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Abstract	The use of specimen pieces of psychoanalytic work has been installed by Freud reporting on the so-called Irma-dream [1]. This material has been re-analyzed a number of times (for example [2]). In the same vein, the Dora-case [3] has retained a prestigious pivotal position in availing itself to continuous re-elaboration and re-interpretation [4]. However, few detailed examples are available to extended scrutiny where "primary data" [5] are at hand.

Keywords (separated by '-')	Process research - Psychotherapy Process Q-Set - repetitive interaction structures - single-case research - single-session process ratings - treatment prototypes

Chapter 26
A Session of Psychoanalysis as Analyzed by the Psychotherapy Process Q-Set: Amalia X, Session 152

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Keywords Process research • Psychotherapy Process Q-Set • Repetitive interaction structures • Single-case research • Single-session process ratings • Treatment prototypes

The use of specimen pieces of psychoanalytic work has been installed by Freud reporting on the so-called Irma-dream [1]. This material has been re-analyzed a number of times (for example [2]). In the same vein, the Dora-case [3] has retained a prestigious pivotal position in availing itself to continuous re-elaboration and re-interpretation [4]. However, few detailed examples are available to extended scrutiny where "primary data" [5] are at hand.

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A central difficulty for psychoanalytic research lies in designing quantitative methods that preserve the depth and complexity of clinical material while conforming to the requirements of empirical science. In order to use empirical data to test psychoanalytic constructs, clinical phenomena must be intersubjectively observable, which means that different judges can independently agree about their characteristics and whether or not they occur. Disagreements about the interpretation or meaning of the same case material are commonplace in clinical work and constitute important grounds for criticism of the scientific status of psychoanalytic methods for acquiring knowledge. A particular problem is that clinical observers may vary a great deal in the concepts they use and in their descriptive language. Observers of the same case material may not arrive at the same conclusions; indeed, they may not even consider the same dimensions of the psychotherapeutic process. The issue of handling differences in inference or judgment among clinical experts is particularly important since there are alternate theoretical models within psychoanalysis itself.

The Ulm study group on psychoanalytic process research in many details has analyzed a tape-recorded psychoanalytic treatment, the case of Amalia X [6, see Chap. 24]. The treating analyst himself considered the Session 152 as a specimen example of modern psychoanalytic technique when he presented this session to the participants of the International Psychoanalytic Congress in 2004 [7]. This session was debated by a fair number of experienced psychoanalysts [8]. Among those, the clinical evaluation by Akhtar [9] was especially strong in pointing out the key features of the analyst's technique in this session: "Dr. Thomä's technique shows flexibility, resilience, and broad-mindness. It is centered upon helping the patient achieve ego freedom though interpretation and transference resolution. However, it incorporates a variety of listening attitudes and a broad range of interventions that can be seen as preparatory for, as well as in lieu of, the interpretive enterprise" [9, p. 691]. [AU2]

This session – available for further scrutiny to all researchers in the field[1] – provided a good opportunity to test the sensitivity of the Psychotherapy Q-Set developed by Jones [10].

Rating a psychotherapy session utilizing the Psychotherapy Process Q-Set (PQS) provides an empirical description of the process of that individual session that is suitable for quantitative analysis and offers process ratings as determined by the PQS. We first present an introduction to the PQS and a brief description of the prescribed approach for rating an hour. We then review our ratings of Session 152 of the aforementioned case and provide a more detailed narrative of our impression of the hour in the context of our rating with the PQS.

The Psychotherapy Process Q-Set

One solution to the consensus problem is to attempt to refine ordinary clinical judgment. An approach that does this in a sophisticated manner is Q-methodology [11, 12]. The Q-technique is a method of measurement with a broad range of potential applications, but it is particularly well suited for the description of qualitative data. A Q-sort consists of a set of items, each of which describes a significant psychological or behavioral feature of an individual or situation. The specific content of the items depends upon the particular objectives of the research and the nature of the individuals or situations to be studied. There is no standard Q-sort; rather, the goal is to provide a set of items that can capture as comprehensively as possible the critical dimensions of variation among cases under study.

The PQS [10] is a 100-item rating instrument designed to provide a basic language for the description and classification of treatment processes in a form suitable for quantitative analysis. The PQS

[1] www.horstkaechele.de, english section: All about Amalia X.

allows clinical judges to formalize and render explicit what usually remains informal, implicit, and intuitive, and helps clinical judges achieve reliable descriptions of complex treatment processes. It provides a standard format that all clinical judges can use to describe the material under study. The instrument was designed to be applied to a record of a single treatment hour as the unit of observation. The application of the Q-technique to a treatment hour in its entirety has the advantage of allowing clinical judges to study the material carefully for evidence supporting alternative conceptualizations and to assess the gradual unfolding of the meaning of events within the hour.

The 100 items that comprise the PQS represent an empirically guided selection from a pool of several hundred items garnered from previously existing process measures, as well as new items constructed by a panel of experts. Several versions of the Q-set were tested in a series of pilot studies conducted on scores of transcripts, videotapes, and audiotapes of psychotherapy and psychoanalytic treatment hours. Each item was individually discussed with respect to its clarity, its importance for psychotherapy and analysis, and its implications for the sufficiency of the total Q-set. Items were amplified or rewritten for conciseness and jargon, and ambiguous language was eliminated. Items were eliminated if they showed little variation over a wide range of subjects and therapy hours, were redundant, or had low inter-rater reliability. Whenever some facet of therapy process judged to be important proved not to be captured or expressed by existing items, item revisions were made or appropriate items were added. The Q-set captures a wide range of phenomena in the domain of analytic and therapeutic process, including transference manifestations, resistance, reconstruction, the therapist's activity (e.g., clarification, interpretation), and the patient's affective states, such as anxiety, depression, or other symptomatic behavior. The standard language provided by the Q-set, the careful definition of items, and its structured format all serve to guide clinical judgments in the direction of reliable, measurable statements.

The Q-method encompasses many of the operations the clinician performs in attempting to analyze the verbal meanings of the analyst–patient discourse. Holt [13] distinguishes several kinds of "internal analyses" of verbal texts that the clinical thinker might perform. These analyses include: summarizing content meanings by way of selection and abstraction; collating verbal messages by examining them for internal consistency and inconsistency; interpreting or translating the content of verbal messages; observing one's affective reaction to the verbal message, and discerning causal relations. Many of these operations are built into the Q-method. The clinician, for example, attempts to type or categorize the patient's behavior; the Q-sort similarly asks judges to identify the form or content of a communication and identify it with a conceptual system or code (the Q-sort). The clinician assesses the frequency with which a kind of event or behavior occurs, or its intensity; similarly, the Q-sort requires judges to rank order or scale the salience of a particular aspect of the therapeutic process. There is, in other words, a direct line of logical continuity from the qualitative classification of the clinical thinker to Q-sort ratings. The Q-sort simply attempts to codify and systematize processes of clinical inference and judgment. Incidentally, causal analysis, the most controversial and difficult to verify in the study of verbal meanings, is not an important aspect of the Q-method, since it is usually not essential in the description and construction of meaning for a given hour. When a causal statement is called for, it is usually interpersonal in nature, rather than an attempt to explain the patient's behavior in terms of underlying dynamic structure or inferred motives. In this case, it is readily deduced from overt behavior, as in the Q-item "When the interaction with the patient is difficult, the therapist accommodates in an effort to improve relations."

The PQS can capture the uniqueness of each treatment hour while also permitting the assessment of the similarities or dissimilarities between hours and patients. It has been used in research involving group comparison designs, in which Q-ratings of groups of cases (or hours) selected on some dimension of interest are compared [14–17] as well as in $N=1$ designs [18, 19]. The instrument has demonstrated high levels of inter-rater reliability, item reliability, and concurrent and predictive validity across a range of studies and treatment samples. Inter-rater reliability, which is calculated by correlating the Q-sorts of multiple raters across all 100 items of the PQS, ranges from 0.83 to 0.89.

t1.1 **Table 26.1** Psychotherapy
t1.2 Process Q-Set distribution

Rating	Number of items	Category
9	5	Extremely characteristic or salient
8	8	Quite characteristic or salient
7	12	Fairly characteristic or salient
6	16	Somewhat characteristic or salient
5	18	Relatively neutral or unimportant
4	16	Somewhat uncharacteristic or negatively salient
3	12	Fairly uncharacteristic or negatively salient
2	8	Quite uncharacteristic or negatively salient
1	5	Extremely uncharacteristic or negatively salient

Rating Treatment Sessions Using the PQS

In this section, we present a sense of the practical requirements for rating. We do not believe that a simple review of this section suffices as necessary training in the use of the PQS; these comments are intended only to inform the reader how we have proceeded in our approach to rating Session 152 of Amalia X's treatment. We proceed from a general description of our thinking about rating with the PQS to the specifics of our approach, and we finish with our impression of the particular session we have rated.

After studying the transcript (or video- or audiotape) of a treatment hour, a clinical judge orders the 100 items of the PQS, each printed separately on cards to permit easy arrangement and re-arrangement. The items are sorted into nine piles on a continuum from least characteristic or negatively salient (category 1) to most characteristic or salient (category 9). The middle pile (category 5) is used for items deemed either neutral or irrelevant to the particular hour being rated. This distribution of items approximates a normal curve. See Table 26.1.

The reasons for utilizing a fixed distribution resembling a normal curve are provided at length by Block [12], but can be summarized briefly. First, the fixed distribution eliminates certain biases in rating procedure; some judges, for example, systematically avoid making extreme judgments while others dichotomize their judgments into one extreme or the other. Second, the fixed distribution ensures that judges will make multiple discriminations among items. By ensuring multiple discriminations, another common response bias, the "halo" effect, is reduced; that is, judges cannot simply group together all favorable or unfavorable items without making distinctions among them. Third, a distribution with relatively fewer items in the extreme categories throws into greater relief the most important features of the description; the extreme items effectively receive the greatest emphasis. Finally, if all Q-sorts have the same distribution, statistical analyses of the data are greatly facilitated.

When considering one's approach to ratings, it is also essential to recognize that the Q-sort is an ipsative method. Its items are ordered within a case, from those most characteristic of the therapy hour described to those least characteristic. The distinctiveness of this procedure is perhaps best understood by contrasting it with the more conventional normative mode of scaling typical of most psychological tests. In normative scaling, comparisons are made between individuals on some dimension of variation. If, for example, we have a scale of some psychological feature, such as level of anxiety, individuals are ordered relative to each other, or relative to a norm. It could then be said that patient A is more anxious than patient B, or that patient A is among the most anxious that a given therapist has seen. Ipsative scaling, on the other hand, takes no account of how an individual compares to others or to a norm (however derived); what matters is how the various dimensions to be described relate to each other within the case under study. For example, is patient A more insightful than he is anxious? Or is he more insightful than emotionally expressive? A judgment can be made, for example, whether the therapist has made more interpretations of defensive maneuvers than clarifying comments, or more frequent (or significant) transference interpretations than he

has defense interpretations within the hour. Each hour is consequently described by a particular patterning of the dimensions, i.e., the Q-sort items.

Each item of the PQS contains a description of the two opposite ends of the continuum along which the items are to be rated. It is important to note that placement in the uncharacteristic direction does not signal that a particular behavior or experience is irrelevant. On the contrary, an uncharacteristic ranking signals that the absence of the item is meaningful and important to capture in the Q-sort description. Most items have specific instructions that provide examples of the distinction between uncharacteristic and neutral ratings. For example, Q-item number 17 describes the therapist as "actively exerting control over the interaction, e.g., structuring and/or introducing new topics" when rated in the characteristic range. However, when rated in the uncharacteristic range, the item indicates that the therapist was "following the lead of the patient; helping the patient to follow his train of thought." Only if the item were irrelevant to the description of the hour would it be placed in the neutral range.

Judges rate the frequency, intensity, and estimated importance or salience of each of the 100 statements. A coding manual [10] details instructions for Q-sorting and provides the items and their definitions, along with examples in order to minimize potentially varying interpretations of the items. The Q-items themselves are anchored, as far as possible, to behavioral and linguistic cues that can be identified in recordings of hours, and more abstract terms are avoided. For example, clinical judges are not asked to identify the presence or absence of a defense mechanism in the patient. The term "defense mechanism" connotes a type of mental functioning; it is a relatively abstract notion, and it is often difficult for clinicians to agree on the presence or absence of a particular "mechanism." Instead, clinical judges are asked to notice whether or not the analyst *makes* a defense interpretation. The items are tied to actual behavior that can be identified in a transcript or other recording. Judges are trained to look for specific evidence.

When rating, judges are asked to take the position of a "generalized other," i.e., an observer who stands midway between patient and therapist and who views the interaction from the outside. In placing each item, judges are instructed to ask themselves: Is this attitude, behavior, or experience clearly present (or absent)? If the evidence is not compelling, the judge is asked to search for specific evidence of the extent to which it is present or absent. Since the items are not closely bound to particular theoretical concepts, but rather to notions of analytic and therapeutic *process*, the influence of observers' theory on their descriptions of the process is subdued within the framework provided by the Q-set. Although inference is sometimes needed for certain items, the inference emanates from observable behavior rather than a theoretical perspective. Therefore, the benefit of the PQS is that it describes what actually occurs or does not occur in a treatment hour and does not place itself in alliance with any set of techniques or theoretical approaches. We learn from the ratings what actually occurs in treatment hours rather than what any therapist or analyst believes should occur because of adherence to a preferred theory. No matter what one's theoretical orientation is, whether psychoanalysis or cognitive behavioral therapy or interpersonal therapy, it is important to subdue one's personal theoretical preference when rating. Raters can encounter psychotherapy sessions from all treatment orientations, and we ask ourselves to consider only the linguistic and behavioral cues of the session as data in the interest of impartial, scientific rating.

During and after an initial reading, listening, or viewing of a session, we note the critical content of the session but emphasize to a greater degree the process of the session, remembering that the PQS was created to help clinicians and researchers describe the critical process variables. We take notes during our reading, listening, or viewing of sessions to help with later rating. We find it useful to summarize the session to ourselves after reading. Again, we emphasize the process variables as well as note the content to recreate the session in our description of the hour. For example, we emphasize aspects of the patient's (P) and analyst's (A) contribution to the session as well as the interaction (P–A) that we have observed. Among other processes that the PQS assesses, we notice who initiates and controls during the session, what the patient's affect is and whether the analyst comments on it during the hour, what the specific interventions of the analyst are and are not, whether

we feel the analyst understands the therapeutic process, whether the discussion is focused, whether the patient is resisting the analyst's attempts to do the work of the session, and how the patient and the analyst respond to and interact with one another. We also consider questions such as: Does P respond with deepening of material after an interpretation or is there silence or an increase in self-protection or withdrawal as a result? How does A proceed after P is increasingly reluctant to proceed or is confused? Does A adjust his style to accommodate P or does A continue with his/her chosen form of interventions? Does the session appear to deepen or develop in a productive manner? Is this because of the connection of P and A or does P have some resilience or momentum that seems independent of the connection with A in this hour? Is there data to suggest that P has been helped in this particular session?

In considering these questions and others related to specific PQS items, we think only of the hour under consideration. If, as raters, we are familiar with other hours of the same treatment, we try to exclude this knowledge and data from our immediate rating criteria. And of course, as raters, we are blind to the order of the hours, or where they fall in an extended treatment. We try to be aware of our own subjective reactions to A and P and separate these reactions from our consideration of the objective data while rating. We have found that raters' affective reactions to analysts need to be carefully self-monitored as they have the potential to bias one's ratings.

When conducting the actual rating procedure, the rater can choose between paper and electronic versions of the PQS, which has been translated into German, Japanese [20], Norwegian, Italian, Portuguese, and Spanish from the English. The electronic version is generally considered to be more convenient and efficient (and also reduces data entry labor and errors), but some raters prefer to see and feel items written on cards that are then distributed into the piles from 1 to 9. For those who proceed with paper, the original sorting after reading the treatment session under consideration is done by placing items in 1 of 3 piles – highly characteristic and salient, neutral, and saliently uncharacteristic. After this initial sorting, items are then distributed to the specific 1 to 9 piles based on the rater's determination of how characteristic and salient each is in the hour. If the electronic version is used, the rater can proceed in a similar fashion, placing items in 1 of 3 groupings to be distributed later. Once raters become more experienced with the measure, some prefer to place items in exact piles and then make necessary shifts according to the demands of the Q-sort distribution the second time through. The number of items in each pile is visible on the electronic Excel sheet. When a rater has reviewed ratings and completed his or her work, he or she assesses the ratings by reviewing the extreme rating piles (1,9), re-telling the story of the hour with these ten items and determining if the "story" of the hour as told by these items conforms to the rater's ultimate impression. [AU3]

All of our sessions are rated by two autonomous raters who have been trained by one of the first two authors. Reliability between the ratings is then computed, and these ratings are only acceptable for use if they correlate at a level above 0.5. We generally find and prefer reliability well above 0.5, except for the more difficult sessions. When reliability is not achieved between two raters for any given session, an expert rater is enlisted to submit a rating to achieve reliability with one of the original session raters. The two reliable ratings are then item-averaged to create a single rating for research use. It is this item-averaged set of ratings for a session that is used in all subsequent data analysis.

Amalia X, Session 152

Thematic Impressions of the Hour [AU4]

Our first impression of Session 152 of the analytic treatment of Amalia X is that the dialogue is complex, the associations very personal, and the exchange very intimate between a patient and analyst who have developed an excellent therapeutic alliance. In fact, this is a session requiring more

than one reading in order to feel confident in one's ratings. We experienced rating this hour as an entry into a very private world of dyadic meaning that requires careful attention to the process. For example, there are occasions when the patient initially resists an interpretation only to be followed by a shift in focus by A or P that deepens the dialogue. We have needed to be certain to follow the process of this particular hour carefully because of the quick recovery and deepening of analytic work which makes the session a strong and positive one; that is, the session achieves its goal of deepening exploration of P's unconscious feelings about the analyst.

The ratings (Tables 26.2 and 26.3) reflect our autonomous impressions that both P and A are active in the hour and make salient contributions to the process. We found that P's presentation of a dream (Q90) stimulates the process of the hour. There is a major emphasis by A on leading P to explore her unconscious (Q67, Q89), and therefore there is no attempt to clarify reality and fantasy with P (Q68). Although P exhibits some moments of resistance, P is engaged in the complementary analytic work of attempting to access her unconscious associations (Q97) within the context of the therapeutic relationship (Q98), within the transference. P is quite active and initiating within the hour (Q15), and A's interventions are attempts to facilitate P's speech (Q3) in a non-judgmental manner (Q18).

We found that the process of the hour proceeds well because A's empathy (Q6) reflects an understanding of P at a deep, unconscious level which allows P to be prompted successfully, most of the time, about her threatening and warded-off feelings (Q50). Because P does feel understood by A (Q14), this item (P does not feel understood by A) is rated saliently uncharacteristic. Because of A's empathy and his ability to understand P, P initiates topics (Q15), which also places this item as saliently uncharacteristic. An additional critical and saliently characteristic process variable is that A understands the therapeutic process (Q28). He allows P some room to resist while at the same time asking her to explore her unconscious. This flexibility leads to a deepening of associations and increasingly intimate exploration of the transference. P's feelings or perceptions are also linked to experiences of childhood (Q92), which helps P proceed with the exploration of her unconscious. In our judgment, she is able to proceed in this way because of A's ability to understand the meaning of her associations, which she experiences as empathic.

Interaction Structures

Factor analysis of many sessions of a treatment rated using the PQS can enable us to identify interaction structures – the repetitive, mutually influencing processes specific to each patient–analyst dyad that are slow to change but often linked to positive or negative outcome. However, in the case of Amalia X, Session 152, we only have one assessment point in time. Next, we discuss an example of what one might imagine to be a repetitive interaction structure in this case which, in our judgment, appears to contribute to P feeling helped in this hour and therefore suggests indication of positive outcome, assuming this interaction repeats throughout the treatment and is recognized and understood by the A and P together. Toward the beginning of the session, P is discussing the dream she had presented to A, and she then associates to it, initially speaking to herself:

P: It was the devil's work, in German class you haven't been putting any, really genuine consideration into it. you teach English and earth science. You have as little to do with all of that as possible.//like 10 years ago. why is//? – I don't know either//? somehow I don't care. – and that, I mean really, is not normal for me. not to be afraid at all anymore.

A: like in the dream?

P: yes. yes, I've got to! somehow. it seems to me like – well, it's gotten to the point where [3], that in my mind I'm considering – hm -. that sometimes these last days I actually consider which convent I should go to. It seems so idiotic, and it does no good at all when I say it to myself.

A: um-hmm.

Table 26.2 Most characteristic PQS items for Amalia X, Session 152

Item	Rating	Examples of salience from session
Item 90: Patient's dreams or fantasies are discussed	9	P: um-hmm. (2 min. pause) (groaning) last night I had a dream, towards morning, while the alarm clock was ringing. I'd been murdered with a dagger A: um-hmm P: but it was kind of, like in the movies – I had to stay lying face down for a long time, and had the dagger in my back and, then lots and lots of people came, – and, I'm not exactly sure anymore, keeping my hands perfectly still, somehow// A: um-hmm
Item 3: Analyst's remarks are aimed at facilitating patient speech	9	P: it was very embarrassing for me that my skirt had slipped up so high in back A: um-hmm P: and then a colleague of mine came, who I could easily see was from *5,382, which was my first position, and he pulled the dagger out of my back. and I remember [1] it was like a souvenir. and then a young couple came up, – I just remember that he was a Negro. and they cut off my hair and wanted, actually to make a wig out of it I think. And that seemed really dreadful to me. just pulled it all down and then they actually began to cut. and, then I got up, – and went to the hairdresser's. and I still had//I was A: so you could get up after all, + when you wanted to go to the hairdresser, ah (p. 2)
Item 67: Analyst interprets warded-off or unconscious wishes, feelings, or ideas	9	A: and then you would be assured, that then you'd, at least know, that, uh, I, uh, how shall I say it, I've out – held out, that, uh, I've been able to take it, that you, uh, that you, uh, um, that I've come through it intact. because you, somewhere there's this concern there, that I won't be able to take it. Is he, is he really strong enough, that he uh- P: no, that's not what I was hoping A: that he, well, that nothing will happen, that you won't - P: I don't find that appropriate A: um, that you won't draw me into it too P: into this delusion, you mean, in my mind A: um-hmm um-hmm (p. 8) In this example, the patient does not accept the analyst's interpretation. However, the item is rated based on the analyst making an interpretation whether the patient accepts it or not
Item 98: The analytic relationship is a focus of discussion	9	A: um-hmm, also. could it - P: could it A: perhaps also be me sitting behind you, – and saying wrong, wrong P: oh, you know, sometimes – I have the feeling – I'd like to rush at you, grab you by the neck, and hold you so tight, and then- A: hm P: then I think, he'd never be able to take it, all of a sudden he'd just drop dead A: hm P: and then I see you, somehow – burning too, or, or, I can't find words for it, I don't know. what I see or feel then
Item 18: Analyst conveys a sense of non-judgmental acceptance	8.5	A: I can't take it, that I, uh P: right A: can't take, can't take you, and P: right, me holding you right A: um-hmm (p. 6–7) (example continues in text) P: …and then you could keep your dogmas A: yes P: then I wouldn't want, really to fight with you A: um-hmm P: that's true.//or tear your neck off A: yes, but then you wouldn't fertilize my, dogmas with yours, would you? P: no+I'd be against the enemy again, wouldn't I A: or move mine closer+move mine closer P: I'd have two! fronts. like just before A: move+mine, with these incursions into the mind your incursions into my mind, into my head… (p. 27)

(continued)

Table 26.2 (continued)

Item	Rating	Examples of salience from session
Item 6: Analyst is sensitive to the patient's feelings, attuned to the patient; empathic	8	A: of course. but as to distancing. but the first thing is to know, if something is going to break off, or, could, or if it, it uh, it'll be able to take it. or if a branch will break, break off, right, somehow there's a feeling – perhaps mixed up in this as well, that you'd like to take something with you, that you'd like to break off a branch P: yes A: break off a piece P: yes, it's your neck A: my neck? mm. mm. my head P: mm, um-hmm
Item 28: Analyst accurately perceived therapeutic process	7.5	A: um-hmm P: that's something I'm, often preoccupied with, your head A: will it stay on? you're preoccupied with my head often, really often P: yes, yes, incredibly often (p. 9) Here, the analyst makes an interpretation that is accepted by the patient as accurate and meaningful to her. Analyst and patient jointly explore the meaning of her fantasy, and the analyst consistently adapts to the changing needs of the patient and to the emergent process between them. This is only one example of the salience of the therapist's perception of the therapeutic process throughout the hour
Item 50: Analyst draws attention to feelings regarded by the patient as unacceptable (e.g., anger, envy, or excitement)	8	A: what was it a moment ago that had occurred to you about your dream P: oh, shit A: that you didn't want to say? please? hmm? P: oh just something or other, that might be in a + book./// A: about, about. + P: something or other, that might be in some textbook A: well, what is it then? P: (laughing) you know that perfectly well A: no, no, no P: no certainly you wouldn't know what kind of textbooks I read A: hmm hmm (p. 4) In this example, the analyst draws the patient's attention to unacceptable feelings. The patient resists but the item is rated only on the analyst's attempt to encourage the patient to attend to unacceptable feelings
Item 92: Patient's feelings or perceptions are linked to experiences from infancy or childhood	8	A: yes, yes, mm-hmm. well you see I think it's a very good thing, that you can laugh, and uh, since you might get the idea from my- not uh, -laughing too, that it wouldn't be good – that it isn't good, to laugh. that's the reason why I uh – really said, I said, I don't laugh enough P: So that's it A: and I do really do think, I don't laugh enough. uh, – and uh – your father didn't laugh enough P: he doesn't laugh at all A: and that is, there you have a negative model, uh - P: the most my father does is smile A: right P: he laughs when I can't laugh A: um-hmm P: but almost- as a rule that's the way it is A: um-hmm P: that is, when he laughs, I don't feel like it anymore. I feel like anything but that… P: that is a very old fear. that you won't be able to take it after all my father could never take anything A: yes P: you wouldn't believe how soft my father was A: um-hmm P: he couldn't take a thing A: but then that makes it all the more important to find out if my head is still really hard because that increases- uh, how hard your hold can be. Because if the head is hard, then it should still be--- in fact it should be easier, easier, to get – to find out, just exactly how hard it really is, you see…

PQS Psychotherapy Process Q-Set. *P* patient, *A* analyst

t3.1 **Table 26.3** Least characteristic PQS items for Amalia X, Session 152

t3.2 Item	Rating	Examples of salience from session with discussion
t3.3 Item 89: Analyst acts to t3.4 strengthen defenses	1	A: yes. yes, and taking hold was the also the issue with – with you, t3.4 grabbing me by the neck, right t3.5 P: yes t3.6 A: and how I wouldn't be able to take it right? t3.7 P: yes I was afraid of that. t3.8 A: um-hmm, um-hmm t3.9 P: that is a very old fear. that you won't be able to take it after all my t3.10 father could never take anything
t3.11 Item 14: Patient does not feel t3.12 understood by analyst	1.5	t3.11 A: yes t3.12 P: you wouldn't believe how soft my father was t3.13 A: um-hmm t3.14 P: he couldn't take a thing t3.15 A: but then that makes it all the more important to find out if my head is t3.16 still really hard because that increases – uh, how hard your hold can t3.17 be. Because if the head is hard, then it should still be –in fact it should t3.18 be easier, easier, to get – to find out, just exactly how hard it really is, t3.19 you see t3.20 P: yes, and you can take hold harder, and t3.21 A: exactly t3.22 P: right t3.23 A: um-hmm, um-hmm, um-hmm t3.24 P: and fight better, right to the knife t3.25 A: right. and then there would be something positive, one might say, to t3.26 that dogmatism. - t3.27 P: right t3.28 A: something [17] to be gained from it. namely, that it isn't so easy – to t3.29 knock over. that it holds firm to something right t3.30 P: right. that it holds firm t3.31 Here, the analyst's interpretation is aimed at getting the patient beyond t3.32 intellectualizing. It is evident that the patient feels understood by this t3.33 interpretation because she accepts it as accurate and meaningful to her. t3.34 The analyst's repeated offering of interpretations that are accepted by t3.35 the patient as meaningful illustrates the salience of the analyst's t3.36 understanding of the therapeutic process (Item 28, rated 9)
t3.37 Item 15: Patient does not initiate t3.38 topics and is passive	1	t3.37 A: and then on top of it in the dream you get stabbed, so uh, – are you t3.38 dead or not dead t3.39 P: but that is how it is too, right now t3.40 A: um-hmm. um-hmm t3.41 P: nothing is fun for me. Everything I do now is just mechanical. Even t3.42 school is not really involving, just mechanical. Or when [5] I'm t3.43 somewhere, I act all excited. well excited is a bit of an exaggeration t3.44 but, at least/.///someone is always observing and censoring it and t3.45 saying///wrong it's all just wrong (50 s pause) at the moment I would t3.46 believe nothing makes any sense. Before I'd believe that two and two t3.47 makes four (p. 6) t3.48 In this example, the patient takes a realization and develops it in depth on t3.49 her own initiative. This active engagement and self-driven exploration t3.50 is characteristic of the patient throughout the session
t3.51 Item 68: Real vs fantasized t3.52 meanings of experiences are t3.53 actively differentiated	1.5	t3.51 A: that then you, uh would actually have what you want, to have the t3.52 knife, and uh, to be able to really get inside yourself- too. in order to t3.53 get something out that would – or to get more out t3.54 P: right and no, – up to now I always thought that, that would be possible, t3.55 to some extent t3.56 A: um-hmm

(continued)

Table 26.3 (continued)

Item	Rating	Examples of salience from session with discussion	
Item 90: patient's dreams or fantasies are discussed		P: but since Sunday absolutely nothing has been possible anymore	t3.57
		A: well, because since Sunday you've obviously been making a special effort, uh not to, – uh get uh, inside here. not to go after my neck and uh, – and try uh, – to -	t3.58 t3.59 t3.60
		P: measure your head	t3.61
		A: measure it, take it in your hand, and uh – take with you what's inside, in there and - (p. 12)	t3.62 t3.63
		A: to, to test the stability of my head, to see, just how big or little to make the hole isn't that right	t3.64 t3.65
		P: um-hmm	t3.66
		A: but you would like to make a big one	t3.67
		P: um-hmm	t3.68
		A: and have easy access	t3.69
		P: um-hmm	t3.70
		A: not difficult access you'd like, with your hand, uh to be able to actually touch what is there not just see it with your eyes. with your eyes you don't see well anyway if a hole is just small isn't that so. with your eyes you don't see a lot either right if it's just a little hole right. so uh, I believe you'd like to make a rather large one uh -	t3.71 t3.72 t3.73 t3.74 t3.75
		P: I'd even like to be able to [21], take a walk in your head	t3.76
		A: right, um-hmm	t3.77
		P: I would like! that	t3.78
		A: yes, um-hmm	t3.79
		P: and I'd even like to have a bench	t3.80
		A: right, right. (p. 25)	t3.81
		In both of these examples, the analyst chooses to pursue the patient's fantasy. The therapist helps the patient make meaning out of her fantasies rather than injecting reality into the session, as a therapist might do for a patient with less intact reality testing. These are just two examples of the approach the analyst takes throughout the session	t3.82 t3.83 t3.84 t3.85 t3.86
Item 9: Analyst is distant, aloof (vs responsive and affectively involved)	1	P: I was already on that you see on, Wednesday	t3.87
		A: um-hmm. and that way also that way the intensification of your idea of entering the convent would be a way of challenging me to a fight	t3.88 t3.89
		P: um-hmm	t3.90
		A: in order, to a fight, uh where you would be taken hold of too not just hold on yourself trying to see how, how	t3.91 t3.92
		P: yes	t3.93
		A: how much I can take but where I finally! get a chance too! – to show in a fight just how! much it matters to me that you don't go to the convent	t3.94 t3.95 t3.96
		P: to my mother	t3.97
		A: but are preserved for life in this world	t3.98
		P: well yes, possibly. I don't know	t3.99
		A: stay on with us here so that you can give me your ideas too, that can fill my head with my with your thoughts more and	t3.100 t3.101
		P: oh I see	t3.102
		A: and, and can give me really uh – fruitful, fruitful ideas. (p. 23)	t3.103
		This is the clearest example of data to support the analyst's affective involvement because of the emphatics in the transcript. However, it is our opinion that the analyst's responsiveness and affective involvement are highly salient throughout the hour	t3.104 t3.105 t3.106 t3.107

(continued)

Table 26.3 (continued)

	Item	Rating	Examples of salience from session with discussion
t3.108	Item 52: Patient relies upon	1	P: it just fascinates me. what's in it too, of course
t3.109	analyst to solve his/her		A: yes, yes, if you keep it intact for yourself, if it – stays there and you,
t3.110	problems		uh, the
t3.111			P: yes,
t3.112			A: yes, if you keep it intact for yourself, if it – stays there and you, uh,
t3.113			then it's, you don't have it. he takes it with him, then it's, uh…
t3.114			P: then it's off
t3.115			A: it's off, right. and then, uh – then the convent is a way out, right. but
t3.116			just a way out, that's all
t3.117			P: another head
t3.118			A: in that case yes, and then – you might not have taken along what
t3.119			P: no
t3.120			A: what you – would like to take along with you, not taken out
t3.121			P: most of all what I'd still like to get inside of
t3.122			A: hmm. get inside -?
t3.123			P: I still want to
t3.124			A: or put inside?
t3.125			P: get inside, – get inside
t3.126			A: get inside, ok, um-hmm
t3.127			P: you see? that's so hard to say in front of a hundred eyes
t3.128			A: yes
t3.129			P: believed – what I could get out by getting inside [9]
t3.130			Throughout the session, the patient works hard in collaboration with the
t3.131			analyst to discover the personal meaning of her dream. This is a
t3.132			session in which the patient's consistent effort is very characteristic,
t3.133			salient, and definitive of the hour. No linguistic or behavioral data
t3.134			exists to suggest that the patient wants the analyst to solve her
t3.135			problems for her

t3.136 *PQS* Psychotherapy Process Q-Set. *P* patient, *A* analyst

285 P: I'm genuinely glad to be at school in the morning. there I simply haven't got time for stuff like
286 that. – somehow I protect myself against it with my routine, but – of course with brooding too,
287 but as soon as I start thinking everything seems to get confused. I don't know, I really don't
288 know. so I think, I'm crazy and then I think, I have guilt feelings and then I think, I uh. these
289 last, – 6 years, I absolutely haven't//. I don't know, it's all so far gone. all of a sudden.
290 A: what was it a moment ago that had occurred to you about your dream.
291 P: oh, shit.
292 A: that you didn't want to say? please? hmm?
293 P: oh just something or other, that might be in a + book.///
294 A: about, about. +
295 P: something or other, that might be in some textbook.
296 A: well, what is it then?
297 P: (laughing) you know that perfectly well.
298 A: no, no, no.
299 P: no certainly you wouldn't know what kind of textbooks I r e a d.
300 A: hmm, hmm.
301 P: oh God. no, I [4], feel so lousy.
302 A: hm. (18 s pause).
303 P: so, now do you think that – that the dream is going to get me anywhere?///

A: well, there certainly is + an, an uh, hm – immobility, a. – you were just, complaining that you're not getting anywhere, that you, uh, – well that is just the picture in the dream.
P: uh +, but in the end I got up.
A: yes. +
P: like I was telling you, a roly-poly doll.
A: but you went to the hairdresser.
P: like some kind of roly-poly doll.
A: hm.
P: who just shakes it all off, and goes to the hairdresser can't think of anything better to do, not to the police either, though I'm not sure. I think, there were police there. on the one hand it was like a film set + and on the other hand there were those.
A: right. +
P: absolutely real streets!, in reality. then I hear people coming and gawking. it's just that now I can't get any further. I get stuck deeper and deeper. and that//to be. and first it was the clock, and now it's the car, and it keeps going on that way.

What occurs here is that P is talking about her life in school as a teacher when A suggests that her experience in the dream is like her recent experience of teaching. P agrees and continues, A's non-judgmental comment (Q18) facilitating P's further exploration (Q3). Unexpectedly, A asks P to recall her avoidance of an earlier thought (Q50) and P resists expressing or exploring (Q58). A then adjusts his approach (Q47) and allows P her resistance and, after an 18-s silence, P initiates (Q15) further exploration on another topic by raising significant material (Q88). The fact that P engages A in consideration of another topic which demonstrates the resumption of mutual exploration into P's unconscious suggests that A has understood the therapeutic process for this patient in this hour (Q28). Presumably, but not for consideration in the rating process, A will address the resistance at another point in treatment as necessary.

This series of A and P process variables is repeated at other moments of Session 152 and proves to be constructive for this dyad in this hour. The session deepens over time with P revealing more of herself to A and accepting his interpretive interventions in the context of the transference relationship. We can only speculate what might have occurred if A had pointed out more strongly to P that she was avoiding some threatening thoughts and feelings, but we know empirically that A's flexibility helped P feel comfortable enough that she wanted to pursue her previously unconscious fantasies about A. Her aggression, envy, and longing, with associated fears and thoughts of escape, emerge later in the session. We speculate that factor analysis of a large sample of sessions from Amalia's treatment might reveal that the items described above cluster together throughout the treatment and that time series analysis might demonstrate empirically that the experience, recognition, and understanding of this interaction pattern would be correlated with positive outcome. In this specific hour, we did not find a negative interaction structure that would reflect unproductive process and be associated with negative outcome.

Assessing Analytic Process

A prototype of psychoanalytic process was created by Ablon and Jones [19] using expert ratings of the PQS. It has been demonstrated using multiple treatment samples that this prototype can be applied to observer ratings of treatment sessions to assess the degree to which analytic process was fostered. The hour of treatment that we are concerned with here, Amalia X, Session 152, has a robust correlation with the Analytic Prototype, 0.65, as might be expected, although we have found that treatment processes often do not conform to their brand names. In this case, the correlation with the prototype of analytic process confirms that A and P together established a very strong analytic

t4.1 **Table 26.4** Twenty most characteristic items of ideal analytic process and their ratings for Amalia X Session 152

t4.2 t4.3 PQS#	Item description	Session rating
t4.4 90	P's dreams or fantasies are discussed	9
t4.5 93	A is neutral	4
t4.6 36	A points out P's use of defensive maneuvers, e.g., undoing, denial	5.5
t4.7 100	A draws connections between the therapeutic relationship and other relationships	7.5
t4.8 6	A is sensitive to the P's feelings, attuned to the P; empathic	8
t4.9 67	A interprets warded-off or unconscious wishes, feelings, or ideas	9
t4.10 18	A conveys a sense of non-judgmental acceptance	8.5
t4.11 32	P achieves a new understanding or insight	6.5
t4.12 98	The therapy relationship is the focus of discussion.	9
t4.13 46	A communicates with P in a clear, coherent style	5.5
t4.14 50	A draws attention to feelings regarded by P as unacceptable (e.g., anger, envy, or excitement)	8
t4.15 11	Sexual feelings and experiences are discussed	3
t4.16 82	P's behavior during the hour is reformulated by A in a way not explicitly recognized previously	4.5
t4.17 35	Self-image is a focus of discussion	5
t4.18 91	Memories or reconstructions of infant and childhood are topics of discussion	6.5
t4.19 92	P's feelings or perceptions are linked to situations or behavior of the past	8
t4.20 62	A identifies a recurrent theme in P's experience or conduct	6
t4.21 3	A's remarks are aimed at facilitating P's speech	9
t4.22 79	A comments on changes in P's mood or affect	4
t4.23 22	A focuses on P's feelings of guilt	5

process throughout the treatment. Being able to measure the degree to which analytic process is fostered in a treatment has obvious implications for teaching, accreditation, and research purposes. Table 26.4 contains the 20 most characteristic items of the prototype of analytic process and displays alongside our item-averaged rating for each of the items specific to Session 152.

Our ratings find several of the most characteristic analytic items to be most salient in this hour. For example, dreams or fantasies are discussed (Q90) and received the most characteristic rating from both raters because P's dream supplies the content for most of the hour's process, making the item saliently characteristic. A conveys a sense of non-judgmental acceptance (Q18) is also saliently characteristic because of its importance in facilitating P's willingness to search deeply into her unconscious associations. A does make a connection between the therapeutic relationship and other relationships, notably P's father (Q100), but this occurrence is not critical to the process and is not a major part of the hour.

However, not all of the most characteristic items of ideal analytic process were rated as characteristic and salient. We rated "A communicates with P in a clear, coherent style" (Q46) in the neutral range because, although it is characteristic, it is not as salient when compared to other process items that we wanted to capture with more extreme ratings. And we rated Item 11, "Sexual feelings and experiences are discussed," as uncharacteristic/negatively salient because P actively resists discussing the obvious sexual content of her associations and we wanted to capture this resistance with our rating.

Difficult Items to Rate

Accurate and reliable rating of psychotherapy sessions is a basic requirement for research using the PQS. Reliable ratings serve as the foundation from which conclusions about process correlates of outcome and the active ingredients of a treatment can be drawn. Moreover, correlational designs rely

on reliable ratings to uncover associations between variables of interest. Individual item rating dilemmas exist with almost all psychotherapy sessions, and in this section, we offer our thoughts about some of the items that were complex in Session 152 of Amalia X's treatment. The reader may find it useful to follow this discussion with the specific rating instructions found in the manual for the items in question. The items are presented in numerical order in the PQS rather than an order reflecting our assessment of level of difficulty.

Item 11: Sexual feelings or experiences are discussed. *Rating*: 3
Our item-averaged rating is 3, reflecting our determination that while discussion of sexual material is not characteristic in the session, P makes several references to sexual content without any direct mention. In fact, P actively resists mention of sexual content which makes the absence of the discussion more salient. If P had mentioned and then discussed sexual content, the rating would be in the characteristic range. If there had been no indirect or resisted sexual content, the rating would be in the neutral range.

This item needs to be distinguished from Item 19: There is an erotic quality to the therapy relationship. For Amalia Session 152, our item-averaged rating of item 19 was 6, reflecting the slight presence of an erotic quality to the therapy relationship existing simultaneously with the lack of discussion. The sexual component is unexpressed, perhaps unconscious, but clearly present in our judgment (pp. 15–17). There is a mildly sexualized quality to the interaction which, if it had been more extreme, would be rated higher reflecting greater salience.

Item 12: Silences occur during the hour. *Rating:* 5
Our item-averaged rating is 5, although there is an 18-s silence at one point in the session reflecting P's resistance to mentioning sexual content just prior to changing the subject. A then accepts her resistance, and we do not feel the silence deserves a higher rating because the session resumes its productive vitality and energy. Had the silence changed the flow of the session significantly, changed the process in a major way, the rating would be higher. There is also a 50-s silence which is followed by resumption of P's dialogue and then an interpretation by A that is accepted by P. Again, the silence does not signify a major shift in the flow of the session. The third silence which lasts 10 s midway through the session is P's way of shifting focus as well. If these silences reflected a rupture in empathy or suppressed aggression for example, we would rate this item higher. While one might argue that it is important to capture the presence of these silences, we did not feel they were particularly salient especially compared to other items we wanted to highlight in our ratings. Keep in mind that we are always rating in relation to other items as the PQS is an ipsative measure.

Item 42: P rejects (rather than accepts) A's comments and observations. *Rating:* 2.5
This is an extreme rating reflecting our belief that P's acceptance of A's comments is a salient process variable in this hour. Although P does reject A's comments at times (pp. 8, 24), the rejections are minor and the overwhelming data suggests P is very accepting of A's major ideas and interpretations, the more salient interventions. Had there been no rejections of A's comments by P, the acceptance of the major interpretations might have been captured with an even more extreme rating. If interpretations had been rejected more frequently, the rating would have been less saliently uncharacteristic, rated in the neutral range, or rated in the characteristic range.

Item 58: P resists examining thoughts, reactions, or motivations related to his or her role. *Rating:* 3
P's acceptance of the need to explore her reactions and motivations, especially within the transference, dominate the session. She initiates activity aimed at understanding her reactions to A, which leads to a deepening understanding of her unconscious wishes and therefore her own contributions to her life situation, problems, and strengths. Her resistance to expression of her sexual feelings and thoughts means that the proper rating here is moderately uncharacteristic rather than more extreme and therefore more salient rating.

Item 70: P struggles to control feelings or impulses. *Rating:* 2.5
In this case, P expresses herself freely and demonstrates anger (pp. 2, 6, 16), apathy (p. 4), envy (pp. 11, 19), guilt (p. 4), and embarrassment (p. 2) without attempts to control these feelings. The rating would be more extreme in the uncharacteristic direction if her affect was more powerfully expressed and her affective expression dominated the process. P does suppress her direct sexual thoughts, presumably accompanied by affect, but this appears minor in relation to the level of comfort she exhibits with her affective life in this session. We can infer that she is controlling shame, but the data is not clear enough to rate strongly based on this inference. There is no discomfort and subsequent attempt to control her affect exhibited in clear behavioral or linguistic cues.

Item 91: Memories or reconstructions of infancy or childhood are topics of discussion. *Rating:* 6.5
The actual mention of family figures occurs three times, but there is very little time spent in discussion of childhood or early experiences of life. Reference to childhood figures is made to explain current feelings with experiences from childhood (see Q92) rather than in discussion of P's time spent when younger. The averaged rating of 6.5 reflects the mention of father's lack of laughing (p. 13), father being "soft" (p. 20), and mother (in an unclear way to the raters) (p. 23) only in passing, with very little further discussion. The rating acknowledges the presence of the item's content, but signifies a lack of strong salience of childhood memories. This item needs to be distinguished from Item 92 which requires early memories to be actively linked, not merely mentioned or discussed, by A or P, to current feelings (see discussion to follow).

Item 92: P's feelings or perceptions are linked to situations or behavior of the past: *Rating:* 8
There are two occasions when P's feelings are linked to the past by A (pp. 13, 20). When A links his concern about P's perception about his laughing to her experience of her father as one who never laughed, our judgment is that P is influenced significantly by the interpretation. She resists immediate further exploration, wants to open the window, and then pursues issues around A's dogma and his adherence to a specific theoretical orientation. She later resumes her exploration of the transference but does not return to her relationship with her father. The interpretive comment clearly affected the process. Our rating of this item provides an example of how salience is not a proxy for frequency. As in this case, highly characteristic ratings can be used to highlight one or two crucial examples.

Item: 97: P is introspective, readily explores inner thoughts and feelings. *Rating:* 7.5
Our rating of 7.5 reflects our belief that P clearly pushes beyond ordinary constraints in her exploration of her conscious and unconscious thoughts. Despite the instances of her resistance to revealing thoughts with sexual content, the session is dominated by P's in-depth cooperation with A's attempts to facilitate her exploration of her feelings about the analyst, her transference. Our rating would be higher if she had not resisted exploration of her sexual thoughts in the transference, and of course lower if there had been less exploration of her inner thoughts.

The hour required a second reading by us to feel confident in our ratings given its complexity. We can only speculate that the entire treatment would also be characterized by a high degree of analytic process. Perhaps, future data analysis from more extensive PQS rating of the treatment would reveal several repetitive interaction structures that correlate with outcome. In this particular session, however, a specific set of interactions that serves the process well involves A allowing P some room to resist, minimal confrontation at these moments, before resuming productive inquiry and exploration. (We would like to refer the interested reader to a review of the book, *From Psychoanalytic Narrative to Empirical Single Case Research: Implications for Psychoanalytic Practice*, in which there is a detailed examination of the treatment of Amalia X, by A. Werbart, *International Journal of Psychoanalysis* 90:1,459–70.)

We remain curious whether different process variables would be more and less characteristic and salient at different stages of this lengthy and in-depth treatment. We have found in other research that treatments often do not adhere solely to processes associated with a single therapeutic orientation

[16, 17, 21]. Rather, the PQS is likely to determine that integrated treatment processes are present to varying degrees at different points in treatment as the process evolves over time. Of course, it is also possible that the characterization of the process remains consistent over time.

Enrico Jones designed the PQS to measure psychotherapy process before the current emphasis on the importance of understanding active ingredients in psychotherapy treatments that transcend brand names [17, 22] He seemed to have predicted the future of research priorities. There is considerable research [23, 24, Chap. 1] that clearly demonstrates the effectiveness of psychodynamic psychotherapy as well as other modalities. Attention has now turned to research aimed at answering the more interesting and challenging question of "How does psychotherapy work?" The PQS is ideally suited to investigate this crucial question for psychodynamic and other psychotherapeutic interventions.

While the PQS is certainly ideally suited to single-case studies of long-term treatment [19, Chaps. 20 and 25], it has also produced a programmatic line of research into process correlates of outcome across a variety of short-term treatments including interpersonal and cognitive-behavioral therapy [15, 16, 21] and naturalistic samples of brief psychodynamic psychotherapy [17]. There are many exciting, future applications of the PQS. New research is already underway using the PQS alongside neuroimaging protocols to assess possible neural correlates of treatment processes. The PQS is also being used to assess the degree to which the use of the couch influences the development of analytic process. In addition, the PQS is being employed as a teaching tool in training programs to allow students to observe actual clinical processes and evaluate them empirically. Prototypes of different treatment processes, including the psychoanalytic process prototype reported in this chapter, are being used as adherence and competency measures.

With so much active research across the globe using the PQS, we have begun the process of revising the scoring manual and providing additional training aids to help new raters become more proficient raters as the integrity of the data and the ability to find important results rest on achieving reliable and valid ratings. As one can clearly see from this chapter, the PQS works hard to maintain the complexity of the clinical hour which, however, results in a complex rating process as well that must be conducted by judges with clinical experience who are sufficiently trained in the use of the measure. The future of psychoanalysis and psychoanalytic psychotherapy likely depends on our ability to study treatment processes and link them to outcome empirically. The PQS provides the technology to be able to do so.

References

1. Freud S. The Traumdeutung. Leipzig/Vienna: Franz Deuticke; 1900.
2. Erikson EH. The dream specimen of psychoanalysis. J Am Psychoanal Assoc. 1954;2:5–56.
3. Freud S. Fragment of an analysis of a case of hysteria. 7th ed. 1905. p. 7–122.
4. Sachs D. Reflection on Freud's Dora case after 48 years. Psychoanal Inq. 2005;25:45–53.
5. Luborsky L, Spence DP. Quantitative research on psychoanalytic therapy. In: Bergin AE, Garfield SL, editors. Handbook of psychotherapy and behavior change. New York: Wiley; 1971. p. 408–38.
6. Kächele H, Albani C, Buchheim A, Hölzer M, Hohage R, Jiménez JP, et al. The German specimen case Amalia X: empirical studies. Int J Psychoanal. 2006;87:809–26.
7. Thomä H, Kächele H. Comparative psychoanalysis on the basis of a new form of treatment report. Psychoanal Inq. 2007;27:650–89.
8. Wilson A. Multiple approaches to a single case: conclusions. Int J Psychoanal. 2004;85:1269–71.
9. Akhtar S. Diversity without fanfare: some reflections on contemporary psychoanalytic technique. Psychoanal Inq. 2007;27:690–704.
10. Jones EE. Therapeutic action. Northvale: Jason Aronson; 2000.
11. Stephenson W. The study of behavior: Q-technique and its methodology. Chicago: University of Chicago Press; 1953.
12. Block J. The Q-sort method in personality assessment and psychiatric research. Palo Alto: Consulting Psychologists Press; 1978 [Original work published in 1961].

13. Holt RR. Methods in clinical psychology, Predictions and research, vol. 2. New York: Plenum; 1978.
14. Jones EE, Pulos SM. Comparing the process in psychodynamic and cognitive-behavioral therapies. J Consult Clin Psychol. 1993;61(2):306–16.
15. Ablon JS, Jones EE. Psychotherapy process in the NIMH Collaborative Research Program. J Consult Clin Psychol. 1999;67(1):64–75.
16. Ablon JS, Jones EE. Validity of controlled clinical trials of psychotherapy: findings from the NIMH Treatment of Depression Collaborative Research Program. Am J Psychiatry. 2002;159:775–83.
17. Ablon JS, Levy RA, Katzenstein T. Beyond brand names of psychotherapy: identifying empirically supported change processes. Psychother Theor Res Pract Training. 2006;43(2):216–31.
18. Jones EE, Windholz M. The psychoanalytic case study: toward a method for systematic inquiry. J Am Psychoanal Assoc. 1990;38:985–1015.
19. Ablon JS, Jones EE. On analytic process. J Am Psychoanal Assoc. 2005;53(2):541–68.
20. Ablon JS, Goodrich C. Forword: Jones EE, Therapeutic action: a guide to psychoanalytic therapy: 1–3. London: Paterson Marsh; 2004.
21. Ablon JS, Jones EE. How expert clinicians' prototypes of an ideal treatment correlated with outcome in psychodynamic and cognitive-behavioral therapy. Psychother Res. 1998;8:71–83.
22. Blatt SJ. Polarities of experience: relatedness and self-definition in personality development, psychopathology, and the therapeutic process. Washington, DC: APA; 2008.
23. Levy RA, Ablon JS, editors. The handbook of evidence-based psychodynamic psychotherapy. Totowa: Humana Press; 2008.
24. Leichsenring FA. Review of efficacy and effectiveness studies in psychodynamic psychotherapy. In: Levy RA, Ablon JS, editors. The handbook of evidence-based psychodynamic psychotherapy. Totowa: Humana Press; 2008. p. 3–27.

Author Queries

Chapter No.: 26 0001331406

Queries	Details Required	Author's Response
AU1	Please provide complete details for the author "Helmut Thomä".	
AU2	Pease check if "broad-mindness" should be changed to "broad-mindedness" in the quoted text starting "Dr. Thomä's technique…".	
AU3	Please confirm whether it is reference citation in the sentence starting "When a rater…".	
AU4	Please check the hierarchy of the section level headings.	