use of "mutative interpretations" where the analyst, acting as an "auxiliary super-ego" gives their permission to release a small amount of id energy to become conscious:

> Since the analyst is also, from the nature of things, the object of the patient's id impulses, the quantity of these impulses which is now released into consciousness will become consciously directed toward the analyst…If all goes well, the patient's ego will become aware of the contrast between the aggressive character of his feelings and the real nature of the analyst, who does not behave like the patient's "good" or "bad" archaic objects. The patient…will become aware of a distinction between his archaic fantasy object and the real external object. (p. 73)

Strachey, in this formulation of "present moment" mutative interpretations foretells certain theorists (Lowewald, 1960, Gill, 1979, and Kernberg, 1983) in the prescribing of "here and now" interpretations informed by past conflicts. Being also "the object of the patient's id impulses" will become an important point in the changing attitude towards counter-transference.

The origins of what Smith (2003) terms the broad view of transference originates with Klein (1946). Klein has a different model for the developmental origin of transference, one she places in the "preoedipol" relations of the infant to its mother and where the Oedipal structure of ego, superego, and id can be described as a developmental achievement. This changes the emphasis from a classical focus on tension between conflicts and drives and into the difficulty of projective identification. Projective identification, by which an infant "puts into" the mother

unconscious fantasies, thoughts, and feelings, can elicit behavior in the mother or the analyst (Klein, 1946). This problematizes the idea of the "blank slate" of classical analysis. Counter-transference, originally postulated as the analyst's own unanalyzed neurotic conflicts (Mitchel, 1993), can now potentially be thought of as clues to what the patient is projecting into the analyst. In this view of transference, Klein (1952) argues the infant's first object relation to the mother's breast is a split object relation between the gratification and frustration offered by the breast. The object remains split in a the "schizoid position," with both idealized and devalued representations, and it is only in the Oedipal stage when the infant is able to enter the "depressive position," where the infant's ego is able to synthesize those destructive impulses aimed at a "loved person" (Klein, 1952, p. 434). Klein then proposes a "total transference" situation, where rather than understanding transference in terms of direct reference to the analyst, Klein's (1952) conception of transference "…as rooted in the earliest stages of development and in deep layers of the unconscious is much wider and entails a technique by which from the whole material presented the unconscious elements of the transference are deduced (p. 437)." The major suggestion of Klein then is that a pre-Oedipal transference is not so much projected *onto* the analyst as much as projected *into* the analyst, eliciting ego alien thoughts, feelings, and fantasies in the analyst as the analyst comes to house unwanted parts of the patient's own projected self.

Bion (1967) continued this idea of projection in developing his theory of Alpha and Beta elements. In normal development, the infant is not able to comprehend the signals his or her body sends in the form of Beta Elements. These elements are evacuated into the mother whom in reverie, makes sense of these Beta elements using her Alpha function, and feeds them back to the infant for reintrojection as Alpha elements. The mother, in this way, makes sense of the infant's experience of its own body and gives the infant back that experience so that the infant

can internalize that understanding and make sense of its own experience. These alpha elements then become the basis for the infant's own alpha function, where she or he is able to receive information about the body and translate it into Alpha elements, there by making meaning of his or her experience. If the infant feels as if she or he is dying for example, and the mother refuses the projective identification, the infant "therefore reintrojects, not a fear of dying made tolerable, but a nameless dread (Bion, 1967, p. 116)." The therapeutic action in this model then comes from the analyst "containing" affect for the patient. The analyst "digests the projected material and feeds that transformed material back to the patient, as a mother would do for an infant. Rather than reintrojecting the unnamable affect over and over again, the affect is named and reinternalized as knowable. The role of the analyst is to "contain" these affects for the patient and often come through the analyst's utilizing their fantasy material as a mother would review their own reverie to understand their patient (Bion, 1967).

Between the narrow and the broad view of the transference, Loewald takes something of the middle ground. The resolution of the distortion caused by fantasies, and the consequent restructuring of the personality, is the therapeutic work of psychoanalysis (Loewald, 1960). Loewald (1960) outlines what he views as the "therapeutic action" of psychoanalysis as it relates to transference. He marks the move from classical interpretations of analytic work in the development of what he calls the "new object" of the analyst, where the analyst acts as a mediator between the fantasy of the relationship and the reality of the relationship. Loewald argues that the action of analysis in regards to transference takes place in the new object of the analyst:

> It should be apparent that a view of transference which stresses the need of the unconscious for transference, for a point of attachment at transference in the preconscious, by which primary process is transformed into secondary process-implies the notion that psychic health has to do with an optimal, although by no means necessarily conscious, communication

between unconscious and preconscious, between infantile, archaic stages and structures of the psychic apparatus and its later stages and structures of organization...Where repression is lifted and unconscious and preconscious are again in communication, infantile object and contemporary object may be united into one-a truly new object as both unconscious and preconscious are changed in mutual communication. (pg. 31)

The analyst does this by acting as a mediator of this union and by becoming a "new object"-free from the distortions of transference. And through this, rather than the blank slate or neutral mirror of a classical analysis, Loewald (1960) argues that "the essence of such new object relationship is the opportunity they offer for rediscovery of early paths of the development of object-relations, leading to a new way of relating to objects as well as of being and relating to oneself (p.17)." By the analyst bringing to consciousness the ways in which the analysand is attempting to unconsciously recreate and repeat a previous relationship, the analyst helps to facilitate ego development into a higher level of organization. This seems to be a middle road between the broad and the narrow view of transference (Smith, 2003), and it is interesting to note how little different he sounds from Strachey (1934) writing nearly thirty years before him.

Loewald's "middle road" represents a moderate view from others who took more "radical" changes in thinking in the American psychoanalytic scene. Racker (1948) began to argue for the importance of countertransference not as detrimental to therapeutic process, but as useful information where the analyst becomes an object of the distortions of transference as well as the interpreter of that transference. The move to focus on interpersonal processes rather than drive continued with thinkers like Sullivan (1953) who argued for the resolution of "parataxic distortions" in the interpersonal field between the analyst and patient. Sullivan (1953) argued against an object relations view made up of fantasied and distorted representations and focused on the real objects in a patient's life. Kohut (1971), in self psychology, would continue this focus, moving away from a Freudian model in the treatment of narcissism. Other thinkers would

move the therapeutic action away from interpretation. Franz Alexander (1951) would argue for the "corrective emotional experience" in analysis, where the analyst could provide the patient with what they missed relationally in order to facilitate health. Bowlby (1969) moved to direct observation of children and developed an alternative motivational system to the drives in developing a motivational system in attachment. These interpersonal trends would combine with the British Object Relations theory to form the American relational movement (Mitchell 1983) as would Merton Gill's change in view regarding transference (Kernberg, 2001).

Merton Gill, according to Mitchell (1983) and Wachtel (2008), represents both sides of the narrow/broad debate. Originally, Gill (1951, 1954) was the spokesperson for a "narrow view" of the transference. However, Gill (1978, 1982) takes the interpret transference early and often route in citing Rapaport's (1967) argument that transference and resistance are always interpersonal phenomena, and as such he argued for the resolution of transference through "here and now" interpretations and interpreting them early and often (Gill, 1978). Gill (1978) cites Freud (1914) to make the argument for a broad view of transference:

> the theory of psychoanalysis is an attempt to account for two striking and unexpected facts of observation whenever an attempt is made to trace the symptoms of a neurotic back to their sources in his past life: the facts of transference and of resistance…anyone who takes up other sides of the problem while avoiding these two hypotheses will hardly escape a charge of misappropriation of property by attempted impersonation, if he persists in calling himself a psychoanalyst. (p.16)

Gill, in his later thinking, strongly argues that transference, rather than being an infantile "distortion," is instead a particular perspective on the part of the patient that has developed from past experiences and that the patient has not questioned (Wachtel, 2008). Gill also argues against the very technical neutrality he once argued for, stating that is it is a "myth" that may lead to emotional deprivation, but may not be a better technical position (Wachtel, 2008). Gill's argument for a more interpersonal/relational view moves the structural change from a focus on

intrapsychic processes to focus more on interpersonal processes, including the analyst's own process (Mitchell, 1983).

However, relational thinkers would make moves to distinguish themselves from object relations thinkers. Mitchell (1983), for example, is critical of certain object relations thinkers in what he describes as their devotion to the "developmental tilt" of their argument. Using the developmental tilt, he argues that certain object relations thinkers are able to hold onto parts of Freud's drive theory in increasing "distortions" of that theory. Mitchell (1983) is also highly critical of calling what he sees as normal aspects of relatedness "infantile" and belonging to "infantile urges." He becomes concerned that this trend may lead to seeing the client as infantile and fragile. Transference then is not an infantile distorted projection, but an immediate aspect of the way the patient relates to others, including the analyst (Mitchell, 1983). Wachtel (2008) illustrates this as the two person model rather than the one person model of classical analysis and describes the change in relation to transference.

> The unconscious is a one person conception par excellence, something waiting inside to be discovered. In contrast, concern with unconscious processes, with the way in which so much of what constitutes psychological life proceeds without awareness, is perfectly compatible with a two person critique. We do not 'discover' or uncover what has been there all along. Rather we engage in processes of construction (and co-construction) which helps bring forth and articulate experiences in a dynamic, constantly evolving fashion. (p. 24)

Other relational thinkers have argued that rather than a two person model, a three person model is needed (Altman, 1995). The analytic third then becomes transference based on culture, race, and socio economic status. To conclude, Kernberg (2001) argues that in the English speaking schools of psychoanalysis, that the contemporary "mainstream" is made up from Kleinian, contemporary Freudian, and British independent sources and that the other major school of thought is the intersubjectivist-interpersonal-self psychology-relational school.

Though this is a very summary overview of the evolution of transference, I traced the history of the concept from a one person drive theory model of transference to a two person interpersonal process oriented model. With the rejection of Freud's metapsychology by the majority of practitioners and a call for empirical verification of parts of his theory (Hart, 1985) I will argue that function words are a way to measure transference in the process as well as the outcome of an analysis. However, the relationship between a theoretical structure of analysis and function words, specifically pronouns, will first be explicated.

The Structure of Transference: I and Me and You

In developing a theoretical argument for the use of pronouns and function words, the development of the structure of transference will now be explored in relation to function words and especially pronouns. I argue that given psychoanalytic stress on speaking in the "talking cure," it is important to consider the self as a linguistic metaphor. Kernberg (1982) for his part looks to Strachey's early translations of Freud and remarks that Strachey mistranslated Freud's structural theory in terms of ego, super ego, and id, where the "ego" in the original German is "I." Freud (1923) defined the ego, or the "das ich" or "I," as being "first and foremost a body ego (p. 26)" constructed from experiences of the body, serving as a representation of bodily experiences in mind. Freud (1923) in some ways supports Kernberg's (1987) position that drives are organized through object relations when he states that "the character of the ego is a precipitate of abandoned object cathexes and that it contains the history of those object choices (Freud, 1923, p. 638)." However, in the developmental link between an internal experience of the body and an experience from the body as viewed outside the self, Lacan (1953) looks to "Mirror stage" as formative of the "I" function.

Lacan (1953) makes this argument in describing his emphasis on the structure of language as offering clues to the function of the ego, where in both passive and active constructions, "I am beating the dog," versus "the dog is being beaten by me," there is a person speaking and "…in either case, [the subject] asserts himself as an object involved in a relationship of some sort, whether one of feeling or doing. Does what is expressed in such statements of the ego give us a picture of the relationship of the subject to reality?" (Lacan, 1953, p. 11) I believe the answer to this rhetorical question is yes. Lacan (1953) argues for a "mirror stage" where the infant becomes fascinated by its image in a mirror, seeing itself from outside itself, typifying "an essential libidinal relationship with the body image" (p. 14). While Lacan has a different etiology and approach to transference, I am more interested in the birth of the self and its relation to language that he describes where through "I" the ego situates itself in relationship to reality.

Thinking in terms of Bion (1967) in the projection and re-introjection of affect changed by the Alpha Function, the baby then internalizes the Alpha function from its mother, and through this process recognizes (or misrecognizes) its body and bodily urges. Ogden (1992) is more clear when he defines object representations as containing both sides of an object relation, both mother and infant: "This is so because an internal object relationship consists of a relationship between two unconscious aspects of the patient, one identified with the self and the one identified with the object in the original relationship" (p. 236). These objects and the analyst's own objects, make up the transference/countertransference phenomena (Ogden, 1992). Lacan (1953) presents this moment as the mirror stage where the infant comes to recognize themselves though the "orthopedic of the mother" and Winnicott (1958), as I will discuss later, uses the "mother's face" rather than a mirror to "see" and recognize itself outside of the self.

This is important for three reasons, as it sets the foundation for the infant to learn to regulate their own bodily homeostasis through internalizing the mother, that there is an object representation of self in relation to another, and that this internalization will serve as the basis for regulating the homeostasis of self in relation to other. It is also the "matrix of transference and countertransference" (Ogden, 2001, p. 236). However, as clinical encounters occur in language, it will be important to understand how transference develops in the linguistic field. Judith Butler (2005) uses pronouns to describe the object relational foundation of the structure of transference.

Judith Butler (2005) describes transference in its relationship to certain structures of the self in the scene of "I" addressing "you." She defines transference as taking place particularly in the analytic "scene of address," and in a way that echoes Loewald's (1960) argument for what constitutes the therapeutic action of analysis and Gill's (1978) emphasis on the current relationship. "Transference is thus the recreation of primary relationality within the analytic space, one that potentially yields a new or altered relationship (and capacity for relationship) on the basis of analytic work" (p. 51). She comments specifically on the linguistic nature of transference, where "narrative functions within the context of transference not only as a means by which information is conveyed but as a rhetorical deployment of language that seeks to *act upon* the other, motivated by a desire or wish that assumes an allegorical form in the interlocutory scene of the analysis… (Author's italics, p. 51)." She then uses this to argue against the idea of psychoanalysis as solely a narrative reconstruction of the subject, as she argues that the "other" of address, the "you," is there from the beginning, "in the place of where the ego will be (p. 52)" and it is the resolution of this transference that reduces distortion, or that need to act upon the other in order to recreate the original scene of address. "So the point of the transference

and countertransference is not only to build or rebuild the story of one's life but also to enact what cannot be narrated, and to enact the unconscious as it is relived in the scene of address itself (p. 52)." Where, "The ego does not come into being without prior encounter, a primary relation, and a set of inaugural impressions from elsewhere (p. 58)." Winnicott (1967) would argue that this scene is at least initiated by the mother, and the mother as mirror.

Winnicott, for his part and in Butler's (2005) thinking, "describes the ego as a relational process" which disputes the notion that "the ego is constituted and there from the outset of life (Butler, 2005, p. 58)." Winnicott (1958) does this through his description of the development of the "matrix of transference" (p. 418) in studying the words "I am alone," where "ego immaturity is naturally balanced by ego support" by the mother of the infant. This marks the achievement of differentiating the "me" from "not me" aspects of the world (Abram, 1996) and marks the emergence from merger with the environment. "First, there is the word 'I,' implying emotional growth. Integration is a fact. The external world is repudiated and an internal world has become possible" (p. 417). This serves as the ego nuclei. Next comes the 'I am,' which the individual can only achieve "if there is an environment which is protective," where the protective environment "is in fact the mother preoccupied with her own infant and oriented to the infant's ego requirements through her identification with her own infant" (p. 418.). This is similar to the Kleinian depressive position or Winnicott's stage of concern (Abram, 1996). However the infant continues to be unaware of the mother until the development of the "I am alone" phase. This development depends "on the infant's awareness of the continued existence of a reliable mother whose reliability makes it possible for the infant to "enjoy being alone, for a limited period" (p. 418). This "capacity to be alone," born from the paradox that this capacity to be alone comes from being alone in the presence of someone, marks the onset of object relations not solely

determined by id impulses, but by what Winnicott called "ego relatedness" (p. 416, 1958). The mother then, as mirror and container of the infant plays an intrinsic role to the development of the ego in interpersonal relationships, setting up a template for later relations. The mother/ child relationship is in fact the relationship between the infant's needs and the mother's ability to meet those needs in a "good enough" way. However, in order to achieve this level of ego relatedness in "object usage," the infant has to be able to use the mother "ruthlessly," in the confirmation of another paradox of Winnicott's (1969): "the baby creates the object but the object was there waiting to be created and to become a cathected object" (pg. 712). That is, like Loewald's (1960) "new object," beyond the infant's projections, or the patient's transference distortions, there is a person waiting to be found.

This brings two important points of thought for Winnicott; the role of the mother as mirror and the idea of the transitional play space. Winnicott cites Lacan's (1934) "Mirror stage," Lacan's scene of the birth of the ego, but Winnicott cites the mother's face as preceding the mirror for the baby. The mother as mirror becomes internalized as a structure of the self-as the initial boundary between self and other in the first "not me" mediated by transitional space. These two parts of the self, the body and its needs and the body as objectified and taken care of by the mother, the preconscious and conscious of Loewald (1960), or the symbolic and subsymbolic of Bucci (2007) or the "I" and the "me" of Ogden (2001) is mediated by a transitional space (1953), or

> *The intermediate area…that is allowed to the infant between primary creativity and objective perception based on reality testing* [author's italics]. The transitional phenomena represent the early stages of the use of illusion, without which there is no meaning for the human being in the idea of a relationship with an object that is perceived by others as external to that being." (p. 94)

In analysis, this transitional space is the space of language (Favero & Ross, 2003). The transitional space of language occurs where "…Words may create an intermediate area between reality and fantasy, public and private meaning, secondary and primary process thinking…words may become hypercathected …(p. 288)" and may be similar in meaning to what Freud posits as the "overdetermined" language of dreams (2004), the "polysemy" of Lacan, or the "metaphor" of Ogden (2001). As Ogden thinks of this relationship in terms of pronoun use, it is worth taking a closer look at his theoretical structure.

Ogden (2001) is most explicit, and for the sense of argument of the self as an interplay between subject and as the object of another person:

> With metaphor, we say one thing in terms of another, or as Frost (1930) liked to put it metaphor is a way of "saying one thing and meaning another (p. 719)." Without metaphor, we are stuck in a world of surfaces whose meanings cannot be reflected upon. Self-reflective thought occurs when "I" (as subject) look at "me" (as object). Metaphor is a form of language in which I describe "me" so that "I" might see myself. In an important sense, naming and describing "me" metaphorically creates both "I" and "me" as interdependent aspects of human self-awareness (human subjectivity). In other words, the individual (as object) is invisible to the self (as subject) until metaphors for "I" are used to describe/ create "me" so that "I" can see myself. This is the mutually creating dialectic of "I" and "me." To put it still another way: "I" as subject do not exist until I can see myself ("me" as object); and the individual (like a tree falling in the forest) is silent/ invisible unless there is a subjective "I" to hear and see it. The event that creates both "I" and "me" is an event mediated by language in general and by metaphorical language in particular. (p. 36-37).

In this way, the "I" and "me" exist together and are linked by language. The "me" that is formed in the matrix of transference as described by Winnicott (1958) and mediated by the mother is a space of "necessary illusion" and it is this objectification of the "me" which is projected on to the other (or the "you" in the "I" and "you" of Butler, 2005) that constitutes the elements of transference. Self-reflection occurs in the "me" aspects of the self-becoming visible to the "I," after the transference that can't be narrated is enacted with the analyst, who somehow

communicates the unconscious projection to the patient. Transference is in some ways an attempt to turn the other into the archaic objectifier of the "me," (or the "you" of the original scene of address (Butler, 2005)), aspect of the personality, the "other" as objectifier of the "I", replete with the original fantasies. The interpretation of the transference leads to the understanding of the "I" to the "me" as object, the way that the "me" was objectified in an archaic relationship by the mother reflecting the infant back. I read Ogden as arguing that through the process of analytic reflection and through the elucidation of the way language is acting upon the other (Butler, 2005), the subject's "I" takes over the function of the objectification of the "me," as mediated by language and originally "invisible."

I→(other/mirror/mother) me=external reality, Where the "I" and "me's" relationship is invisible in the "original scene of address."

I→ ("you"/analyst) "me"= external reality, where the analyst gets in the way of an invisible circuit that is re/creating "new editions" of the old relationship.

The "new object" (Loewald, 1960) posits a different object relation, one self-aware of the transference distortion. To reiterate, in this model of an object relation, there is the self (I) in relation to an objectification (me) that is projected onto the analyst through transference (you). The relationship within the self is related via metaphor, or the transitional play space, a play area between internal and external, subject and object that is originally the space between the baby's internal needs and the external mother's recognition (or misrecognition) of those needs. The structure of language, as illuminated through function words becomes important then in the way the analysand attempts to act on the analyst in order to recreate an archaic object relationship. In function words, rather than in content words, there is a discernible structure that can be measured according to Pennebaker's (2003) method, as the "I" attempts to act on the "you" of the present

reality through the "me" of transference to see "me" externally as I was once seen and objectified in the "original scene of address."

Using function words, then, which implicitly suggest a relational position between the speaker and the listener in the "scene of address" (Butler, 2005), provides a natural way to examine where the speaker places themselves and where they are positioning the listener in accordance with archaic object relations. By looking at the "how" something is said, rather than "what" is said can become a natural way to observe unconscious object relations and the seeking by the speaker to position the listener in an archaic relationship. Due to the repetitive nature of transference, this should manifest in a certain rigidity of certain function word use as the patient attempts to rhetorically locate the analyst in a "new edition" of a previous style of relating.

Empirical Studies of Related Paradigms

While Freud's theory has been difficult to operationalize (Bucci, 1997), similar paradigms to object relations have been more amendable to empirical investigation. Bowlby's (1969) theory of internal working models of attachment is one such theory, and provides important methodological considerations in the linguistic study of relations from the Adult Attachment Interview (Steele & Steele, 2008).

Bowlby's (1969) concept of internal working models of attachment bypasses the dual drive theory of Freud and is based on a different motivational system of the young child wishing to maintain proximity to an adult caregiver. Bowlby (1969) argues that as in the "traditional model" of psychoanalysis, "much psychopathology is regarded as being due to models that are greater or less degree inadequate or inaccurate" (p. 82). These internal working models, much like object relations internalized from caretakers as "stimulus barrier" (Freud, 1917), act to

regulate the organism and alert it to danger. However, they also act to help the organism maintain homeostatic equilibrium, where the organism uses these models in order to return to a homeostatic equilibrium after the activation of the attachment system and are separate but equally important too sex and feeding systems. These attachment patterns have been empirically studied by the strange situation (Ainsworth, Blehar, Waters, & Wall, 1978) and divided into secure and insecure forms of attachment, and organized and disorganized modes of attachment (Hesse & Main, 2000). These forms have been empirically studied through the use of the "strange situation" as well as the Adult Attachment Interview, which has been recommended for use in clinical settings (Steele & Steele, 2008).

The AAI measures flexible versus inflexible attention while the attachment system is activated (Main, 2000). She argues that securely attached children present flexible attention "in that the infant readily alters the focus of its attention as circumstances change, the insecure forms may rest upon specific kinds of restrictions in attentional and behavior patterning" (pg. 1077) and this inflexibility of attention will manifest when adults discuss attachment related experiences. As it goes, those judged to be "secure autonomous" in attachment style are in their narratives able to balance a deep caring for the attachment related experience but maintain some objectivity about the attachment relationship. The speech in these narratives "is strikingly fresh and original" (pg. 1079) and maintains coherence. In those dismissing of attachment experiences, the language was often short and the content contradictory as the speaker inflexibly avoided topics that may induce anxiety or anger from remembering attachment related events. Those in the preoccupied category talked angrily about their attachment experiences and rather than short, the narratives were often long, showing them to be inflexibly focused on the caregiver (Maine, 2000).

Flexibility is the key, as Campbell and Pennebaker (2003) argue that flexibility in function word usage across journal entries predicted health outcomes. Theoretically, insecurely attached people would be inflexible in function word use while secure people would be more flexible in function word use, as they would not need to defensively manage attentional focus in their reports. Fonagy and Target (2000) similarly argue for rigidity of self in relation to others as an indicator of psychopathology. However, others have looked more closely at transference specifically in analytic process research.

Analytic Process Research

During the seventies, eighties, and nineties, several measures of transference were defined and studied in therapeutic process research (Luborsky & Crits-Christoph, 1988; Gill& Hoffman, 1982; Teller & Dahl, 1986; Waldron et al., 2004). Luborsky's and Crits-Christoph's (1993) Core Conflictual Relationship Theme (CCRT) was developed by the author examining transcripts and finding three prominent components to each narrative. The first component was comprised of what the patient wanted or wished from other people, the second was how the other people reacted, and the third component was then how the patient reacted to the other people's reactions. Core Conflictual Relationship Themes were then extracted in a multipart part system where judges extracted the above three components from relationship episodes in the patient's narratives to create a glossary of core conflictual relationship themes. The judges would look for CCRT conflicts that originated with an early parent figure. The judges would then look for examples of CCRTs that came to involve the therapist. They compared their method to Freud's concept of transference, and used data from the CCRT to objectively measure the accuracy of

therapist's transference interpretations. They found that while wishes did not change, the expected reaction of others did show change during the course of treatment.

PERT, or the Patient's Experience of the Relationship with the Therapist (Gill and Hoffman, 1982) coded disguised allusions as well as more overt references to the relationship with the analyst. The system focused on the degree to which the therapist's interventions deal with the patient's experience of the relationship and provided a way to track the transference and the effectiveness of transference interpretations. It could also be used to track transference and countertransference enactments as measured by a judge in which the analyst is unaware of the enactment.

Teller and Dahl (1986), in the Fundamental Repetitive and Maladaptive Emotion Structures (FRAMES) developed a way to use content analysis while working with transcripts of analyses. Dahl came up with the measure when he began to notice repetitive structures in sessions with his analytic patients. Teller and Dahl described a "FRAME" as an event sequence structure observed from their patients, where the events are variable mental events like acting, wishing, or knowing. These events are listed in sequential order from the session material. The analyst is then able to observe the movement from one frame to another without the predetermined categories of the CCRT and PERT. Through this, the analyst can track the progress of the patient's internal memories of a wide range of wishes, defenses, and emotions.

Waldron and his colleagues (Waldron et al., 2004) created the Analytic Process Scales containing fourteen patient variables and eighteen analyst variables in a manualized format. The researchers first divided analytic sessions into segments delineated by who was speaking (the patient or the analyst). The sessions were then scored using a five point Likert scale by a group of judges. They used variables to assess the type of analyst contribution (clarification,

interpretation, elaboration) and the aim of the analyst contribution (does the analyst address defenses, transference, or conflicts). Judges then assess the involvement of the analyst, and rate the quality of the analyst's contribution. The scales have a high rate of inter-rater reliability, supporting good internal validity. In one study using three prerecorded analyses, (Waldron et al., 2004b), they found the strongest analyst variable influencing patient productivity where patient productivity was judged on a five point scale for assessing their progress in understanding, collaboration in the analyses, and emotional involvement was in fact the quality of the intervention that preceded it, rather than the type of intervention. They argue from this finding that the quality rather than type of intervention suggests that "attunement to the patient's present state, the choice of an effective intervention, and its timing and tactfulness are most important to the progress of the analysis-refuting any suggestion that interpretation in general is necessarily more helpful then clarification, or that analysis of transference is necessarily more helpful than analyzing resistance (pg. 1105)."

To sum up, the PERT, CCRT, and APS use clinician-determined categories in order to view transference phenomena, while the FRAMES system is more subjectively focused in that the subjectivity of the patient determines the frames created. The Analytic Process Scale however is unique for two reasons in that the analyst is rated along with the patient and in that it is manualized. Though these measures are clinically useful, they do not evaluate or assess the underlying structure of language used. As the flexibility of attention on the AAI (Main, 2000) suggests, there may be measurable underlying linguistic structures that reflect different relational pattern organizations that can be measured.

Noting the difficulties and contradictions of operationalizing Freud's structural theory, Wilma Bucci (2002) has examined changes in process therapy using multiple code theory. Bucci

(2010) sums up some of the commonality of different ways object relations have been empirically investigated in her description of emotional schemas, which she defines as "psychic structures that shape our individual personalities, and influence the way we interact with other people, experience our emotions, and interpret our reactions" (p.771). Bucci, 1998 posits that schematic representations of this nature are similar to Bowlby's (1969) concept of internal working models, or Stern's (1985) concept of representations of interactions that have been generalized (RIGs) or Kernberg's (1990) affectively invested relationships between self and object relations. Bucci (2010) argues that these emotional schemas contain components that are sub symbolic and may include imagery, though language may be added to these schemas later. "The subsymbolic bodily, sensory, and motoric elements constitute the affective core of the schema-the basis on which the schema comes to be organized. The settings of time and place and the individuals who figure in our interactions constitute the specific contexts and contents of the emotion schemas, which continue to be elaborated throughout life" (p. 1362). Each emotional schema has an affective core that contains sub-symbolic bodily, sensory, and motoric elements. Schemas can become highly interconnected, with the memory system for anger becoming entangled with the schema of control, sex, love, etc. These schemas are memory schemas that contain information related to repeated interactions with caregivers over time. However, rather than "repressed," certain painful or traumatic schemas become dissociated, and when they are triggered, are likely to not to be recognized or are mislabeled. Bucci (2010) calls the activity of linking these non-verbal aspects of these structures to language referential activity, where the referential process "links all types of non-verbal representations to one another and to words" (Bucci, 2002, p. 767).

The referential process can be broken down into three component sub phases for study in psychotherapy: arousal, symbolizing, and reorganizing (Bucci and Maskit, 2007). Arousal occurs when the affective core of an emotional schema is activated within a session and the dissociated sub symbolic bodily elements are activated. The client will try and shield themselves from unsymbolized affect from problematic schemas as they have always done through a defensive operation like avoidance, somatitization or externalization. Symbolizing occurs when the sub symbolic affective elements are linked to images and words. These representations of events in the here and now relationship with the therapist interact with fantasies and autobiographical material. Within the shared context of the session, these elements are eventually reorganized when the material is reflected on along with the here and now material. This potential emotional insight leads to a reorganization and change in the problematic schema. Each change can potentially lead to deeper levels of sub-symbolic material that can also then be reorganized. This process may not happen in a linear order, and some patients may emphasize some elements of the process during some parts of the treatment. Bucci and Maskit (2007), in developing their methods, believe that each phase of the reflective process contains certain language content and style. They have developed a computer assisted way to measure each phase that is constructed from function words.

Bucci can be critiqued from an object relations perspective. Bucci (2002) writes in discussing how psychopathology develops, that when a painful emotional schema is triggered and the stimulus is not recognized, "the individual will try to provide meaning for the activated state, to know 'why I feel this way.' The attempt to establish substitute meaning, while avoiding knowledge of the actual aroused schema or triggering event, is likely to be destructive in itself, appearing in such forms as somatization, displacement, or acting out" (p. 781). Winnicott (1958)

and Bion (1967), for example, would argue that the origin of the individual misrecognizing its bodily states comes from the internalized caregiver who misrecognized the needs of the child from the beginning. In other words, the "painful emotional schema" doesn't exist in a vacuum, but is rather always a "scene of address," in the Butler (2004) conception.

Therapy process research has been criticized for not providing the kind of data concerning treatment effectiveness that is needed to support the professional status of the field and to validate treatment orientations (Bucci 2007). The process oriented nature of the CCRT, FRAMES, and PERT system, for example, have not been established as valid measures of outcome. In order to establish transference interpretations as effective mechanisms of change in therapy, it is then necessary to turn to outcome research.

Outcome Research of Transference Interpretations

Though the definitions of transference vary across psychology as well as within psychoanalysis, contemporary transference researchers Levy and Scala (2009) defines it as "a tendency in which representational aspects of important and formative relationships (such as parents and siblings) can be both consciously and/or unconsciously ascribed to other relationships" (p. 392). This definition keeps in mind the dynamic unconscious, where these processes are related to conflicts and defensive processes in interpersonal relationships between self and others.

Transference focused psychotherapies using an object relations paradigm have been studied (Kernberg, Yeomans, Clarkin, & Levy 2008) and have been developed into an empirically focused psychotherapy for borderline personality disorder. In the Transference Focused Psychotherapy model, something like the personality in identity diffusion is:

based on the idea of a psychological structure composed of multiple split off object relations, positive and negative, each of them reflecting a dyadic unit of a self-representation, an object representation and a dominant affect linking them. These dyadic units, or dyads, originate in the internalization, and subsequent unconscious revision, or affectively intense experiences in the course of early development. (p. 603)

One of the benefits of this description of the personality over the others is the stress on transference, which is the repetition and recreation of these object relations' dyads. It is also useful as transference interpretations have been empirically validated as a treatment for Borderline Personality Disorder (Kernberg, Yeomans, Clarkin, & Levy 2008). They (Clarkin, Foelsch, Levy, Hull, Delaney, and Kernberg 2001) found that after a year in treatment, compared to baseline, patients' rate of suicide attempts significantly decreased, that hospitalizations as compared to the year beginning treatment was significantly reduced, and those who were hospitalized were hospitalized for a significantly shorter time. After the year, 52.9% of the patients did not meet criteria for BPD anymore. However, this was an uncontrolled study and focused on borderline patients.

Hoglend (2004) examined the mixed conclusions of previous studies in reviewing empirical work on psychodynamic treatment featuring transference. In an early review of empirical research looking at previous studies involving the efficacy of transference interpretations, Hogeland (2004) found that five out of eight naturalistic studies reported negative findings, and two reported non-significant correlations. Only one study reported a positive correlation between frequency of transference interpretations and outcome. However, Hoglend (2004) argued that these previous studies had faulty designs in that the patients were not randomly assigned. He (Hoglend et al., 2008) presented his own work in a large national controlled study where patients were randomly assigned to psychodynamic treatment groups using different frequencies of transference interpretations. Hogeland and his colleagues

(Joahansson at al., 2010) found that those placed in transference-based treatments versus psychodynamic treatments that did not stress transference showed an increase of insight in interpersonal relationships at a three year follow up. They also found, that while there were significant changes both in patients assigned to psychodynamic therapy with and without transference interpretations, personality disordered patients in the transference interpretation group with poor quality of relationships improved more on measures of interpersonal functioning on the Psychodynamic Scales of Functioning (Bogwald and Dahlbender 2004) with increase in insight being a key moderator. (Personality disordered patients found to have low Quality of Object Relations as measured by Hogeland's scale, (1993) showed the most improvement in interpersonal functioning, in particular.) They also found that patients in the transference group were less likely to have received treatment from a mental health professional at a one year follow up when compared to the non-transference group (15% versus 55%). Ulberg, Hoglend, Marble and Johansson (2012) found in a randomized year long psychodynamic treatment that women responded better to a moderate level of transference interpretations when compared to men, where women in the moderate rather than no transference interpretation group showed improved relational functioning at 1 and 3 year follow ups.

In sum it seems that transference interpretations work well for patients that have a history of interpersonal relationship issues, personality disordered patients, patients with low quality of object relations, and better for woman than for men. As a technique, they work substantially better with borderline and personality disordered patients. It could be, however, that the standardization of transference focused psychotherapy has led to better outcomes as the interpretations become structured and adhere to timing in treatment so that most direct transference interpretations come in the later third of treatment when the patient has been

prepared through other interventions (Clarkins et. al, 2006). Though more research is needed, these outcomes suggest that transference interpretations as a technique may be moderated in effectiveness by frequency, accuracy, and patient type. The APS (Waldron et al., 2004a) points to quality as another possible moderator of the success of transference interpretations.

Pronoun and Function Word Analysis in Personality Assessment

There is considerable research having used function word analysis in personality assessment. Transference, as Butler (2005) points out, works "in order to recreate[s] and constitute[s] anew the tacit presumptions about communication and relationality that structure the mode of address" (p. 50). The study of function words is one way to measure the analysand's attempt to structure the scene of address, as they have been used to measure various aspects of personality. As Weintraub (1986) states, "while it is possible to control what one says to a considerable degree, grammatical choices are unconsciously determined" (p. 295) and therefore could be a useful avenue through which to tap unconscious processes. Aronson and Weintraub (1962, 1964, 1969, 1974) used verbal speech patterns to study the language of psychoanalytic defenses by linking personality patterns with grammatical choices. Their method evolved from observing the verbal behavior of twenty patients as measured by ten minute "free speech" sessions and comparing the language to free speech scripts of a non-clinical control population (Weintraub and Aronson, 1962). They compared the speech patterns of certain language classes such as negations (no, not, never), qualifiers, and evaluators. For example, they (1964) found that impulsivity, which they linked to the analytic defense of undoing, in inpatient mental patients could be measured through frequent use of adversative expressions such as "but," "however," "nevertheless." They (1969) found a similar pattern in overeaters, in those who binge eat and

then try and undo the consequences of their eating. They also found that obsessive compulsive inpatients had a much higher use of explanatory expressions-the use of the defense of rationalization- using "because," "therefore," and "in order to" as they argued that their personalities adhered to an internal need for logic (Weintraub, 1981).

Further, Weintraub (1981) found that the infrequent use of "I" indicated an avoidance of intimacy; showing movement by the speaker away from intimate topics towards more impersonal topics, whereas a high rate of the use of "I" represented a self-preoccupation indicative of depression. In looking at egocentrism in children, he found high rates of "I" and "me" in children aged 5 and 6, while after 7, the use of "we" increased greatly while "I" and "me" decreased. He also found that "we" in moderation can measure an ability to collaborate with others, while a high "me" score can represent passivity. Very high and very low Non-personal references, as in reference to people or objects that are not known to the speaker, reflected avoidance of responsibility and preoccupation. Those who used negatives tended to be oppositional and made frequent use of the defenses of denial and negation, as they rigidly negated themselves and what other people said. They also found that the use of qualifiers like "sort of" or "kind of" as well as retractors such as "but" or "however" when used in high numbers suggested impulsivity as it showed an ability to undo commitment and that this was found in impulsive patients. While Aronson and Weintraub focused on defenses, Steingart and Freedman (1972) focused on the structure of the personality organization as revealed through object relations.

Steingart and Freedman (1972) developed a language construction analysis believing that "certain types of grammatical diversity…suggest some important, quantifiable dimensions for constructs pertaining to representations of self and objects in varying clinical states" (p. 132).

They used function words and pronouns to observe the degree of differentiation in self-other representations, the balance between narcissistic and libidinal attachment to objects, and the division of selective attention between interactional and solitary features of the representational world by looking at inpatient clinical interviews. They coded language according to fragmented language (grammatically incoherent language), narrative language, and complex language. In order to do this, they removed all punctuation and determined sentence units by finding where one grammatically well-formed sentence ended and another could begin. A simple sentence then only contained a single independent clause, while a complex sentence contained a subordinate clause. They also included two sub headings for simple sentences of either specified simple narrative language or extended simple narrative language. The researchers further coded contiguous language (or conditional language) which included any two sentences that are connected and where the second sentence refers to the first. They also broke the coding down into self/object, where the object could be inanimate or not, and also coded for whether the language focused on monadic relationships or dyadic relationships. According to this methodology, they found that depending on the level of pathology in the patient, the complexity of their language declined with the level of their pathology, where a schizophrenic patient exhibited the most fragmented speech with the least amount of complex contiguous language. Steingart and Freedman also noted that a bipolar patient would produce more narrative language and much less conditional complex when depressed. However, this methodology was not applied to therapy process research.

Spence, Mayes, and Dahl (1994) used a systematic analysis of pronouns, specifically you/me clusters to look at the "analytic surface" and as a way to plan interpretations when both the analyst and analysand had entered the "analytic space." They used the co-occurrence rate of

"you" and "me" as a potential measure for transference intensity, hypothesizing that "A single "you" followed many sentences later by a single "me" (high separation) is telling a very different story from "you" almost followed immediately by "me" (low separation)" (p. 47). They further hypothesized but did not test that a high co-occurrence rate of personal pronouns like "I/me" or "me/mine" would mean the client had not entered the shared analytic space, and that this would be a time when the client was absorbed by their inner world. They found that the highest level of co-occurrence of "you/me" pairings happened during what the author's judged to be an intense transference fantasy in the analysis of Mrs. C. Further, during these moments of high co-occurrence of you and me in the patient's speech, Spence (1995) found that the analyst's interpretations were more comprehensive and probing, that he intervened earlier and more often, and that these interventions resulted in a greater frequency of the patient's associations. Low scoring hours, on the other hand, resulted in a decrease of the patient's production of associations, fewer interventions, and greater misunderstanding between the analyst and patient.

Van Staden and Fulford (2004), looking at changes in linguistic markers in the course of psychotherapy, were clear in what changes they saw in pronoun usage in mental health improvements. The authors used Frege's "logic of relations" to define the meaning of first person pronouns as variables distinct from grammatical usage variables. They derived this meaning by looking at first person pronouns occupied an "alpha" or "omega position. The author's argue that the alpha position is the agent of the sentence while the omega position is accidental to the sentence. For example, in "I hit the dog" and the "dog was hit by me," the first person pronoun still inhabits the alpha position while the dog occupies the omega position, where as in both "I was bitten by the dog," and the "dog bit me," the positions switch. The authors argued that the alpha position has more to do with agency and that increases of alpha

positions in semantic analysis would correlate with other methods of improved mental health outcomes. The authors looked at shifts in semantic usage of pronouns in looking at a collection of psychotherapy transcripts. The authors examined the top ten most productive and bottom ten least productive psychotherapies and found that increases in alpha position and decreases in omega position occurred in the improvement cases while decreases in alpha and increases in omega positon happened in the worsening cases.

Bucci and Maskit (2007) have developed various dictionary systems to measure reflective activity, and have used this computerized language analysis software to measure referential activity across therapy. Like Weintraub (1986), they argue that function word usage is largely unconscious. They developed a computerized dictionary system to measure Reflective Activity, the Weighted Referential Activity Dictionary, or WRAD. The dictionary highly correlates with clinical judgment of RA scored from RA scales including specificity (quantity of detail), imagery, (degree to which language evokes imagery), clarity (organization and focus), and concreteness, (degree of reference to sensory and other body experiences). It is primarily composed of function and auxiliary words most associated with this type of material. They also developed dictionaries for Affect, Reflection, and Disfluency. The Affect dictionary contains words such as "sad," or "angry," and are coded by negative, positive or neutral valence. They also created a Reflective dictionary, containing words referring to cognitive or logical functions like "if" "and" "but" and "think" and "believe." They also created a Disfluency dictionary, created from words like "ummm," "ah," and "etc." In looking at of sixteen sessions, the WRAD positively correlated (.538, $p<.05$) with clinical ratings of reflective functioning within sessions, positively correlated with the Affect dictionary (.457, $p. <.10$), and negatively correlated with Disfluency (-.421, $p<.10$).

Thinking of Pennebaker's (2003) changes in flexibility in terms of function word use as predicting better health outcomes, Weintraub's (1981) look at defensive formation would suggest that an overuse of certain words indicates a certain type of defensive structure, and that the continuation of that structure would be indicative of unchanging defensive operations, i.e., lack of therapeutic change. If change were shown, it could be argued that the person was less defensive. Thinking in terms of Steingart and Freedman's (1972) study, in order to make a more complex sentence indicating a higher level of object relations, more and different function words would need to be used in order to connect the clauses, indicating that function words would be a useful measure. Dahl's (1994) study would suggest that function word use, especially pronouns, would be a way to measure the attentional focus of the patient, where "you" and "me" would indicate the patient's focus has turned outwards, and that "I/me/mine" clusters showed attentional focus on the self. Echoing Lacan (1953), Van Staden and Fulford (2004) showed how pronoun use can show the ego's orientation to reality and that successful therapy can help the patient become more agentive. Bucci's (2007) development of the WRAD dictionary illustrated that a dictionary system comprised of function words is an elegant way to linguistically measure certain therapeutic states.

Pennebaker and Non-Clinical Literature Review

To outline their process, Pennebaker et al. (2010), as mentioned earlier, follows certain linguistic precedents in splitting language into two distinct classes of words. Content words are the first class of words and include nouns, adjectives, most adverbs, and regular verbs. This class of words carries the content and meaning of a sentence in lexical communication. Content words contrast with function words, or what Pennebaker and Tausczik (2010) call "style words."

Function words are made up of articles, prepositions, conjunctions, auxiliary verbs, and pronouns. In linguistic terms, this is a split between semantics and syntax. Pennebaker and Tauszik argue that style words reflect "how people are communicating whereas content words convey what they are saying" (p. 29). In measuring the "how" and the "what" of verbal communication, Pennebaker has found that style words are closely linked to measures of people's social and psychological worlds. This is based partly on the expectation that the speaker and listener will share the same knowledge of style words, as they lack the specificity of content words (Chung and Pennebaker, 2007). For example, for a particle such as "here" to make sense, both listener and speaker must know where "here" is referring to. Below is a summary of the different ways function and content words have been used to measure different psychological and social issues that will inform parts of my proposed study, as outlined by Tausczik and Pennebaker (2010).

Attentional Focus

Pennebaker (2010) and others have found that function words, such as personal pronouns, can be used to look at attentional focus. People who are in emotional pain tend to have attention drawn to themselves and subsequently use more first person singular pronouns (Rude, Gortner, & Pennebaker, 2004). It has also been found that people who sit in front of a mirror and complete a questionnaire tend to use more "I" and "me" than when the mirror is not present (Davis and Brock, 1975). Given the theorized role between the mother as mirror as described by Winnicott (1967), it is not surprising to find that people who scored higher on a narcissism scale used more first person singular pronouns and fewer first person plural pronouns on a monologue task, with no change in third person pronouns (Raskin and Shaw, 1988). This follows also from a

study of depression where depressed participants used more negatively valenced content words and used the word "I" more than never depressed participants, which follows Pycsinski and Greenberg's (1987) self-focus model of depression. This self-focus in the use of "I" also follows a finding by Stirman and Pennebaker (2001) that looked at suicidal versus non-suicidal poets. Suicidal poets were found to use far more first person singular (I, me, my) words, and fewer words referring to a social collective (we, us, our) when compared to matched non-suicidal poets. This is despite there being no difference between the poets' use of negative or positive emotional words. Higher use of first person nouns are further associated with lower status, where higher status individuals use more first person plural pronouns and refer to other people more (Pennebaker and Tausczik, 2010).

In non-therapeutic studies that may have implications for looking at pronoun change and attentional focus, (Gunsch, Brownlow, Haynes & Mabe, 2000) found that more self-reference (I and me) was present in positive ad campaigns while more "other" references (he and she) were present in negative ads. Similarly, in looking at differences between pronouns usage in teasing, Kowlaski (2000) found that the attention always fell on the victim of the teasing. In the study, where participants wrote one narrative about being teased and one narrative about teasing someone else, they found that in the teasing narrative, more other focused words (e.g. he, she, they) was used while in the being teased group, participants made more reference to themselves (more first person singular reference). This fits well with my thesis in the idea of looking at the self as subject and the self as object of others in the matrix of transference.

Improving Mental Health Outcomes

In text analyses of improving mental health outcomes, many studies have looked at changing pronoun use. Dunnack and Park (2009) found that use of the pronoun "I" was initially related to poor adjustment as measured in college students writing about loss. However, the use of "I" by the final journal entry was linked to several aspects of better psychological adjustment. Pennebaker and Greybeal (2001) found that journaling was associated for certain mental health outcomes in certain writing styles. Those that used the writing to "vent" in an idea of catharsis were found to not improve in mental health outcomes. However, those that showed an overall increase in causal words (e.g. "because", "cause," "reason") and insight words ("realized," "know," understand") showed comparatively larger and more significant health improvements then those who did not increase their use of causal words. In another study (Campbell and Pennebaker, 2003), the authors found that changes in function words were correlated with better health outcomes.

The tense of verbs can also be used to look at temporal focus. In the study of political ads, the authors found that there was much more focus on the future in positive ads in the use of present and future tense while negative ads had more past tense verbs. The authors infer that this is because the positive ads focused on the present and future acts of the candidate while the negative ads focused on past actions of the opponent (Gunsch et al., 2000). In looking at the resolution of a past event, Pasupathi (2007) found that participants used greater past tense in discussing a disclosed event and greater present tense in discussing an undisclosed event. Verb tense differences could indicate increased psychological distance and a higher degree of resolution for disclosed events compared with undisclosed events. "Pronouns and verb tense are

useful linguistic elements that can help identify focus, which in turn can show priorities, intentions, and processing" (p. 31).

Thinking styles: Conjunctions, Nouns, Verbs, and Cognitive mechanisms

Pennebaker (2010) argues that the depth of thinking can also be measured by language, and points to language changing when people are actively reevaluating a past event. This seems particularly interesting to my proposed research given the reappraisal of past events that occur in the context of psychoanalysis. Pennebaker argues that the LIWC system can capture two aspects of complex thinking through exclusion words and conjunctions. Exclusion words like "but," "without," and "exclude" help in making categories and therefore act as a way to differentiate between multiple competing ideas. Conjunctions "like," "and," "also," and "although" join words together and allow for someone to integrate language into a coherent idea. In terms of complexity, they can be used as a measure of integration of one's speech or narrative and as a measure of differentiation. High numbers of prepositions and cognitive words such as "know," "cause," "ought," and "realize" can also be used as a measure of more complex language.

In a reanalysis of expressive writing samples, Pennebaker, Mayne, and Francis (1997) found that increasing use of causal words and insight words lead to greater health improvements. The greater use of causal words such as "because," "hence," or "effect" and insight words like "think," "know," and "consider" suggest the active reappraisal of past events. Furthermore, certain language can be used to measure the extent to which a given story has been established or is still being formed. Insecurity can be measured in the use of tentative words like maybe, perhaps, or guess and more filler words like ummm, blah, you know, I mean. When stories are

more formed, people tend to use less filler words then those who have are disclosing a story for the first time (Pasupathi, 2007).

Summary and Hypothesis

The review of the literature suggested several exploratory hypotheses. To summarize: Weintraub (1981) found that certain defenses manifest in the dependable use of particular function words. Further, in his scoring manual Weintraub (1981) found that the infrequent use of "I" indicated an avoidance of intimacy; showing movement by the speaker away from more personal topics towards more impersonal topics, whereas a high rate represented self-preoccupation that can be indicative of depression. In looking at egocentrism in children, he found high rates of "I" and "me" in children aged 5 and 6 while after 7, the use of "we" increased greatly while "I" and "me" decreased. He also found that "we" in moderation can measure an ability to collaborate with others. Stirman and Pennebaker (2001) also found that "I" was significantly associated with poet's that had completed suicide, while Choudhury et. Al (2013) in a non-academic study of social media found that high use of "I" was associated with post-partum depression in new mothers. Main (Main, 2000) found in using the AAI that the predictability of inflexible attention could be seen in language and used as a way to measure attachment style. This inflexibility in language links to the inflexibility in the attachment style, which seems to suggest and support Fonagy's and Target (2000) notion that rigidity of self/other relations is one way to define psychopathology.

Further, Weintraub (1986), and Freedman's (1972) findings suggest that one way to measure that inflexibility or rigidity is through linguistic patterns that reflect either structural or defensive operations. Pennebaker and Campbell's (2003) findings that flexibility rather than

inflexibility in function word use is indicative of health would then be another way to measure this phenomena. However, adding the analytic literature, suggests that an inflexibility in function word use reflects an inflexibility in object relating, that the patient is attempting to recreate the "scene of address" (Butler, 2005) into a "new edition" (Freud, 2017) of a past relationship. Studies (e.g. Van Staden and Fulford, 2004) show that changes in pronoun usage can show therapeutic improvement or lack thereof. Due to the uniqueness of the analytic "scene of address" (Butler, 2005), and Pennebaker and Campbell's (2003) findings, several exploratory hypotheses can be generated.

If we believe that transference interpretations are mutative for the patient, than we can assume that transference interpretations will result in a measurable change in the flexibility of the of the patient's function word use. This presupposes that the patient's verbal behavior will show inflexible patterns of function word use that will become more flexible over the course of the analysis. Hypothesis one is that there will be a measurable change in the flexibility of the patient's verbal behavior as measured by function words during the course of the analysis.

The second hypothesis is that there will be a measurable change in self reference as measured by pronouns over the course of the analysis. The null hypothesis is that there will be no measurable change in self reference. Given Campbell and Pennebaker's (2001) findings concerning change in self reference and the use of "I" especially, and my own hypothesized link between "I" and transference, "I" will be looked at as the primary measure of change. Hypothesis two is that there will be a measurable change in pronoun use over the course of the analysis.

Finally, assuming there is a change in pronoun use hypothetically related to transference, the third hypothesis is that there should be other changes in language that can also be measured

that would reflect on different linguistic self/other states due to hypothesized therapeutic changes. The third hypothesis is that there will be other observable language changes that are related to the hypothesized pronoun changes.

A further qualitative analysis will be undertaken to investigate if there is a relationship between this assumed change in function word use and transference. As there is no external measure of transference available, this part of the analysis will take place in the form of a qualitative textual analysis looking in depth at selected sessions. The exploratory hypothesis is that there is a relationship between transference and any measurable change in function word use.

Freud (1916, 1917), believed resolving transference to be one necessary goal of an analytic process. The work of several authors' (Luborsky & Crits-Christoph, 1988; Gill& Hoffman, 1982; Teller & Dahl, 1986; Waldron et al., 2004) indicates that measuring transference maybe be possible through changes in language use by the patient. To date there appears to be little or no research on the relationship between transference and its relationship to the use of pronouns to describe the self. This is especially important given the idea that the self is composed of the self in relationship to others, built on the decay of past object relations (Freud, 1923). Therefore my primary hypothesis is that there is a relationship between the reliable use of certain function words and the state of the transference with the analyst.

Chapter 2. Methods

Data

The data for this experiment are comprised of the transcripts of the psychoanalysis of "A2;" a young agoraphobic housewife who had physical symptoms of vomiting and diarrhea. The analysis took place in a large Midwestern town during the 1970s. Her symptoms improved considerably in a more than 300 hour, four times a week analysis, which became a twice weekly treatment as termination approached. This patient has been used in psychoanalytic outcome research performed using the Analytic Process Scale (Waldron, Scharf, Hurst, Firestein, & Burton, 2004, 2004). These data were selected for the high number of transference interpretations. Given my interest in pronouns, the data was edited according to the LIWC 2007 protocol so that statements such as "you know" were counted in the non-fluency category rather than as a pronoun.

Measures

Pennebaker, Booth, and Francis (2007) developed the Language Inquiry and Word Count (LIWC) system to analyze text and to break it down into different categories based on linguistic categories. The program is split into the processing system which does the actual text analysis and the dictionary system. The processing system goes through every word of a text that is loaded into the program and is then compared to a dictionary file. A dictionary file is defined as the "collection of words that define a particular category" (Tausczik and Pennebaker, 2010) and the investigator can create a unique dictionary or dictionaries in order to study their chosen phenomena. The system also has preprogrammed dictionary files for cognitive words, verb tense, and function word analysis. Objective dictionaries, such as verbs, were created by simply

creating an LIWC dictionary for verbs and adding all verbs to it. For more subjective words, like the LIWC category for "Cognitive Words," two out of three judges voted to include or to exclude the word of a given category (Tausczik and Pennebaker, 2010). The system then calculates a percentage match of a given text to the dictionaries provided, allowing the researcher to analyze up to 82 unique variables within a text. The default LIWC 2007 software is comprised of 2,290 words and word stems. The word "cried," for example, would match five different LIWC categories including verbs, past tense, sadness, affect, and negative emotion (Pennebaker, Boyd, Jordan, and Blackburn, 2015). In clinical research, the LIWC has been used in therapeutic process research to study aspects of integration and disintegration in patient speech (Gilhooley, 2005). While all preexisting LIWC dictionaries will be used to examine aspects of the hypothesized changes, function words, pronouns, and the LIWC category for "I" will be examined most closely. This category is comprised of words such as "I, me, and my."

Design

As change in psychotherapy is often non-linear (Hayes, Laurenceau, Feldma, Strauss, and Cardaciotto, 2007), graphs will be used to show fluctuations of change across the course of the analysis. Hypothesis one is that there will be a measurable change in the flexibility of the patient's verbal behavior as measured by function words during the course of the analysis

The analysis will be segmented into three sections representing the beginning, middle, and late stages of the analysis. Similarity of the means of function word use from individual sessions will be compared to each other session in the phase of treatment creating a similarity coefficient based on the degree of correlation from consecutive session segment to consecutive session segment. Flexibility will be operationally defined as statistically significant differences in mean function word use, where the beginning sessions are expected to be the most highly

correlated. That is to say, there should be more variability as measured by a lessening correlation coefficient as the treatment progresses. It is expected that there will be far more variability (dissimilarity in correlation coefficient) in function word use in section three than section one. The least amount of change is expected in phase one, with each mean being similar to the other, and the greatest amount of change is expected in phase three, where the means will be most dissimilar. The first third of the analysis will show less variability in function word use than the middle phase and that the third will show the most overall.

Function words will be operationalized as the LIWC category for function words. As there are 48 sessions available, the beginning, middle, and late phase of the analysis will each contain sixteen sessions. Segments less than 450 words will not be included in the correlations. Each phase (beginning, middle, and end) of treatment will be divided into 16 sessions then further divided into sequences of 8 consecutive sessions. This will come to six segments total, each consisting of 8 sessions.

Each eight-session segment will then be divided in half so that comparisons within consecutive sessions could be included. In order to increase the number of comparisons, the data will be broken down further into five hundred word segments. The rationale for this is that correlation within segments should higher than correlations with other segments, given the distance between certain consecutive sessions. For example, for phase one of the treatment, segment 1, part 1 contains sessions 1-4, segment 1 part 2 contains sessions 5-8, while segment 2, part 1 contains sessions 26-29, segment 2 part 2 contains 30-33. For phase 2 of the treatment, segment 3 part1 contains sessions 140-143, segment 3 part 2 contains sessions 144-147, segment 4 part 1 contains sessions 265-268, segment 4 part 2 contains sessions 269-272. For Phase 3 of the treatment, segment 5 part 1 contains sessions 305-308 and segment 5 part 2 contains sessions

309-312, while segment 6 part1 contains 317-320 and segment 6 part 2 contains sessions 321-324. See table 1.

Table 1.
Segmentation of Sessions

Beginning (16 Sessions)	Middle (16 Sessions)	End (16 Sessions)
Segment 1 part 1 Sessions 1-4	Segment 3 part 1 Sessions 140-143	Segment 5 part 1 Sessions 305-308
Segment 1 part 2 Sessions 5-8	Segment 3 part 2 Sessions 144-147	Segment 5 part 2 Sessions 309-312
Segment 2 part 2 Sessions 26-29	Segment 4 part 1 Sessions 265-268	Segment 6 part 1 Sessions 317-320
Segment 2 part 3 Sessions 30-33	Segment 4 part 2 Sessions 269-272	Session 6 part 2 Sessions 321-324

Each segment will then be correlated to each other segment within a given phase of treatment (beginning to beginning, middle to middle, end to end) giving six correlations total for each phase of treatment using a Spearman's rank order, as the data is non-normal. The correlation coefficients from each phase of treatment (Beginning, middle, and end) will then be added together and divided by the number of comparisons in order to get the mean correlation coefficient for each phase of treatment. It is hypothesized that phase one will be the closest to a mean correlation coefficient of one for both the use of "I" and for the overall category of function words using the LIWC system.

The second exploratory hypothesis is that there will be a measurable change in pronoun use over the course of the analysis. A preliminary look at the available session sequences made it clear that the data points do not support a three-section break down as there is no true middle section. The forty eight sessions available come in 8 consecutive session blocks such that the first eight sessions are the first eight sessions of the analysis, while the next eight sessions are

actually the 26th sessions through the 33rd, and the next eight session block is session 140 to session 147. There are nearly 118 sessions missing in the middle, with the next eight session segment starting at session 265-272, with the remaining sixteen sessions occurring after this session. Given the gap in the distribution in the middle sessions versus the comparably smaller gaps in the beginning cluster of sessions and the ending cluster of sessions discovered in the preliminary analysis, the distribution and nature of the data as an N=1 case suggested a more statistically descriptive approach to the data which informed the following hypotheses.

Given the distribution of available sessions, it made sense to break the analysis first and second half of the analysis. As change in psychotherapy is often non-linear (Hayes, Laurenceau, Feldma, Strauss, and Cardaciotto, 2007), graphs will be used to depict fluctuations of change across the course of the analysis. As the data is non-parametric, descriptive statistics and Z-scores will also be used to show change. Though all function words will be analyzed, pronouns will be predicted to show the most amount of change due to their hypothesized links to self/other relationships, and the way they are hypothesized to change given a treatment focusing on transference.

The third exploratory hypothesis is that there will be specific observable LIWC language categories will be related to hypothesized pronoun changes. Changes in pronouns should correlate with other language category changes as the focus shifts from the self (I) to others in what is described as more "dominant" (Tausczik and Pennebaker, 2010) speech patterns and as the transference is explored and resolved. These hypothesized relationships between self-states and transference should be manifest in verbal behavior. Relationships between pronouns and other language categories will be explored examining Z Scores, as the data is non-parametric and only descriptive statistics are available for analysis.

A separate section will examine whether a relationship between transference and the measurable change in function word use can be seen. A qualitative examination of the text will be carried out based on the findings of the first hypothesis, focusing on hypothesized changes in pronoun use and other verbal categories as measured by the existing LIWC dictionaries. Data from the previous hypotheses will be used to guide a qualitative examination of specific session transcripts in order to establish a relationship between hypothetical changes in self-reference. Given Campbell and Pennebaker's (2001) findings concerning pronouns, three outlying sessions exhibiting the hypothesized pronoun change will be selected from the first half and second half of the analysis. As there is no external measure of transference available for this data, a qualitative analysis will undertake to understand the relationship between proposed findings in changes in function word use and its possible relationship to transference. The analyst's interventions will then be examined to see if there is a relationship between pronoun usage and analyst intervention to see if there is a relationship between pronouns, functions words, and transference. A transference interpretation will be operationalized according to Levy and Scala's (2012) definition, where a: "*transference interpretation* is *a tactful comment that clarifies and links the patient's experience of others outside of therapy with that of the therapist in therapy and to the patient's experience of past relationships with caregivers" (*Author's Italics, p. 394). Where, "Transference interpretations focus on connecting the patient's feelings and behaviors that are occurring in the here-and-now of the therapy with regard to the therapist with the patient's preconceived representational models of significant others" (Levy and Scala, 2012, p. 394).

Chapter 3. Results

It was hypothesized that when comparing the mean correlations of function words as an overall category as measured by the LIWC system and the LIWC category for "I" specifically, that of the beginning, middle and end phases, the beginning phase would show the highest correlation mean score representing the least flexible language use and that the end phase would show the lowest mean correlation score meaning the most flexible language use.

After segmentation into 500 word segments, and the elimination of points containing less than 450 words, there were 523 points of data. (Table 2 below outlines how the beginning, middle, and end phases of the treatment were organized.) The beginning phase comprised 196 data points, the middle phase was comprised of 172 data points, and the end phase comprised 155 points of data. The beginning phase, middle, and end phases were then broken down into 4 comparable section for correlations. In the beginning phase, there were four groups of 49 data points each, in the middle phase, there were four groups of 43 points each, and in the end phase, there were three groups of 39 and one group of 38. Each Phase segments was correlated to each other phase segment using a Spearman's rank order, as the data has a non-normal distribution. The correlation coefficients from each phase were then added together and divided by the number of comparisons in order to get the mean correlation coefficient. See tables 3-5 in the appendix for the results for correlations using the LIWC function words category. See tables 6-9 for the LIWC "I" category also in the appendix.

Table 2.

Beginning, Middle, and End Phase Segmentation by Session Number

Beginning (16 Sessions) 196 total data points of 500 words each	**Middle (16 Sessions)** 172 total data points of 500 words each	**End (16 Sessions)** 155 data points of 500 words each
Segment 1 part 1 (func11, "I" 11)	Segment 3 part 1 (func 31, "I" 31)	Segment 5 part 1 (func51, "I"51)
Segment 1 part 2 (func12, "I" 12)	Segment 3 part 2 (func32, "I" 32)	Segment 5 part 2 (func52, "I"52)
Segment 2 part 1 (func21, "I" 21)	Segment 4 part 1 (func41, "I" 41)	Segment 6 part 1 (func61, "I"61)
Segment 2 part 2 (func22, "I" 23)	Segment 4 part 2 (func42, "I" 42)	Session 6 part 2 (func62, "I"62)

My hypothesis was that there should be more variability as measured by a lessening correlation coefficient as the treatment progresses. It was expected that there would be far more variability (dissimilarity in correlation coefficient or a correlation coefficient furthest from one, positive one being an exact match) in function word use in section three than section one. The mean correlation coefficient for the use of function words for the beginning phase was R=-0.1145 (table 4, appendix), for the middle phase R=-0.0818 (table 5, appendix), and for the end phase R=-0.0382 (table 6, appendix). For the LIWC category for "I", the mean correlation coefficient for the beginning phase was R=0.1308 (table 7, appendix), for the middle phase R=-0.0138 (table 8, appendix), and for the end phase R=0.1733 (table 9, appendix). The results did not confirm the initial hypothesis, as for both the Function word category and "I" category, the

most similar sessions are in the end section. For function words, the beginning phase is the least similar from session to session, followed by the middle phase, and then the third phase. For the LIWC category of "I," the most similar sessions are towards the end, then the beginning phase, followed by the middle phase. In attempting to look at variance as a measure of inflexibility, there were the same findings as "I" in that the middle phase had the most variance, followed by the beginning, then end phase. Given that the most dissimilarity for "I" is found in the middle section, this indicates that the dissimilarity is most likely due to the 118 session gap in the data analyzed. Furthermore, of the two 8 session parts that make up the middle, the first eight session is closer in distance as measured by session (107 sessions between the beginning section ending at session 33) to beginning of the data, and the second 8 session part might be more like the end part of that data (given there is only a 34 session gap between the last eight sessions of the middle and the beginning 8 sessions of the end segment). Given the findings that there is a missing middle in the available data, separating the data into two parts rather than three became the logical next step. (This difference becomes quite clear when examining graph 2.)

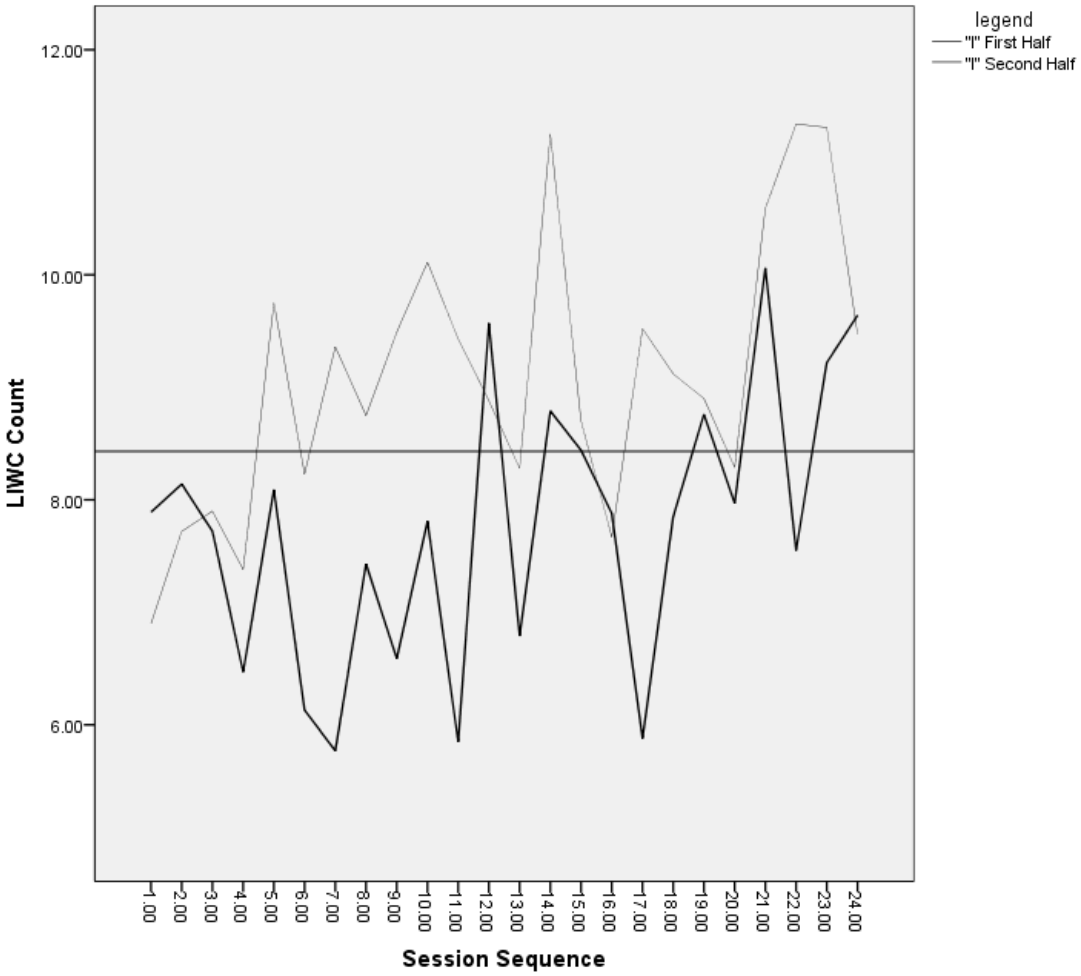

Figure 1. *Mean "I" use for first half and second half of the analysis*

One of the findings generated from the first hypothesis is that there is no true middle section to the analysis, as the available data does not provide a proper middle section. If we split the sessions in half instead of in thirds, we find that out of the first 24 sessions, 16 sessions are above the mean for the LIWC category for "I", while for the second half, 6 sessions are higher than the overall mean. In other words, in the first half of treatment, 67% of the sessions are above the mean for use of "I" per session. For the second half of treatment, only 25% are above the mean for the use of "I" per session. This represents a 42% change from the first half of the treatment to

the second half of the treatment. The changes are clearer if we look at the changes relative to the entire data set as represented by the second graph, which shows the mean LIWC category for "I" over all time points in the analysis, with a clear change in the middle of the treatment.

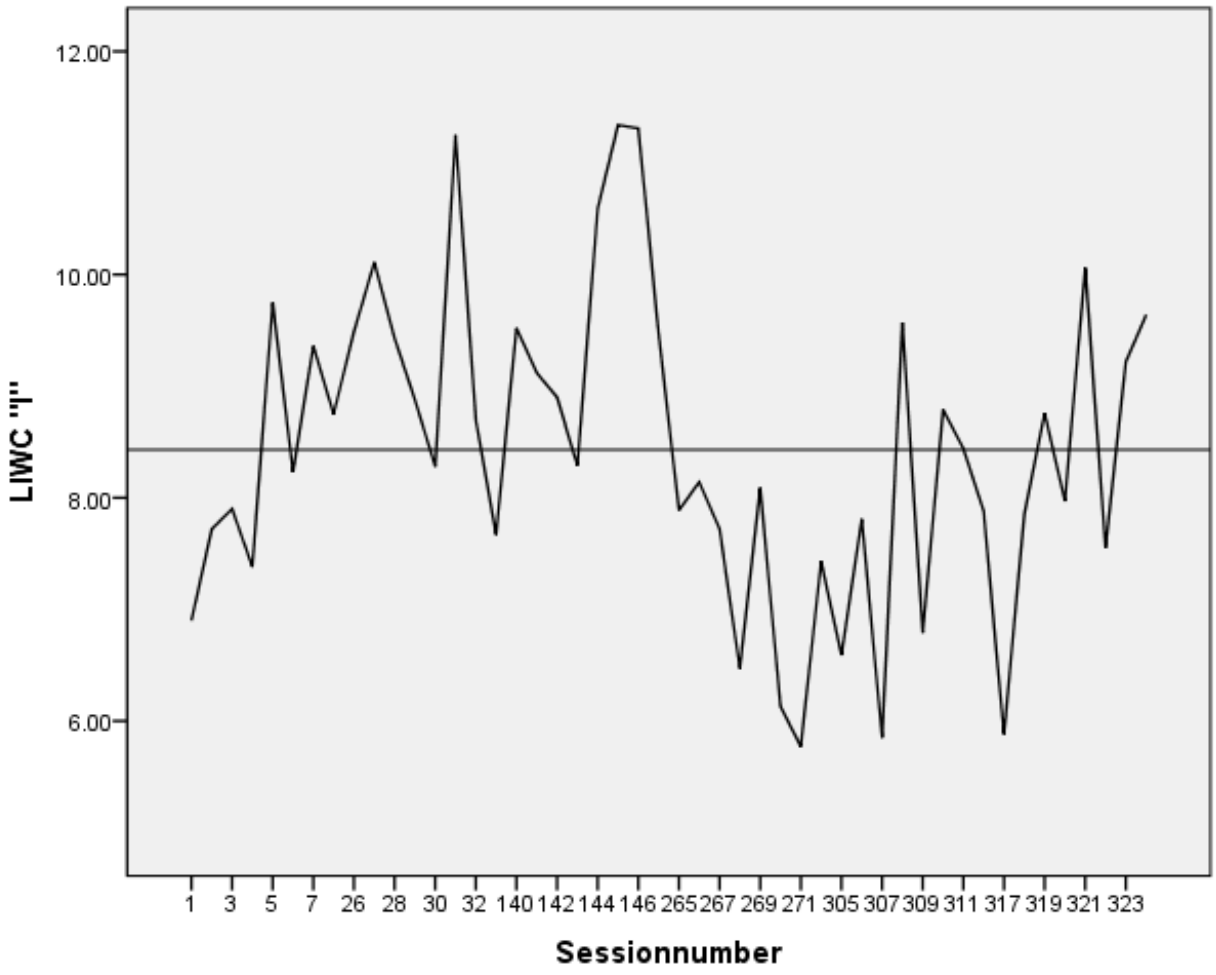

Figure 2. *Mean "I" usage across the complete analysis*

The above graph (Graph 2) shows a preponderance of "I" usage in the first half of the analysis, and then a steady but notable decline in usage towards the end of the analysis with an uptick towards the end. In order to further investigate the graph data, quantitative and qualitative analysis will be undertaken by examining the content of outlying High I sessions for patterns that characterize the sessions. Keeping in mind the original idea that language use in terms of self-

reference is related to the state of the transference, outlying Low I sessions will also be studied then compared to the High I sessions to see if there is a relationship between therapeutic action and the findings of decreasing LIWC "I" usage throughout the analysis. Z scores tabulated from the overall mean of the entire data set will be used.

Hypothesis 3

In examining outlying High I sessions from Graph 1, the three sessions with the Highest "I" score in the first half of the analysis and three sessions from the second half of the analysis will be selected. Other function words and LIWC language Categories that are unusually high (Z score above one) or unusually low (Z score below one) will be identified. This procedure will be repeated for the Low I sessions. The highest three "I" sessions from the first half of the analysis are sessions 31 with a mean of 11.25 (Z score= 2.03), 145 with a mean of 11.34 (Z Score=2.09), and session 146 with a mean of 11.31 (Z score=2.09) The mean for the LIWC I category for the first half of the analysis is 9.10 and the overall mean is 8.43.

In the second half of the analysis, the three highest I scores are for sessions 308 with a mean of 9.57 (Z score=0.82), 321 with a mean of 10.07 (Z score=1.17) and 324 with a mean of 9.64 (Z score=0.87). The mean I use for the second half of the analysis is 7.76 and the overall mean is 8.43.

If we examine the Z scores, what we find are that High I session tend to have high affect, especially negative affect such as sadness, anxiety, or anger (31, 145, 146, 308, 321, 324), high you scores (31, 145, 308), low we scores (31, 145, 308, 321), high present tense scores (31, 146, 308, 321), low conjunction scores (31,146, 321, 324), low preposition scores, and high verb scores (146, 308, 321). See the following table for Z scores that were above or below one in at least two sessions.

Table 3.

High "I" z scores for selected LIWC categories

Session number	31	145	146		308	321	324
Z I	2.02796	2.09267	2.0711		0.8199	1.17225	0.87024
Z you	1.98273	0.80554	0.03584		1.43941	-1.91104	0.37542
Z we	-1.10219	-0.87102	0.44996		-0.47472	-1.46546	-0.7059
Z heshe	-1.51348	-0.61704	1.36407		-1.70173	-0.9308	-0.81426
Z they	-0.67069	-0.61617	-1.8701		-1.51573	1.59183	-0.94328
Z negation	0.55928	0.41724	3.17684		1.28976	0.90423	-0.45528
Z verbs	0.57679	0.10057	2.74313		1.82804	2.01479	0.63282
Z affect	1.86816	2.376	-0.2503		0.7654	0.60579	-0.16324
Z posemo	-0.73961	1.6088	-1.45894		1.82037	-0.65498	0.80484
Z negemo	1.56773	0.56908	0.27536		-0.40019	1.77333	-0.69391
Z anx	1.89172	0.60829	-2.06552		-0.88904	3.54948	0.44786
Z anger	-0.47264	0.30608	1.75971		0.46183	-1.14754	-1.40712
Z sad	1.85974	-0.52073	2.45486		-0.58685	0.60338	1.33075
Z conj	-0.72945	0.10107	-2.60141		-0.84809	-0.63717	-0.99311
Z preps	-1.70792	-1.40853	-0.32813		-1.83808	-0.04176	-0.3021
Z present	1.66526	-0.26819	2.08531		1.81969	0.66456	-0.02728
Z past	-1.64351	0.29756	-0.16288		-1.41781	-0.14483	-0.67749
Z future	-0.7305	0.52427	-0.24253		0.00145	2.40643	3.10352

Low I Text

For the first half of the sessions the three sessions that have the least LIWC I category use are session 1 with a mean score of 6.90 (Z score=-1.10), session 4 with a score of 7.38 (Z score=-0.75), and session 33 with a score of 7.67 (Z score=-0.55).

For the second half of the analysis, the lowest "I" sessions are 271 with a use of 5.77 (Z score=-1.91), 307 with 5.85 (Z score=-1.86), and session 317 with 5.88 (Z score=-1.83). The mean for the second half is lower than the first at 7.76 while the overall mean remains 8.43. See the following table for a list of Z scores. Categories were selected based on High I categories with two or more sessions above or below a Z score of one.

Table 4.

Low "I" z scores for selected LIWC categories

Session number	1	4	33		271	307	317
Z I	-1.10004	-0.75488	-0.54635		-1.9126	-1.85508	-1.8335
Z you	-1.09606	0.05848	-0.89232		0.01321	-0.73385	-1.36772
Z we	1.17649	-0.47472	1.07742		3.25703	0.68113	2.03513
Z heshe	-0.24951	0.3511	1.03239		-0.07918	1.57922	-0.76944
Z they	-0.83425	0.63775	-0.64343		1.10116	1.15568	3.20012
Z negation	-0.15092	-1.22635	-0.09004		0.39695	-1.95683	-0.77994
Z verbs	-0.57174	-0.22624	-0.68379		0.24998	-1.62689	-1.80431
Z affect	0.27206	-1.58521	1.24423		1.02658	-0.16324	-1.44011
Z posemo	0.93178	-1.58588	-0.82423		1.69343	0.12782	-1.58588
Z negemo	0.33411	-0.40019	1.09778		0.09913	-0.45894	-0.16522
Z anx	0.87567	-0.88904	-0.24733		-0.24733	0.23396	1.67782
Z anger	-1.30329	-0.88797	0.15034		-0.42073	-0.57648	-0.47264
Z sad	0.73563	0.40501	1.92586		0.07439	-0.25623	-1.18197
Z conj	-0.62399	-0.37351	1.10296		0.76021	1.97303	0.50974
Z preps	-0.3021	-0.84881	-0.224		-0.10685	-0.36718	0.71321
Z present	-0.20024	-0.157	-0.19407		0.09008	-1.67041	-1.49127
Z past	-0.24414	0.27047	-0.16288		0.14408	1.38997	0.758
Z future	0.31514	-0.83506	0.21058		-0.45166	-1.1139	0.14087

Low I sessions were not as dramatic in terms of observable changes as the High I sessions. Some trends observed were that Low I sessions were characterized by low "you" scores (sessions 1, 317), high "we" scores (sessions 1, 33, 271, 317), high "he/she" scores (sessions 33, 307), high "they" scores (sessions 271, 307, 317), low negation (sessions 4, 307), low verbs (sessions 307, 317), mixed affect (high scores in sessions 33, 271, low scores in sessions 4, 317), mixed positive emotion (high scores in session 271, low scores in sessions 4, 317), one session high for negative emotion (33), one session high for anxiety (317), one session low for anger (1), one session high and one session low for sadness (high 33, low 317), high conjugations (sessions 33, 307), low present tense (sessions 307, 317), one session with high past tense (307), and one session with low future tense (307).

High I Versus Low I sessions

As many of the differences are not apparent in examining Low I sessions in isolation, the difference between Low I and High I sessions becomes clearer if we compare the two using the mean scores calculated from the outlying sessions. In comparing High I and Low I sessions, I took the average of each category and calculated the average Z Score difference for each category for these twelve sessions. See table 5.

Table 5.

Mean z score difference between low "I" and high "I" means by LIWC category

	High I Mean	Low I Mean	Mean Difference
Z I	1.50902	-1.33374	2.84276
Z you	0.45465	-0.66971	1.12436
Z we	-0.69489	1.29208	1.98697
Z heshe	-0.70221	0.310763	1.012973
Z they	-0.67069	0.769505	1.440195
Z negation	0.982012	-0.63452	1.616532
Z verbs	1.316023	-0.77717	2.093193
Z affect	0.866968	-0.10762	0.974588
Z posemo	0.23008	-0.20716	0.43724
Z negemo	0.515233	0.084445	0.430788
Z anx	0.590465	0.233958	0.356507
Z anger	-0.08328	-0.58513	0.50185
Z sad	0.856858	0.283782	0.573068
Z conj	-0.95136	0.558073	1.509433
Z preps	-0.93775	-0.18929	0.74846
Z present	0.989892	-0.60382	1.593712
Z past	-0.62483	0.35925	0.98408
Z future	0.843773	-0.28901	1.132783

In comparing High I versus Low I sessions, the largest difference by word class appears in examining the other pronouns. This is similar to Campbell and Pennebaker's (2001) findings. For High I sessions, "you" use is also high, while "we," "he/she" use, and "they" use are low.

For Low I sessions, four of the six are actually high "we" sessions. These Low I sessions tend to have a high "we" use, high "they" use, and low "you" use. "He/she" use is somewhat neutral. There is a also a noticeable difference between the first half of the analysis, where all three high "I" sessions from the first half of the analysis have a Z score above 2 while in the second half only one session has a Z score above one, with the other two sessions below one. For the Low I sessions, whereas two out the three for the first half of the analysis have "we" Z scores above one, in the second half of the analysis two out of the three sessions have "we" Z scores above 2. Given this relationship found, the following graph further illuminates some of the pronoun changes over time and showing that "I" dominant and "we" dominant sessions appear to be discrete entities, with "I" heavily used in the first half of the analysis and more "we" language used in the second half of the analysis. Pronouns then appear to show the most change when examining differences between High I and Low I sessions.

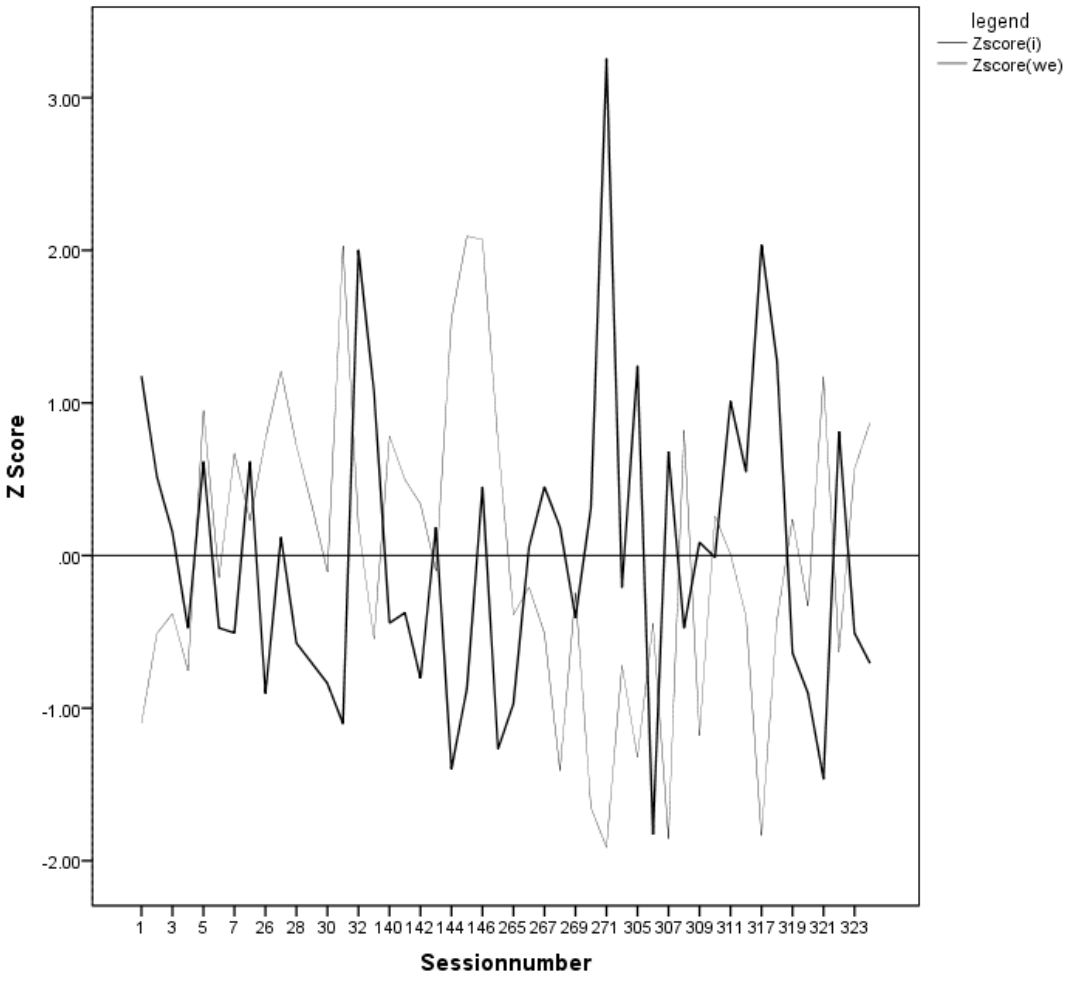

Figure 3. *Mean z scores for "we" versus "I" across the analysis*

Interestingly, the pattern is similar for the LIWC categories for "you" versus "they," where "you" occurs more in the first half of the analysis, and they occurs more in the second half as seen in Graph 3.

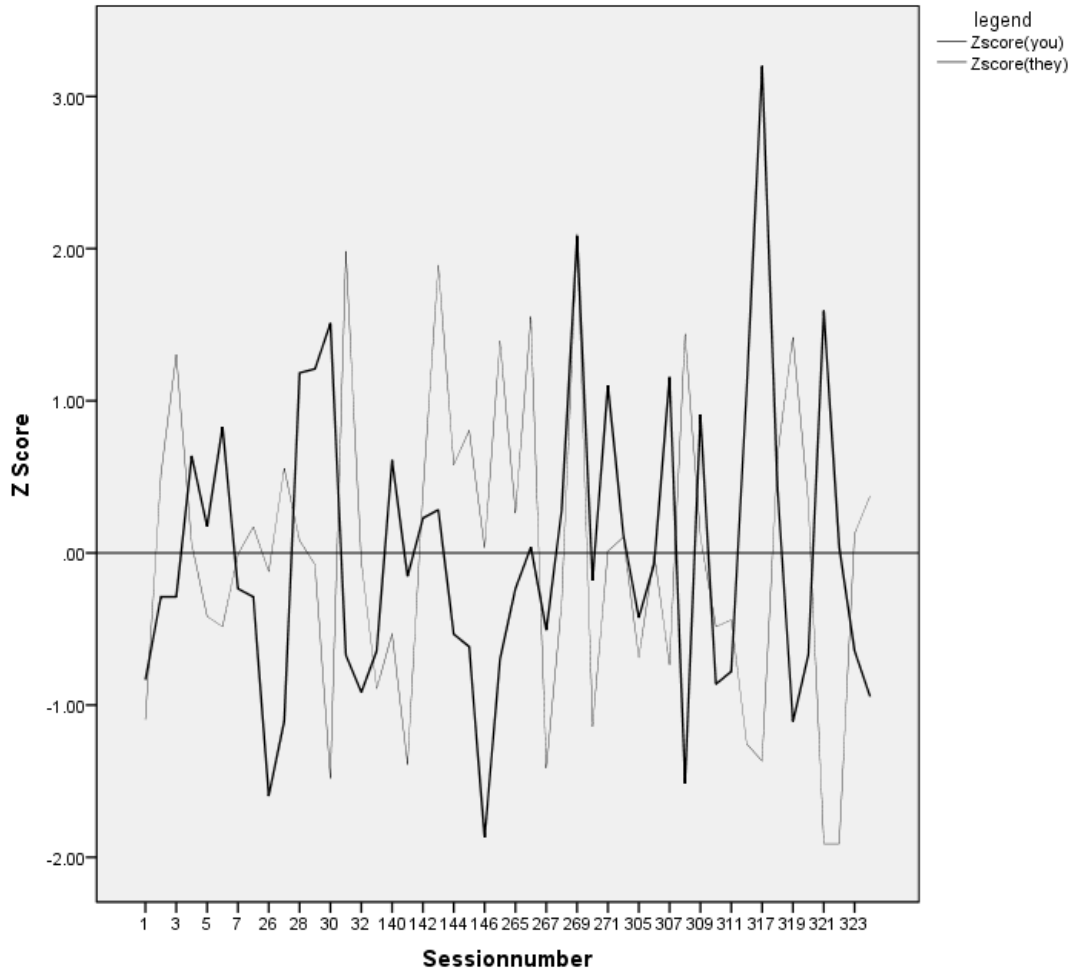

Figure 4. *Mean z scores for "they" and "you" across the analysis*

Affect

In looking at other categories, such as Affect, High I sessions tended to also score high in the LIWC overall category for Affect (sessions 31, 145), with two high (sessions 145, 308) and one low session (146) in the "positive emotion" category, two high (sessions 31, 321) in the "negative emotion" category, two high (sessions 31, 321) in the anxiety category (with one low session, 146), one high session (146) in the anger category (with two low sessions 321, 324) and three high (sessions 31, 146, 324) in the sadness category.

For the Low I category, we find that there are two high (sessions 33, 271) in the overall Affect category and two Low (sessions 4, 317). There is one high session (271) in the positive emotion category and two below (sessions 4, 317). There is one session above one (33) in the negative emotion category. There is one high anxiety session (317), one low anger session (4), and one low (317) and one high (33) sad session. Interestingly, while the High I sessions tend to have more in the overall Affect category, there is not too much difference between the sessions in terms of the positive/negative emotion categories, and angry, sad, and anxiety categories specifically (see table 11).

Tense

In terms of verb tense, High I sessions tended to score higher in the present tense, lower in the past tense, and higher, especially in the second half of the analysis, with the future tense. Low I sessions tended to not have much of an association with tense, with two sessions below a Z score of one for present tense, one session above one for past tense, and one session below for future tense.

Other categories

Most other function word categories did not show as much of a difference as the pronouns. However, Verbs and the category for negation were both found to be higher in the High I sessions, while Conjunctions and prepositions were found to be lower. Conjunctions were found to be slightly higher in the Low I sessions, while verbs and negations were found to be lower.

Chapter 4. Qualitative Analysis

Given a measurable change in self-reference in the "I" pronoun and "we" pronoun, an exploratory analysis sought to examine whether a relationship existed between the shift in "I" use and transference. As there is no external measure of transference available, a qualitative textual analysis examining selected sessions of the twelve sessions comprising High I and Low I sessions was used for hypothesis 4.

Do outlying High I and Low I sessions differ in aspects of the structure of address? The structure of address will be looked at from the point of view of transference, with the hypothesis that the transferential relationship between the analyst and the patient is driving the changes in self-reference as measured by pronouns. In looking at High I sessions, the highest three as measured by the LIWC system for "I" from the first half (sessions 31, 145, and 146) and the highest three from the second half (sessions 308, 321, and 324) will be examined. Though all will be examined, I will go into depth for the High I sessions with session 31 and session 145 from the first half and sessions 308 and 321 from the second half. Session 146 was omitted due to its proximity to session 145, session 324 was omitted as it is the final session.

For Low I usage, the three lowest LIWC "I" sessions from the first half are sessions 1, 4, and 33 and the lowest three from the second half are sessions 271, 307, and 317. Sessions 4, 33, 271 307, and 317 will be looked at for the Low I sessions. Session 1 from the first half will not be looked at in depth as it is the first session. In the qualitative contextual look at the sessions, patterns and themes will be looked for that link the sessions thematically, both within High I and Low I sessions respectively, as well as between High I and Low I sessions.

With that in mind, let us examine the common themes of conflicts that the patient presents and the common themes and interventions that the analyst uses in High I sessions. These themes, conflicts, and interventions will then be compared to the Low I sessions.

High I Sessions
Who are you?

Session 31

Session 31 takes place about 7 weeks into the treatment. It is on Friday after a Thursday break. The first thing the patient says is "*do you switch chairs around on purpose*?" This is the last hour before a week long break. Here the patient makes direct reference to the analyst.

The analyst asks why he would want to throw her off by confusing her with the chairs. She then discusses her "guilt" over "letting loose" in a previous session in discussing her enjoyment of playing volleyball. She then discusses her difficulty with accepting analysis, that she can't even ask him where he is going and that she feels like she violated a "taboo" by seeing his face in the Wednesday before session. She goes on to talk about another common theme that comes up again from session 4:

*Well, the fact that that as long as, as long as I'm not happy as I'm not enjoying myself that the world's going to be ok too, you know. Its going to go along fully but surely not if I start letting loose and I start being happy and if I start going out every once in a while and really enjoying myself and whatever; the company, the people I'm with or whatever we're doing (sighs) that we're going to get a depression [*From the context of the session, she means an economic depression-Lentz*]; like, I'll get punished for it you know.*

The analyst interprets that she may fear he will side with her father, and say she is crazy. She discusses her concern that if she lets him in on her inside thoughts, he may think she is crazy and she continues in this vein after some clarification:

I mean is that crazy? oh, it's goofy, but that's that's, I don't know what to think about myself when I; when I tell you that, you know. Geez. I don't know what I did. You know, I don't know if telling you what I really feel is right or wrong, you know, just ; I know that what you want to

hear but but…you might think I'm really crazy…I get scared, you know, that :well, maybe he'll tell somebody that I should be put away.

The above shows the high I usage, low conjunction, high verb, high negation, high you use, and low we use. The high you use is both from attempting to predict what the analyst is thinking ("I know what you want to hear") and from the repetition of "you know" followed by "I don't know."

She continues the session by recounting the guilt she feels for discussing her anger at her parents for things they have done. Inside the analysis, she is feeling abandoned by her analyst as he is about to leave for a trip and he won't tell her where he is going, and they discuss what it might mean for her to become dependent on him. It is also the last session before a week long break. She may be trying to preemptively distance herself and abandon the relationship before she can be abandoned by the analyst for the break. She discusses feeling stupid for not knowing her own feelings and her guilt for talking badly about her mother in a previous session. She also discusses a conflict in sending the analyst a Christmas card. She "doesn't know" if she can send him one or not. The analyst asks why she thinks he might object, and she states that he might not be happy to get one from a "lower class" person.

The analyst interprets: *mm-hmm. I think there are some aspects of this situation that are very irritating to you and that, in a way,*
Patient states: *very degrading*
Yeah, okay, degrading, and degrading maybe, in a way, that to you feels an awful lot like some of your complaints about your parents, that they, uh, as I understand it, you felt pushed around and as if they're supposed to know everything about you, but you're not supposed to know anything about them…and it seems to me you have similar feelings here. You're not supposed to know anything about me, not even such a simple thing as whether I 'm going to a meeting or a vacation or God knows what or…uh, I guess the right word is the one you used, you feel degraded as if you're being treated like lower class stuff even to the point that if you were to send me a Christmas card, you have the idea that "well, who the hell does she think she is?"
He continues*:*
It also reminds me of another way in which you've spoken about your relationship with your parents, you've said you're so tied by their rules and that you think you ought to be able to make certain judgements of your own and abide by them…and here, you see, you're doing the same

thing with me about the card; it's as if you feel you have no right to think it through and make up your own mind to do, no, you've got to do what I want or even worse, as I say, it S such a put down because you feel that I would find it insulting even to get a card from you. She replies: *I don't know*.

They talk about if the doctor thinks she is nuts or if he thinks the treatment will work. They then talk about where she thinks he is going. She states that he uses words so much better than she does. He counters with stating that he thinks she is putting herself down. They talk about how she may miss him when he is gone and he interprets that she may be scared she is becoming dependent on him.

The patient and analyst's relationship in this session is marked and represents both a real and a transferential conflict. His not telling her how he will react to getting a Christmas Card or where he is going creates anxiety for the patient and she fills in the blank of his non-answer with a previous traumatic object relation. She also acts in ways to withdraw from the relationship. Her use of "I" in this session is both a retreat and an attack, as it becomes a way to isolate herself from the relationship, and therefore to isolate herself from the painful but unacknowledged affect generated by the impending break.

Session 145

In session 145, she is ten minutes late. This session is one of the highest in positive emotions at Z=1.61. It also has a very high discrepancy word score (discrepancy words are words like could, should, would). Her first statement is *"I'm late. I know I'm going to lay here being bothered about something unless I ask you something."*

She then asks to borrow money from the analyst. She is reeling from feeling angry at her husband the day before. She is also discussing leaving analysis and wanted to set a definitive termination date in session 144. The analyst lends her the money. After much questioning, the patient reveals it is her birthday. The husband has forgotten her birthday and the patient feels her

parents aren't celebrating correctly. She expresses her conflict around her birthday feelings which explains the high positive emotion score and high negation score:

Patient: *It just boils down to (sighs) it's so difficult sometimes to be happy about things, and that, that, that's so wrong. Goddamn (pause) (Sighs) (Sighs) do you know why I'm supposed to be happy today-it's my birthday. And I don't feel happy about it. I've been getting cards and presents and I should be happy and I'm not happy and I don't understand that. I'm happy to a point but I think I should be happier, that's what's upsetting me.*

In the middle of the session, the analyst has figured out it is her birthday, and interprets that he has given her a "birthday present" in the form of the money he has lent her, and he states: "*then it seems to have to do with wanting one (a gift) from me then*."

The patient replies: *um, like I'm figuring what I would like for you to sit there and say "you know what? I'm going to give you your wish, you don't have to come here anymore." That would be the best present I think, of all.*

The therapist replies "*you still feel you have to come here, don't you*?
And the patient states: *I I guess I am really afraid that I'll hurt your feelings , I'll never see you again and you'll think I'm making the wrong mistake.*

The analyst then makes a transference interpretation*: Yeah. I think that's very important in connection with this business of liking, you have a feeling that, uh, if I like you, then you you acquire certain very powerful obligations towards me and you can't, you're no longer a free agent to come or not come or do as you wish because you'll disappoint me and just mustn't. My liking you make some kind of a slave to me.*

Patient: *I don't know how else to do it. I don't know, I can't even imagine not feeling like this, feeling you have to give so much or you have to always return things; always be careful of other people's feelings or they won't like you.*

The analyst interprets: *as if nobody must be one up on you in terms of giving you something. Obviously, you know, I'm just repeating it but I think it can hardly be emphasized too much; you feel to be loved is a demand and you know it's not hard to understand but apparently that was the essence of the way your parents treated you. They said they loved you and they made it perfectly clear that it meant you were their slave.*

The patient confirms that the interpretation works: *I don't know. It brings a lot of memories that flood; them, I picture my mother and father doing doing different things, uh, my father sitting at the table saying, uh, he stands all day on his feet to bring the money and we have to appreciate it and we have to eat everything we're given.*

Here again, as in session 33, there is a question of what is the real relationship between the analyst and the patient and the patient acts in such a way (by wanting to borrow money) to move the analyst out of a neutral stance. She is also communicating some disappointment in the

analyst, and her use of "I" may be her attempt at maintain separation from the analyst. The analyst, for his part, engages in the enactment by lending her money, but also interprets the previous object relation that may be interfering with her entering into a relationship with him. He is interpreting her defense against entering into a "we" with him. In some way, she is asking "who are you?" And in another, she is saying "this is who I want you to be." The analyst is saying you don't want to be a "we" with me because this is what "we" has meant to you in the past.

Session 308

In session 308, the patient is three minutes late. She begins in relation to a question of the analyst's: "*Not too bad. I left a little earlier because I knew they were working on the expressway but I still got tied up in it. It's a real bottle neck*." This is the first session back from a week long break. The patient discusses her wish to know where the analyst has been and her conflict in wondering. He also comments on her by asking if she has a new hairdo. She talks about her new hairdo and then brings up her desire to know where the analyst has been.

She discusses her conflict: *See? But then I get this conflict where, okay, we have here a contract or whatever, that I'm supposed to tell him what ever comes to my mind and this and that and everything else and it's –it seems sort of unfair because some of the things I have are very personal and yet, I 'm supposed to share them; the that's part of the analysis, so you know, it's not that I'm asking you to; to, you know, divulge any of your private life or anything, it's just that , uh; if , if it is something of a common occurrence you know I figure maybe you'll tell me. But some time I think it is common and you don't, you know (laughs)…*

The analyst attempts to explain why he won't answer her question. The analysand responds: *Now that I can't understand, That I'm under-because it seems dumb (laughs) and cruel, to not just be natural, you know, to another person, and it seems like, well, I relate it with the time I asked someone how the gas bill is paid and they tell you it is none of your business; that seems dumb and cruel because it is a simple explanation is all a human being needs…*

Here again, the patient is perhaps struggling to understand the difference between the analytic relationship and a regular relationship. She in some ways is attempting to assimilate the analyst's answer into a previously formed relational schema rather than accommodate the new

relational information. The analyst discusses why he won't answer the question and then interprets and this leads to misunderstandings.

Analyst: *I'll start over. I have been away, this is the first session after my return. You have the idea before you come here that what you'd like to do is say; well, how you been, where you been something like that…and you would like for me to just answer that. Though you can understand that if it was something quite personal, I wouldn't. My point is that I believe that you're having had that idea beforehand that you'd ask me and wanting an answer, is a way of establishing a relationship between us, of a kind that would hide something else; that it would be worth finding out about. And that when I didn't answer the question and you said that's dumb and cruel, that's a clue to something that could be hidden…*

The patient responds: *That's the part that's really throwing me. When you're saying that, nothing happens. I supposed something is supposed to happen if I'm hiding something…* [the patient keeps thinking and states]*… what would I be hiding and nothing happens and then I think about it a little more and then I remembered that article about, uh, uh, patient sand psychiatrists and so forth and I started thinking, is that what he means? Maybe I'm falling in love with him or something, I don't know, because I was trying to find something because I couldn't find anything…*

They then discuss how the patient was at one point in love with the analyst and had one "crazy afternoon" where she was sexually aroused because of their relationship. After some back and forth, he makes the following transference interpretation:

I don't know exactly how it fits in because it was, one of those things you said that struck me especially. That I, I have a feeling that you do feel quite strongly that I am behaving toward you the way they did and that if you said "how do you pay the gas bill?" they didn't answer you or that they were always ready to see in you something in you, you were doing, something bad and sexual; that you were either masturbating or you'd gotten interested in a boy in a way that you shouldn't; that they didn't trust you and they were looking for hidden badness in you. I think you are reacting to my not answering your question and to my looking for,uh, hidden meanings in it as exactly the same thing and that that's why you call it dumb and cruel, and I would even say if it was a question of, you know, a simple how do you pay the gas bill, that my not answering that is dumb because you're just asking for an ordinary piece of information and you should be enlightened. Or that my picking at it looking for some terrible thing that's hidden there is cruel, and that, in a sense, you do have the feeling that I am behaving like they did and that the only difference is that you didn't dare say to them; that's dumb and cruel; though you would have wanted to, but you can, you dare say it to me, that's dumb and cruel; but just as soon as I begin to try and examine it in the way that I do, you get scared, and you, maybe this is the one thing we could get out of it (laughs) that uh, the reason you didn't say to them it was dumb and cruel
Patient: *I know the reason (laughs*)

The "reason" the patient points to, is her previous relationships. Here again, the patient acts in a way to move the analyst from a neutral position and works to assimilate the relationship into a previously formed schema. The analyst resists this in order to do the analytic work of understanding the way the patient is attempting to "recreate the original scene of address" (Butler, 2005). She confirms his hypothesis by stating "I know the reason" and goes on in the session to describe genetic memory of her relationship with her mother and father.

Session 321

In session 321, she has skipped a session the day before, another separation, but oneshe had control over, and she has brought her children to the session. She begins the session by speaking to her children with: *"you get to see everything from this height…that reminds me of this. I'm getting them slow but sure."* She then addresses the analyst: *"Okay. Fourth of July got me with a firecracker, believe it or not…dangerous around our neighborhood."* This is three sessions before she decides to leave the analysis, and the session is very high for anxiety.

They discuss the reason she missed her appointment the day before. The patient had been worried about sending her children to go swimming and had had an attack of her symptoms with nausea, diarrhea, and vomiting. She is also set to do a presentation for her new job as a cosmetics saleswoman and she discusses her conflict around doing the presentation. *Person (her boss) thought I could do it. He asked me. I didn't say yes. I didn't say no. All I said was "I'll try" (laughs) that's all I keep saying. I hesitate but I say I'll try. (Pause) (Sighs) last night nick says, "I know you like a book. You're worried about that aren't you? And I says "yeah." He says, "I knew it, I knew it.*

The analyst asks why she didn't come into the session when she was having her symptoms, as, that's what they are there to treat. Finally she states "*Well, I think what it is is I don't want to hear you say I'm silly or foolish for not allowing the kids to go to the beach, you know, something like that and then after my friend had said that I still—I've got the confidence and I don't have the confidence for the decision I made.*

They discuss her conflict around whether choosing to not send her children to the beach was a symptom or not. Her conflict in the analysis is her concern that the analyst may think she has symptoms.

The analyst then makes a transference interpretation: *I think you regard the whole treatment-the whole- the fact that I take the position that you need treatment and that these are symptoms and that you're more caution than necessary, I think—that for you that amounts to my saying you're a rotten kid…and I'm sorry I ever had you. I think you didn't come yesterday because you expected that I would say something that would make you feel just as bad as your father makes you feel when he says the kinds of things that he does about his children and that, in a way, even if only in the sense that I would say—here, we've been working together, you know, all this time and I've done my best to help you and you still have the same kinds of fears that you wouldn't let the kids go swimming and you're worried about the presentation tonight, you're a rotten patient and I'm sorry I've ever gotten mixed up with you. That—if I would have said anything to the effect that I thought it was a symptom and so on, you wouldn't have heard—that wouldn't have sounded to you, you know, like a doctor saying, you know, I'm sorry, you still have that trouble, and I guess we haven't licked it yet so let's work some more. I think that would have been meant to you my saying you're a rotten patient and I'm sorry I ever took you as a patient and you're just no damn good and no good is ever gonna come of you and why did god give me these rotten patients.*
She then says, *you know the problem is I really believe some of that stuff*.

Here again, there is the conflict between the real and imagined relationship, the way she attempts to recreate the original scene of address, the real relationship between patient and doctor, and patient expressing a wish that the relationship was real, and what that relationship would look like. By refusing to gratify this wish, the patient then acts as if the doctor were the original frustrating or traumatizing object. The analyst uses this as an opportunity to point out the way that his refusal to make the relationship anything more or less than an analytic relationship is a result of her transferring previous relationships onto the analysis as per Levy's (2012) description of a transference interpretation. These interpretations often come at crises points in the real relationship between the doctor and the patient. The patient, in this case, may also be reacting to being told she still has "symptoms" which under cut her feelings of mastery and confidence.

In sum, the analyst uses the high I/high affect sessions to interpret transference in the here and now relationship. High I sessions tend to occur either before or after breaks in the analysis. High I sessions tend to contain some kind of "acting out" behavior. There may be two things happening in these sessions. On the one hand, the patient is in some ways recreating the "original scene of address" (Butler, 2005) and is communicating to the analyst not in words but through transference something she has been unable to articulate about her genetic relationships. On the other hand, she is also insisting on separation and is defending against some disappointment in the transference object by not entering into another kind of relationship with the analyst- a "we" relationship. (Though not examined, the analyst's speech is also full of "I" and "you" as seen in his interpretations in these sessions. He is not joining her in a "we" either, and this may serve to distance her as well, basically casting her out of a "we" relationship.) The analyst interprets her resistance to entering a relationship with him based on genetic relationships using Levy (2012) transference interpretations. With this in mind, let us now examine the Low I sessions and their relationship to High I sessions and transference.

Contextually Low I Sessions
Who are we?

Low I Sessions

In the qualitative contextual look at the sessions, patterns and themes will be looked for that link the sessions thematically. Session 4, session 31, session 271, session 307 and session 317 will be investigated in further detail.

Session 4

Interestingly, the patient starts the session with "*still don't like this*" with a notable lack of "I" to represent the self. She talks about not wanting to come in that day. This is a low overall Affect session (Z score=-1.585) which may mean she is not really bringing her affect into the room.

They discuss if someone is supposed to enjoy seeing a doctor. As this is still early in the analysis, and only the second or third time she has lain on the couch, his statements are mostly orienting her to the treatment. The analyst discusses how they will approach her anxiety issues indirectly, and how he does not intend to direct what she talks about. His interventions are mainly about explaining analysis:

Analyst: *And also, as I explained to you there are things one, you have to learn about this process as you go along. I do not intend to direct you in any way in so far as your behavior is concerned. What effects will come from the treatment will be applications you will make of what you have learned.*

They discuss a dream of her children falling from a palm tree. This is the first dream discussed in the analysis. He asks her to associate to the dream. He introduces what an interpretation will be like:

When I express an idea, that's all it is, an idea. It could be right. It could be wrong. And you'll react to it one way or another. If you think it's right, you'll agree, if you don't think it's wrong and so on.

They then discuss how important it is for her to make her own judgements.
He makes a transference interpretation from the content of her dreams:
So the idea of the palm tree is associated with your father …one of other reasons I was suggesting that maybe that's tied up with your father is that, as you know, as I said, I think that since the dream may have something to do with your own fear of what will happen here, that would be a connection too because you have already said a few things that indicate that you're afraid that I will treat you like he did…and I will be critical and scold you and say you're worthless and a nothing and wave my hand and heaven know what else…
She replies: *Possibly. And uh and it I just feel that a lot of things he has done and my mother had done, really kinda changed my attitude about people and the way I do things. I'm –like it's always like I'm out for approval. Uh, even in myself,--out for my own approval..*
They continue to discuss this and she states, in relation to the analyst asking why she has a low opinion of herself:

Well, I guess, all I can remember are things I've done wrong but I—you know, I get—and when I do things, I guess I feel I don't –when they are right, they're not 100% right—

They discuss the reason she feels she is never right. He replies, *You see, one way of putting that would be to say you treat yourself like your father did.*

She states "*Right*" and associates to when she was gardening the other day, her father came over and criticized her gardening.

Interestingly, in the High I sessions, we do not get identification interpretations or the patient discussing how she has identified with significant objects in her life. So, while it appears this session contains a transference interpretation, the transference interpretation sessions do not contain an understanding of the way the patient may be identifying with significant objects.

Session 33

Session 33 begins with the patient stating "*I don't want to come here anymore. Would you believe that?*" This is before a break in the treatment.

She follows by discussing her relationship with the analyst explaining she might be afraid she has offended him for not wanting to come in. They talk about the fear she may feel in becoming intimate with him in a non-physical sense and they discuss the differences between her relationship with the analyst and her relationship with her husband. She then discusses her and her husband's relationship, that she is angry with him, and that she is afraid the analysis may interfere with her marriage.

Patient*: Well, at least you could say now that I'm telling you what I'm thinking and instead of just thinking it inside, at least, I'm expressing it, you know. I'm just not (sighs) maybe it's just because of Christmas and there's so many other things that I want to do.*

She talks at length about her family and the analyst interprets that she may be concerned he will think her family is crazy. She then discusses trying to pick up a present for her husband, and discusses feeling mad at him. The analyst asks what she is mainly mad at.

Oh, like my birthday and Friday night. See, that's petty too. That's like my parents, you know. I don't tell him about I, you know, but I think about it inside sometimes, but that; you know, like that I just try and overlook things like that and say that's silly and, you know, you don't think like that and you just go on with the next day, you know. I don't know.

Here, as in session 4, there is some acknowledgement of identification with her parents. She is also using "you" here to mean "I," which may be a difference between High I sessions and

Low I sessions, as there may be more flexibility in self-reference, where "I" becomes "you" used to refer to the self. The use of "you" here, as in the above example, is not really linked to affect; it is used as hypothetical or "what if" and as a way for her to think about how she relates to other people. She has some greater distance as a second person narrator of herself than as first person narrator. The analyst then makes a transference interpretation about her not being able to find the right present for her husband being like looking for the right thing to say in analysis, which the patient agrees with, but this is not really in line with Levy's (2012) definition. It is commenting on a current rather than past conflict, though it does act to bring the discussion into the here and now of the analysis. The bulk of the session is taken up however by discussing relationships outside of the analysis and about how the process of analysis is done.

Session 271

She is four minutes late. She begins the session "*hi, oh, life is life, I swear*." They discuss some of the goings on in the session the day before, and she states she has been asking herself about why she is so curious about the analyst. She then goes on to invite him to come to a winter dance she is holding and that she doesn't know if she should give him one ticket or two, since she doesn't know if he has a wife or not. They discuss a block party that she is involved in, and part of the high "we" score (Z score=3.257) for this session is her talking about her relationship with her husband. They then talk about how she would react if he did not go to the dance and what it would be like to end analysis, if they would continue to have a relationship or not. Part of the other high "we" score from this session is her using "we" to refer to herself and the analyst. The analyst makes a transference interpretation about her maybe feeling disapproved of as a person, if he did not go to the party, and that this would mean he was acting like her parents. She states that she would feel rejected.

She then discusses her conflict around feeling special: *My parents, my dad especially, would would; if you do something, right away, right away, you're a smart ass, you know, you, you, you're better than him or something like that. And I don't know, I get very, very confused because sometimes, well, now recently, I've been telling myself; it's ok to feel the way you're feeling. It's only natural, like, uh, I forgot to tell you; I was feeling pretty lousy last night. But I'm getting to feel a little better about the day. I turned thirty last night. Today is my birthday. Believe it or not.*

This turns out to be the one year anniversary of her birthday from session 145. She discusses feeling special and her conflict in feeling special, as it makes her feel like an "egomaniac." She does her thing of asking if she should give him a ticket to a dance.

I'm still really (sighs) you know, this; I've been doing this for years to people too if they've been acting somewhat I don't even know what words to put in it anymore; that they were putting themselves ahead of people like my husband Nick for many years, many years; of course, he was on the selfish side too in some respects, But I would be doing what my father was doing and I'd be looking at them like; who, I mean they're crazy for being that way; they're wrong for putting themselves up high and they're wrong and they would be more humble, you know.

The patient here discusses her conflict of on the one hand, being an "egomaniac" and being disapproved of by her father, or on the other hand being like her father in identification. Though she brings up the idea of inviting the analyst to a party, she is able to use the analysis to think about both sides of an object relation. She discusses being like her father for the way she treats her husband, and articulates her conflict around feeling special because of the way her father had treated her but also acting like her father by disapproving of other people, including herself for being an "egomaniac." In other words, in these sessions, she may be turning from a passive recipient to an active doer, while also thinking through past and current relationships. She is actually enjoying her birthday this year and she is able to feel positive feelings in her birthday in a far less conflicted way then she did a year ago, in session 145. During that birthday, Her family's actions nearly led her to cheat on her husband out of anger for him forgetting her birthday in session 146, a High I session, whereas here she discusses how much more attentive her husband was this year, even staying up until midnight with her counting the minutes until it

was her birthday. This different attitude or different relational stance could be manifest in the higher amount of positive emotion (Z score=1.693) in this session and has the highest "we" usage of almost any session, with a "we" that includes the analyst as well as her husband and other significant relationships.

Interestingly, as this is a high "we" session, the "we" refers mostly to her relationship with her husband. She also frequently uses it to refer to her relationship with the analyst. Here again, along with using "you" to refer to the self, as illustrated in the above quote, she also uses "we" for self-reference. This may be a pattern where High I sessions are using "I" more exclusively to refer to the self, whereas Low I sessions may have multiple ways of referring to the self, using "I," "you," and "we." Using "you" as she does in the above quotation allows her to gain reflective distance and to think about how her father treated her, and how she sometimes acts like her father in relation to other people.

Session 307

She is three minutes late. This is the last session before a 6 day break as she is seeing the analyst less. It is unclear why they have decreased sessions, but it has been mentioned in passing in session 271 that they have reduced to twice a week. She begins: *I went to the basement, then I went to the sixth floor. I got off and I ran there and opened the door and, all of a sudden, all these colors hit me. They got orange and blue and green, this ain't the right floor.*
She goes on to discuss her improving mood and it's relation to "PMA", meaning positive mental attitude*: I was asking myself, why don't you get mad instead of getting hurt, you know. Then I asked myself; why don't you stand up on your own two feet, you know, and, and not care and I'm going, well, I do care because my husband is the closest thing to me, you know, compared to any other adult, you know, like I could be myself and he'll still be there even if I make big mistakes, you know. I guess the thought of losing him was more than I could handle. Then I asked myself the question: I look at myself in the mirror and I say; are you upset because Dr. Johnson's leaving next week too?*

Interestingly, in using "you" here to refer to herself, she is commenting on the process of her coming to be able to observe her relationship to the analyst and to herself, to see herself outside of herself. This speaks to some internalization of the analyst and an increasing ability of the patient to think about her-self and her affective relation to others, as well as her relationship

with the analyst, Dr. Johnson (a pseudonym). They discuss how she is doing better and better in a company she is working in, selling cosmetics. She talks about being angry at her husband for being out late the night before.

He makes a transference interpretation that in discussing selling the product, if she might be discussing her relationship with him?

…and here I was doing something good and I was thinking someone was going to come up and holler at me for; "what are you doing" you know, that type of thing. I think I'm doing; I'm carrying my father's role and my mother's role type of thing; that type of third degree. I'm carrying on their …

The analyst asks: *did you do anything of that sort last night in relation to his [her husband] being late?*

Hm…yeah. There was one small point where I was, I think I was sounding like my father saying; or my mother who got it from my father (laughs)…

Here we have a session that does not have a Levy (2012) type transference interpretation, but does include reflection on her identifying with her parents, as well as being able to step back from her relationship with the analyst to think about her affect in relation to others. Most of the action of the session is again taking place outside of the analytic relationship, she is reporting to the analyst her thoughts and feelings about events outside of the room. This is a trend in the Low I sessions, where most of the action of the session concerns discussions of relationships outside the room of analysis.

Session 317

She begins the session 5 minutes late with "*We're all here today*" meaning her children, whom are waiting in the therapy room. This is a very different session from 308 however, where she also brought her children. She had cancelled the previous appointment due to a sick child and had worried the analyst would be mad. Most of the action of the session, like the other Low I sessions, takes place outside of the therapy room. The patient discusses leaving her children to be babysat by her parents, and that she and her husband had come home to find the door unlocked and that her parents had asked the children to lie about it.

She talks about being able to do things on her own. The analyst interprets: *Are you implying that the, um,fact, that you can deal with these situations without getting so upset means you're better as far as the treatment is concerned, is that what you mean…both in regards to your parents and me?*

Patient*: Yeah. If I'm not going to be taking my parents in some ways, I'm not going to be taking you in that direction either.*

She talks about going flying on a plane soon and that she is scared the plane will crash and she will die, and that she is blowing this fear out of proportion.

The analyst clarifies: *So you think to take the ordinary fear that you suppose, uh, a lot of people have who have never flown and you blow it up into this worst possible thing -as you said, like your parents, they uh—they couldn't just deal with it on the level of the house and open door but right away they blew it up into this huge business that they can't take proper care of the kids and you would think if the kids stayed with them if the kids would get killed and so on.*

She then discusses how in feeling good, she expects punishment. Interestingly, this has similar themes to session 4, which discusses her dream about children falling from a palm tree and how she expects to bring on a "depression" for feeling good. In terms of transference, it is interesting to note that she in some ways is bucking the idea of transference and beginning to reject the analyst. She is not going to take her parents in the real world, why would she continue to take him as well? Also, while anxiety is very high (Z score=1.678) in this session, the highest of the Low I sessions, it seems so is her ability to tolerate that anxiety. This could be because "we" is also quite high (Z score=2.035). The ability to share her anxiety, that is disperse her anxiety in a community of a "we" rather than be isolated and alone with her anxiety in an "I," might make the anxiety more tolerable. It could also be anxiety about leaving the treatment and "performing" on her own (the content of her anxiety is concern over performing a work presentation), a step she will take when she leaves the analysis 9 sessions from this one.

Summary of Low I Sessions

In the Low I sessions, there is less focus on the relationship between the analyst and the patient and more of an attentional focus on goings on outside the room, especially the patient's relationships outside the room. In session 317, she discusses joining with her husband in her

anger at her parents over babysitting and asking the children to lie about it, in 307 it is primarily about her relationship with her husband and her work selling cosmetics, in 271 it is about a block party she is involved in planning, her family in session 33, and the dream in session 4. This suggests that the high "he/she" and "they" LIWC category scores for these sessions is a marker that the analyst and patient are discussing relationships outside the room. The analyst may still make a transference interpretation ins these sessions, but they are less likely to be in line with the Levy (2012) definition of linking genetic relationships to previous experience. Either the patient or the analyst is likely to remark on how the patient is acting like one of her parents.

Summary of High I versus Low I sessions by context

In the High I sessions, the patient seems to be feeling her feelings with some immediacy in the session and these often involve some conflict in her relationship with the analyst or a crises in one of her relationships outside of the analysis. In these sessions, she often acts or does something provocative. The patient often voices some conflict in her relationship with herself and with either coming to analysis or her feelings about being in analysis. She then acts in a way to assimilate her relationship with the analyst into a previous relational schema, at least in the opinion of the analyst, who interprets transference according to the Levi (2012) definition in 4 out of the 6 High I sessions. This usually results from her either engaging in an enactment, which ranges from suggesting the analyst is trying to trick her in session 31 and not knowing if she should send him a Christmas card, to asking for money/birthday present in session 145, to dressing provocatively in session 146 while discussing seeing another man out of anger towards her husband, to bringing her children with her to session 308, and to bringing a firecracker with her in 321. In terms of enactment, this may relate to the high verb usage in these sessions in that she is set to act or is talking about acting, which she ultimately does in session 324 when she ends the treatment. Typically, while the patient is caught up in her real relationship with the

doctor and the rules of analysis, the analyst tends to interpret her feelings as transference, pointing out that she is assimilating rather than accommodating relational experience.

The analyst plays a role as well, as he sometimes steers the conversation to external events and sometimes steers the conversation into the room by remarking on something the patient is doing or saying. In the High I sessions, he tends to do this by sticking with the enactment, for instance following up with the patient about why she might think he is trying to trick her by moving a chair in session 31, or why he might object to lending her money in session 145. In session 308, he steers the conversation into the room by commenting on the patient's hair. In Low I sessions, his line of query tends to follow the patient as he asks questions that attempt to clarify her relationships outside the room-for example in session 33 he asks questions to clarify why she might be mad at her husband and asks clarifying questions about certain relationships in her family, and in session 271 he asks questions about the patient's role in a block party she helped to plan, and in session 307 he asks the patient about her work in cosmetics.

The analyst attempts to remain neutral in some sessions but occasionally engages with patient in an action, such as in session 145 where he gives her money for parking and as a "birthday present" and in session 146 where he gives her direct advice and tells her to wait to contact the man she is thinking of contacting as an act of retaliation for her husband forgetting her birthday. These sessions, with the exception of 146, where he interprets her transferring feelings she has for her husband onto him, and 324, where he does not interpret her deciding to make that their last session, tend to have transference interpretations that align with the way Levy (2012) outlined them as linking present feelings about the analyst with unprocessed feelings about past formative relationships. For the analyst then, he is interpreting transference in

the here and now when affect is at its highest, as every High I session also scores above one Z score in one of the LIWC affect categories (Affect, Positive emotion, Negative Emotion, Anxiety, Anger, or Sadness). The patient, for her part, tends to in some direct way let the analyst know if the interpretation is correct or not by offering further associations or agreeing with the interpretation. She also in these sessions discusses her troubles with feeling good about herself, that is her self-esteem, and she tends to discuss conflicts in how she feels about herself, which is the essence of an internalized object relation. It is often her discussing her parent's judgment of feeling good about oneself and how her in family, that is considered having too much "ego."

The Low I sessions often share similar content with the High I sessions, especially around feelings of self-worth, and about what it means to be in a relationship with the analyst. Session 271 for example follows this pattern where she invites him to a family dance. In this session, her use of "we" often includes the analyst, that is as a "we" inside the room, as well as a "we" that refers to her and her husband or her and her family. However, the content of these sessions is generally about people and affiliations outside of the room. In the Low I sessions, the use of "we" is quite high, as are "heshe" or "they" whereas the use of "you" is much lower. In terms of attentional focus as measured by "we" and "he/she" and "they," the focus of these sessions is on relationships outside of the room, whereas in the High I sessions, where "I" and "you" are more dominant, the action is taking place between the analyst and the patient. The analyst may make an effort to bring the action into the relationship in Low I sessions, but these interpretations are not usually successful. (In session 307, for example, he interprets that in talking about her role in the company she is talking about her relationship to him.) There are also a fair number of transference interpretations in the Low I sessions, but less in line with the Levy (2012) definition. When the analyst interprets, or when the patient becomes reflective

enough to bring it up herself, the content of the session becomes about how the patient is in some way acting like her parents towards either herself or someone else. In the High I transference interpretation sessions, however, there is rarely a statement by either the analyst or the patient suggesting identification. This is most likely due to the patient inhabiting one end of the transference spectrum in these sessions-genetic transference in child to parent, while in the Low I sessions she is in a post-oedipal identification position.

Interestingly, these findings are in line with Foelsch and Kernberg (1998) in their thinking regarding transference focused psychotherapy and their and Ogden's (1992) understanding of object relations as inhabiting both sides of an internalized relationship linked by affect. For example, if a child is neglected by an alcoholic father, but cared for by a mother, they may internalize both the angry uncared for child and the ineffective mother. In the data, this seems to occur and be the major difference between the High I and Low I sessions. In the High I sessions, the patient is acting as if she were in a historical relationship with her parents in the present tense with the analyst. She is feeling very strong affect and is working to act on that affect and may be attempting to enact a historical object relation and to recreate "the original scene of address" (Butler, 2005), something Butler points out is composed of an "I" and a "you." In the Low I sessions, she is acting as if she were the parent in relationship to someone else, as this is remarked upon in the Low I sessions-I am acting like my parents. The action in these sessions is generally outside of the room, as the patient is discussing events outside of the analysis such as her work, family life, or civic life and generally has high "we," high "he/she/ they" use, and low "I/you" use.

Chapter 5. Discussion

Campbell and Pennebaker (2003) found that change in pronoun use in journal writing about a traumatic event was associated with improvements in health outcomes. However, these authors felt unable to explain the reason for this finding. The purpose of this project was to explore if there was a relationship between the change they observed in pronoun usage and the relationship with a hypothesized "other" such as might be observed in transference using sessions from a psychoanalysis focused on transference interpretations. Four main hypotheses were generated. The first was that inflexibility of language use could be observed using repeated Spearman's Rho Correlations focusing on the LIWC category for "I" and the LIWC category for Function words if the data were split into a beginning, middle, and end phase. Typically, psychotherapy process research is broken down into the beginning, middle, and end phase of treatment in accordance with psychoanalytic process studies and short term psychotherapy studies. This break down into three phases is based on assumptions underlying pharmacological studies which assume both a linear and gradual change (Luyten, Blatt, and Horst, 2011).This experiment found a minimal difference from one phase to another, and actually showed that the end phase sessions of treatment were more correlated one to another than the beginning. While it is possible that these changes were not observed because the patient did not get better, this seems unlikely as she becomes noticeably more assertive in her relationships with her husband, parents, and analyst and she takes on more and more civic and work related roles, the content of which dominate the Low I sessions. It seems more likely that the limits are due to the use of the comparativly weak Spearman's Rho and the nature of the breakdown of the data as discussed in the results section. However, this analysis led to a better understanding of the distribution of the

data available in the 48 sessions and led to the data being split into two parts for the subsequent explorations.

When the data is split in half, changes in the LIWC category for "I" are readily observed. There does seem to be a marked decrease in "I" use across the analysis, and evidence for a movement in High I usage in the first half of the analysis followed by a steady drop in I over time, followed again by a brief uptick right before the end of the analysis. Indeed, the first half of the analysis is so heavy in the total "I" usage, that High I sessions in the second half do not exceed a Z score of one, meaning that the bulk of "I" use is found in the first half of the analysis.

As "I" dominates in terms of Z Scores in the first half of the analysis, "we" in terms of Z scores tends to increase in the second half of the analysis. They also seem to switch places over the course of the analysis with "we" increasing in usage and "I" decreasing in usage over time. They also appear to never be high in the same session. Instead, they co-vary with High I sessions being low "we" sessions, and vice versa. With these findings, there does seem to be some change observed in the verbal behavior of the patient in regards to self-reference. However, given the limits of using descriptive statistics, we are unable to state if this is a significant change over time.

In the third hypothesis, other changes in speech associated with two different self-other states were observed. In terms of pronouns as measured by the LIWC system's pronoun categories, co-occurring with the "I" self-reference state was the pronoun for "you" (also sometimes used for self-reference), while in the Low I self-reference state, four out of six were actually high "we" sessions, where "we" co-occurred with "they" and "he/she." Further, High I sessions tended to be lower in "he/she/they," higher in "you," higher in negation, higher in verbs, high in all affect categories, high in present tense, high in future tense, and low in conjugations

and prepositions. Low I sessions tended to be higher in the use of "he/she/they," low in "you," low in negation, low in verbs, also high in some affect categories, and lower in present and future tense. Low I sessions had more conjugations, similarly low preposition use, and somewhat neutral difference in the use of past tense.

From the fourth hypothesis, the qualitative examination of the High I sessions (4 out of 6) tended to be associated with Levy (2012) type transference interpretations while Low I sessions (5 out of 6) tended to be associated with some type of comment by either the analyst or patient that there was an identification going on with an internalized object, as in session 4 when the analyst states "*You see, one way of putting that is would be to say you treat yourself like your father did*", session 33 when the patient observes that she's being "*petty*" towards her husband and "*that's like my parents, you know*." Similar comments by the patient or analyst is present in session 271, 307, and 317 as shown in the qualitative section. Given these findings and their hypothesized link to transference, it is worth investigating these two language categories further.

High I Sessions

With the decrease of LIWC category "I" use over time, and the increase of "we," is it possible to say that the patient's mental health improved over the course of the analysis? High I sessions tended to be lower in he/she/they, higher in you, higher in negation, higher in verbs, high in all affect categories, high in present tense, high in future tense, low in conjugations and prepositions. High rates of use of the first person singular pronoun have been found to be related to higher rates of depression, social anxiety, marital dissatisfaction, and neuroticism (Zimmerman, Wolf, Bock, Peham, and Benecke, 2013) as well as successfully completed suicides in poets (Stirman and Pennebaker, 2001), and depression (Bucci and Freedman, 1981;

Rude, Gortner, and Pennebaker, 2004). Zimmerman et al. (2013) also found, using transcribed psychodynamic interviews with predominantly female, inpatient participants, that high first person singular use was related to an elevated interpersonal distress and an intrusive personality type on a measure of interpersonal style (The Interpersonal Problems Circumplex, or IIP-C,, Aldin Wiggins, and Pincus, 1990). Patients who scored highly on this measure described themselves as inappropriately self-disclosing, attention seeking, and unable to spend time alone. Chung and Pennebaker (2007) also found that higher use of first person singular pronouns was associated with a "self-focus" rather than "other" focus. What seems to happen in the analysis then, is a move from self-focus, to other focus, and in the final sessions given the overall arc of High I use, a move back to a "self" as separate and withdrawing from the analysis. Given that the High I sessions tend to occur before or after a break, and given that the "I" itself is a separate-that is-apart from the "we" of a community-the "I" seems to be a self-state of separation and withdrawal from the relationship rather than one of joining with the analyst.

Negation and verbs were also high in High I sessions. Negation has been found to be linked to defensiveness (Weintraub, 1981, Bucci, 2002, Halfon, 2012) and theoretically, is one of the hallmarks of resistance (Freud, 1925). In the same paper, Freud describes thought as "a pre-cathexis to acting." Verbs are the language of action and from the qualitative examination, these sessions include what might be thought of as "acting out" behavior on the part of the patient. Verbs are high, for example in her building up to leave the analysis in session 321 and 324, as well as in Session 146, where she discusses acting on her anger at her husband by contacting a man in order to sleep with him.

As there is no outside measure of transference for these sessions, we cannot say definitively that this type of language (high first person pronoun use, high "you" use, high

negation, high verb, low preposition and low conjunction) as language indicative of a transference state. However, the analyst does consider these sessions to be transferential in that he consistently interprets the patient's language as transference in these sessions, and more closely follows the Levy (2012) definition of linking past relationships to present feelings and behavior felt towards the analyst. The LIWC categories for overall affect (overall Affect, positive/negative affect, sad, mad, anxious) becomes interesting then, as "I" is associated with "you," in the present tense in three out of the six High I sessions, with each High I session also being high in at least one of these affect categories. As Butler (2005) points out in "recreating the scene of address," this takes place in the interpersonal space of "I" and "you," where in High I sessions the affect is in the room from "I" to "you" with high verbs, perhaps meaning that there is an underlying relationship being "acted out" with high affect of the "I" that "cannot narrate itself," as Butler (2005) argues, but can only communicate through transference. The patient may be unconsciously working to create the genetic "you" that defined the "I." In another possible explanation of High I use, Zimmerman et al. (2013) hypothesizes that first person singular pronoun use may reflect the "tendency to seek attention from others rather than self-focused attention (pg. 223)." The authors elaborate to say that rather than being self-regulating, High I use may be field regulating, where "field regulation denotes the fact that interpersonal behaviors tend to pull or evoke complementary responses from others, thereby regulating the interpersonal situation (pg. 223)." In both Butler's (2005) understanding of the role of "I" in creating "you," and in Zimmerman's, there is an inflexibility in relating to the other in the dyad. In both conceptualizations, as linked to first person singular pronoun usage, there is an unconscious attempt to control the "you" in the relationship, either by asking for positive feedback or by attempts to turn the other into the "you" of transference. (In a more reflective state of mind, as in

session 4, the patient is able to articulate this by stating "I am always out for approval.") In either case, the "you" is interpolated into a relationship with predefined parameters of behavior.

Whereas Zimmerman et al. (2013) focuses on the here and now, and do not focus on genetic transference, Butler (2005) makes explicit the link to a transference that is necessarily an unconscious act predicated on the analyst's ability to disrupt this externalized relationship that results in change. In other words, the use of "I" is a somewhat unconsciously rhetorical position, where the "you" in the relationship is cast into a predefined role created from the patient's past. Both Zimmerman and Butler refer to a rigidity in the relationship of "I" to the "you" in the relationship, where the speaker is attempting to act on the listener. Given the available evidence, this is quite a different stance from the self-other stance of the Low I position, especially as seen in the "we" sessions.

Low I Sessions

The first person plural pronoun "we" has been found to be related with commitment and interpersonal closeness (Agnew et al., 1998), relationship quality (Abe 2009), marital satisfactions and positive problem solutions in marital interactions (Rohrbaugh, Shoham, Skoyen, Jensen and Mehl, 2012), positive mental health (Chung and Pennebaker, 2007), a more "dominant" social position (Kacewicz, Pennebaker, Davis, Jeon, and Graesser, 2014), and can be thought of as being "embedded in social relationships" (Zimmerman et al. 2013, pg. 223). Both Pennebaker (2011) and Zimmerman et al. (2013) found that those with overall higher use of "we," "us," and "our" had significantly lower rates of depression. Zimmerman et al. (2013) argued that the patients who used first person plural pronouns more were "negatively associated with interpersonal distress" and that in terms of their personality measure (The Interpersonal

Problems Circumplex, or IIP-C, Aldin, Wiggins, and Pincus, 1990) they found that first person plural pronouns reflected "the (adaptive *sic*) tendency to balance social pressures and one's own social needs (pg. 223)." In other words, "we" can represent a more healthy self-other position, and it would appear, given the graph of the movement from Heavy I use in the beginning of the analysis to the lower I use and heavier we use, that the patient changes from a more interpersonally vulnerable position to a more interpersonally assertive or "dominant" (Kacewicz, et al., 2014) position. The "we" self-other stance is a more cooperative self-other stance based on a shared reality. It is worth noting that session one is both a Low I session and a high "we" session. The content of this session is generally a negotiation between Doctor and patient; it focuses on the proscribed relationship of these mutual objectively agreed upon social roles, perhaps rather than a projected subjective transferential relationship. The true Low I session, Session 4 which is not a high we session as assessed by Z score, has similar content where the doctor is instructing the patient in how analytic work is done. There is less negation, meaning less defensiveness or resistance. There is less use of verbs, perhaps meaning less of an urge to act.

The use of "we" then maybe a different stance than a transference stance the way Levi (2012) describes it. Affect is still high, but the affect is perhaps felt *with* the analyst rather than *against* the analyst as the affect is directed outside the room at he/she/they, and, attentionally, the analyst and the patient are not talking about their own relationship, and the patient is not speaking to bring attention to herself, but they are talking together about relationships outside the room. Theoretically then, "we" use versus "I" use may have implications for further studying levels of transference saturation, in the Bionian (1962) sense. Rather than being two separate self-other states, the level of "I" use may rather be on a spectrum showing a desire for affiliation

in the "we" stance and a desire for separation in the "I" stance. This affiliation/separation spectrum may be governed by something like transference saturation, where the more the patient (re)experiences the immediate relationship as a recapitulation of a genetic relationship, (or works to recreate the "original scene of address "Butler 2005), the higher the "I" will be. A higher use of "we" may be a signal on the patient's part that they are moving towards affiliation and away from a need for separation. The patient and analyst are in a different relational stance from a transference relationship in Low I sessions, or at least an ancillary relationship to a transference relationship. There is some evidence (four out of six sessions) that "we" represents a different self-other stance (as does Low I usage, five out of six sessions), one marked by identification with significant figures from the past as either the analyst or the patient remarks on this in the content of the sessions. This will be discussed more in the theoretical discussion.

One surprising finding came in the affect categories, where, though the overall LIWC category for Affect nearly showed a Z Score difference of one (Z score difference was 0.975 on average between High I and Low I sessions, see table 5), not much difference was found in negative (Z Score difference 0.437) or positive (Z Score difference 0.431) affect. There was a very little difference on average in these other Affect categories (Anxiety Z Score difference 0.357, Anger, Z score difference 0.502, and Sadness, Z score Difference 0.573)between the High I and Low I sessions. That is to say, for these sessions negative and positive affect was still experienced in this self-other stance. Only in the Low I sessions, it is not as tied to past, present, or future tense and appears more free floating in time. In this way, affect is felt not in an "I" in relation to either a real or projected "you," but is felt with the analyst. "We" are feeling these things (which for the patient may mean "we" as a family or we as husband and wife or we as patient and analyst) together, rather than "I" am feeling this against or towards "you." It is a

language of shared experience in a larger than singular social unit (as represented by "I"). High "we" may be a language of community and of objectively shared experience rather than of subjectivity and separation. Lower verb use in these sessions may mean less of a need to act on the felt emotions. The High I sessions then may show a higher intensity of feeling feelings in the room against the analyst in transference, whereas Lower I and higher we sessions may show a less transference saturated session signaling a more flexible ability to affiliate with the analyst.

The present study provides evidence for the utility of assessing "I" and "we" as a measure of therapeutic progress. Furthermore there does seem to be a relationship between the "I"/"you" self-other stance and the state of the transference, as theorized by Butler (2005). There also appears to be a different self-other state in the "we"/"they" or "we/he/she" stance (or perhaps located as two ends of a spectrum governed by transference saturation), as these pronouns suggest that the action of these sessions is outside the analytic room. There also seem to be implications that a heavy use of "I" could be a barrier to entering a relationship and that through transference interpretations, the analyst may be able to help the patient enter into a relationship with him by bringing those previous barriers to intimacy and affiliation to light. Given the rise in "I" use before the patient's ending of the therapeutic relationship, "I" use could also be a signal that one is leaving a relationship. It could also signal that the analytic "we" has broken down, and that some sort of repair is needed on the relationship to reestablish the "we."

Given this evidence of changes in language and especially in pronoun use, an argument can be made that the patient's mental health improved. There seems to be a relationship between this improvement and the patient's ability to move from an "I" position to a "we" position within the analysis. Further, this change was imbedded in the process of the therapy itself. This ability relates to the relationship that the patient has with her analyst, and analyst's ability to interpret

past barriers transferred onto the analyst that are interfering with forming a relationship with him, indeed, barriers to affiliating and becoming a "we" with him. This leaves however, the question of why the patient decided to leave the treatment. Given that "we" points to a shared, objective, communal reality, further considerations of the "I" and "we" positions are undertaken in the theoretical considerations section in order to better understand the patient's decision.

Theoretical Considerations

In my original consideration of the origin of transference (see the theoretical section), there is the self (I) in relation to an objectification (me) that is projected onto the analyst (you) through transference. The relationship within the self is related via metaphor, or the transitional play space, a play area between internal and external, subject and object that is originally the space between the baby's internal needs and the external mother's recognition (or misrecognition) of those needs. The structure of language, as illuminated through function words then becomes important in the way the patient attempts to act on the analyst in order to recreate an archaic object relationship. In function words, rather than in content words, there is a discernible structure that can be measured according to Pennebaker's (2003) method, as the "I" attempts to act on the "you" through "me" to see "me" externally as I was once seen and objectified. While this study found evidence for this process in pronouns and pronoun's relationship to transference, I had neglected to consider the "we" pronoun given that the findings suggest change from the "I" position to the "we" position back to the "I" as seen over the course of the analysis.

For Butler (2005), in transference, the "I" creates the "you." Behind this rhetorical you is a "real" you, however, in the subjectivity of the analyst, as Winnicott (1958) wrote, "waiting to

be discovered." This seems to be the realm of the high I/you sessions, where the analyst is yet to be discovered as the patient interpolates the analyst into a preexisting role, a "mirror" role, the role of the "you" that defines the "I." In order for the patient to understand this "recreation of the scene of address," the analyst must act in some way to disrupt the process and bring the patient's attention to this creation of previous relationships in the here and now relationship with the analyst. This enables the patient to take a step outside the self to view the self, to take an "objective" look at the "subjective" self, what Ogden (2001) writes as a "more reflective position (pg. 37)." Freud (1925) argues that this is the heart of resistance; an insistence that the subjective reality of the patient, the subjective reality of transference governed by the pleasure principle, is an objective reality. In order to take an objective look at oneself through the lens of the supposedly neutral analyst, one necessarily has to have or develop the ability to enter into a "we" position of a shared "objective" reality. At the same time this admits of a separate individual with their own subjectivity. The patient has to have the ability to relinquish some idea that the "I" position is all there is, that subjective reality is the only reality. The "we" position, both for Moss (2001) and as demonstrated in the analytical data of this study, seems to be related to the process of identification rather than earlier, more primitive forms of interaction. Rather than requiring the other to act as a mirror that defines the self, the "you" that creates the "I," in a "we" position one is able to identify parts of the self in the other in a shared community with known and agreed upon parameters. For example, in the first session, both members of this community of two know and agree upon who is the "patient" and who is the "doctor" within the agreed upon frame of treatment.

Identification, however, may not always be a good thing. Moss (2001) argues that a "we" can also be a mechanism for repression when he states that sometimes, in order to be a part of a

"we," "we" have to dissociate "not me" parts of the self and project them onto others. As an example, he cites homophobia coming from people who have unresolved homosexual desires or misogynistic prejudices projecting that "not me" (gay, feminine) part of the self onto others, where the first person singular "I want" becomes the first person plural "we hate" (pg.1315). While this patient's symptoms are not related to homophobia, they are related to the patient's genetic experience of "we," where being part of her abusive family has meant identifying with the aggressor-her parents-against herself. While I agree with his thesis, I believe what is missing in some ways is that this mechanism also works like introjection and projection, in Bionian terms, on the part of the patient as the patient's unconscious recreation of events from the past become understood and resolved in the analysis, where the patient is able to identify with the analyst outside the subjective reality created from maladaptive transference relationships. For Moss, like Kacewicz et al. (2014), a "we" position is a way to establish a place in a social hierarchy.

> …when we hate-racistly, homophobically, misogynistically, we are hating not as isolated individuals but as part of a group; not in the first person singular but in the first person plural. Within the sphere of these hatreds, "I" hate not as "I" alone, but as a white person, straight person, a man. Our hatred is directed, as it were, taxonomically downward. Disidentification downward, identification upward; this dynamic may seem to offer the only purchase against taxonomical descent." (pg. 1317)

For the patient, a "we" position has traditionally meant identifying with her parents-often this meant identifying with her parents against herself, "taxonomically downwards" in "fixed, transference-based taxonomical hierarchies" (pg. 1317). In a "we" position, one is able to take part in a relationship where the other person is "like me" in that there is something common in the relationship that both parties of the "we" identify with, an "objective" reality that is communally constructed and agreed upon rather than the "subjective" insistence of reality in a

transference position. In a transference interpretation, "we" agree "objectively" that the patient's subjective reaction to the analyst is just that-subjective and coming from the patient. To use Moss's (2001) language, the patient identifies with the analyst in a "we" "upwards" and dis-identifies with the self that is enacting the transference. For Moss, analysis is inherently egalitarian and allows for another type of relationship to self and other to develop with the analyst and with oneself outside the hierarchy in which transference taxonomically locates the patient. Analysis, according to Moss, "is grounded in identifications," and the work of analysis is "the owning, usually against resistance, of the 'not me' aspects of our mental lives (pg.1317)." For Moss, this is resolved when we are able to recognize within ourselves both the hater and the hated, and how mentally we have constructed our perceptions to keep these parts of the self separate.

The key word here is "constructed" reality, as the "we" is a constructed self-state made up of identifications and dis-identifications. Waldron et al. (2004) wrote of the relationship in the analysis used in my study that:

> "Despite her improvement, her analyst thought she would have benefited from further work. Our raters concurred. Generally, they thought that the analyst-patient interaction was negatively influenced by this male analyst's imposing presence, towards which the patient seemed unusually compliant. They also thought that the analyst emphasized transference analysis in ways that were often not meaningful or useful to the patient (pg. 454)."

Given the analyst's copious use of transference interpretations in the analysis of this patient, a "high risk" intervention normally according to Hogeland et al. (2006) as it carries the risk of alienating the patient, it is possible the analyst over did it or was insensitive to when the patient could not tolerate it. An inaccurate transference interpretation can become a "misrecognition" in the Lacanian (1954) sense. That is, it runs the risk of labelling of affect inaccurately and even when not inaccurate, the timing may be important. As Waldron et al.

(2004) found, it was not the intervention as much as the timing of the intervention coming from the analyst's attunement to the patient that resulted in positive therapeutic change. It appears in the course of this analysis, that the mutually agreed upon reality of the "we" began to fray at some point as the patient, through her use of "I" in the latter sessions, begins to signal her withdrawal from the relationship. While this negation of the patient's subjectivity is in some ways necessary to analysis, it must be an accurate negation (this is your reality, the analyst is saying, not our shared "objective" reality). In other words, the patient had enough of her subjective reality being negated, and began to disidentify with the "we" that they had created. Some evidence of this is seen towards the end of the analysis in session 317 when she says "*I'm not going to be taking my parents in some ways, I'm not going to be taking you in that directions either."* In this, she is saying look, I understand genetic transference and it is somewhat resolved. But she is also saying I understand reality in the here and now, and if I don't have to take my parents anymore, I don't have to take you either. In other words, she may have more accurately been able to see what was her subjective reality, and what the analyst was subjectively doing and she decided to leave the relationship.

Another key word of Moss's (2001) in regards to analysis is "egalitarian," as in the "overbearing" nature of the analyst, and in terms of the analytic third of ideology and culture, there is something to be said for the gender relationships that are enacted in the room of this 1970's analysis. As the patient decides to leave the analysis in session 324, near July 4th, 1976, an act the analyst interprets as a "declaration of independence," the patient leaves the analysis. She reports that she "fears" her judgment might be different from his about ending the relationship, and that he might come on "strongly" about it. By leaving, however, she asserts that she trusts her judgment enough and that she is "independent" of either the need or the fear of the

analyst's judgment, just as she has freed herself, though the analysis, from the fear or need for her parent's judgment. Interestingly, the High I of this session and the previous High I session of session 321 are strongly linked with the future tense, lending this "I" a different quality than the High I of the present tense which dominated the High I sessions from the first half of the analysis. Having gone through the treatment, and having her "I" or ego be reconstituted somewhat during the course of the analysis, we may suppose that the "I" had a chance to therapeutically reformulate itself into a more agentive actor.

This movement of the patient to leave the analysis allows some comments on transference interpretations proper. If the analyst is wrong in the interpretation, or they are not attuned to timing their interventions, the analyst may risk recreating the very misrecognition that caused the problem in the first place. In this analysis, the patient may have found the "object waiting to be found," in the Winnicottian (1969) sense, and in finding the analyst past her transference distortions, did not like who was there. She may have seen what Waldron et al. (2004) saw-that the analyst was overbearing, and that it was not just her transferential/subjective experience of him. The patient may well have benefitted from the interpretation of her subjective analytic transferences. However, the whole analysis may have been an enactment of the pre-women's liberation/pre-sexual revolution gender roles of men and women in this particular time and place, one that may seem obvious to a contemporary reader, and one that was probably operating in many different relationships of the female patient. By leaving the analysis, the patient may have been leaving an interpolation or construction on the part of the analyst based on gender relations; less an unanalyzed countertransference than an ideological "third" (Altman, 1995) of more contemporary theory.

Finally, my findings provide some evidence for how thinking is constructed. Thought, in the object relations understanding I am arguing for, is always a "scene of address (Butler, 2005)," where even in "thinking to oneself," the thought is directed from a speaker to a listener, even if both the speaker and listener are part of a single self. Unlike the I/you position, wrapped up as it is in transference control, and dichotomous separation (I am I because you are you) that the "we" position includes parts of the speaker that are both internal (first person) and external (plural), and includes parts of the addressee that are both internal and external (the part of the self that one identifies with in the other to form a "we"). Those non-present must necessarily be symbolized, as they are not physically in the room, so to speak. The external/internal features of the "we" is similar to the "transitional space" as defined Winnicott (1953), where the internal world and external world mingle in a community of "we." In this stance, one can "play" with the boundaries between self and other without an insistence on the "other" performing a predefined role.

In this way, when the patient joins the analyst in a "we," the patient has an opportunity to take a look at herself from a removed, objective positon, from the position of self in the other, a common self that is mutually created and shared. The "we" then may be a much less resistant therapeutic stance when the "we" includes the analyst. The patient is able to move into the external part of the "we" to look at the internal part of the "we." This may lead to changes in the "I," as one moves from a subjective judgment to a more objective judgment.

For Butler (2005), it is impossible for the "I" to narrate itself fully, as in the I's narration, and in it's recreation of the scene of address, the "I" cannot know that it is recreating the "original scene of the address" because it is inherent to the I/ you dynamic. For Freud (1925), there will be resistance to acknowledging that the patient's reality is subjective rather than

objective reality, with the ego, the "Ich," the "I," as seat of judgment. In both cases, the difficulty of the "I" rather than the "we" to observe the self is made apparent, as it would be like asking a telescope to look at itself. It is only in the relationship where the "you" projection can be brought to the attention of the patient that it can be disrupted/interpreted etc. in the enactment of the object relationship. In this arrangement, the other acts as a predetermined mirror, and continues as the "undiscovered" object of Winnicott (1953). For Butler, the "I" creates the "you," and necessitates that the analyst be able to observe the "you" with the patient, which is what we see in the High I sessions. Given the prevalence of I in the first half, and the we in the second half, it would appear that building that alliance and trust is a process, as is the playing out, mutual recognition, and then diminishment of the transference distortion.

In terms of flexibility in identification, it would appear that both the High I and Low I positions are important-as it is the ability to flexibly move from one position to another, from inside the group to outside the group when the group begins to threaten the cohesion of the self. For Freud (1925), the matter of the patient's ability to take a more "objective view" of oneself via the analyst's neutral stance is the seat of reality testing. The judgement of this reality lies with the patient and her ability to see the world through her supposedly more objective analyst. However, in a more relational point of view, it is more the ability of the analyst and patient to discuss and understand their roles in constructing the reality of their relationship, and something the analyst in this analysis does not reflect on. In this analysis, the analyst has been described by other writers (Waldron et al 2005) as "overbearing" and those same author's argue that this attribute of the analyst probably led to a premature termination of the patient's analysis.

Relationship to Transference Interpretations

Hogeland et al. (2006) remarks that the transference interpretation can be a risky intervention; this analysis supports that view. While it can be argued that the transference interpretations led to health improvements as measured by a move from I to we use, this gain is lost when the patient decides to end the analysis and separates back into an "I" in the final sessions. The transference interpretation itself, or rather, at least this analyst's repeated use, could be seen as an impingement, or misrecognition. For Waldron et al. (2004), they found that the type of intervention used (clarification, confrontation, interpretation, transference interpretation) wasn't as important as when the intervention was made. As per their raters, the more attuned the analyst was to the patient, the better the quality of the intervention, with no significant differences for the type of intervention.

Interestingly, if this is the case, the analyst's following of Gill (1979) in continuing to interpret transference so often, so repeatedly, and so far into the analysis that leads to trouble rather than stating how important he is to the patient; as a real, subjective person, as a "new object," in the Loewald (1969) sense, or as someone the patient has "discovered" in the Winnicottian (1968) sense. The analyst's continued insistence on interpreting as subjective what might have at that point been objective (Waldron et al., 2005) is what might have led her to end the analysis prematurely, as it marks such a mis-attunement to what the patient may have felt. In terms of implications for technique, the patient's move to more consistent "we" usage could have been a signal to the analyst to change his style of intervention with her to a more relational, two subjectivities in the room style, rather than a "blank-slate" approach. As Waldron et al. (2004) suggest, it may be about timing and attunement that marks a quality intervention rather than the type of intervention. Given this, a High I session may mark the right time for exploring the

transference and making a transference intervention. A high "we" session may mark a time to make a different type of intervention, and might be interpreted by the analyst as a time to pull back and to give "unsaturated" interpretations.

Limits of the study

There are a number of limitations to this study. As with all case studies, there is a problem with generalizability. As this is one analyst working with one patient, it is difficult to know if these findings could be found in another treatment under similar conditions. While there are many technical reasons for this, two reasons are most relevant for my study. One problem is the relative weakness of some of the findings-I can speak of trends but have no way of defining the statistical significance of these findings or if they are that different really. Another is found in the limits of the data available, as there was there was no true middle section to the data included in my analysis. Out of a total of three hundred and twenty four sessions, over one hundred were not included. Unfortunately, there is no way to know what happened in those sessions or to know if that is where the change from "I" to "we" occurred, and it does not help to explain the hypothesized therapeutic action that lead to this change. A further issue in terms of generalizability is that the analysis take place in English. It is unclear if the findings in terms of pronouns would hold up in another language.

Another issue is that in my initial findings from middle phase I constructed (though not very different and impossible to determine the significance level) shows the opposite of my hypotheses, where the final phase is the most alike, followed by the beginning phase, followed by the middle phase. It can be surmised that the problems with the distribution of the data, with the enormous gap in between the middle two eight session segments that made up the middle

phase, explain the lack of similarity in these sessions. However, the findings that the final stage were more similar than the beginning leads to some interesting questions, suggesting that the final segment shows more cohesion than the beginning. Another possibility is simply that the analysis itself was a failure.

Another limit is the lack of external measures of any sort including symptom change, level of object relations, or interpersonal relatedness measures. There is no measure of patient change and the only evidence of change comes from the sessions themselves in her change in pronoun usage. As there are no valid external measures used, it is also difficult to tell whether the patient's mental health improved or not during the course of the analysis. However, as there are no external measures, it leaves open the door that some unknown factor-such as the passage of time-influenced and improved the patient's mental health rather than the interpretation and resolution of the transference. Furthermore, there are some significant limits in the limited sampling of the 48 sessions used in this analysis. The true therapeutic transformations may have occurred in other sessions that were not studied, and the tendencies observed may not have been observed if the entirety of the 324 sessions were used.

A further confounder is that the frame of the treatment changes, something observed in the text of the data itself. Session 271 is the first mention of the switch to a twice a week treatment, and it is not until session 324 that the analyst makes a reference to the patient sitting rather than laying down. It is unclear when these changes in the frame occur. This may confound ideas about the changes in "I" seen in the graph, as less time and not laying down may theoretically influence the transference relationship and may account for some of the changes seen in the graph rather than reflecting an intrapsychic or interpersonal change in the patient.

Maybe the patient improved because she was in less analysis, rather than any action on the part of the analysis itself.

Future directions for research

While a randomized study seems difficult, a movement towards quantitative confirmation of these findings would be beneficial. A possibility for further research would be to perform a double blind study of other therapeutic transcripts. It would seem that those transcripts that showed no improvement would likely conform to the "Low I" type use of language. It would seem likely that those using "we" or I at a lower rate would mean that the patient is more able to enter treatment, while those that use I at a higher rate might be more resistant. Randomized control trial of therapeutic transcripts to see if using this language can predict therapeutic success or failure. Further, it might be interesting, given the findings with pronouns of the patient, to examine the pronouns of the analyst in helping to identify interventions and potential "attunement."

Another direction for possible research may involve an examination of multiple psychotherapies looking at the language associated with Low I and High I sessions. The language associated with a genetic transferential self-state in the way that Scala and Levy (2012) define it, may look like this: High I, high you, high mostly negative affect, low we, low he/she/they, and high negation. The language of identification may be low I, high we, high he she they. For future research, if this is the case, then hypothetically language associated with High I use would be correlated with other words in High I sessions, while words in Low I sessions would be negatively correlated to language associated with High I sessions and positively correlated with other language in Low I sessions.

Finally, another area of further study would be to explore how the analyst's use of pronouns influences the patient's use of pronouns. In looking at the analyst's pronoun use, for example, in some of the interpretations he makes, he seems to use the form "you are doing this." It would be interesting to see if there is a relationship between his use of pronouns and the patient's use of pronouns.

Conclusion

I've found something that contributes to the study of transference and to the study of the process of therapy. Pronouns matter in the course of a psychoanalysis, as they do in Campbell and Pennebaker's (2001) research. This use is unconscious, but may give us clues in further research about what type of intervention to make when. It would seem, in the study of this particular analysis, that there is a time and place for transference interpretations.

Appendix

Table 6.

Correlations Beginning Phase For LIWC Function Words Category

			Segment 1 func11	Segment 1.2 func12	func21	func22
Spearman's rho	func11	Correlation Coefficient	1.000	-.182	.036	-.173
		Sig. (2-tailed)	.	.210	.805	.234
		N	49	49	49	49
	func12	Correlation Coefficient	-.182	1.000	-.445**	.038
		Sig. (2-tailed)	.210	.	.001	.794
		N	49	49	49	49
	func21	Correlation Coefficient	.036	-.445**	1.000	.039
		Sig. (2-tailed)	.805	.001	.	.790
		N	49	49	49	49
	func22	Correlation Coefficient	-.173	.038	.039	1.000
		Sig. (2-tailed)	.234	.794	.790	.
		N	49	49	49	49

**. Correlation is significant at the 0.01 level (2-tailed).

Mean score for beginning phase: -.182+.036+-.173+-.445+.038+.039=-.687/6=-0.1145

Table 7.

Correlations Middle Phase LIWC Function Words Category

			func31	func32	func41	func42
Spearman's rho	func31	Correlation Coefficient	1.000	.041	-.267	-.188
		Sig. (2-tailed)	.	.795	.083	.228
		N	43	43	43	43
	func32	Correlation Coefficient	.041	1.000	-.131	.130
		Sig. (2-tailed)	.795	.	.402	.405
		N	43	43	43	43
	func41	Correlation Coefficient	-.267	-.131	1.000	-.076
		Sig. (2-tailed)	.083	.402	.	.630
		N	43	43	43	43
	func42	Correlation Coefficient	-.188	.130	-.076	1.000
		Sig. (2-tailed)	.228	.405	.630	.
		N	43	43	43	43

Mean score for Middle phase: 0.041+-.267+-.188+-.131+.130+-.076=-.491/6=-0.0818

Table 8.

Correlations End Phase LIWC Function Words Category

			func51	func52	func61	func62
Spearman's rho	func51	Correlation Coefficient	1.000	-.206	-.083	-.165
		Sig. (2-tailed)	.	.208	.617	.323
		N	39	39	39	38
	func52	Correlation Coefficient	-.206	1.000	.271	.028
		Sig. (2-tailed)	.208	.	.095	.866
		N	39	39	39	38
	func61	Correlation Coefficient	-.083	.271	1.000	-.074
		Sig. (2-tailed)	.617	.095	.	.659
		N	39	39	39	38
	func62	Correlation Coefficient	-.165	.028	-.074	1.000
		Sig. (2-tailed)	.323	.866	.659	.
		N	38	38	38	38

Mean score for end phase: -.206+-.083+-.165+.271+.028+-.074=-.229/6=-0.0382

Table 9.

Correlations Beginning Phase for LIWC "I" Category

			i11	i12	i21	i22
Spearman's rho	i11	Correlation Coefficient	1.000	.077	.090	.203
		Sig. (2-tailed)	.	.597	.540	.161
		N	49	49	49	49
	i12	Correlation Coefficient	.077	1.000	.131	-.035
		Sig. (2-tailed)	.597	.	.368	.810
		N	49	49	49	49
	i21	Correlation Coefficient	.090	.131	1.000	.319*
		Sig. (2-tailed)	.540	.368	.	.025
		N	49	49	49	49
	i22	Correlation Coefficient	.203	-.035	.319*	1.000
		Sig. (2-tailed)	.161	.810	.025	.
		N	49	49	49	49

*. Correlation is significant at the 0.05 level (2-tailed).

Mean score for beginning phase: 0.077+.090+.203+.131+-.035+.319=.785/6=0.1308

Table 10.

Correlations Middle Phase for LIWC "I" Category

			i31	i32	i41	i42
Spearman's rho	i31	Correlation Coefficient	1.000	-.038	-.332*	.042
		Sig. (2-tailed)	.	.808	.029	.788
		N	43	43	43	43
	i32	Correlation Coefficient	-.038	1.000	.142	-.025
		Sig. (2-tailed)	.808	.	.363	.871
		N	43	43	43	43
	i41	Correlation Coefficient	-.332*	.142	1.000	.128
		Sig. (2-tailed)	.029	.363	.	.412
		N	43	43	43	43
	i42	Correlation Coefficient	.042	-.025	.128	1.000
		Sig. (2-tailed)	.788	.871	.412	.
		N	43	43	43	43

*. Correlation is significant at the 0.05 level (2-tailed).

Mean score for middle phase: -.038+-.332+.042+.142+-.025+.128=-.083/6=-0.0138

Table 11.

Correlations End Phase for LIWC "I" Category

			i51	i52	i61	i62
Spearman's rho	i51	Correlation Coefficient	1.000	.074	.243	.043
		Sig. (2-tailed)	.	.656	.137	.797
		N	39	39	39	38
	i52	Correlation Coefficient	.074	1.000	.103	.250
		Sig. (2-tailed)	.656	.	.533	.129
		N	39	39	39	38
	i61	Correlation Coefficient	.243	.103	1.000	.327*
		Sig. (2-tailed)	.137	.533	.	.045
		N	39	39	39	38
	i62	Correlation Coefficient	.043	.250	.327*	1.000
		Sig. (2-tailed)	.797	.129	.045	.
		N	38	38	38	38

*. Correlation is significant at the 0.05 level (2-tailed).

Mean score for end phase: 0.074+.243+.043+.103+.250+.327=1.04/6=0.1733

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