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TRANSFERENCE AND INFORMATION PROCESSING

Drew Westen

Departments of Psychology and Psychiatry
University of Michigan

ABSTRACT. *The importance of transference has been emphasized by psychodynamically oriented clinicians since Freud. This article examines transference phenomena from an information processing perspective, delineates several different aspects of transference experience, and shows how experimental research documents processes involved in transference. It distinguishes between transference as person schemas/object representations, attachment, schema-triggered affect, interpersonal expectancies, scripts, and defenses, and argues for the importance of making such distinctions. It attempts, further, to demonstrate the clinical utility of examining and working with transference phenomena in the alteration of dysfunctional schemas and maladaptive mechanisms of affect-regulation.*

> The play's the thing wherein I'll catch the conscience of the king. — Hamlet
>
> For when all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*. — Freud (1912, p. 108)

I was recently referred for projective testing of a woman who was hospitalized for depression and possible borderline personality disorder. The first session proceeded rather uneventfully; she had a jaded, cynical style about her and tended to give up on tasks when she had the slightest reason to believe that she might not complete them successfully. When I returned for the second session, it was clear that she would not give me any more information unless I backed away from the more rigid testing format and simply talked with her for a while. After doing so for a half an hour, we returned to the testing, at which point she proceeded to keep me for two hours in order to complete a test that normally takes about 30 minutes. At the end of the session, having manipulated me into staying (in various only dimly masked ways), she denounced me as a liar for having kept her beyond the hour-and-a-half that I had, the previous day, forecast for the second session.

Requests for should be addressed to Departments of Psychology and Psychiatry, University of Michigan, 580 Union Drive, Ann Arbor, MI 48109.
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The process I had just experienced with this patient was far more useful diagnostically than an MMPI profile, a Hamilton depression score, or a set of TAT responses. I came out of the session feeling as if I had victimized her, while in reality I had merely administered a standard battery of psychological tests. The theme of victimization permeated both the content and process of the testing, as she presented herself as a person who pushes people away with derision and cynicism in order to protect herself from the abuse she expects to receive. The extent to which she does this in all relationships obviously cannot be assessed in her interaction with a single tester in a single situation, but the fact that she turned a situation that most patients find somewhat anxiety-provoking—but basically benign—into a battle to protect herself from abuse clearly suggests something regarding the nature of her assumptions about the social world. The relatively brief relationship between this woman and myself thus proved to be a useful tool for the assessment of her object relations or "interpersonal schemata."

Repeated encounters such as this led Freud to focus, as early as 1895, on the relationship between therapist and patient, and to the notion of transference. Freud noticed that the attitude of the patient toward the therapist continually kept interfering with the business at hand of uncovering memories and associations. Eventually, he came to conclude that this peculiarity of the analytic situation is not in fact a hindrance but instead represents a fundamental part of the therapeutic process.

The aim of this paper is to reanalyze the concept of transference from an information processing perspective and to show, from that perspective, how utilization of the interpersonal process between patient and therapist can be therapeutically useful. The purpose of applying information processing theory and research to the concept of transference is twofold. First, it provides an empirical grounding to a basic psychoanalytic concept, and demonstrates, using experimental research that is likely to be more convincing to empirically oriented clinicians and researchers, that transference phenomena not only occur but are therapeutically useful. In so doing, it puts transference notions into a language compatible with the understanding of a vast number of therapists (and cognitive psychologists) who do not otherwise find the psychoanalytic notion of transference compelling, and thus allows a greater number of practitioners to make use of a crucial therapeutic tool. Secondly, it offers a way of explaining transference that many psychodynamic clinicians may find useful, which retains the psychoanalytic understanding of unconscious motivational processes and intrapsychic transformations without invoking a problematic tension-release, drive-discharge model of motivation that leaves many forms of adaptive behavior unexplained. In so doing, it tries to show how one can develop a more fine-grained understanding of transference by analyzing the specific information-processing mechanisms involved.

The article will begin by summarizing very briefly the psychoanalytic theory of transference. It will then apply recent research on information processing and social cognition to the concept of transference and delineate six components of the transference process. Finally, it will attempt to integrate cognitive and psychodynamic concepts to demonstrate the importance of transference in psychotherapy as a mechanism for the assessment and alteration of dysfunctional scripts, expectancies, and wishes; the uncovering of state-dependent memories and schema-triggered affects; and the reworking of maladaptive modes of affect-regulation. It

will argue that to work therapeutically without utilizing transference phenomena is to discard a useful source of data and an important tool for therapeutic change.

TRANSFERENCE IN PSYCHOANALYTIC PSYCHOLOGY

While Freud first introduced the concept of transference in his *Studies on Hysteria* (1895) and discussed it again in the Dora case (1905), his first systematic treatment of the subject appeared in a 1912 essay in which he argues that people carry with them certain "stereotype plates" that determine their later erotic interests. He asserts that part of those templates is conscious and not immune to change, whereas another part, which forms the basis for transference, remains inaccessible to consciousness and impervious to development. In that essay he introduces the notion of transference as a resistance, arguing that patients use transference feelings to distract them from conflictual issues. He ascribes in that essay an enormous role to transference in psychotherapy, arguing that the resolution of transference is synonymous with the resolution of neurosis (p. 101).

In a later paper (1915) he grapples with the relationship between transference-love and normal love and argues that transference-love is never related to aspects of the present situation and instead is "entirely composed of repetitions and copies of earlier reactions . . . " (p. 167). In that essay he reiterates the therapeutic importance of working with transference, asserting that "the only really serious difficulties" the analyst must face "lie in the management of the transference" (p. 159).

In his *Introductory Lectures on Psychoanalysis*, Freud (1917) provides the first comprehensive definition of transference:

> We mean a transference of feelings on to the person of the doctor since we do not believe that the situation in the treatment could justify the development of such feelings. We suspect, on the contrary, that the whole readiness for these feelings is derived from elsewhere, that they were already prepared in the patient and, upon the opportunity offered by the analytic treatment, are transferred on to the person of the doctor. (p. 442)

The patient's relationship to the therapist, he contends, stirs "new editions of the old conflicts," and the function of examining the transference is to help the patient re-evaluate these conflicts as an adult and revise previous repressions (p. 454). He returns to the same theme 20 years later in his last important discussion of transference (1937), arguing that analysis of transference is central to the mechanism of therapeutic change, which entails the "replacement (owing to the strengthening of the ego) of the inadequate decision made in infancy by a correct solution" (p. 321). He is arguing, in essence, that what seems frightening to a child and sets in motion various more or less automatic defenses to reduce the fear may not be frightening to an adult. Thus, by examining the conflict and the defense consciously as an adult, the person may find that the fear which elicited the defense is unrealistic, and that he therefore need not distort himself to protect against it.

Currently, psychodynamic clinicians tend to use the term "transference" in one of two ways. They either use it narrowly to refer strictly to the transferring of thoughts, feelings, and fantasies about some childhood figure onto the therapist; or broadly, to refer to any aspect of the interpersonal process between patient and

therapist. This latter is the sense in which the term "counter-transference" is often used to refer to any emotional reaction the patient evokes in the therapist. (For more recent thought on transference, see Gill, 1982.)

INFORMATION PROCESSING AND THE COMPONENTS OF TRANSFERENCE

The psychoanalytic theory of transference leaves several important questions unresolved. The first pertains to the generality of a patient's reaction to the therapist. The notion of transference as it has been used often does not distinguish between relatively circumscribed responses cued by specific features of the therapist or therapeutic situation, as opposed to more global responses that may be triggered in many or most interpersonal interactions or are uniquely reactivated in the therapy situation. As Wachtel (1981) has pointed out, clinicians tend not to look at the particular stimuli that elicit transference phenomena at a given point in a given therapy.

A second issue relates to the distinction between transference and any other bond of affection. Freud (1915) argued that transference involves the reactivation of archaic imagoes and is thus, unlike real love, unrelated to the present reality. The problem with this is that, as Freud pointed out, every object finding is in some sense a refinding; to distinguish between reality elements and infantile elements is thus difficult in both theory and practice because any adult attachment is the end-product of a history of prior attachments.

Finally, the suggestion that therapeutic work is completed with the resolution of the transference is problematic, as Freud (1937) himself came to acknowledge. Freud's contention that all neurotic conflict becomes transferred onto the person of the analyst rests less upon clinical practice and observation than upon a theory of psychic energy that many in the psychoanalytic community now reject (e.g., Holt, 1976). Freud argued that the libido attached to the neurotic symptoms detaches itself from the symptoms and reattaches itself to the analyst in the course of the treatment. Without this assumption, one has little reason to believe that all of the patient's conflicts come to revolve around the analyst so that resolving the transference would mean resolving the neurosis.

Many of these problems stem from the use of the term transference to refer to many different phenomena, including thoughts about the therapist, feelings about the therapist, expectations of the therapist, expectations of people in general, thoughts and feelings about the therapist that are *analogous* to early thoughts and feelings, thoughts and feelings about the therapist that are *homologous* or identical to early such thoughts and feelings, behavior patterns toward the therapist, resistance, erotic interest, etc. These difficulties can be ameliorated by applying ideas from cognitive psychology to the concept of transference[1] and separating out several distinct phenomena that are related to one another but not isomorphic.

Before doing so it is important to note the parameters within which information-processing concepts can be expected to be useful. The notion that people

[1]Since this article was written, Singer (1985) has published an excellent paper in which he relates concepts of schema, script, and expectancy to the psychoanalytic notion of transference.

form representations of social and nonsocial objects and ideas is central to both cognitive psychology and psychoanalysis, as is the concept of associational networks that link various representations. To the extent that information-processing psychologists have developed methods for the rigorous study of these phenomena, their research can certainly be expected to enrich clinical understanding.[2] Similarly, recent research on social cognition and on cognitive-affective interactions undertaken from an information-processing perspective should be of enormous interest to psychoanalytically oriented clinical psychologists. Studies of social-cognitive development (Shantz, 1983), for example, are clearly of relevance to object-relations theory (see Westen, 1985).

The limitation of information-processing psychology for clinical and psychoanalytic theory and practice stems from the limits imposed by a computer metaphor: computers do not feel or wish. Cognitive psychology has yet to grapple with questions of motivation, though the recent turn to the study of cognitive-affective interactions holds the promise of future integrations of our knowledge of cognition and psychodynamics. This article represents an effort in that direction.

Transference as Person Schema/Object Representation

The concept of "schema" has a long history, dating back to Piaget (1926) and Bartlett (1932), and it is currently being put to widespread use by social cognition researchers (e.g., Taylor & Crocker, 1981). Within academic psychology, Cantor and Mischel (1979) have argued that people tend to form prototypes for categorization of classes of people, and that the more the characteristics of a given person fit prototypical features, the more likely the stimulus person is to be treated as a member of that class. Within psychoanalysis, object-relations theorists have similarly focused for decades on mental representations of social objects.

Piaget emphasized that forming an understanding in a given domain is an active process, and this is true in social cognition as in any other area of schema-building. A patient is always going to form a schema/object-representation of what the therapist is like, and this schema is likely to be distorted for both cognitive and motivational reasons, just as any social schema (or self-schema) is distorted. In terms of cognitive biases, Nisbett and Ross (1980) have catalogued a host of such sources of error in person perception, and it is the fate of creatures who must construct their understanding of reality that their constructions will always be imperfect. From the motivational side, patients have any number of reasons to distort their perceptions of their therapists, some of which will be detailed below. For example, they may idealize the therapist in order to identify with him or her, or they may vilify her in order to avoid hearing something painful she or he has to say. Though one may be tempted to restrict the use of the word transference to schemas distorted by motivational factors, as Wachtel (1981) argues, separating reality from distortion in defining transference is no easy task, since in any relationship neither party has a monopoly on objectivity, and ambiguity calling for inference is the rule, not the exception.

Various social schemas become transferentially relevant when they are evoked

[2]Landau and Goldfried (1981) have recently discussed the assessment of schemas in psychotherapy from a cognitive-behavioral standpoint.

because of similarity to the therapist or some situational cue. To the extent that the manner or appearance of the therapist resembles another person or exemplar of a category, schemas relevant to that person or category are likely to be activated. Freud (1912) had just such a scenario in mind when discussing how a father-image could be activated in the course of therapy. Over an extended period of time the therapist is likely to see the activation of many such schemas and to become aware of patterns in their elicitation. Once the schema is activated, the person is likely to ignore details of the therapist's behavior that do not fit the schema, as numerous studies have demonstrated the tenacity of schemas and the tendency to assimilate and selectively attend rather than to accommodate (see, e.g., Markus, 1977, on the tendency to recall confirming evidence).

Not only may characteristics of the therapist evoke prior person schemas, but aspects of the therapeutic situation itself may do so. Cantor, Mischel, and Schwartz (1982) have proposed that people construct situation prototypes, and to the extent that features of the therapy situation meet prototypical features, the person is likely to assimilate the current situation to old schemas. Patients frequently discuss feeling judged by therapists who maintain a nonjudgmental stance; telling one's inner thoughts and confessing wishes and deeds to someone in a position of authority and with whom one has an asymmetrical relationship evokes various parental and other authority prototypes. One patient, when discussing his feelings toward therapy or toward me, would frequently shift into talking about his relationships with his students. Putting aside for a moment whatever dynamic significance that may have had, at a strictly cognitive level he appears to have assimilated therapy to his "school schema." He informed me during one session that he felt very uncomfortable in therapy because he wanted me to correct his character like one would criticize a paper, by marking "good" by certain parts and red-penciling others that could use some improvement. If only I would do that, he thought, he could quickly revise those characterological sentence splices. He commented that he finds the lack of explicit expectations on my part unnerving, adding that his students know precisely what they must do to receive a good grade. In this case an elaborate schema has been evoked, and one has reason to suspect that earlier aspects of the schema in which he was pupil rather than teacher were operative as well.

Transference as Attachment

A second aspect of transference is the patient's attachment to the therapist. One could account for this attachment in a number of ways. First, as Bowlby (1969, 1973) and others (e.g., Sroufe & Waters, 1979) have argued, human beings appear to have an innately based tendency to form attachments, and that a person would do so in a relationship which fits a number of person- and situation-prototypes of early attachments is not surprising. Freud meant by his comment that every object finding is really an object re-finding that we learn to love in the context of our early relationships with our caretakers, and that the understanding we form of love is forever conditioned by these experiences. From a cognitive perspective, one can readily see how one schema builds upon the next developmentally, and how early images of relationships may be integrated into later schemas. This is by no means to deny that significant accommodation occurs along the way; rather, it is to suggest that prototypes of love objects and modes of

attaching formed in infancy and childhood are likely to exert influence on subsequent object choices because old schemas never die: they fade away through disuse, are incorporated in various ways into subsequent schemas, or are repressed and periodically activated without conscious awareness.

As I have argued elsewhere (Westen, 1985), one need not accept the more mechanistic aspects of Freud's drive theory to believe in the impact of early object relations on later social experience. One could argue, instead, that human infants have a genetically wired tendency toward social behavior and attachment, and that this differentiates into various social needs (including friendship, love, intimacy, sexual intimacy, etc.), rather than that all such needs are manifestations of the sexual instinct. Any of these needs may be evoked in psychotherapy, so that one would expect to see, for example, erotic transferences as well as simple attachments to the therapist. As will be argued shortly, these various needs are likely to call upon similar information processing channels, so that in many cases they can be expected to arise in conjunction with one another.

Attachment to the therapist may arise through a second way. As Zajonc (1968) has shown, familiarity tends to lead to liking, and to the extent that the therapist becomes a familiar figure, he is likely to evoke positive feeling. Thirdly, symptom reduction, if attributed to therapy, will lead to attachment as the therapist becomes associated with relief, although the opposite side of this coin is that anxiety experienced in therapeutic work also becomes associated with the therapist (and frequently is responsible for premature terminations). Finally, telling intimate details of one's life to another person is likely to evoke schemas previously associated with attachment, such as parental schemas and "close friend" schemas.

Transference as Schema-Triggered Affect

Clinicians frequently speak of transference when a patient expresses positive or negative feelings toward the therapist. The patient may develop both continuous and momentary feelings toward the therapist just as he would toward anyone else. These feelings must obviously be understood in the context of the person's prior experience, as resulting from interactions between that experience and the current situation. Affects may be triggered directly by schemas activated through their perceived similarity to aspects of the therapist or therapy situation. Fiske (1982) has developed the notion of schema-triggered affect, by which she means that when features of a stimulus match characteristics of a cognitive prototype, the affect associated with the previous schema will be activated. In other words, classes of stimuli—and she studied social stimuli in particular—have affects attached, so that presentation of a member of that class will evoke the category-based affect. This is, of course, a phenomenon stereotype researchers (and victims of stereotypes) have known for decades. A member of a minority group may find that those around him begin with negative feelings toward him simply because they have attached an affect to a category, and he is an instance of that category.

Fiske performed a series of experiments which demonstrated that the greater the number of prototypic features that characterize the stimulus person, the more likely is schema-based affect to be triggered, and degree of affect varies by degree of association (i.e., number of shared attributes). According to Fiske, "When new

information can be fit into old affectively laden knowledge, then the person has available an immediate affective response" (p. 57).

In psychotherapy an affect may be triggered in precisely this way. The patient may not always be aware of the category that is being triggered; she may simply experience the affect and have no awareness of the schema to which she has assimilated something in the therapy situation. Assumptions about unconscious processes of this sort, essential to clinical understanding, have recently received considerable experimental support. Shevrin and Dickman (1980) and Nisbett and Wilson (1977) have impressively demonstrated the extent of cognitive processing of which a person is not aware, and the likelihood is high that recognition of categorical processing may be an experience to which the individual is not introspectively privy and can only reconstruct post facto. If such is the case, an important aspect of therapeutic work may be to explore associations to the affect that may give a clue to its category-triggered origins, in order to examine whether the affect attached to the category is really an appropriate one or one that may need to be reworked. Interestingly, Freud argued that the cathexis of the analyst "will have recourse to *prototypes*, will attach itself to one of the stereotype plates which are present in the subject; or, to put the position in another way, the cathexis will introduce the doctor into one of the psychical 'series' which the patient has already formed" (1912, p. 100, emphasis added). Emotions in psychotherapy that can be called transference-related may also arise through the cueing of episodic memories (Tulving, 1972) with affects attached. For example, a patient who began coming late to sessions appraised my relatively neutral suggestion that we try to understand the meaning of the lateness during one session as a sadistic expression of rage at her. She associated shortly afterward to a painful memory in which her father beat her for coming home late. In this example a strongly charged memory intervened in her appraisal of my response and produced an inappropriate affective reaction of fear. In this case, however, I had reason to believe that her lateness was a dynamically meaningful repetition of her early experience, so that the memory may have been operative prior to her lateness and involved in producing it.

Transference as Interpersonal Expectancies

People carry with them expectations about what the world holds in store, and these expectations apply not only to the natural world but to the social world as well. Rotter (1966) has emphasized the extent to which we form such expectancies about ourselves, such as internal or external locus of control. Hume argued that as scientists we must make the rationally unfounded assumption that nature will continue to operate much the same tomorrow as it did today, and as intuitive scientists (Ross, 1977) we must make a similar assumption if we wish to maintain some sort of order in our lives. Without such an assumption, a scientist could never generalize or predict, and a person could never plan or anticipate. At the interpersonal level, Erikson's (1963) notion of basic trust denotes a similar assumption of the continuity and sameness over time of ourselves and significant others. Without such an assumption, the world of people appears malevolent and capricious, and life is perpetual chaos.

The vignette with which this paper opened portrays rather starkly the phenomenological reality of a woman who lives in such a world, a reality common to

many with borderline personality disorders. One can readily see how her encounter with me revealed certain generalized expectancies about what people will do to her. One crucial distinction that is too seldom made in psychoanalytic discussions of transference is between relatively specific, and generalized expectancies. Cognitive psychology has for years relied upon hierarchical models of the storage of information within categories and sub-categories. One should therefore not be surprised to find interpersonal expectancies ordered in such a fashion, and one could hypothesize that to the extent that such expectancies are more generalized, they will be more recalcitrant to therapeutic change. Unfortunately, such expectancies can also be expected to have the most pervasive impact on interpersonal functioning.

Generalized expectancies of the behavioral responses of social actors form a large category, of which expectancies about men, women, authority figures, and the like form sub-classes with more specific expectancies. At the least general level are expectancies related to the behaviors of particular persons in particular situations. Whenever the patient displays an expectation about the therapist, the latter must—within the limitations of admittedly imperfect clinical inference processes (see Turk & Salovey, in press)—attempt to discover the highest-level category to which the expectation applies. The clinician should ideally do this through an hypothesis-testing process that entails looking for patterns and comparing specific reactions to the therapist with known reactions of the patient to other people and classes of people (see Strupp & Binder, 1984). While in theory the distinction between levels of expectancy has not been made in psychoanalytic writing on transference, in practice clinicians comment far less upon reactions to the therapist that appear idiosyncratic and situation-specific, as compared to those that emerge repeatedly in the patient's life.

Transference as Scripts

Another aspect of transference is the activation of scripts. Abelson (1981) and Schank and Abelson (1977) have elaborated the concept of scripts, by which they mean schemas embodying knowledge of stereotyped event sequences. Scripts permit comprehension of social events and organize action. They often include expectations of specific sequences of action, and studies such as Bower, Black, and Turner (1979) and Graesser, Woll, Kowalski, and Smith (1980) provide evidence that people tend to fill in gaps of knowledge about specific social interactions with stereotyped scripted knowledge.

Scripts are routinized and do not necessarily require conscious attention. One completes the steps required to dine at a restaurant, for example, without consciously planning each step (such as reading the menu). The routinized nature of scripts renders them likely to be evoked without conscious attention, and one suspects that, as in the case of other schemas, they will be activated to the extent that consciously or unconsciously cognized events or cues match certain features encoded in the script. This renders likely the elicitation of scripts in psychotherapy that have become routinized in relation to other situations. Numerous scripts may, for example, be activated when in the presence of an authority, and such scripts are likely to bear imprints of early authority relationships.

With scripts as with other schemas, the clinician must attempt to assess the generality or specificity of eliciting conditions. At the broadest level, an individual

may have a script for general social interaction and a series of hierarchically arranged subscripts ranging from interaction with women to interaction with mother when confessing a misdeed. Patients frequently recognize the activation of such scripts in therapy, as when a patient spontaneously offered that he was telling me all of his failures and avoiding discussing any triumphs just as he did with his mother, who would commiserate with the cruelty of the world but turn icy at any indication of pride. The activation of such scripts is obviously not independent of the evocation of related schemas such as generalized or specific interpersonal expectancies. This particular patient not only behaved toward me as he had toward his mother but expected me to respond as she did, and he was at first angry and surprised when I did not. The script notion can encompass such schemas since it includes knowledge of reciprocal role relations.

Transference as Wishes

In the above example, one should note that the patient may not only have been activating an interactional script but may also have been wishing for a particular type of interaction that he expected to find gratifying. The script notion cannot speak to motivational factors such as the patient's *desire* for me to be like his mother. One of the central aspects of transference described by psychoanalysts and psychodynamic psychotherapists is the activation of archaic wishes that are transferred onto the therapist. The question arises as to whether such phenomena can be usefully examined in relation to information-processing theory and research.

As yet, motivational constructs have not proven easily integrable into information processing theory. In a recent book (Westen, 1985) I have suggested that certain cognitive-affective structures may be useful in accounting for motivation and in integrating psychodynamic and cognitive-behavioral theories. One form of these is the *wish*. A wish includes a cognition of a desired state and an anticipated affect associated with attainment of that state. It also includes a cognition of the current status of one's attainment or non-attainment of that state, and an affect arising from the discrepancy between desired and cognized reality. A person can be motivated to act either by the anticipated positive affect associated with attainment of the wish, or by the negative affect arising from the discrepancy between ideal and cognized reality. For example, a patient who has developed an erotic transference has a wish to have sexual contact with her or his therapist. This means that she has formed an affect-laden schema of an end-state or goal and is motivated to reduce the discrepancy between the goal and cognized reality by an aversive affect (e.g., a sense of longing) or by an imagined positive affect (e.g., joy or sexual gratification) if she could achieve her desire. She may achieve this goal in displacement by acting out behaviorally, or she may perform a mental operation, such as fantasizing, to allay her distress or achieve satisfaction. In both cases her action (either behavioral or mental) is motivated by an affect produced by this schema. Every element of this cognitive-affective schema and the responses it evokes (including the affect-laden set-goal, the understanding of reality and expectations of resultant affect if the wish is fulfilled, the discrepancy, and the choice of response to the affect) has a history which is involved in producing the transference experience.

This view of wishes is not incompatible with psychoanalytic drive theory, as

recently reformulated by Brenner (1982). Brenner has argued that the concept of "drive" is actually an abstraction or generalization from the empirical observation of wishes. According to Brenner, wishes are the motivating force in mental life, and are primary data in analytic hours. Drives, in contrast, are theoretical constructs derived from these data. A central aspect of Freud's theory of transference is that transference involves the reactivation of old drives or drive derivatives transferred onto the analyst. From the perspective of Brenner's reformulation, this means that transference entails the displacement of archaic wishes onto the therapist.

Psychoanalytic theory is weak in its explanation of why particular wishes will become salient at particular times, or why certain people will become the object of a wish. Freudian psychosexual theory focuses on a biological timetable of unfolding instinctual aims and objects, but this strictly biological developmental view cannot explain why particular wishes of various sorts become associated with specific objects in adulthood. Empirical research is also lacking on conditions for the evocation of wishes, but one has reason to suppose that one way they may be activated is through typical information processing channels, similar to the activation of other schemas (see, e.g., Collins & Loftus, 1975; Anderson, 1983). A wish may be viewed as a "node" on a semantic network which can be activated when other associations along the network have been "primed." Wishes that are associatively connected to particular thoughts, feelings, or memories can thus be reawakened if these associated mental events are activated. Further, one may suppose that a wish, like any other schema, is more likely to be elicited to the extent that situational (or intrapsychic) circumstances fit certain prototypical characteristics. In psychotherapy, wishes from previous situations and relationships may thus be evoked, so that the patient desires things from the therapist that she or he desired from significant others. Since the therapy relationship may be one of a small number of relationships with elements that resemble early relationships, the possibility arises that the patient may experience archaic wishes with the therapist that may have been dormant for years.

As with other schemas, one must distinguish between category levels with respect to wishes. Wishes may be quite general (e.g., broad interpersonal wishes such as the desire to be liked) or specific (e.g., the wish for one's father to stay home on one's birthday as a child rather than to travel out of town, to prove his affection). Again, the clinician must attempt to discover the level of generality of wishes experienced toward the therapist and any pattern of their elicitation within and without the therapy situation.

Transference as Defense

Psychoanalytic psychologists argue that not only does transference entail the reenactment of archaic wishes, but that many of these wishes are repressed. One of the greatest stumbling blocks to integration of psychodynamic with information processing models is that cognitivists and psychodynamic psychologists disagree upon whether one needs to explain certain phenomena with motivational constructs (such as drives and defenses) or whether one can more parsimoniously explain the same phenomena in cognitive terms. Nisbett and Ross (1980), for example, detail a bevy of factors that bias that "intuitive scientist's" understanding of self and others, and they argue for strictly cognitive explanations. Elsewhere

(Westen, 1985) I have argued that one need not pose the question as information processing *versus* defense if one synthesizes an understanding of the elicitation and management of affect with information processing mechanisms. In so doing one can bring together certain aspects of psychodynamic and cognitive-behavioral theory. One can do this by examining what I have called a *cognitive-evaluative mismatch*, of which a wish (as described earlier) is a subtype. The basic notion is derived from systems theory and suggests that an individual establishes a "set-goal" or ideal state with respect to some stimulus or situation, and that a discrepancy or "mismatch" between set-goal and cognized reality produces an affect or feeling. The affect performs a feedback function, activating various control mechanisms designed to minimize the affect.

These control mechanisms may be either behavioral or mental. The function of both is to alleviate the dysphoric affect, and to the extent that a control mechanism is successful, it will be "negatively reinforced" through its association with reduction of a painful emotional state. The behavior or defense mechanism will be encoded as a successful solution and will thus be more likely to be activated upon presentation of a similar situation. If, for example, a child develops death wishes toward a parent and compares these wishes with internalized moral standards, the discrepancy between these standards and cognized reality produces a painful affect, guilt. In order to alleviate the guilt, he may utilize a behavior (acting especially nice to the parent) or a defense (denying his aggressive wishes) or some combination of behavior and defense. In each case he is reducing the cognitive-evaluative mismatch between ideal and cognized reality, either by making reparation or by distorting his self-understanding. The result is a diminution of the guilt and an association of the control mechanism with guilt reduction.

Repeated success with a particular mechanism may result in its automatic elicitation in similar circumstances. Again, in evaluating the use of such mechanisms a therapist must try to pin down the specificity or generality of their use and of the stimuli that elicit them. The notion of cognitive-evaluative mismatch is in many ways similar to Lazarus's (1981) discussion of the processes through which stress activates various coping mechanisms, and Plutchik's (1980) analysis, following Freud, of the utilization of defenses to modulate anxiety.[3]

Freud argued as early as 1912 that transference can be used as a defense or, as defenses are frequently considered in psychoanalysis and psychodynamic psychotherapy, a resistance. (For a comparative analysis of resistance in cognitive-behavioral and psychoanalytic treatment, see Wachtel, 1982.) This defensive function of transference must be distinguished from other aspects of the relationship between patient and therapist that are often labeled as transference (such as attachment or erotic interest) because it may operate independently of these other aspects. One defensive use of the transference occurs when a patient focuses upon current features of the relationship with the therapist in order to avoid bringing to awareness painful prototypes of the present situation. Characteristics of the relationship with the therapist may become salient because of their association with affect-laden material, while the thoughts or wishes originally associated with the

[3]See also Haan's (1977) work on coping and defending. I have here provided only an extremely simplified example; elsewhere (Westen, 1985) I have developed the model in considerable detail.

affect remain repressed. Similarly, the patient may defensively focus on the therapist or the therapeutic relationship to aid in repression of, or selective inattention to material not related to the therapist. Another defensive use of the transference occurs when the patient distorts his image of the therapist into someone inept or untrustworthy; in so doing he can prevent himself from processing comments or interpretations that are potentially painful or anxiety-provoking.

THERAPEUTIC USES OF TRANSFERENCE

One may thus distinguish seven phenomena that frequently fall under the rubric of transference: person schemas/object representations, attachments, schema-triggered affects, interpersonal expectancies, scripts, wishes, and defenses. If one wishes to speak coherently about transference, it is important to distinguish between these aspects, since the degree to which they, or their eliciting events covary is by no means clear.

I will now try to demonstrate the usefulness of working with transference as a therapeutic tool, using convergent data from the laboratory to corroborate the psychodynamic assertion, based on clinical experience, that the use of transference material is therapeutically critical.

The Assessment and Alteration of Scripts, Expectancies, and Wishes

One important use of transference is in the assessment and alteration of scripts, expectancies, and wishes. Transference phenomena allow the therapist to peer beyond the patient's self-reports by demonstrating in vivid detail the way the patient interacts with, and what the patient expects and desires from, significant others (see Strupp & Binder, 1984). This is not to imply that clinicians are always successful in assessing the generality of those schemas. Clinical inference is difficult enough when dealing with behaviors, let alone with schemas (especially schemas uncovered through interaction). In this respect, the analysis of transference is a microcosm of social scientific method: it is at once hermeneutic and positivist. On the one hand, interpretation of transference material is a hermeneutic art, akin to the interpretation of a text because the words and deeds of the patient are likely to function as metaphor. This can be explained by examining the interaction of cognitive and dynamic processes. Since certain thoughts and wishes are connected with painful affects, they are likely to be repressed and thus to remain inaccessible to consciousness. Yet cognitions associated with them may emerge into consciousness (because the repression does not obliterate the entire associational network), or be incorporated into easily assimilable aspects of the therapy situation, such as thoughts about the therapist or events being described in the treatment hour. The result is that the patient communicates in metaphor, and the interpretation of symbols is as difficult in therapeutic discourse as it is in literature. On the other hand, once the therapist begins to suspect the presence of a latent web of associations, he must act like a natural scientist as hypothesis tester, presenting and listening for situations likely to confirm or disconfirm the hypothesis. He may speak to the patient in related metaphor or directly interpret the material and gauge the patient's reactions. In his hypothesis-testing he is vulnerable to the same distortions as other "intuitive scientists" (Ross, 1977), whose schemas tend to be more robust in assimilating or ignoring discrepant

information than they should, but this is a limitation of all science, not just intuitive science or clinical practice.[4]

The relationship between therapist and patient is an invaluable source of information about the patient's interpersonal action schemas (scripts), assumptions about the social world (expectancies), and wishes. As noted earlier, a great deal of research has demonstrated that much of cognitive processing occurs outside of awareness, and decades of clinical work attests to the unconscious "processing" of motives and affects. Indeed, a wealth of experimental evidence has recently been adduced to document unconscious emotional processes as well (Westen, 1985). Many of these scripts, expectancies, and wishes become routinized and are activated automatically in relevant circumstances. Consequently, if recognized at all, they appear "natural" to the patient, who has been using them for years. The therapist may use such phenomena in the transference not only to learn about the patient's schemas but also to point them out to the patient and thus de-routinize them. By making these schemas explicit and conscious, the therapist can help the patient examine and change them if they appear to be erroneous or maladaptive.

The Uncovering of State-Dependent Memories and Schema-Triggered Affects

Much recent experimental research (Bower, 1981; Derry & Kuiper, 1981; Roth & Rehm, 1980; Clark & Teasdale, 1982) has demonstrated the significance of feeling states on memory retrieval. This research has shown that retrieval of affect-laden thoughts or memories is influenced by mood at the time of retrieval. Bower (1981) has applied this to both semantic and episodic memory (Tulving, 1972) and has demonstrated the effect of mood on recall of childhood memories. To the extent that the therapeutic situation evokes old schemas, it is likely to activate associated affects, which in turn trigger state-dependent memories. Freud (1917, p. 454) similarly argued that a central function of transference is that it awakens old conflicts. From a perspective that integrates cognitive and dynamic concepts, a conflict can be understood as the presence of wishes, cognitive-evaluative mismatches, or other cognitive-affective schemas, such that satisfaction of one such motive has a negative influence on another. Satisfaction of an aggressive wish, for example, may simultaneously conflict with an "ideal self" set-goal (or "superego prohibition"), producing a cognitive-evaluative mismatch and consequently a feeling of guilt. As psychoanalytic theory and practice suggests, the response to a conflict of this sort is likely to be a compromise formation.

The utility of triggering such memories, affects, and conflicts is that they may lie at the root of dysfunctional behavior and mental processes. One of the fundamental assumptions of psychoanalytic method (see Rapaport, 1944) is that every thought, wish, and fantasy has a history. In Piagetian terms, every schema is the end-product of a series of assimilations and accommodations. A crucial aspect of the schemas determinative of much of human behavior—and of psychopathology—is that they are affective as well as cognitive.

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[4]Kuhn (1970), in fact, rejected Popper's (1963) view of science as a hypothetico-deductive, hypothesis-testing enterprise precisely because he found, in scrutinizing the history of science, that disconfirming instances only topple a paradigm when they are overwhelming and when an alternative paradigm is in existence.

Developmentally, as the cognitive component of a schema changes, associated affects may also change, but in other cases they may not. Similarly, while a new schema may become more prominent in a network of associations and therefore more retrievable, old versions of the schema may continue to influence behavior despite their relative inaccessibility to consciousness. In both cases more primitive affects associated with a cognition may inhibit satisfaction or maintain a dysfunctional behavior. For example, as Freud's psychosexual theory has long made clear, affects attached to sex that are either culturally prescribed or based upon ontogenetically primitive conceptions of sexuality may impede sexual pleasure or behavior. Wishes developed in childhood toward significant others may similarly continue to be operative and may be revealed in the transference. A crucial feature of primitive wishes, conflicts, affective responses, and memories of this sort is that they may become repressed in childhood to avoid dysphoric affect. As a result, they may remain encapsulated in "pockets" of unworked-through cognitive-affective networks and may continue to direct thought and behavior. By bringing these cognitive-affective structures to consciousness, the patient can begin to reassess as an adult whether these structures are realistic and whether the way they were regulated in childhood should continue to operate.[5]

Freud (1937, p. 321) referred to this aspect of the therapeutic process as the replacement of an infantile decision by a more adaptive one. At times, the transference provides the only access to such material, by eliciting affects that recruit relevant memories and wishes. For example, a borderline patient whom I had been seeing for over a year started to withdraw without clear cause, refusing to talk and sitting glumly in her chair. We had previously discussed a similar pattern in her life of suddenly severing relations with people important to her, but the pattern was now emerging—with corresponding affect—in the transference. She was aware of her actions but angrily told me that she would not and could not explain them. I suggested to her that someone does not pull away from another person like that unless she is afraid of something, at which point she volunteered that she did not know what she feared, but that she was sure something terribly bad would happen if she did not run. The combination of her experiencing this feeling with me and eliciting thoughts and memories congruent with the affect allowed us to explore the fear behind her behavior, and repeated experiences of this sort allowed her both to reanalyze (cognitively) conditions under which fear has been inappropriately evoked, and to see that, in fact, her fears are not confirmed in interaction with me. This latter aspect of use of the transference is similar to *in vivo* exposure techniques in behavioral treatment. Wachtel (1977) has lucidly argued for the importance of exposure to anxiety-provoking thoughts, images, and stimuli in both psychoanalytic and behavioral therapies, proposing

[5]Analysis of schema-related affects is central to both psychodynamic and cognitive-behavioral understanding of behavior and psychopathology. For example, with respect to phobias, while the two approaches differ significantly in etiological theories, both presuppose (translating into information processing terms) that an affect has erroneously become attached to a cognitive representation, so that the person is afraid of an innocuous stimulus. Similarly, the person may have developed presently maladaptive self-efficacy and outcome expectancies (Bandura, 1977, 1982) at a time in which they may or may not have been appropriate, and bringing these to light can help the person alter his behavior.

that the gradual movement from screen memories and thoughts to more deeply repressed material is, in part, similar to systematic desensitization.

The Reworking of Behavioral and Intrapsychic Affect-Regulation Mechanisms

In the above example, one avenue for making inroads on the patient's very problematic object relations was to address her pattern of withdrawing from intimate relationships as a way of reducing her fear. She was afraid both of her own rage and destructiveness and of the motives of anyone who would become close to her, and these fears had roots in her earliest experiences of intimacy and closeness. In order to be of help to someone in a situation such as this, the therapist must first point out the behavior, then link it with the affect, explore the source of the affect (which in this case no longer conforms to reality), and finally either reduce the affect or help the patient develop a more adaptive response. Many of the responses that appear pathological in adults were originally responses to rational or irrational fears earlier in life; the response became routinized in childhood when it was associated with regulation of the aversive affect. One significant aim of treatment is thus, as Freud put it, to make the unconscious conscious: a person cannot alter a behavior of which he is not aware, and he is unlikely even then to change it unless he understands that the function it serves is unnecessary or that a more efficient mechanism may be used in its place.

If this is true of behaviors or scripts that are automatically evoked, it is equally true of intrapsychic processes (defenses and other compromise formations) which fulfill the similar function of regulation of affect. Defenses are more difficult to expose than many behaviors because their efficacy presupposes their inaccessibility to consciousness; repression does not work (i.e., does not alleviate an aversive emotional state) if one is aware that one is repressing. The patient has good reason to avoid awareness of such defenses because their use has been "reinforced" by the elimination of a painful affect. The patient is thus unlikely to be willing to relinquish a defense unless he has come to see that the situation is not so unpleasant or frightening, or that he can respond to it in ways that will not so greatly compromise other motives or produce as much distress.

Examination of transference is especially useful because it allows the therapist directly to observe the behavioral and defensive processes the patient brings to bear, especially in social situations. It also gives the therapist concrete and mutually verifiable evidence of these processes to help the patient recognize them, even when doing so is threatening or painful. In addition, bringing to light conflictual material allows for the emergence of more deeply buried issues that are themselves likely to emerge in the transference, in part sometimes creating what psychoanalysts refer to as the "transference neurosis" (see, e.g., Blum, 1971; Weinshel, 1971). Further, Freud emphasized the patient's use of transference as resistance, a resistance which, if not interpreted, can frequently lead to termination of treatment. This resistance may emerge whether or not the therapist believes in the concept of transference (see Wachtel, 1982).

CONCLUSIONS

A general discussion of the causal agents in therapeutic change is obviously outside the parameters of the article, though the foregoing suggests two crucial avenues for change: the alteration of dysfunctional schemas, and the reworking of

behavioral and defensive responses evoked to regulate affect.[6] Both are central to psychodynamic psychotherapy, though the alteration of childhood constructions of reality has received less attention at a theoretical level than motivational and defensive shifts. The theoretical systems underlying cognitive therapies have paid great attention to the (conscious) cognitive processes involved in psychopathology but have not as yet come to integrate an understanding of the dynamic influence of affect and affect-regulation mechanisms on mental and behavioral events. To the extent that the phenomena delineated here as aspects of transference can be useful in the assessment and alteration of schemas and modes of affect-regulation, they provide an important tool for therapeutic change. That the use of a process which enlists the active participation of the patient may be especially efficacious in treatment should not be surprising to cognitive-behavioral clinicians. Behavioral therapists for some time have known that participatory modeling is more efficacious that observational learning, and one would thus expect that activating real feelings, interactional patterns, and schemas in psychotherapy would have greater impact than simply talking about them or observing them at a distance.

One could conclude from all this that Freud was overstating the matter somewhat when he claimed that the transference is the battlefield upon which *all* battles must be fought in psychotherapy (1917, p. 454). The schemas and affect-regulation mechanisms evoked in therapy are only a subset of the person's repertoire, albeit a subset to which the therapist will have greater access and with which he is more likely to effect lasting change.[7] Nevertheless, while Freud was not entirely correct in asserting, in the passage with which this paper began, that one can never destroy anyone in absentia, he was no doubt brilliantly insightful in his recognition that even a straw man burns faster than a memory.

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[6]For a more detailed discussion, particularly as applied to short-term psychodynamic psychotherapy, see Westen (1986).

[7]A tendency to exaggerate the role of transference is not surprising in a therapeutic mode in which the therapist must take such a self-abnegatory stance, utilizing his own feelings only insofar as they provide insight into the patient's conflicts and the interpersonal process. Transference is a way for the therapist to bring himself—even a distorted version thereof—into his work.

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