5. GUIDED CLINICAL JUDGMENTS STUDIES

COMPARATIVE PSYCHOANALYSIS ON THE BASIS OF A NEW FORM OF TREATMENT REPORT: THE CASE AMALIA X[1]

Comparative Psychoanalysis

Although making comparisons, i.e. judging similarities and differences, is part and parcel of our life and of our professional thinking and acting, the phrase ”comparative psychoanalysis” has recently made its way into our professional vocabulary (Scarfone 2002). It refers to a qualitative comparison of various forms of psychotherapy, psychoanalysis among them. In view of the official recognition of psychoanalytic pluralism brought about by the courage of Wallerstein (1988, 1990, 2005a,b), we are now obliged to compare various psychoanalytic techniques and theoretical assumptions with each other. To make the comparison reasonable, reliable and fruitful, shared criteria are needed. In membership papers and published case reports, criteria are usually only implied, if not totally missing.

A corollary of “comparative psychoanalysis” is the growing interest in different ways of documenting clinical facts. Within the last decade an impressive number of original papers on this topic have been published. In his foreword to the special 75th anniversary edition of the *International Journal of Psychoanalysis*, devoted to ”Conceptualisation and Communication of Clinical Facts in Psychoanalysis” Tuckett (1994) wrote: ”After 75 years it is time not only to review our methodology for assessing our truth, but also to develop approaches that will make it possible to be open to new ideas while also being able to evaluate their usefulness by reasoned argument. The alternative is the tower of Babel” (p. 865). Therefore to make ”comparative psychoanalysis” a fruitful enterprise, it is essential to evaluate how the treating analyst applies his professional knowledge in specific interactions. In many respects, psychoanalysis is an applied science based on clinical observation, but for all kinds of practical reasons the analyst as participant observer would be overburdened by having to combine his therapeutic task with being at the same time the researcher. Therapy

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research in psychoanalysis is a most complex endeavor far beyond the capacity of the treating clinician working in isolation.

Only a team can do the job implied by Freud's "inseparable bond" thesis, namely that of testing the validity of causal connections observed in the analytic situation (see chap.1). The psychoanalytic literature abounds in vignettes about new discoveries which often even lack a convincing description. The "contemporary countertransference subjectivism" seems to solve all practical and scientific problems: If the emotions of the analyst indeed mirrored the unconscious of the patient correctly, if the "third ear or eye" heard or saw the unconscious voices and scenes (as Goethe imagined the "Urphaenomene") then without further ado psychoanalysts would be in a unique godlike position. Although we enjoy similar fantasies, we don't think they offer solutions.

To bring symptomatic - and let alone structural - changes into correlation with intersubjective processes and eventually with unconscious schemata as their determining conditions is a difficult undertaking. In other words: micro-analytic descriptions of intersubjective processes have to be related to whatever unconscious clichés generate typical patterns of symptomatic conflict-resolution. We will demonstrate the relationship between hypothesised unconscious processes and detailed interpretations in two session reports of Amalia X.

Our interpretation of the Junktim stresses the responsibility of the treating analyst. Clinical research originates in the analytic situation; everything depends on the participation of the analyst. To this extent there is some truth in the 'inseparable bond' thesis, especially if the context of the phrase is taken seriously. The Junktim is only fulfilled if its "beneficent effect" (in German: "wohltätige Wirkung") is proven. Our emphasis that treatment reports have to be centered on processes of change is once more justified. As those processes refer to manifest experiences and behavior and their assumed unconscious roots (Freud's template or schema), it is essential to discuss their relationship to the intersubjective processes in the psychoanalytic situation. Only parts of the patient's experience can be expressed in a "language of observation"; but to deny such a language to psychoanalysis, as Ricoeur (1970 p.366 ff.) did, is from our point of view unjustified.

Introductory Comments to the Audio-recording of Analytic Treatments

It is remarkable how many problems an analyst has to cope with when he gives a colleague the data from his work even more so if the dialogue is audio-taped and transcribed. Colleagues confirm more or less bluntly what one's self evaluation actually cannot overlook, namely that there can be a significant discrepancy between one's professional ideal and reality. The very idiosyncratic style of interpreting of any analyst makes some editing of the original text necessary.

Tape recording is a relative neutral procedure with respect to the contents of recording; it will not miss spoken words as long they are loud enough to be recorded. Transcripts often seem paltry in comparison to the recollections that the analyst has of the session. When reading a transcript or listening to a tape one has to revitalize the clinical situation by identifying with both, the patient or the analyst. It is the rich cognitive and emotional context that adds vitality to the sentences expressed by the patient and the analyst. It certainly will be a matter of training to fill in the gaps with the aid of one's imagination and one's own experience (like musicians able to read scores). In the traditional presentation of case material, which in general contains much less of the original data, this enrichment is provided by the author's narrative comments. Even the use of generalizations, for example, of the abstract concepts that are regularly employed in clinical narratives, probably contributes to making the reader feel at home. The concepts that are used are filled – automatically, as it were – with the views that the reader associates with them. If a report refers to trauma or orality, we all attribute it a meaning on the basis of our own understanding of these and other concepts that is in itself suited to lead us into approving or skeptical dialogue with the author.

For Sandler and Sandler (1984, p. 396) the "major task for future researchers" is "to discover why it is that the transcribed material of other analysts' sessions so often makes one feel that they are very bad analysts indeed." They qualify this by adding that this reaction "is far too frequent to reflect reality" and ask "can so many analysts really be so bad?" It is remarkable that the Sandlers made this comment in a special issue of the "Psychoanalytic Inquiry", devoted to Merton Gill's innovative contribution to psychoanalytic technique. Our somewhat ironic rejoinder to this observation is the following: Both of the Sandlers would belong to those bad analysts, if they had presented audio-taped dialogues without giving their thoughts and feelings to put the flesh on the verbal skeleton. In other words, oral reports convey some of the emotional climate of the analytic situation to the audience; but without

additional editing, and an augmentation of the transcribed material by the treating analyst, the pure written record alone is, indeed, paltry.

In retrospect we can say that the introduction of tape-recordings into psychoanalytic treatment was linked with the beginning of a critical reappraisal of therapeutic processes (Gill et al. 1968; Rosenkötter and Thomä 1970). This simple technical tool was, and still is the object of a subsiding controversy among psychoanalysts (Wallerstein 2003).

We believe that the introduction of research into the psychoanalytic situation is of great benefit to the patient. It enables the analyst to learn more than from any other kind of supervision. Clinical discussions based on audio-taped sessions come very close to the heart of the matter, if the analyst gives background information. A transcript creates the impression of being one-dimensional: the analyst's interpretation and the patient's answers do not automatically reflect latent structures, although typical interpretations disclose which school the analyst belongs to. Some 20 years after our empirical investigations of audio-recordings of psychoanalytic dialogues (Kächele et al. 1988) we would like to encourage our colleagues to use that instrument in order to improve their therapeutic capacities.

Two Sessions of the Case of Amalia[2]

The Need for Annotation

In order to enrich the understanding of the following sessions I shall give each intervention some background information. These "considerations" are subsequently added to the exchange between patient's and analyst´s responses. It is obvious that in arriving at my interventions I was led not only by the ideas described in the text. Whatever way interpretations have been created, any interpretation actually made must be aligned along 'cognitive' criteria, as demanded by Arlow (1979). My comments refer to the 'cognitively' and 'rationally' determined "end-products" (the interventions themselves) and neglect the intuitive, unconscious components in their genesis. Therefore I rarely refer to my countertransference. I am an eclectic psychoanalyst and an intersubjectivist (Thomä 2005). With regard to the countertransference I am as old-fashioned as Melanie Klein. I do not believe that countertransference is brought about by projective identification. There may be typical interactional patterns of transference and countertransference, but I think it is the responsibility of the analyst to make the best for the patient of his emotional reactions.

[2] Note the change the style of our text. The treating analyst (H.T.) speaks now in the first person.

The source of each of my analytic thoughts remains an open question. If we assume that the analyst's perceptive apparatus is steered by his personality, values and hopefully theoretical knowledge, which may have become preconscious, then it is very difficult to trace the genesis of interpretations back to their starting points. For example, theoretical knowledge about displacement also facilitates preconscious perception; it pervades the analyst's intuition and blends with his emotional reactions. These ”considerations” are my second thoughts. For all clinical and naturally controversial discussions, I recommend taking the background information as the starting point of our exchange. In other words, I hope that my considerations are coherent enough to be critically discussed. Such a coherence is important because it supports my hypotheses about the patterns in the patient.

Some Remarks about the Psychodynamic Background of the Two Sessions

When structuring the psychoanalytic situation and dealing with problems of the described type, the analyst must pay extra attention to not letting the asymmetry of the relationship excessively strengthen the patient's feeling of being different.

This is important because the idea of being different - that is, the question of similarity and difference, of identity and non-identity - forms the general framework within which unconscious problems appear. In this case the analyst and patient succeeded relatively quickly in establishing a good working relationship, creating the preconditions for recognizing during the development of the transference the internalization of earlier forms of interaction with primary reference persons – such as parents and teachers. The correction that was achieved can be seen in the changes in her self-esteem, in her increased security, and in the disappearance of her symptoms (see Neudert-Dreyer et al. this vol. chap. 5.3).

In retrospect, almost thirty years later, I have the following after-thoughts about my personal understanding of the psychoanalytic method at the time. I think I was quite successful in establishing a helping alliance which made it possible to make transference interpretations with regard to processes of ”displacement and condensation”. The head is the symbol for understanding and communication and simultaneously a symbolic expression of the penis and the phallus in the sense of Lacan.

The two excerpts of sessions given below are linked by the fact that each is concerned with enabling the patient to make new identifications as a result of the analysis of transference. The analyst's "head" became the surrogate of old, unconscious "objects," and its

contents the representative of new opportunities. The representation of the "object," which is simultaneously a self-representation, made it possible to establish a distance, because the analyst made his head available and kept it too. Thus he became a model for both closeness and distance. This example clearly demonstrates the therapeutic effect that insight into unconscious connections mediated by the analyst's interpretations can have. I think that my fantasies and thoughts tallied with the psychic reality of the patient.

I have selected this material because in my opinion it is suited to provide several lines of support to my argument. Although the head acquired sexual importance as a result of the process of unconscious displacement, this displacement did not alter anything regarding the primacy of emotional and intellectual communication, between the patient and the analyst, about what she was looking for as if it were hidden inside my head. The search for knowledge was directed at sexuality. This secret and well-guarded (repressed) treasure was assumed to be in the head (as the object of transference) because of the unconscious displacement. The revelation of "displacement" brought something to light that was "new" to the patient.

The two sessions are taken from a period of the treatment (No VII) when the patient explicitly experienced severe feelings of guilt, which were actualized in her relationship to me. The Biblical law of an eye for an eye and a tooth for a tooth was reinforced in her experience because of her sexual desires. Her life-historical role-model for the contents of her transference was a fantasized incestuous relationship to her brother. The increase in inner tension led the patient on the one hand to reconsider the idea of dedicating her life to the church as a missionary and on the other to contemplate committing suicide. (As a young girl she had wanted to become a nun and nurse, but gave up this idea after a trial period because the pious confinement became too much for her. Leaving also helped her to establish some distance from the strict biblical commandments.) Now she wielded her "old" Bible against me, "in a fight to the finish." This fight took place at different levels, and the patient invented a series of similes for them. She had the feeling that the analyst's dogma, the "Freud Bible," could not be reconciled with her Christian Bible. Both bibles, however, contained a prohibition of sexual relations with the analyst.

The patient struggled for her independence and needs, which she defended against both of these bibles. She developed an intense defense against my interpretations, and she had the feeling that I knew in advance exactly "what's going to happen." She felt humiliated because her detours and distractions had been detected. She had the intense desire to mean something

to me and to live in me; she thought about giving me an old, lovely, and wonderful clock that would strike every hour for me (and for her).

In this phase of the treatment one topic took on special significance and intensity: this was her interest in my head. What had she learned from measuring my head? In a similar situation Amalia X had once said that for a long time she had thought that I was looking in her – of what was already there – in books, in my thoughts, in my head. She wished that something completely new would come out. She herself looked for interpretations and made an effort to understand my ideas.

Transcripts of Parts of Sessions 152 and 153

At the beginning of the session Amalia reported an uncanny dream in which she was stabbed in the back by a man, thus she introduced the general topic of a fight between a man and herself with all the different levels and meanings of fights between the sexes. Then Amalia changed her role as a victim and became a perpetrator. In the next session she remembered that she had completely forgotten that she had looked on me as a young man with a head symbolizing a phallus. Her momentary forgetting is a beautiful example of Luborsky's (1967; 2001) attention to small parapraxes as symptoms.

At first Amalia reporting about her chief fell into a role of masochistic subordination and I commented by saying:

A: *You presume that I'm sitting behind you and saying "wrong, wrong*.

Consideration. This transference interpretation was based on the following assumption. The patient attributed to me a "superego function." This interpretation took the burden off her and gave her the courage to rebel (the patient had recognized long before that I was different and would not criticize her, but she was not sure and could not believe it because she still had considerable unconscious aggressions against old objects). I assumed that she had much more intense transference feelings and that both the patient and I could tolerate an increase in tension. I repeated her concern that I could not bear it, and finally formulated the following statement: "Thus it's a kind of a fight to the finish, with a knife" (not specifying who has the knife). I made this allusion to phallic symbolism to stimulate her unconscious desires. It was an overdose! The patient reacted by withdrawing. Assumption: self-punishment.

P: Sometimes I have the feeling that I would like to rush at you, grab your neck, and hold you tight. Then I think, "He can't take it and will suddenly fall over dead".

A: *That I can't take it*.

The patient varied this topic, expressing her overall concern about asking too much of me and of my not being able to tolerate the struggle.

A: *It's a kind of a fight to the finish, with a knife*.

(This interpretation alludes to Amalia's dream about being stabbed, reported at the beginning of the session..)

P: Probably.

She then reflected that she had always, throughout the years, given up prematurely, before the struggle had really begun, and withdrawn.

P: And I don't doubt any more that it was right for me to withdraw. After such a long time I have the urge to give up again.

A: *Withdrawal and self-sacrifice in the service of the mission instead of struggling to the end.*

P: Exactly, nerve-racking.

Consideration. She was very anxious about losing her object.

A: *Then I would have the guarantee of being preserved. Then you would have broken off my test prematurely*.

We continued on the topic of what I can take and whether I let myself be carried along by her "delusion." The patient had previously made comparisons to a tree, asking whether she could take anything from it, and what it would be. I returned to this image and raised the question of what she wanted to take along by breaking off branches.

Consideration. Tree of knowledge – aggression.

P: It's your neck, it's your head. I'm often preoccupied with your head.

A: *Does it stay on? You're often preoccupied with my head?*

P: Yes, yes, incredibly often. From the beginning I've measured it in every direction.

A: *Hum, it is . .*

P: It's peculiar, from the back to the front and from the bottom. I believe I'm practicing a real cult with your head. This is just too funny. With other people I'm more likely to see what they have on, just instinctively, without having to study them.

Consideration. To create shared things as primary identification. [This topic was discussed for a long period of time, with some pauses and "hums" by the analyst.]

P: It's simply too much for me. I sometimes ask myself afterwards why I didn't see it, it's such a simple connection. I am incredibly interested in your head. Naturally, what's inside too. No, not just to take it along, but to get inside your head, yes above all, to get inside.

Consideration. The partial withdrawal of the object increased her unconscious phallic aggressiveness.

The patient spoke so softly that I did not even understand "get inside" at first, mistaking it for "put inside." The patient corrected me and added a peculiar image, "Yes, it's so hard to say in front of 100 eyes."

P: Get inside, the point is to get inside and to get something out.

Consideration: I saw this getting inside and taking something out in connection with the subject of fighting. It was possible to put the sexual symbolism, resulting from the displacement from the bottom to the top, to therapeutic use by referring to a story that the patient had told in an earlier session. A woman she knew had prevented her boyfriend from having intercourse with her and had masturbated him, which she had described by analogy to head-hunter jargon as "head-shrinking." The unconscious castration-intention dictated by her penis envy created profound sexual anxiety and was paralleled by general and specific defloration anxieties. These anxieties led in turn to frustration, but one which she herself had instinctively caused, as a neurotic self-perpetuating cycle. The repression of her sexual and erotic desires that now occurred unconsciously strengthened the aggressive components of her wanting to have and possess (penis desire and penis envy).

A: *That you want to have the knife in order to be able to force your way in, in order to get more out.*

After we exchanged a few more thoughts, I gave an explanation, saying that there was something very concrete behind our concern with the topics of getting inside, head, and the fight to the end with a knife.

A: *The woman you mentioned didn't speak of "head shrinkers"[3] for nothing.*

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[3] The derogatory colloquial "headshrinker" (=psychiatrist) has no German counterpart and is unknown to Amalia. Her expression "Schrumpfköpfe machen" refers to a custom of Polynesian cannibalistic warriors who dry up the heads of enemies they have killed.

P: That's just the reason I broke off this line of thought. [For about ten minutes the patient had switched to a completely different subject.]

After expressing her insight into her resistance to an intensification of transference, she again evaded the topic. She interrupted the intensification, making numerous critical comments.

P: Because at the moment it can be so stupid, so distant. Yes, my wishes and desires are the point, but it's tricky, and I get real mad, and when head and head shrinking are now . . .

She laughed, immediately expressed her regret, and was silent. I attempted to encourage her.

A: *You know what's in your head.*

P: Right now I'm not at all at home in mine. How do I know what will happen tomorrow. I have to think back. I was just on dogma and your head, and if you want to go down . . .[to a shrunken head]. It's really grotesque.

Consideration. I first mentioned the shrunken heads because I assumed that the patient would be more cooperative if the envious object relationship could be replaced by a pleasurable one. Then the patient came to speak of external things. She described how she saw me and how she saw herself, independent of the head, which then again became the focus of attention in a general sense.

A: *By thinking about the head you're attempting to find out what you are and what I am.*

P: I sometimes measure your head as if I wanted to bend your brain.

The patient then described the associations she had once had when she had seen my picture printed somewhere.

P: I discovered something completely different at the time. There was an incredible amount of envy of your head. An incredible amount. Now I'm getting somewhere at any rate. Whenever I think of the dagger and of some lovely dream.

Consideration. The patient obviously felt caught. She felt humiliated by her own association, as if she had guessed my assumption as to what the envy might refer to. In this case I would have rushed ahead of her, so to speak.

A: *Humiliating, apparently to you, as if I already knew which category to put it in when you express envy, as if I already knew what you are envious of.*

P: That came just now because you had referred to the shrunken heads, which I didn't even make. But what fascinated me is this fight to the finish, for the knife, to get to the hard part . . . .Yes, I was afraid that you couldn't take it. My fear that you can't take it is very

old. My father could never take anything. You wouldn't believe how bland I think my father is. He couldn't take anything.

Consideration. A surprising turn. The patient's insecurity and her anxiety about taking hold developed "unspecifically" on her father.

A: *It's all the more important whether my head is hard. That increases the hardness when you take hold.*

P: Yes, you can take hold harder . . .and can - simply - fight better.

The patient then made numerous comments to the effect of how important it was that I did not let myself be capsized, and she returned to her envy. Then she mentioned her university studies again, and how she used to "measure" the heads of the others. Then she introduced a new thought.

P: I want to cut a little hole in your head and put in some of my thoughts.

Consideration. An objectivistic image of "intellectual" exchange as a displacement?

The patient's idea about the two-sided nature of the exchange led me to recognize another aspect of this fight. It was also an expression of how important it was to me that she remains a part of the world (and in contact with me), and digress neither into masochistic self-sacrifice nor into suicide.

P: That came to me recently. Couldn't I exchange a little of your dogma for mine. The thought of such an exchange made it easier for me to say all of this about your head.

A: *That you continue coming here so that you can continue filling my head with your thoughts.*

Consideration. Fertilization in numerous senses – balance and acknowledgment of reciprocity.

P: Oh yes, and mentioning really productive ideas.

The patient returned to the thoughts and fantasies she had had before the session, about how she had been torn back and forth. Whether she had a future at all, and whether she shouldn't withdraw in some way or other and put an end to it all.

At the beginning I had attempted to relieve her intense feelings of guilt with regard to her destructiveness. I picked up the idea once again that her thoughts about my stability were in proportion to her degree of aggressiveness. The patient could only gain security and further unfold her destructiveness if she found strong, unshakable stability. The topic of dogmatism probably belonged in this context. Although she criticized it - both her own Bible and my

presumed belief in the Freud bible - it also provided her security, and for this reason the dogmatism could not be too rigorous or pronounced.

A: *Naturally you wouldn't like a small hole; you would like to put in a lot, not a little. The idea of a small or large hole was your shy attempt to test my head's stability.*

My subsequent interpretation was that the patient could also see more through a larger hole and could touch it. She picked up this idea:

P: I would even like to be able to go for a walk in your head.

She elaborated on this idea and emphasized that even earlier, i.e., before that day's session, she had often thought to herself how nice it would be to relax in me, to have a bench in my head. Very peacefully she mentioned that I could say, when looking back on my life when I die, that I had had a lovely, quiet, and peaceful place to work. (My office was opposite a very old cemetery, now used as a park.)

Consideration. Quiet and peacefulness clearly had a regressive quality, namely of completely avoiding the struggle for life.

The patient now viewed her entering the motherhouse as if a door had been wide open and she had turned away from life. She then drew a parallel to the beginning of the session, when the door was open.

P: I really didn't have to drill my way in. Yes, there I could leave the struggle outside, I could also leave you outside, and you could keep your dogmas.

A: *Hum.*

P: And then I wouldn't fight with you.

A: *Yes, but then you and your dogma would not be afraid of mine. In that setting of peace and quiet everything would remain unchanged, but the fact that you interfere in my thoughts and enter my head shows that you do want to change something, that you can and want to change something.*

About five minutes into the next session (153), the patient returned to my head and measuring it and to the fact that it had disturbed her that I had started talking about the shrunken heads.

P: I told you so. Why do you simply want to slip down from the head?

She then described how she had hardly arrived at home before she recalled the thoughts she had had when she had said hello but then had completely forgotten during the session.

P: To me, he [the analyst] looks as if he is in his prime, and then I thought about the genitals and the shrunken heads. [But she quickly pushed this thought aside, and it was

completely gone.] When you started with the shrunken heads, I thought, "Where has he got that again?"

The next topic was the question of my security and my dogmatism, and it was clear that the patient had taken a comment I had once completely undogmatically made about Freud and Jung (I have forgotten what it was) to be dogmatic. She then thought about living a full life, about the moment when everything stopped for her and she became "ascetic," and about whether everything could be revived. Then she again mentioned fighting and my head.

P: I was really afraid of tearing it off. And today I think that it's so stiff and straight, and I think to myself, "I somehow can't really get into my head. I'm not at home. Then how should I get into yours?"

The patient then began to speak about an aunt who was sometimes so very hard that you might think you were facing a wall. She then continued about how hard and how soft she would like her head to be. Her fantasies revolved, on the one hand, around quiet and security; on the other hand, she was concerned about what might be hidden in her head and the danger of it consuming her.

Consideration. This obviously involved a regressive movement. The patient could not find any quiet and relaxation because her sexual desires were linked with pregenital fantasies, which returned in projected form because they were in danger of being consumed. These components were given their clearest, and in a certain sense also their ultimate, expression in an Indian story the patient later associated, in which mothers gave pleasure to their little sons by sucking on their penises but bit them off in the process.

The comparisons of the heads and their contents always revolved around the question of whether they went together or not.

P: The question of how you have your thoughts and how I have mine . . .Thoughts stand for many things . . . .

A: *How they meet, how they rub off on one another, how far they penetrate, how friendly or unfriendly they are.*

P: Yes, exactly.

A: *Hum, well.*

P: You said that a little too smooth.

The patient thought about all the things that scared her and returned again to the shrunken heads.

P: There I feel too tied to sexuality. The jump was too big.

The topic was continued in the question of her speed and of the consideration I pay to her and her speed.

P: But it is true; naturally it wasn't just your head but your penis too.

Amalia X was now in a position, with phases of increasing and receding anxiety, to distinguish between pleasure from discovering intellectual connections and sexual pleasure. The couch became her mental location of sexual union, and her resting in my head the symbol of pregenital harmony and ultimately the location of shared elements and insight. This aspect became even clearer a little later.

Discussion

Comparative evaluation

The claim of this communication was to provide data for a comparative evaluation. In the center of the psychodynamic focus of the two sessions is the process of displacement within the patient's body-image into the transference. The head is used as a transference object. At the same time the patient uses the analyst's thought processes localized in his head as new experience in order to overcome transference repetitions. Insofar, the two sessions contain changes brought about by the offer of the thoughts and feelings of the analyst as a new object (Loewald 1960, Gabbard and Westen 2003). From a microanalytic point of view the verbatim protocol contains details, which cannot be covered by the molar abstraction of the session.

An alternative conceptualization, based on the Weiss – Sampson plan analysis of the patient´s material (see chap. 5.7) pointed to traumatizing experiences of early upbringing. The analyst, although knowing about these early experiences gave less weight to these early experience in his case conception. He was convinced –whatever the early experiences had been - that the salient impact would had to come from a corrective emotional experience within a new subject-object relationship in order to attain new internalized structures. In this sense we fully agree with Weiss´ ideas about unconscious efforts of patients to disconfirm their unconscious, pathogenic, grim beliefs.

The comparative evaluation of these two case conceptions in the case of the specimen session 152 leads to an interpretation that the patient´s wish to reside peacefully in the analyst´s head not only signifies a phallic intrusion as some discussant of the case

presentation in New Orleans have pointed out – but also could represent the patient´s pregenital wish for reunion with her mother. This unconscious phantasy could reflect the reparation of the early cumulative traumatizing separations experiences. The experimentum crucis consists in identifying behaviors and experiences of the patient that could be weighted for or against these two macro-conceptions. However the psychoanalytic proposition of overdetermination would not rule out that both interpretations have their own justification for which empirical referents have been identified. Therefore the concept of mini-models in smaller or more extended form linked up to our concept of focal conflicts points to a crucial issue: without such signposts marking meso-working models the analyst easily gets lost in almost infinite microscopic states of mind. Taking into accounts the conscious activity has a time window of about 3 sec it becomes obvious that such models are operating below consciousness and are guiding the analyst´s listening and observational capacities. A beautiful example of such an unconcious model of psychic function has been spelled out by Spence et al. (1994) describing the monitoring process.

Collegial discusssions

As this material was presented at a panel held at the 43rd Congress of the International Psychoanalytical Association, New Orleans, we quote from the final panel report by Wilson (2004):

> Jimenez discussed the issues along four dimensions: (1) what made agreement difficult was that everyone defines clinical material from a very different point of view; (2) everyone struggled with how to discuss clinical material in a respectful way and avoid the temptation to 'supervise' the technique of the Ulm-based presenters; (3) an exuberance of theory and scarcity of empirical observations (4) there was a wide consensus throughout the panels, that, no matter what the difference in theoretical perspective, the patient-analyst dyad was proceeding in a way that could be described as characterized by a 'psychoanalytic process' and what was interesting was that panellists of different persuasions provided different descriptions of how the sessions were evolving, although all agreed that a psychoanalytic process was present. (Wilson 2004, p. 1269)

Beyond this friendly bonfire of agreement we felt that S. Akhtar´s discussion of the technical points of this analysts presentation were quite enlightening:

Like his developmental understanding, 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. Six such measures, evident in his approach, are the following:

Forming a helping alliance

Dr. Thomä emphasizes that forming a 'helping alliance' (Luborsky, 1984) is an important therapeutic task in the beginning phase of the analysis. Far from fostering regressive dependence, encouragement of realistic hope and assistance in developing unused mental abilities goes a long way in enhancing the 'working alliance' (Greenson, 1967) and thus the analysis of transference. The analyst's open acknowledgement of the inherent awkardness of the psychoanalytic situation, for instance, paradoxically causes the patient to relax. The analyst's explanatory attitude towards pauses in the flow of their dialogue serves the same function. Discussions of how the analytic dialogue differs from social discourse, how free association facilitates the discovery of hidden meanings, and how the analyst's not providing factual answers to the patient's questions also lead to the patient's greater participation in the analytic process (Thomä and Kächele, 1994b, p. 35-38). Helping to get analyzed and analyzing are not enemies; they are friendly cousins.

Titrating the asymmetry gradient

Dr. Thomä acknowledges that a certain asymmetry within the dyad is essential for the analytic process to occur. However, the gradient of this asymmetry needs to be carefully titrated lest it add to the patient's feeling inferior and alienated. All this is important because the patient must experience both affinity and difference within the dyad; the former facilitates trust and self-revelation, and the latter helps in learning about oneself and assimilation of insights. In Stone's (1980) words, the former meets the condition of 'resemblance' that is necessary for the development of transference and the latter places the analyst in a position to interpret the transference.

Dr. Thomä's equanimity and his viewing a patient's desire to read his papers and books as quite natural, even healthy, is a testimony to his respect for the patient's need for affinity. His stance on accepting gifts from a patient also exemplifies this point. He

is opposed to categorically rejecting all such offers. In opposition to the prevalent view that accepting gifts derails analysis of such a gesture, he posits that 'rejecting presents often prevents analysts from recognizing their true meanings' (p. 301). He acknowledges that accepting gifts can complicate matters but emphasizes that rejecting them can increase the asymmetry of the dyad to a painful extreme and the consequences might sometimes be irremediable. It is in the same spirit that Pine's (1998) reminds us that the usually helpful aspects of psychoanalytic frame (e.g. couch, time limits, not giving information about where one is going for vacation) can be traumatic to some individuals, is in the same spirit.

Correcting major distortions of reality

As analysts we constantly bear and 'contain' (Bion, 1967) patient's distorted views of us as well as of external reality. We hope that a piecemeal deconstruction of such scenarios would provide the patient a greater ego dominance over internal realities. Dr. Thomä certainly concurs with this stance but adds that the analyst must provide corrective information when there is a genuine matter of ignorance (e.g. in the treatment of fresh immigrants, an example he does not mention but I think would find agreeable) and when the patient's reality testing is getting seriously compromised. (Akhtar in press).

The analyst commmented on this evaluative statement as follows:

Dr. Akhtar's evaluation is gratifying. Indeed I was surprised about his capacity to discover my psychoanalytic attitude as expressed in the verbal communication. It is a very rare event in my professional career that a colleague just by reading a few transcribed sessions is able to describe in a colourfull language the theory of a colleagues technique. He attested to me flexibility, resilience and broad-mindness.

Of course I am pleased about it and even more so for a very special reason: I started this analysis about 35 years ago, long before I met Merton Gill and before I was influenced by his turn towards intersubjectivity. Akhtar's evaluation is therefore especially noteworthy as a proof of my independent development towards relational psychoanalysis.

Akhtar extracts a most important issue of my psychoanalytic thinking, which is documented in these two sessions: The head is the autonomous location of the

individual mind and in so far the organ of individual perspective on transferences and countertransferences. At the same time, the head can be used by mechanisms of displacements to differentiate various aspects of the intersubjective processes in the psychoanalytic situation, which is a permanent task. These sessions are good examples for displacement within the body image and a demonstration of beneficial therapeutic action in the psychoanalytic encounter. (Akthar 2007)

EMOTIONAL INSIGHT[4]

Introduction

The mechanism of therapeutic change in psychoanalysis has been a matter of discussion since long (Luborsky and Schimek 1964). On the one hand the analysis of resistance and the uncovering of unconscious conflicts or of repressed memories is expected to result in changes of cognitive styles and of manifest behavior. On the other hand the patient will approach this task only in the framework of actual interactions with his analyst (Gill 1982). Monadic and dyadic points of view are mixed up even in theories of transference and of the therapeutic relationship, as Thomä and Kächele (1994a) pointed out.

Insight is regarded as one of the central concepts of psychoanalytic treatment: therapeutic change should result from gaining insight and not from behavioral training or from suggestions of the analyst. However, it has been difficult to define and to put into operational terms the concept of insight for empirical studies (Roback 1974; Fisher and Greenberg 1977; Messer and McWilliams 2007). The concept sometimes refers to a goal of treatment (Myerson 1965), to a prerequisite of change (Segal 1962), to a personality attribute, or even to an epiphenomenon of therapeutic change (Fonagy 1999a). These debates are summarized neatly by Connolly Gibbons et al (2007):

> One central question that has not been addressed is wether the task of therapy is to make patients generally more insightful, or wether what is crucial is obtaining insight about one or a few central issues. Arguments could be made in both types of gains in insight. Psychotherapy may function, in part, by teaching the skills of acquiring insight... To the extent that such skills are acquired, there is a greater likelihood that an important specific insight is obtained, leading to improvements in symptoms and functioning. (p. 161).

The most recent agreed upon definition by an impressive number of researchers from all diverse kinds of therapy runs as follows:

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[4] Roderich Hohage & Horst Kächele

> Insight usually is conscious (as opposed to unconscious or implicit) and involves both a sense of *newness* (i.e., the client understands something in a new way) and in making *connections* (e.g. figuring out the relationship between past and present events, the therapist and significant others, cognition and affect, or disparate statements). Hence, most of us agreed that we could define insight as a conscious meaning shift involving new connections (i.e., "this relates to that" or some sense of causality). (Hill et al. 2007, p. 442)

This corresponds to agreement among psychoanalytically oriented scientists that a kind of integrative activity of mind is a predominant feature of insight (Kris 1956). Scharfman (see the panel report by Blacker 1981) presented a very short definition: "Insight is bridging different levels of mind." (p. 660). The term 'emotional insight' refers to the fact that self-knowledge is not sufficient to produce changes in patients. Emotional aspects have to be integrated with cognitive aspects of self-awareness.

We regard emotional insight as integration of different frameworks of self-perception. Inner experiences can either be perceived on a framework of emotional reactions or on a framework of cognitive judgments (Caspar and Berger 2007). The patient deals with self-perceptions in an insightful manner if he is able to integrate the emotional access with a cognitive access to inner experiences. If we define insight in this way there are striking similarities between insight and the concept of tolerance of ambiguity (Frenkel-Brunswik 1949). Different frameworks of a self-perception have influence similar to the stimulus ambiguity of outer perceptions and they may provoke certain psychic conflicts (Hohage 1986). As Kafka (1971) pointed out, tolerance of ambiguity in self-perception and in social interaction is a prerequisite of emotional growth.

Method: The Rating Procedure

The Emotional Insight Rating Scale is a content analysis approach using verbatim transcripts of psychotherapeutic sessions. The raters do not have to be clinically trained because the judgments are based on the language characteristics and not on clinical inferences. The rater has mainly to follow his intuitions based on his knowledge of the natural language and his common sense.

Coding units are single significant statements by the patient with a minimum length of ten lines of text. A significant statement is delimited either by the analyst's statements or by pauses of a minimum of ten seconds.

1. *Extent of Experiencing*: the coding units are rated on a 6-point scale (gwE-Scale) according to the extent of experiencing included. There are two points of view that must be taken into account. First, experiencing requires references in the patient's statements to his "inner world", to his thoughts, feelings, fantasies and wishes. If he only deals with concrete interactions or with descriptions of other people or of situations, there is no reference to experiencing. It must be possible to reformulate his statements in a meaningful way according to a statement such as: "The patient is internally ... or internally does..." Second, statements of the patient refer to experiencing only if the patient focuses his attention on this inner world. He has to deal with it consciously and to refer directly to it. The nature of insight requires that the patient recognizes internal acts. This operationalization of experiencing has important consequences: even if a patient is accusing another person in an emotional way, his statements are not rated as revealing experiencing unless he refers consciously and directly to his own feelings. If the coding unit does not refer to any experiencing, it is excluded from further ratings.

2. *Emotional Access*: the emotional access to experiencing is determined by rating on a 5-point scale to assess how much the patient is immersed in his experiences (Sub-Scale E). We choose the phrase "immersed in experiences" because it has connotations of "feelings," "lack of control," and even "overwhelmed." By analyzing portions of text that obviously showed a strong emotional access to experiencing we found three main factors indicating modes of being immersed:

a) The intensity and vividness of the experienced feelings.

b) The extent of imaginative plasticity of the experiences.

c) The extent of the spontaneity and presence of experiencing.

The first indicator refers mainly to the patient's affectivity while the second and the third indicators refer more to the primary process thinking or to the concept of regression in the service of the ego.

The following statement may illustrate how the patient is immersed in her experiencing:

> Oh, that girl, Cathy! I think sometimes I wanted to kill her! I guess she is the only person I would like to put my hands around her throat and choke — where really I must be aware not to have really bad wishes toward her; really bad, you know. She is so, so domineering and haughty, when I imagine how she walks and how she writes her name. I know about each piece of her hair and her skin and I detested her. I hated her like nobody else.

3. *Cognitive Access*: The cognitive access to experiencing is determined by rating on a 5-point scale, the degree to which the patient is at a distance from his experiences (Sub-Scale C). Again, by analyzing typical statements, we isolated three factors indicating that the patient is at some distance:

a) The extent to which the patient observes his experiencing, wonders about it and describes it ironically or expresses it in abstract terms.

b) The extent to which the patient evaluates his experiencing by classifying, by judging, by summarizing, or by confronting it with reality.

c) The extent to which the patient tries to give logical explanations or to analyze his experiences.

The cognitive access to experiencing is illustrated by the following statement:

> In a certain way I suspect that this behavior of mine is sort of tricky, and that it always plays a role. But when I reflect on this, and when I try to find my own way of living, then I am aware that it is necessary to keep on this way, and that I have to clarify my point of view, and strengthen my convictions. I think in the area of sexuality I´ve changed my mind in recent years, and the only problem is that I can´t discuss this point of view in the right way.

4. *Rating of Ambiguity*: The raters were instructed to judge the coding units on Sub-Scale E and Sub-Scale C independently, although the scales are in some respect antagonistic. Normally opposites do not vary independently. However the independent rating procedure opens the possibility that the emotional as well as the cognitive access to experiencing is integrated and therefore present at the same time. In this case we regard the contradictions to be logical ones and integration of this contradiction is synonymous with logical ambiguity. The following statement represents this kind of logical ambiguity:

> The water in that dream, so much water! That was incredibly exciting, how this woman pulled the wagon through the water and it splashed around and she had trouble

keeping the wagon on track. That was a — Oh, the water! (Laughs) Now I know, oh I know what it means, the water and splashing, and before that the snake as a symbol. Oh I don't have to go on. Lately I've been very fascinated reading a report that described the origin of life, proteins, sperm, procreation ... extraordinary and fascinating!

The combination of two sub-scales denoting opposite dimensions includes four extreme positions, as shown in Figure 5x1.

{Figure 5x1 about here}

Figure 5. 1 Extreme Positions Obtained by the Combination of Sub-Scales E and C

Polarization reflects a position in which only one access to experiencing is present. Logical ambiguity reflects a position where both kinds of access are present at the same time. If neither an emotional nor a cognitive access is present in the given text, the patient is in a neutral position. The scores of sub-scale E as well as of sub-scale C indicate some kind of active involvement of the patient. In a neutral position there is no involvement at all. We assess the total involvement of the patient by adding the scores of the sub-scales E and C (IN-Score = E/2+C/2)

In principal, ambiguity can be calculated by multiplying the scores of both sub-scales. By definition no ambiguity is observable when one sub-scale has a zero score; multiplication therefore is an adequate operation. We observed, however, that sometimes by chance there are high scores on both scales without any integration, because being immersed and being at a distance are not related to each other. To avoid such pseudo-ambiguity, the rater has to judge the extent of ambiguity on a separate 5-point rating scale (EC-Scale). He has to especially take into account the degree of tension between being immersed and being at a distance at the same time.

In summary the rater has to answer the following questions regarding the manual instructions:

1. Which are the coding units?
2. How important is the experiencing reported according to the weighting-scale?
3. How intense are the emotional access and the cognitive access to experiencing?

4. What is the extent of ambiguity?

The verbatim transcripts are judged by three raters. They obtained 5 scores from each statement: gwE-Score, E-Score, C-Score, EC-Score, and the IN-Score.

Empirical Investigations

We now report on changes of emotional insight in the course of the psychoanalysis of Ms Amalia X, our research case. We compared the initial phase of the treatment that is, the first eight sessions to the eight sessions just before termination. As the treatment was successful according to clinical judgment as well as psychodiagnostic test results we expected that there would be more insight at termination than at the beginning. Therefore, all significant statements of the initial phase and of the termination phase were rated on the emotional insight scales. The rates doing this job were blind to the location of the session. Table 1 shows the reliability of these ratings. Following thorough training, 3 raters showed a high degree of agreement, with reliabilities ranging between 0.85 and 0.88.

	Cronbach Alpha Coefficient. (pooled for 3 judges)
E - Score	0.87
C - Score	0.87
EC - Score	0.85
IN - Score	0.88
gwE - Score n=216	0.88

Table 5x1 Reliability of Statement Scores

In comparing the initial phase of this treatment to the termination phase, we had to take into account that there are time-series dependencies among the statements during each session, so that for statistical evaluation we could not treat the single statements as independent test samples. No time-series dependency however was detected when we compared not single statements, but the mean-scores for each session.

Mean Score of Sessions	E-Score	C-Score	EC-Score	IN-Score	gwE-Score
Session 1 - 8	1.04	1.24	0.31	1.14	1.42
Session 510 - 517	1.63	1.16	0.68	1.39	1.79
n = 16	p < 0.01	n.s.	p < 0.01	p < 0.05	p < 0.01

Table 5x2 Average of Eight Mean Scores of the Initial Phase and of Eight Mean Scores of the Termination Phase

Table 5x2 shows the average of 8 mean scores of the initial sessions and of 8 termination sessions. The table reveals that there is significant increase of the emotional access, of ambiguity, of involvement and of experiencing. The scores for the cognitive access show a slight decrease at the termination phase. We determined the p-value from the t-test (one-tailed). Although the number of cases is only 8 in each sample, the differences are statistically significant with the exception of the C-Scores.

The data indicate that the emotional insight increased, as we expected. The increase in the emotional access is of special clinical interest also because the patient, as described before, reacted in a self-conscious, often obsessive-compulsive manner, which is reflected in the high C-Scores in the initial phase. In this case particularly, the increase in emotional involvement appears to be an important indicator of therapeutic change.

Discussion

We have reported on a method for assessing certain aspects of emotional insight and we have demonstrated changes in emotional insight in the course of early and late sessions taken from psychoanalysis.

This approach consists of a quantitative assessment not only of insight itself but of the emotional and the cognitive involvement of the patient as well. Of course therapeutic change is reflected not only by different insight scores. Nonetheless it may indicate an important step if the patient begins to deal with himself and not only with other persons. In such cases an increase in the extent of experiencing is a relevant result. The patient

described in this report however seems to be psychologically minded and often deals with her own thoughts and feelings. Therefore, changes in the experiencing score here are of less importance. On the other hand, under the impact of psychic conflict this patient seems to strengthen her cognitive access to experiencing and it is therefore an important therapeutic change that, under the pressure of termination, she is able to remain emotionally involved. This finding is supplementary to the finding of increased insight scores.

By rating not only integration, but the emotional and the cognitive access separately as well, we differ from other content analysis approaches that quantify related phenomena, such as the Meaningfulness Scale of Isaacs and Haggard (1966), the Productivity Scale of Simon et al. (1967) and especially the Experiencing Scale, provided by Gendlin and Tomlinson (1962). The Experiencing Scale has some striking similarities to our approach, but the cognitive dimension is neglected, as criticized by Wexler (1974) and Bense (1977). Another recent interesting measure is the Rutgers Psychotherapy Progress Scale (RPPS; Messer and Mc Williams 2007) "that was designed to measure patient progress using context that precedes the material to be rated". (p. 21).

One has to take into account however that this approach only determines certain aspects of insight, not insight itself. By focusing on the patient's access to experiencing, the concept of insight as an increase in self-knowledge or of insight as awareness of unconscious motives is neglected. We cannot rule out that the patient may report in an insightful way but about insignificant matters, or that she draws the wrong conclusions. The correctness of her conclusions or the significance of her thoughts can be decided only by clinical judgment, and this judgment may itself be right or wrong. On the other hand, a decrease in emotional insight as well as an increase in resistance, if observed in the course of psychoanalytic treatment, cannot simply be regarded as a step backward. The psychoanalytic process has more than one dimension and becoming more insightful is only one among many targets of the process. In the service of therapeutic progress it may be necessary that the patient develops resistances and activates conflicts. Only if it is impossible to overcome such resistances and to work through relationship problems, will the therapeutic effect be questioned. We offer the emotional insight scale to help study such developments and thereby contribute to the understanding of the therapeutic process.

CHANGES IN SELF-ESTEEM DURING A PSYCHOANALYTIC THERAPY[5]

Self-esteem as a Concept in Treatment Research

In the personality research of recent years, self-esteem and a number of related concepts have played an increasingly important part, as Cheshire and Thomä (1987b) have shown. This development has continued; at present clinical aspects are discussed as well (Bracken 1996). Stipulated by the theory of mentalization – the theory-of-mind discussion in developmental psychology - a psychoanalytic highly relevant discussion was opened (Fonagy et al. 2002).

In systematic empirical psychoanalytic research, such concepts as self-esteem largely have been neglected. Nevertheless, it is precisely this concept which can, in our opinion, most readily create meaningful links between process and outcome research, because it is a variable, equally relevant to both process and outcome. If the process of therapy is understood as a gradual acquisition of certain attitudes and abilities, and if outcome is assessed in terms of the possession and availability for action of these very attitudes and abilities, then it follows that the researcher should gather information about those features of the patient that are reflections of this process of acquisition and its stability of outcome.

In psychoanalytic theory-construction, and also in clinical practice, self esteem was for a long time regarded as an epiphenomenon without greater psychodynamic importance. Freud used the concept not so much as a technical term but somewhat colloquially, though in close connection with the idea of narcissism. He mentions (1914c) three factors which constitute self-esteem:

(1) Everything a person possesses or achieves, every remnant of the primitive feeling of omnipotence which experience has confirmed;

(2) The fulfillment of the ego-ideal which represents the lost narcissism of infancy;

(3) The satisfaction of being loved in the context of a narcissistic object-choice.

Self-esteem acquired theoretical and clinical importance in connection with the wider dissemination of the concept of narcissism and its revised formulation (Kohut, 1971, 1977). But also, independently of its involvement in narcissism-theory (and consequently also in drive-theory), increasing attention was being paid within psychoanalysis to the self and

[5]Lisbeth Neudert-Dreyer, Hans-J. Grünzig and Helmut Thomä; adapted from Neudert et al. (1987)

self-esteem, especially since self-psychology can be seen as a consequential development of ego-psychology (Dare and Holder, 1981; Thomä, 1980).

In client-centered psychotherapy, the concepts of self-esteem and self-acceptance, respectively, are of major importance for the underlying theory of personality and psychotherapy. Rogers' process-model assumes that the client will increasingly be able to develop self-esteem by means of the unconditional positive regard of the therapist. Acceptance by others however does not lead directly to self-acceptance, but rather creates a secure atmosphere free of fear. The client can experience, re-evaluate and thus diminish incongruities between experiences and self-concept in such a climate without feeling threatened (Rogers 1959).

The increase in self-esteem in turn makes it possible that the client integrates experiences, which until now were not, or not correctly, symbolized. Cheshire and Thomä (1987c, p.127) have discussed how Rogers' concept of the therapist's "regard" relates to specifically psychoanalytic hypotheses about the functioning of the transference and the "helping alliance;" and they also indicate how some of Rogers' assumptions have been tested empirically.

We supplement this clinical framework by a model, derived from general psychological self-concept research, which seems appropriate for generating process-hypotheses (Epstein 1982). According to this model, a distinction has to be made between global self-esteem and a situation or area-specific type. In our investigation we had data on the external situation at our disposal, but these data were altered by the subjective reaction of the patient. We therefore refrained from dividing between these two criteria of classification (namely external situation *versus* subjective quality of emotions) and started from the assumption that overall self-esteem is constituted by components of self-esteem drawn from different life-areas and/or problem-areas. With these theoretical considerations established, we now turn to our empirical process-study.

Case Description and Hypotheses

The study aims at testing process-hypotheses related to changes in self-esteem in the course of the psychoanalytic treatment of the patient described in Chapter 4. However it is timely to remember the important investigation of Meyer and Zerssen (1960) studying women with idiopathic hirsutism. Those researchers, both psychoanalysts, pointed out that the

combination of genetic factors and stress reactions may lead to an increase of the level of androgens. In women suffering from hirsutism in absence of distinct genetic disposition the handling of stressful situations most likely is not very favorable (see Fava and Sonino 2000). This assumption is favored by the circumstance that neurotic disturbances, that are independent from the hirsute symptomatology, are seen more frequent in these women. Speculating on ground of their empirical findings Meyer and Zerssen assume that a hirsute endocrine disturbance in females reactivates a wide spread unconscious wish to be a man. As a sequelae many women suffer from problems of acceptation. Meyer (1963) clearly distinguished between a decrease of subjective acceptance (can I love me as I am?) and an assumed rejection by significant others (can he or she love me as I am?).

Therefore we take up the consideration and state the following:

a) Hirsutism reactivates the wish to be a man and therefore leads to problems in female identity.

b) Women with hirsutism suffer from a problem of acceptation.

Hypotheses:

In investigating changes of self-esteem in the psychoanalytic process, we are especially interested in three areas. First, changes in general self-esteem, and in area-specific self-esteem as a function of the therapeutic process; second, the impact of acceptance by important objects, especially the psychoanalyst, upon changes in self-esteem; third, the identification of intrapsychic conditions which are obstacles to an increase in self-esteem.

In explicitly formulating the hypotheses, it is assumed that these phenomena can be subject to objective assessment only insofar as they are openly verbalized by the patient. With this restriction we are formulating hypotheses about both general and area-specific changes in self-esteem.

General hypotheses:

A person's self-esteem is decidedly dependent upon his feeling accepted by significant others (acceptance by others). This relationship between self-esteem and acceptance by others is of essential importance for determining the *level* of self-esteem, and also contributes to the actual genesis and maintenance of self-esteem in the first place. Consequently, the patient's capacity for developing solid self-esteem in the course of therapeutic treatment depends upon his capacity for experiencing acceptance by others; and in the realm of psychoanalytic treatment, the psychoanalyst is of course regarded as a paradigmatic "significant other" for

the patient. A successful treatment-process should therefore display an increase in the experience of acceptance by others, and consequently an increase in self-esteem.

This acceptance by others is experienced first of all in the therapeutic relationship. This repeated experience of being accepted in therapy enables the patient to question his hitherto unfavorable and negative self-estimation. This is regarded as a prerequisite for the patient's new experiences outside therapy, namely those to do with feeling accepted by others. This new experience of feeling accepted by others consequently enables the patient to accept himself.

This therapeutic strategy is above all aimed at reducing the discrepancy between the experienced self and the ideal-self, and therefore at self-esteem. In addition, psychotherapy must supply for the patient relief from his threatening superego; and this may be achieved by working through the feared consequences of those sexual and aggressive wishes, which the patient is regarding here and now as equally dangerous as he did in his childhood.

Area-specific hypotheses:

We restricted ourselves to three essential problem-areas for this patient: (1) the area of body, sexuality and female identity; (2) the area of achievement and success; (3) the area of aggressivity and assertiveness. Our formulations related to the patient's psychodynamics and to the derivation of process hypotheses for each of the three problem-areas were as follows:

Problem-area: "body, sexuality and female identity"

Psychodynamic considerations:

The virile body hair leads to insecurities on the patient's side concerning her female identity. Real or assumed rejections decrease the patient's self-esteem, which is a further negative feedback for her attitude towards her body and her sexuality: of special importance in this respect is her anticipation of rejection by men. Therefore she is doomed to fail, both with respect to her ego-ideal, by which she is obliged to be a valuable woman with an integrated sexuality, and with respect to her superego, which prohibits the fulfillment of her sexual needs.

Another most important influence in this area is the patient's relationship to her mother. Besides needing acknowledgement by men, a positively experienced female identity can only result out of the fact that mother-figures are positively perceived in their female identity, and that these present good objects of identification. In the case of this patient, it is to

be expected that her insecurity with respect to her identity as a woman is connected with a negative attitude towards mother-figures.

Process-hypotheses:

Since the patient's sexual needs are closely related to feelings of guilt and to castration fantasies, an elaboration and eventual realization of her sexual needs can be expected only when the themes of guilt and punishment have been worked through. An indispensable step on this way is the acceptance of her autoerotic needs. These psychodynamics will play an important part in the transference neurosis. Her insecure female identity can be overcome to the extent that she is able to perceive positive elements in her "mother-figures."

Problem-area: "achievement and success"

Psychodynamic considerations:

The patient's low self-esteem is expressed, among other things, in her low confidence in successfully achieving something. This especially relates to her work and to the social field. The patient's unconscious fear of envy and of consequent aggression from others can be traced back biographically to the relationship to her brothers, from whom she had actually experienced such consequences of achievement on her own part. With her low self-esteem, she is highly dependent upon acceptance by others. Therefore, she experiences the danger of being rejected or attacked as especially dangerous. The patient can be seen to be in the following dilemma: if she achieves too little, her self-esteem decreases; but if she achieves more than others, then she has to be afraid of their envy and aggression.

Process hypotheses:

In this problem-area it is necessary to work through her feelings of guilt about achievement; she has to become independent of valuation and appreciation from her brothers, in order to be able to be successful without constantly fearing envy and aggression; and in addition, she has to gain the experience that she can tolerate envy and aggression if they occur.

Problem-area. "aggressivity and assertiveness"

Psychodynamic considerations:

This problem-area overlaps to some extent with the previous one. If she is not able to be assertive in an aggressive manner towards others, her self-esteem decreases. If, by contrast, she does try to be aggressive, feelings of guilt emerge out of her fantasy that her aggressivity

could mutilate or (even worse) destroy others. There is a discrepancy in this problem-area, too: on the one hand, she wants to be able to pursue her needs aggressively, but on the other hand feels that such dangerous aggressive tendencies are prohibited.

Process hypotheses:

These problems can be worked through directly in the therapeutic relationship. Experiencing acceptance by the analyst, even though she has aggressive fantasies, is a prerequisite for accepting her aggressivity herself.

Sample and Method

Sample:

From the treatment, which consisted of 517 tape-recorded sessions, a sample of 115 verbatim transcribed sessions was used in this study. This sample of sessions was made up of 21 separate periods of consecutive sessions taken from different stages of treatment: namely, the first ten and the last ten sessions, plus 19 five-session periods taken at regular intervals in between. The reason for choosing longer runs of sessions at the beginning and end of treatment was that we wanted to have a broader data-base for making comparisons between the beginning and the end of treatment.

The category-system for content-analysis

In order to test the hypotheses, we created a category-system for content-analysis. This consists of 23 categories. When defining these categories for the purpose of a coding manual (cp. Neudert and Grünzig, 1983), we were careful to stay as close as possible to direct observation, which is an important condition for getting reliable judgements from non-experts, because it minimizes the need for inference and interpretation. The 23 content-categories, as used in the main study, together with their resultant reliability values, are listed in Table 5.3. (Details to the definitions of the categories are presented in the original paper).

Categories:

1	positive self-esteem	0.81
2	negative self-esteem	0.92
3	positive acceptance by others	0.95
4	negative acceptance by others	0.76
5	positive view of motherly significant others	0.83

6	negative view of motherly significant others	0.94
7	motherly significant others (neutral view)	0.95
8	fatherly significant others	0.97
9	analyst	0.96
10	female peers	0.98
11	male peers	0.97
12	brothers	0.99
13	body	0.90
14	body hair	0.98
15	sexuality	0.97
16	real heterosexuality	0.98
17	imagined heterosexuality	0.96
18	autoeroticism	0.98
19	security concerning female identity	0.73
20	insecurity concerning female identity	0.73
21	achievement, success	0.90
22	aggressivity, assertiveness	0.88
23	feelings of guilt, fear of punishment	0.88

Table 5x3. Reliability values derived from combined ratings according to the formula of Spearman-Brown (Lienert, 1969).

Evaluation

In order to test the trends we used Foster and Stuart's (1954) "record-breaker," and a linearity test (Cochran 1954); for the frequency of categories we used a test for change in level (Cochran 1954); and in the case of the correlation coefficients, we computed product-moment values and tested their significance.

Although the most powerful model for describing time-series fluctuations is ARIMA (Box and Jenkins, 1976), we had to give it up in the end for two reasons. First, our data took the form of frequency-counts with many zero values, and this seemed inappropriate to the parametric algorithm of ARIMA. Second, our time-sampling is made up from a number of separate blocks and it became apparent that the five-session blocks were too short to allow us to compute both ARIMA-based time-dependencies and our process- dependent hypotheses.

Results and Discussion

Results of Process Study

The two central hypotheses about changes in overall self-esteem could be confirmed. That is to say, positive self-esteem increased during the course of treatment ($p < 0.01$), but the trend did not set in right at the start of treatment but only after wide fluctuations over the first 100 sessions; negative self-esteem, on the other hand, shows a continuous decrease from the beginning of treatment ($p < 0.01$). However, the hypotheses to do with changes in acceptance by others were not confirmed, because there were no systematic trends. Nor were the hypotheses to do with the relative incidence of different categories before and after focal working-through confirmed. But with regard to hypotheses about differences between correlations among categories, there are indeed two confirmatory results: self-esteem in connection with imagined heterosexuality improved according to expectations ($p < 0.05$); and negative self-esteem in connection with autoeroticism decreased as predicted ($p < 0.05$).

Comparison between the Beginning and the End of Therapy

In addition to our investigation of the continuous treatment process, we present a comparison between initial and terminal stages of the treatment; and we establish a connection between research on the treatment process and that on treatment outcome. We are referring here to the same variables as we used in the process study, and are supplementing them by the use of typical standardized personality questionnaires.

As a sample for this comparison of initial and terminal treatment periods, we used the first ten treatment sessions and the last ten treatment sessions that were evaluated by means of the same content-analysis system. It is necessary to state that the raters were blind for the location of the sessions within the treatment. For statistical purposes, we are assuming the independence of these two samples. This assumption seems plausible since an objective period of five years has passed in the course of treatment, during which the essential problems of the patient have decidedly changed.

For each of the content-analytic categories, a test was done on the differences between the means of the two samples. Those eight variables whose significance value is $p = 0.10$ or less were included in a MANOVA (discriminant analysis). As was expected, the two samples were sharply discriminated by these variables ($F= 20.8$; $d.f. = 41.15$; $p < 0.01$), although only four of these variables contributed substantially to the discriminant function because of high

inter-correlations (Table 5x4). These four variables are the categories “positive self-esteem” (1), “negative self-esteem” (2), “fatherly significant others” (8) and “analyst” (9).

Category		First ten	Last ten	p	t (two-tailed)
1	positive self-esteem	2.4	5.8	- 2.67	0.02
2	negative self-esteem	20.4	7.7	7.07	0.00
6	negative view of motherly “significant others”	2.0	0.6	2.41	0.03
8	fatherly “significant others”	8.5	2.6	2.08	0.06
9	analyst	5.6	14.5	- 3.77	0.00
11	male peers	7.4	15.2	- 2.80	0.01
12	brothers	9.2	2.3	3.22	0.00
14	body hair	1.1	0.0	1.72	0.10

Table 5.4. The eight statistically significant categories for the first ten and the last ten treatment sessions: means, *t*-values, and probabilities *(p)* for *t*.

Let us briefly summarize this findings. The level of the patient’s self-esteem at the end of treatment is considerably higher than at the beginning. She talks less often about father-figures, more often in contrast about the analyst and about peer men. Her brothers have lost their importance to a considerable extent at the end of treatment, as also has her negative experience of mother figures. She does not mention her body hair any more and is more secure in the realm of the autoerotic as well as in that of her female identity.

Compared with her state at the beginning of therapy, the patient is presenting herself as a woman who has succeeded in her psychic separation from parents and siblings, and who is able to establish relationships with people who are of significance for her reality-life and for the further development of her life-circumstances.

Theoretical Considerations

Our conception of overall self-esteem as being composed of a number of area-specific elements, which had the advantage of lending itself readily to objective testing, was always perhaps somewhat simplistic and only one of various possibilities. Another of these possibilities, which is more consistent with our results, is that area-specific and general self-esteem are in fact a good deal more independent than we had supposed. Our results on the topic of overall self-esteem may reflect something more akin to Bandura's conception of "self-efficacy (1977) that consists in a fundamental sense of being able to bring about changes in one's life, but is entirely consistent with having problems in specific areas of self-esteem and consequently bringing them into therapy. It may well be this essential independence, which has been captured in our observation, that ratings of area-specific esteem fluctuate much more widely over the sessions (perhaps because they are relatively situation-specific and cognitively monitored), whereas overall self-esteem (which may reflect a more fundamental emotional property) stays relatively constant over time.

Furthermore, it is perhaps to be expected that during the course of therapy the patient's problems with overall self-esteem will be analysed out into more specific areas that then become individually the focus of attention at different times and with different degrees of attendant anxiety or other emotion. Since also, a main function of therapy, at least from the patient's point of view, is to deal with difficulties and malfunctions in various areas, it is not surprising that what she actually talks about (and what is therefore recorded in the categories) does not show either an increase in general positive self-evaluation or a decrease in its negative counterpart.

Our study also set out to clarify how favorable changes in self-esteem might be brought about in therapy, and for this purpose we paid attention both to its presumed infantile origins and also to here-and-now experiences of being accepted by others. Accordingly, we assumed that the analyst would function as a catalyst for both these sorts of feeling, by serving as a projection-screen in the transference and by exemplifying acceptance by others in the reality-situation. We were unable, however, to draw any conclusions on this point from the category-scores, since there were too few references to acceptance-by-others (in only 15 out of 115 sessions) to allow us to compute their correlation with references to the analyst, as would have been necessary to serve as the evidence relevant to our hypotheses. Two suggestions may be made about why this was the case:

The analyst's acceptance of the patient would have been communicated largely, and even exclusively perhaps, by non-verbal means, which the patient would have acknowledged and responded to, not by explicit verbalization, but by (for example) being able to relax and produce more material that she felt able to release in the atmosphere of acceptance. It will be evident from this that we were conceptualizing the therapist's acceptance as a quite specific factor in the treatment of patients suffering from disturbances in self-esteem and not simply as part of a generally facilitating background.

The second possibility is that the patient had internalized rejecting objects from the past so effectively that she was unable to perceive any acceptance in some contexts of her present situation even when it was there. This impression is given by many passages of the verbatim transcript, including one where she indicates that it is self-evident to her that every man will experience her hairiness as repulsive, without her ever having taken the risk of encountering this judgement in reality. From this point of view it might be expected that such obstructive internalizations gradually become to be recognized for what they are, in the course of therapy, and are eventually tested out in reality against the perceived judgements of currently significant others: in which case, an increase in the categories to do with acceptance by others is to be expected. But this result would be observed only if the testing-out were explicitly reported in therapy, as opposed to being alluded to or symbolized in the latent content of various utterances, or taking the form of an improvement in interpersonal perceptions and social skills. To clarify these questions further it would be important to establish whether the therapist did in fact give non-verbal indications of acceptance, etc., which were simply not recognized as such by the patient, or whether such cues were unclear, inconsistent or infrequent.

A second general purpose of our study, apart from that of trying to monitor changes in self-esteem, was to use the category-data to test a model of the therapeutic process according to which it is seen as a succession of focal working-through of particular psychodynamic themes. To this end we formulated a number of hypotheses about changes in three problem-areas that might be apparent after relevant focal working-through had taken place. But these hypotheses, which were couched in terms of differences between mean values of category usage and changes in correlation values, were supported by the data in only two instances.

Therefore, our findings do not in themselves support such a model; but we are aware that our method of identifying a therapeutic focus (see chap. 5.6), although appropriate enough in itself, may have been invalidated by the fact that our sampling left out 80% of the total data. As far as the process-model itself goes, even changes that do set in after certain themes have been worked through focally cannot be expected to do so at once, let alone to be revealed immediately in overt verbal behavior. In any case, we suppose that focal working-through may be only a necessary, and not a sufficient, condition for lasting psychological change. It may simply lay the foundations for revised patterns of information-processing and cognitive structuring, which in their turn are the basis for acquiring alternative ways of behaving. In which case, to base calculations on data from sessions immediately after a therapeutic focus is to fail to give such complex processes time to develop.

These are all points to be borne in mind for future studies of the complex processes which contribute to beneficial change, such as was observed in this case, over the course of interpretive psychoanalytic therapy.

SUFFERING FROM ONESELF AND FROM OTHERS[6]

Theoretical Remarks

All psychotherapeutic schools agree that a patient's motivation to seek therapy depends decisively on the degree of suffering at the beginning of treatment. However, opinions differ as to how important suffering becomes in the course of therapy. Moreover, within psychoanalysis one finds contradictory views.

In "Lines of advance in psycho-analytic therapy" (1919a) Freud took a strong position on this question:

> Cruel though it may sound, we must see to it that the patient's suffering, to a degree that is in some way or other effective, does not come to an end prematurely. If, owing to the symptoms having been taken apart and having lost their value, his suffering becomes mitigated, we must reinstate it elsewhere in the form of some appreciable privations; otherwise we run the danger of never achieving any improvements except quite insignificant and transitory ones. (p. 163)

The technical means by which Freud tried to achieve this was the rule of abstinence in order to frustrate the patient's instinctual wishes. The energy, finding no discharge, would flow back to its infantile origins and bring their representations to consciousness, leading to the conflict being recalled instead of being acted out. From this point of view the patient must suffer in order to improve.

These considerations, anchored in Freud's theories of energies and instincts, have influenced psychoanalytic practice until today. The rule of abstinence, more than any other of Freud's technical recommendations, was set up as an absolute by many psychoanalysts and often has become a synonym for the psychoanalytic attitude. This frequently created an unhealthy climate in psychoanalytic treatments so that even in 1967 Greenson warned in his popular textbook against excessive frustration of the patient because this would produce "interminable or interrupted analyses" (p. 278). Of course, many psychoanalysts soon started to justify the rule of abstinence not so much by theoretical, but by technical considerations, because they were getting more and more skeptical of the economical aspects of the libido-

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6 Lisbeth Neudert-Dreyer, Roderich Hohage and Helmut Thomä; adapted from Neudert & Hohage (1988)

theory. Abstinence was no longer to maintain the suffering of the patient, but to guarantee the objectivity of the psychoanalyst — objectivity as seen from a positivistic ideal of science.

There is one approach, which in our opinion deserves particular interest, namely the control-mastery theory (Weiss and Sampson 1986). In this theory the patient's transference behavior is defined as an instrument of reality-testing: in the relationship with his psychoanalyst, the patient wants to test whether his unconscious pathogenic beliefs are true. These beliefs are the result not of instinctual wishes, but of a primitive theorizing originating in conflict situations of childhood. Being influenced by these theories the patient sets aside important life goals and establishes defense mechanisms, inhibitions, and symptoms. It depends on the behavior of the psychoanalyst whether these infantile theories will appear confirmed or refuted. To be abstinent in this context means to pass the patient's test, that is, to *not* fulfill his pathogenic expectations.

In regard to the patient's suffering, the control-mastery theory predicts that the psychoanalyst, by means of being abstinent according to this theoretical view, refutes the threatening beliefs and thus meets the unconscious hope that led the patient to seek help in analysis. Instead of suffering more, the patient will feel relieved and relaxed because of his psychoanalyst's passing the test. This model of the psychoanalytic process was empirically tested against the process model derived from the theory of instincts repeatedly and turned out to be superior (cf. Weiss and Sampson 1986).

We think that often different sources of suffering related to the psychoanalyst get mixed up. First, it may be the expression of a patient's specific conflict. Second, he may suffer due to specific characteristics of the psychoanalyst's personality, because every negative transference reaction has a larger or smaller component that is focused on the specific personality of the psychoanalyst and how it has been shaped during his professional education, a point emphasized by Gill (1982). And last, the patient may eventually experience suffering due to the psychoanalyst's *technique*. Only this is the context of the suffering related to abstinence.

Unfortunately, neither critics nor defenders of a particular psychoanalytic view present empirical data to support their opinions. This single-case study is an attempt to offer data on this subject. We are interested in the following questions:

(a) Which part of the patient's suffering during psychoanalysis is related to his psychoanalyst? Which part has other sources? What are those?

(b) How does the suffering in regard to the psychoanalyst change in the course of treatment? Is it constantly present as one would expect according to Freud? Is it worse at the beginning, while the therapist's behavior is still unfamiliar and strange? Or is there a crisis in the course of treatment? If so, what causes it?

(c) How much suffering related to the therapist is in fact due to his abstinence?

(d) What does the therapist do when he becomes the object of the patient's suffering?

Methods

Since we have previously described the method (Neudert et al. 1985) we can be brief. We investigated a single case because only this kind of study permits an examination in detail of the variability of suffering during the psychoanalysis. It also offers the opportunity to gather complex and differentiated information, including qualitative clinical data that enable the generation of more adequate hypotheses about the psychoanalytic process. The study was carried out on verbatim transcripts of psychoanalytic sessions by means of content-analysis methods. Since none of the available content-analysis instruments for measuring painful affects (Dollard and Mowrer 1947; Dollard and Auld 1959; Mahl 1961; Gottschalk and Gleser 1969; Knapp et al. 1975) was suitable for our questions, we developed two special content-analysis manuals.

Manual I was used by independent judges to identify all sequences in the verbatim transcripts in which the patient verbalized painful or unpleasant feelings. In a second step the judges scored the degree of suffering and the way of dealing with it as it was expressed in the pertinent sequences. This manual consists of four distinct categories and four rating scales. In this chapter we refer to only two of the rating scales:

(a) A 5-point rating scale for judging the *intensity of suffering* in every sequence of the text where suffering was expressed. The various values of intensity from one session are added up to yield a sum score of "global suffering" (= GS) for each session.

(b) Another 5-point scale on which the independent judges mark the degree of the patient's *helplessness in dealing with his suffering* for every pertinent sequence.

After having been corrected according to the Spearman-Brown formula (cf. Lienert 1969, p. 119), Pearson's r as the coefficient of reliability between judges was .85 for both rating scales.

Manual II was used to measure what the patient suffered from or what he "blamed" for his suffering. The coding units were the same sequences that were identified according to Manual I. The main categories are "self" and "environment." The judgment is made on a 5-point scale with the poles labeled "the suffering is exclusively related to self" and "the suffering is exclusively related to environment." If the environment is involved, i.e., when the raters check off one of the scale points between 2 and 5, they additionally have to choose one of the following subcategories:

human environment (= h)
therapist (= th)
extra-human environment (= e). (This category includes weather, fortune, animals, etc.).

When the raters are not able to decide who the patient blamed, they are to choose the category "unclear."

The measures of agreement were also very adequate for Manual II: Pearson's r (again corrected according to Spearman-Brown) for the rating scale "relatedness of suffering" was .92 (n = 342), and the Kappa-coefficients (Cohen 1960), which we used to compute the agreement on nominal data, were .76 for the three types of environment and .75 for the category "unclear."

Our *sample* consisted of 7 blocks of 8 consecutive sessions each for a total of 56 sessions. We chose this type of sample in order to be able to explore thematic connections across several sessions as well as examine medium-term effects of therapeutic interventions. The 7 blocks were spread over the entire treatment at varying intervals to avoid periodically recurring effects. For a discussion of sampling problems in time-series see Grünzig (1988).

Results

Given the independent psychometric evaluations (chap. 4) we assumed that our process data would also show a successful course of treatment. For this purpose we used a nonparametric trend test for dichotomous data according to Haldane and Smith (1947-1949). The course of each variable can be described as a negative monotonic trend, that is, "global suffering" ($z = -2.14$; $p<.05$) as well as "helplessness" ($z= -3.67$; $p < .001$) decreased significantly during treatment. Further serial dependencies according to an ARIMA-model (cf. Box and Jenkins 1976) did not exist. Figure 5.2 shows the course of Global Suffering and displays two potential trends:

{Figure 5x2 about here}

Figure 5.2 Course of Global Suffering (= GS): Values of intensity summed over all of the sequences of the session.

A simple linear trend may be good enough to catch the overall decrease of Global Suffering (GS); however visual inspection suggests to model the course of suffering in a non-linear fashion: a first negative trend prevails in the first half of the analysis; then there is an increase from block 4 to block 6 which then returns to a decreasing negative trend. Statistical check allows to formulate that the simple trend explains only 11% of the total variance, whereas the more complicated three-phase trend model explains 40% of the variation of Global Suffering.

Now what are the main sources of this patient's suffering during her psychoanalysis? The next Figure 5.3 shows the percentages of the different types of suffering for the entire treatment:

{Figure 5x3 about here}

Figure 5.3 Percentage of the different types of suffering during the entire treatment (total suffering = 100%)

40.6 % of the total suffering is predominantly or exclusively related to the environment. Here people outside the therapy seem most often to be the source of her suffering, 30.5% compared with the therapist's 7.2% and the "extra-human" environment's 2.9%. For 35% of the time the patient's source of suffering is predominantly or exclusively herself, and 11.1% of her total suffering is evenly divided in relation to her environment and herself (scale point 3). 13.3% of the total suffering was categorized as "unclear."

To compare the proportion of the suffering related to the psychoanalyst with the total suffering, we selected all sequences in which the patient's suffering was predominantly (scale point 4) or exclusively (scale point 5) related to the therapist (Fig. 5.4).

{Figure 5x4 about here}

Figure 5.4 Mean percentage of suffering related to the therapist per block (total suffering = 100%)

The mean score for the whole treatment is 7.2 %. In 6 out of 7 blocks the suffering in regard to the therapist is less than 10%, and in 3 blocks less than 5%. Only Block 5 presents a totally different result with 34.3 %. For that reason we will later explore this block in more detail from a clinical-qualitative point of view. One could argue that it might have been difficult for the patient to complain about the therapist; she either may not have talked about this delicate matter at all or tried cautiously to hint at it. But not to talk about one's suffering seems hardly compatible with the successful course of treatment. The objection that the patient might not have risked talking about it would only hold true in our opinion for the beginning of a treatment until a trusting relationship has been established. The second possibility, that the patient might have hinted at the suffering related to the psychoanalyst only very cautiously, is not supported by our data. It is likely that cautiously expressed suffering would have been reflected in an increased value of the category "unclear."

So far we have considered only those sequences that received ratings of 4 and 5, i.e., suffering predominantly or exclusively related to the therapist. But the patient's cautiousness might still have found expression in reducing the degree to which her suffering was related to the therapist, thereby increasing the degree to which it was related to herself, i.e., the raters would then have chosen scale points 2 and 3 more often. It was possible to test this alternative by examining those sequences in which the patient spoke in this toned-down manner about the analyst on the one hand and on the other hand about people who were not present and about whom she could presumably talk more easily. The data do not confirm this alternative. On the contrary, in 78% of the sequences in which any degree of suffering related to the therapist was expressed, this degree was scored as "predominantly" or "exclusively." This

percentage of 4's and 5's related to the therapist was even higher than the comparable 63% for sequences of suffering related to people other than the therapist.

In Block 5 (session 348-355) suffering related to the therapist reached its peak immediately *following* Block 4 (sessions 248-255) in which the *total suffering* was the *lowest* for the entire treatment (see Figure 5.2). What might have happened? Could it be that the increase in the suffering related to the psychoanalyst was the result of the psychoanalyst having taken Freud's call for abstinence seriously? Could it be that the therapist, intending to increase the patient's level of suffering, did so by becoming more abstinent? We tried to answer this question with the help of a very simple and reliable indicator of abstinence, namely, a count of the number of words spoken by the psychoanalyst per session.

Comparing both the mean number of the psychoanalyst's words per session for each of the 7 blocks and for comparison, the level of the patient's suffering related to the psychoanalyst for each session gives a clear answer.

The therapist's mean number of words for the block 5 in question is 855, which is higher than the average of 779 words across the entire treatment. The striking increase of the suffering in regard to the therapist was evidently *not* caused by the psychoanalyst's silence. In fact, if one looks at the entire course of the treatment, it was not true that the patient's suffering related to the therapist was a function of his silence. On the contrary, there is a small, not quite significant *positive* correlation ($r = .21$, $n = 56$, $p = .06$) between the number of words spoken by the psychoanalyst and the patient's suffering related to him, suggesting, if anything, that the more he talked the more the patient appeared to suffer at his hands!

What then might account for the surge of suffering related to the psychoanalyst in Block 5? An explanatory hypothesis occurred to us when we took a close look at the variation in all the types of suffering over the course of the seven blocks, as shown in figure 5.5.

{Figure 5x5 about here}

Figure 5.5. Mean percentages for each block of the categories: unclear, suffering related to self, suffering related to both self and environment, suffering related to environment, suffering related to therapist (sub-category).

The diagram concerning the sources of suffering (Fig 5.5) makes clear that, for the first time in Block 5, the suffering related to the environment evidently replaces the suffering in regard to herself. Until then the patient apparently had been primarily occupied with her own insufficiencies, insecurities and inhibitions. Now she began — as our data suggest — to tackle her environment, even though it was painful for her. And the psychoanalyst as a significant part of the environment became the primary and, according to the Weiss and Sampson control-mastery theory, *safe* object for her painful conflicts. The usefulness of this hypothesis will now be examined in the light of a more detailed qualitative consideration of clinical material from Block 5 (sessions 348-355).

Qualitative Results and Discussion

The following clinical descriptions are meant to complete the quantitative results and stick as closely as possible to the text of the verbatim transcripts. Our purpose is to make *plausible* relations among events, which seem to be of importance for the psychoanalytic process. Our understanding of and reasoning about the material will proceed primarily along commonsense lines. When we use specifically psychoanalytic interpretations we shall do so explicitly.

The external situation during the sessions in question was the following: at the beginning of this period (block 5) the psychoanalyst had moved his office. The consistency of the setting was disturbed; a previously unknown part of the psychoanalyst's personal life became visible to the patient.

In five out of eight sessions of this block the patient manifestly deals with topics of suffering which may be understood as paradigmatic complaints about abstinence. She complains that the psychoanalyst is silent so much and that he does not pick up on her offerings. She regards him as inaccessible and not interested in her. On the other hand there are many other sequences that contain no reference to suffering from the psychoanalyst's abstinence. The complaints in these sequences focus on a number of topics. The therapist's move has created confusion. She feels unprotected from his gaze because there are no curtains to dim the light in the new office. And here he also sits too close behind her. He expects too much from her. He asks too many questions about her holidays. And most of these complaints are based upon the patient's *assumptions* about the psychoanalyst rather than on his actual behavior (e.g. he does not express any overt expectation of her, at least not verbally).

The psychoanalyst focuses on the patient's concern about both his distance (too silent, not interested, inaccessible) and his getting too close (sitting too close, seeing her too clearly, intruding on her holidays). And the patient in turn is very eager to explain why she is concerned with his getting too close. She might loose control. Her defects (especially her unwanted hair) would become too obvious. And, above all, physical closeness is forbidden: she tells of a colleague who criticized her for touching someone. In psychoanalytic terms, during this period the patient appears to be dealing with an oedipal conflict if this is defined as a conflict about gender and generational boundaries.

So far the psychoanalyst has been looked at only from the patient's perspective. What did he actually do in this block? An evaluation of his interventions shows the following:

(a) He does not intervene less than in the other treatment blocks in which suffering in regard to the therapist seldom occurs. Remember the quantitative finding that the number of the psychoanalyst's words is higher than his mean for the entire treatment.

(b) In the sessions with a high score for patient's suffering in regard to the therapist, most of his interventions are focused on her critical, accusing and irritated comments about him. He explicitly encourages the patient to complain about him. When the patient's complaints are directed toward a specific behavior he does not attempt to neutralize them, e.g. via a transference interpretation, but confirms their realistic aspects — in the manner suggested by Gill (1982). In one sequence the psychoanalyst even accepts the patient's reproach that he once used the word "dumb" in connection with her, although this term could not be found in the verbatim transcript.

(c) A smaller group of the interventions seems to connect several of the patient's themes. For instance he links her fear of staying in the session too long with her fear of her boundaries being violated by a forbidden touch. But very few of his interventions are interpretations in a stricter sense, i.e., connections with infantile wishes or hints at (deeply) unconscious content. More often, but only in certain sequences, the psychoanalyst focuses on latent meaning.

(d) Frequently the psychoanalyst intervenes by introducing alternative ideas. For example, he suggests that silence could mean approval, not just criticism, as interpreted by the patient.

In summary one can state that during this treatment period the therapist absolutely avoided defending himself. If he had had a defensive attitude he might have glossed over the patient's criticism and suffering or have doubted their justification. Although, he was

> not abstinent in the sense of formally complying with a rule, he handled the principle of abstinence in a functional way (according to Thomä and Kächele 1994a, p. 218), that is against the background of a case-specific psychodynamic understanding: to be abstinent in regard to *this* patient during *this* phase of the psychoanalytic process means that the psychoanalyst had to avoid, even indirectly through an interpretation, personally defending himself.

Of course, the way the patient experiences the psychoanalyst's behavior is of crucial importance for the development of the therapeutic process. How then did she respond to this therapist's particular form of abstinence, that is, to his abstaining from being defensive? Fortunately we can get a clear answer to this question by examining the last hour of this block when the patient begins to talk about how she had recently perceived the psychoanalyst. She had repeatedly complained about the bright daylight in the new office. But suddenly, since the previous session, curtains have been put up. She realizes that the psychoanalyst must have known that this has been planned but hadn't mentioned it when she had complained about the lack of curtains. She then becomes aware that his not telling her was just what made it possible for her to clearly experience what it feels like to be subjected to someone looking at her. And she gets some insight into the benefits of the psychoanalyst having withheld this information. She feels at ease and relieved by his calm reaction to her attacks. She describes the "impersonal" in the therapeutic relationship as a welcome protection. This sense of "impersonality" becomes so strong that she suddenly can no longer remember exactly what her therapist looks like.

Finally, from a psychoanalytic point of view, one can assume that the patient perceived her psychoanalyst's calm reaction as a relief not only in regard to her aggressive attacks but also in regard to her wishes to be close, even if she still experienced these wishes predominantly as anxieties. The analyst's abstinence did not manifest itself as a rigid clinging to a rule, but was based on a correct understanding of her conflicts. Obviously he passed her test, as predicted by Weiss and Sampson's control-mastery theory, by reacting in a calm way in both her criticism of him and her fear of being too close. The patient reacted according to the theory's prediction: she talked about her feelings of relief and relaxation. The "total suffering" is very low in this session and her suffering in regard to the therapist completely disappeared.

AMALIA'S DREAMS: DREAM SERIES ANALYSIS AS PROCESS TOOL[7]

Dream Series in Clinical Practice and in Research

Even if most discussions about dreams in clinical practice are focused around a single dream it is evident that reporting of dreams during a psychoanalytic treatment belongs to one of the most regular and repetitive phenomena of that kind of therapy. Patients dream more or less, and analysts differ in the extent they use the dreams offered by the patient. As a compromise formation a non-conscious, non-intentional agreement on the relevance of dreams for the treatments between patient and analyst is established: "Analytic therapy finds the analyst drawn into the intrapsychic as well as external communicative system of the dreamer" (Kanzer 1955, p.265).

Depending on the agreement a treatment may be based wholly on the analysis of the dream material or the dreams are treated like any other material (Fliess 1953, p. 123). The first analyst to emphasize the use of dream series for the evaluation of the course of treatment has been Stekel: "The dreams in their totality have to be studied like a novel in progress (Fortsetzungsroman). There is no such thing as an individual interpretation of dreams, there is only a serial interpretation" (Stekel 1935, p. 12). Without following Stekel's idea of the "prospective tendency" that he thought he would find in this serial interpretation, it remains clinically impressive how the repeated observation is able to strengthen the understanding of a patient's dynamics.

In the United States one of the first to systematically study manifest dream content per se was (Saul 1940); he discussed the "utilization of early current dreams in formulating psychoanalytic cases." Later he and his colleague Sheppard attempted to quantify emotional forces using manifest dreams (Saul and Sheppard 1954, 1956). This track was also taken up by Beck and his colleagues (Beck and Hurvich 1959; Beck and Ward 1961)[8].

Pioneering work on dream series was achieved by Thomas French who from 1952 onward published his three volumes on "The Integration of Behavior." In the second volume

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[7]Horst Kächele & Marianne Leuzinger-Bohleber; adapted from Leuzinger-Bohleber and Kächele (1988) and Kächele et al. (1999)

[8] These papers are true precursors of his later work on cognitive theory of depression (Beck 1967)

using a dream series of more than 200 dreams he shows "that every dream has also a logical structure and the logical structures of different dreams of the same person are interrelated, and that they are all parts of a single intercommunicative system" (French 1954). In the third volume he applied this understanding for a thorough description of the re-integrative process within one psychoanalytic treatment (French 1958).

Our own experience with dream series analysis began with demonstrating the usefulness of the spotlight analysis of Hall and van de Castle (1966), studying two levels of transference constellations in a dream series in the case Christian Y[9] (Geist and Kächele 1979). Later the study group by Leuzinger-Bohleber and Kächele (1988) implemented a project to study cognitive changes based on dream reports in five psychoanalytic treatments. In that investigation we used dreams from the beginning phase (session 1-100) and the terminal phase (100 sessions before the end) comparing the cognitive functioning by a content-analytic tool that was based on an integrative model on dreaming based on computer simulation models by Clippinger (1977) and by Pauker's et al. (1976) In this first study on dreams we did not evaluate the development over the whole of the treatments; a task we have taken up in this study. We shall use the available dream material of the patient Amalia X that has been clinically summarized in Leuzinger-Bohleber's write-up of the whole project in her second volume (Leuzinger-Bohleber 1989; see chap. 4 of this volume)[10].

Theoretical Model

Our first study used a theory-guided content analysis of cognitive processes based on computer simulation models to investigate changes in dreams processes of a patient in long-term psychoanalytic treatment. Although the latest fashion in neuroscience is based on connectionist models, especially neuronal networks (Spitzer 1999), we have found it useful for our purpose to remain with the old descriptive model of cognitive-affective problem solving:

Clippinger's theory of cognitive processes was convincing to us because it embodies the conception of conflictual processes taking place inside a black box, just as the structural theory in psychoanalysis does. That is, it conceptualizes cognitive processes as being

[9] The patient Christian Y has been discussed in Thomä & Kächele (1994b)

[10] A study on Amalia X´s dreams using another qualitative strategy has been reported by Spiegel & Boothe (2006)

determined by the interaction of separate cognitive modules. The processes (programs) running in one module can complete, modify or inhibit and interrupt those running in other modules. Among other things this leads to characteristic structures in the interaction of the different modules and specific ways of perceiving and processing information" (Leuzinger-Bohleber and Kächele 1988, p. 292).

A modified version of Clippinger's and Pauker et al´s models that has been developed by Leuzinger (1984) defines the six modules shown in Figure 5.6.

{Figure 5x6 about here}

Figure 5.6 Model of cognitive functions

These modules perform the following tasks:
MOZART selects what is attended to.
CALVIN represents the superego and the patient's values, and acts as censor.
MACHIAVELLI develops problem-solving strategies.
CICERO translates cognition into verbalizations.
MARX perceives and tests reality.
FREUD introspects and performs specific ego functions.

The model assumes reciprocal pathways of communication among the cognitive modules; for a detailed discussion of the operation of the model see Clippinger (1977). Its basic assumption is that unconscious motivations consist in cognitive processes and it is the manifestation of these in the transcripts of what patients verbalize on the couch that we study. In all that follows it should be understood that we use a very broad definition of "cognitive processes" as inner processes of perceiving and processing information that are always connected with physiological and emotional processes and cannot be studied separately (Pfeifer and Leuzinger-Bohleber 1986).

Another theoretical input came from Moser's and his colleagues (Moser et al. 1980) work on sleep-dream simulation; there they have developed a very detailed item list for the description of the manifest content of dreams with respect to what Clippinger has termed the functions of the MOZART module. This has been described in detail already in the doctoral

dissertation of Merkle (1987) that had been part of our first project. Our second study using the same instrument yet applying it to a longitudinal data base of the patient´s dreams.

Results of the First Study

Comparing dreams from the opening phase with dreams from the end phase of Amalia X analyis the main findings were (Leuzinger-Bohleber 1989):

Changes in Problem-solving Cognitive Processes: Interactions among Cognitive Modules

The problem-solving cognitive processes of the patient comparing beginning and end of the treatment can be characterized by a high degree of flexibility, by an enlarged cognitive range, an associative and "gestalt-like" way of thinking, and by a capacity for a functional and realistic style of problem-solving. Different information could be perceived and worked on at the same time and led to a process of generating and testing hypotheses that could compete with, modify, or contradict each other. Cognitive dissonances were recognized, reflected and influenced, among other things, the decision-making process.

Unpleasant affects had an important function as signals indicating cognitive processes to be taken into account in the problem-solving process. In terms of our model, we found: (a) increased cognitive and affective knowledge used in a functional way in different modules; (b) interrupt programs that functioned well and corresponded better to reality; and (c) an uninhibited interaction of cognitive processes in the different modules.

Changes within the Cognitive Module MOZART:

Changes in what was attended to

The later sessions in the successful treatment the more the following changes were observable:

-More of the text of the dreams was attended to and worked over cognitively.

-The context of the dreams was taken into account.

-The analyst's interventions were part of the patient's dream associations.

-The patient pursued hypotheses about her dreams more systematically.

-The process of generating hypotheses took place easily, without much hesitation.

-The patient considered more than one hypothesis about the meaning of a dream.

In a separate assessment Merkle (1987) observed the following systematic changes in three dimensions of the manifest dream content, based on the model by Moser et al. (1980) comparing beginning and end of treatment: *Expressed relationships, dream atmosphere and problem solving*.

Expressed Relationships:

- The dreamer expressed better relationships with both her objects and herself.
- The range of interactions in these relationships was increased e.g. in the late dreams she was more often alone, as well as interacting with one or more partners.
- Although the relationships were more often tender and friendly than in early dreams, to our surprise, they were also seldom neutral, and included conflict relations — an indication, to us, that the range had been increased.

Dream Atmosphere:

- The variety and intensity of affects in the manifest dream content was increased.
- The atmosphere was more positive with less anxiety, but aggressive, sad and frightened moods were also expressed. This contradicted our original hypothesis that a single positive mood would prevail.

Problem solving:

- More problem-solving strategies were recognizable.
- Problem solving was more successful than not and the dreamer was more active in doing it, and seldom avoided it.
- The range of problem solving was greater than in early dreams.

Summarizing the beginning and end-phases of five analyses comparing successful with the less successful cases we found less concern with the major psychopathological symptoms in the patient Amalia. In the later dreams the content was more personal, with a greater variety of expressed activities. Moreover, the patient's dream interpretations were more "dialogue oriented," more convincing and more directed at understanding the unconscious meanings of the dream. The associations were more constricted early and more varied in the late sessions. These are hints that the range of attention to dream material of the patient Amalia X was enlarged.

Method: Theory-guided Complex Ratings and Hypothesis

The second study on which we now report utilized the total dream materials that we could identify in the transcribed sessions. The tool for the description of the dream material consists of three parts:

Part A Relationships

A.1 How does the marker happen to be in the dream ?

(Active = 3; passive = 2; as observer = 1; not at all = 0)

A.2 Are there human partners in the dream ?

(none = 0; one = 1; more than one = 2)

A.3.1 What kind of relationship between dreamer and dream partner do you find in the manifest dream ?

(8 categories:loving, friendly, respectful, conflictual, clinch, neutral, sexual, non decisive)

A.3.2 Describe the relationships of the dream partner among them:

(8 categories: loving, friendly, respectful, conflictual, clinch, neutral, sexual, non decisive)

Part B Dream atmosphere

B.1 Does the dreamer comment upon the atmosphere of her dreams?

(yes = 2; no = 1)

B.2.1 How do you judge the atmosphere in the manifest dream ?

(8 bipolar adjective items scale 1 - 5)

B.2.2 How do you judge the atmosphere in the manifest dream ?

(4 unipolar items from more to less)

C Strategies of Problem-Solving

C.1 Is there one or more problem solving strategies ?

(cannot judge any = 0; none = 1; one = 2; more than one = 3)

C.2 Is problem-solving successful

(8 categories: yes, no, partially, indecisive, trial with support, trial with hindrance, problem solved, passive solution)

C.3 What kinds of problem-solving strategies do you find the in manifest dream content?

(deferred = 1; avoiding = 2; active = 3)

C.4 Are the problem-solving strategies reflecting upon by the dreamer ?

(scale 1 - 5; a lot = 5; very little = 1)

This study explores the issue whether the afore mentioned pre-post design in our first study — comparing the dreams from the beginning to the termination phase — is able to generate reliable statements on the development of psychological functioning that needs time to develop. Do we have to observe the development over the course of treatment? Particularly for the long-term treatments, what kind of models do we have to map the process? In our

work in the long-term processes we have seen different courses for different variables (Kächele and Thomä 1993); however we assume that a linear trend model for changes in basic cognitive functioning is the most plausible.

To test this assumption we need more than data covering the course of the analysis from beginning and end phases of a treatment. Therefore this study fills a gap in our understanding of cognitive changes process in long-term treatments. At least in using a single case design we might find out which of the descriptors are most likely to follow the linear trend model.

Description of the Material

At the time when we performed this replication study we had a large number of transcribed sessions: out of 517 recorded sessions 218 had been transcribed for various studies. We divided the total sample into portions of hundred sessions each to check for an adaequate coverage of the treatment:

Part 1; sessions 1-45, 51-55, 61-62, 71-80, 98-99: a total 63 sessions

Part 2: sessions 100-105,109-116,126-130,150-157,172-179,181: a total of 33 sessions

Part 3: sessions 202-209,213,221-225, 236-237,241-243, 246-256, 276-280, 286-287, 297-299: a total of 43 sessions

Part 4: sessions 300-304,326-330, 335, 339, 343-346, 348-357, 376-383; a total of 34 sessions

Part 5: sessions 401-404, 406, 421-425, 431-433, 435, 442-449, 476-480, 482, 489, 501-508, 510-517; a total of 45 sessions

In these sessions a student rater (M.E.) identified all dreams; the dreams in part 1 and part 5 already had been localized by our former study. A total of 93 dream reports were identified with some sessions containing multiple dreams; so the total number of dreams used in this replication study was 111.

Part 1: 63 sessions: dreams No 1-18

Part 2: 33 sessions: dreams No 19-34

Part 3: 43 sessions: dreams No 35-54

Part 4: 34 sessions: dreams No 55-70

Part 5: 45 sessions: dreams No 71-111

The Reliability Study:

Three raters — two of them medical students (M.E. and M.B.) and one of them a psychoanalytically experienced clinical psychologist with more than ten years of clinical experience (L.T) — were intensively trained to understand Clippinger's and Moser's models of cognitive processes. In several pre-tests they were acquainted with the kind of material to be rated. The training was very time-consuming; the inter-rater-reliability achieved was quite impressive: The three raters jointly judged 1/3 of all identified dream reports (N = 38 out of 111 in 93 sessions):

Item B2.1, B2.2, C4:	Kappa 0.82 - 0.89
Item A1, A2, C1, C3:	Kappa 0.90 - 1.0
Item A3.1, A3.2, B1, C2:	Kappa 0.47 - 1.0

It is noteworthy that 84% of all values are beyond 0.7

Results

The replication study focused on the three aspects from the study by Merkle (1987); the new results were as follows:

Expressed Relationships

A1. How does the dreamer appear in the dream action?

Most frequently during the whole course of the treatment the dreamer is actively involved in the action. This is more surprising since the patient came with a depressive basic mood to analysis. In contrast to Beck and Ward (1961) findings: this patient never gave up the pace making function — at least in her dreams.

A2. Do dream partners occur in the dream?

Again the patient is heavily involved with more than one partner all the time. A clinician might "see" in the data a slight increase of dyadic relationship, probably reflecting the patient's gain in intimate relationships of which one is the relationship with the analyst.

A3.1. What kind of relationship occurs between dreamer and dream partner?

Statistically there are more loving, friendly, respectful relationships and less neutral relationships. We see this as a shift to the development of more pronounced positive qualities in relationships.

A3.2 What are the relationships between the dream partners?

The findings point to the same development as in A3.1

To summarize the findings we use graphical illustrations to make our point that the overall impression of these items, along the course of the analysis, allows quite straight

forward conclusions. There is less dramatic change and more stability as the findings from the Merkle-study had suggested (Fig. 5.7):

{Figure 5x7 about here}

Figure 5.7 What kind of relations do you find between the dreamer and the dream partner in the manifest dream content?

Dream Atmosphere

B.1.1 Does the dreamer comment about the atmosphere of her dreams more often?

No obvious change.

B1.2 If yes, how does she comment?

The findings are presented as a ratio of neutral-positive in relation to the total amount of sentences where she comments about the atmosphere in the dream (Table 5.5):

Phase / Sessions	Dreams	Sentences with neutral-positive to total	Percentage
I 1- 99	1-18	1/11	9%
II 100-199	19-34	3/14	21%
III 200-299	35-54	5/16	31%
IV 300-399	55-70	6/08	75%
V 400-517	71-111	6/10	60%

Table 5.5 Atmosphere in the dreams

There is a definite increase in the second half of the analysis of neutral-positive comments in regard to the dream atmosphere. From our clinical knowledge we find this is in good correspondence to the development of her personal life.

B2.1 How do you judge the atmosphere of the manifest dream?

By Spearman rank correlations of time and bipolar adjective list we find rather impressive systematic changes in time in some of the bipolar adjectives like pleasurable / non-

pleasurable (-0.56), euphoric / depressive (-0.64), harmonic / disharmonic (-0.42), hopeful / resigned (-0.70), happy / sad (-0.58), easygoing / painful (-0.61), peaceful / dangerous (-0,52), happy / desperate (-0.68); all of these correlations are below <0.001 p value.

B2.2 How do you judge the atmosphere of the manifest dream?

By Spearman rank correlations we also find rather impressive systematic changes with time in some of the unipolar adjectives such as anxiety ridden (-0.43), neutral (-0.26). However, aggressive atmosphere remained the same shifting from very low to very high level along the treatment. The category lustful exhibited a more complicated relation to time: at the beginning there was very little; then it peaked.

By factor analytic technique[11] we identified a strong general factor that demonstrated the development of dream atmosphere over the course of treatment from negative to positive.

{Figure 5.8 about here}

Figure 5.8 Global dream atmosphere: General factor: negative (high) versus positive (low) emotions.

Keeping in mind the diverse findings on the level of single items an orthogonal varimax rotation was performed. The outcome of this operation pointed to two components. The factor "negative me" using Dahl's system of classification of emotions (Dahl et al. 1992) incorporates the self emotion states and displays a decreasing trend from whereas the factor "negative it" assembles the aggressive and anxious states that are object-oriented showing an up-and down across treatment.

Problem solving

C1 Are there one or more problem solving strategies?

One or two problem solving strategies are equally distributed across the treatment. There is no substantial change.

C2 Is the problem solving successful?

[11]We acknowledge the help of Dr. Pokorny

The percentage of successful problem solving strategies is increasing and the unsuccessful strategies are decreasing; furthermore partially successful solutions tend to be increasing.

C3. What problem solving strategies do you find?

The patient throughout the analysis is actively seeking solutions of problems; there is a slight increase in deferred actions. A clinician might be surprised by this result.

C4. Are the problem solving strategies reflected upon?

There is a powerful increase of the reflection upon these strategies continuously taking place over the course of the analysis. This finding is well represented in a graphical representation (Fig. 5.9). The changes occur in a continuous non-dramatic fashion along the continuum of treatment.

{Figure 5x9 about here}

Figure 5.9 Reflection of problem solving

Discussion and Summary

The overall hypothesis of this replication study focused on the issue whether the changes can be modelled as linear trends or whether other, non-linear models, are necessary. Here the findings are very unequivocal: either we find stationary processes with variations in intensity (such as in aggressive or anxious feelings) or the changes are either inclines or declines that are patterned along the time axis in a linear fashion.

Some surprises in the findings have to do with the patient's particular capacities that she already brought to the treatment. From the start she brought the capacity to actively organize relationship patterns in her dreams; however the change occurred in the quality of these relationships: they became more friendly and caring.

The impressive findings concern the systematic change in dream atmosphere along the time axis: "negative me" emotions decreased, but "negative it" emotions display a stable variability. Another impressive finding is the systematic tendency for the capacity to shift from unsuccessful to successful problem strategies along the analysis.

Our conclusion is that the process of change in psychoanalysis in basic psychological capacities, take place all along the way. If the textual material dreams are made of is

considered a valid extract from the patient psychic life, than this study has demonstrated the following:

a) Intrapsychic change does occur

b) Intrapsychic change mainly takes place in linear trend

c) Relationship, atmosphere and problem solving are valuable dimensions of capturing a patient's intrapsychic change process.

STUDYING THE CORE CONFLICTUAL RELATIONSHIP THEME (CCRT)[12]

Introduction

The great volume of material that is brought to light in the course of a psychoanalytic treatment must be reduced to what is most significant. Events are not significant in themselves, however: significance is given to them. What an analyst considers significant in the analytic process depends on the criteria for meaningfulness that he or she applies to the course of the psychoanalytic process. One idea of process will be more differentiated or more explicit than another, yet as a fundamental premise no treatment can be upheld unless the therapist is in possession of conceptual models of courses of therapy, which suggest ways of proceeding and criteria for evaluation.

A psychoanalytic treatment can be characterized in a great number of ways. Freud compared the analytic process with a chess game and made analogies between the activities of the archaeologist, the painter and the sculptor and those of the analyst. Freud's work, however, provides no definite conception of process beyond specifying a beginning, middle, and final phase (Glover 1955a). To this day the number of coherent models of the psychoanalytic process remains small. In the Ulm Process Model (Thomä and Kächele, 2004a; Kächele, 1988), psychoanalytic therapy is conceptualized as a continuing, temporally unlimited focal therapy with a changing, interactively developed focus. The sequence of foci is regarded as a result of an unconscious exchange between the needs of the patient and the resources of the analyst. The patient may make various "offers" within a certain period of time, but it is only the selecting activity of the analyst that can result in the forming of a focus. The mutual work of patient and analyst on one focus leads to further areas of concentration that would not have been possible without the preceding work. When the first focus has been worked through, access is gained to a second one; thorough exploration of the second focus may in turn make it possible to revisit the first focus in a qualitatively new way.

The thematic "offers" made by the patient may be understood in terms of what French calls "focal conflicts," which represent unconscious infantile conflict constellations

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[12]Cornelia Albani, Dan Pokorny, Gerd Blaser, Michael Geyer and Horst Kächele. The study was supported by the Deutsche Forschungsgemeinschaft.

(thematized by French as “nuclear conflicts”): in other words, they are the solutions generated under the pressure of the problem at hand. French, however, is left with an unresolved problem: “Still, searching for the patient's focal conflict is an intuitive art which cannot be completely reduced to rules.” (French, 1958, p. 101)

The Core Conflictual Relationship Theme method developed by Lester Luborsky (Luborsky, 1977; Luborsky, Albani, and Eckert, 1992; Luborsky and Crits-Christoph, 1998) offers a way of making such focal and core conflicts operational. The aim of the present study is to investigate how effective the Core Conflictual Relationship Theme (CCRT) method is, in depicting the therapeutic course of a psychoanalytic treatment according to the Ulm Process Model.

Current Status of Research and Aim of the Study

Although a considerable number and a great variety of studies have been conducted with the CCRT method (for an overview, see Luborsky et al., 1999), to date there have been very few that follow courses of therapy with the CCRT method. The studies known to us are of short-term therapies (Albani, Pokorny, Dahlbender, and Kächele, 1994; Anstadt, Merten, Ullrich, and Krause, 1996; Grabhorn, Overbeck, Kernhof, Jordan, and Mueller, 1994; Luborsky, Crits-Cristoph, Friedman, Mark, and Schaffler, 1991). To our knowledge there have as yet been no investigations of long-term psychoanalytic therapies using the CCRT method. The aim of our exploratory study was to describe the course of the 517-hour psychoanalysis of the patient Amalia by the CCRT method. A guiding intention behind the study was to determine if and in what form the Ulm Process Model can be demonstrated in a psychoanalytic treatment.

Clinical Notes

The clinical evaluation of the case has been detailed in Chapter 4. Here we only repeat the systematic description of the transference themes as they will be used in this study as a clinical anchoring point.

Clinical Transference Configurations	**Therapy phase**	**Session numbers**
Analysis as confession	I	1-5
Analysis as a test	II	26-30
The bad mother	III	50-54
The offer of submission and secret defiance	VI	76-80
The search for norms of one's own	V	100-104
The disappointing father and helplessness of the daughter	VI	116-120
The distant, cold father and the incipient longing for identification	VII	151-155
Ambivalence in the father-relationship	VIII	176-180
The father as seducer or moral judge	IX	202-206
He loves me – he loves me not	X	226-230
Even father cannot make a son out of a girl	XI	251-255
The apron-strings feeling	XII	276-280
The poor maiden and the rich king	XIII	300-304
Fear of rejection	XIV	326-330
Helpless love for powerful father and jealousy of his wife	XV	351-355
Active separation and resisting abandonment	XVI	376-380
Discovery of her own critical powers, recognition of the analyst's deficiencies, new attempt at leave-taking	XVII	401-404, 406
The daughter held on the left hand – rivalry with the firstborn for the mother	XVIII	426-430
Hatred for the bountifully giving analyst and growing out of this expectation	XIX	445-449
The art of love is to endure love and hate	XX	476-480
Mastering leave-taking: having worked through the oral-aggressive fantasy about the analyst	XXI	501-505

Farewell symphony: the return of many fears and discovery of many changes	XXII	513-17

Table 5.6 Clinical Transference Configurations

It is not difficult to "invent" such descriptions, even as a non-specialist reading the transcribed sessions. Yet it is in fact a painstaking process: the texts are first read and reread with the utmost care by two medical students (AS and BS), who then prepare an extract, which is in turn checked against the text for accuracy by two psychoanalysts (HK and RH). As a form of qualitative research, the resulting product is now finally gaining greater respect (Frommer and Rennie, 2001). From the beginning, the Core Conflictual Relationship method has occupied a middle position between qualitative evaluation and exact quantification. Let us now look at the first application of this method to a psychoanalytic therapy.

The CCRT Method

The CCRT method makes it possible to show internalized relationship patterns. It is based on an analysis of narrative episodes of the patient's relationship experiences. As these "relationship episodes" are the foundation of the method, the first step is to identify them. Three types of components are then determined: wishes, needs and intentions (W-component); reactions of the object (RO-component); and reactions of the subject (RS-component). Positive and negative reactions are categorized. Initially, formulation of the categories is kept as close to the text as possible ("tailor-made formulation"). Since the current American standard categories and clusters of the method have more than once been criticized (e.g. Albani et al., 1999), a reformulation of the category structures of the CCRT method was undertaken (for details see Albani et al., 2002; Albani et al. 2007). Unlike in the old system, a directional dimension was introduced into the wish component showing whether the activity comes from the object or the subject (WO — "What I wish the object to do for me" and WS — "What I wish to do for the object (or myself)"). This addition has proven relevant in initial studies.

In contrast to the old categories, the structure of the reformulated system has a consistent logic to it: all three dimensions are coded on the basis of the same predicate list, which is hierarchically structured. Reactions of the subject and object are analogous, and there is a complete analogy between wishes and reactions; both of the object and of the

subject (e.g. cluster A "Being attentive to someone:" WO "The other should be attentive to me;" WS "I want to be attentive to the other;" RO "The other is attentive;" RS "I am attentive to the other"). In the resulting reformulation there is a predicate list of a total of 119 subcategories grouped into 30 categories, which in turn are grouped into 13 clusters. In the present study, the evaluation was done on the subcategory level, while the results were presented on the cluster level (for names of the clusters, cf. Table 5.7).

The Core Conflictual Relationship Theme (CCRT) is composed of the most frequent wish, the most frequent reaction of the object and the most frequent reaction of the subject.

Sample and Statistics

The data were provided by the session transcripts of this completely taped psychoanalytic treatment that are accessible in the ULMER TEXTBANK. A systematic time sampling was made of the transcripts by selecting blocks of 25 consecutive sessions with a 25-session interval between each block. In the present study we evaluated only the first and last time-blocks, here designated as therapy phases and numbered with Roman numerals. These were sessions 1 – 30 and 510 – 517. In addition, beginning with the 50th session, blocks composed generally of five sessions, were analyzed at 50-session intervals.[13] When a block was not found to contain at least ten relationship episodes, further sessions were added until a minimum of ten relationship episodes was reached. Our sample includes 11 of the 22 available blocks, but has 92 sessions in it.

Evaluation of the sessions was carried out in random order by an experienced CCRT evaluator on the subcategory level. Subcategories were not assigned to the clusters until statistical evaluation was undertaken.

Because of our rich database, it was possible to analyze not only the absolute frequencies but the complex structure of the data as well. On a two-dimensional contingency table, the variable "therapy phase" is set over against one of the CCRT variables (wish, reaction of the object and reaction of the subject). As the null hypothesis, the observed frequencies of the individual dimensions are noted (e.g., wish clusters and therapy phases), and it is assumed that the two dimensions are independent, i.e., that the frequency distributions of the CCRT components are the same in all therapy phases. The alternative

[13] The sample description of the transcribed text of Amalia X (Kächele et al., 1999) is based on 22 transcribed blocks of five sessions each, selected at 25-session intervals. The sessions analyzed here by the CCRT method were selected from half of the available sessions. For the sake of clarity and maintaining the connection to the other Ulm studies, we chose the numbering of 1 – 22 here as well. Thus the therapy phases examined here are the odd–numbered ones.

hypothesis then is that some categories occur more frequently in certain therapy phases than might be expected from the observed frequencies of the individual dimensions.

This hypothesis of the homogeneity of the therapy phases is first globally tested by the generalized Fisher Test (Monte-Carlo method).

In the following exploratory stage, using a one-tailed classical Fisher test, the CCRT categories are determined, which occur more frequently than expected in a particular therapy phase. Thus both the absolute highest-frequency categories as well as the more-frequent-than-expected categories are presented. (For details of this process, see Albani et al., 1994; Pokorny 2007).

Results

Reliability of the CCRT Evaluation

The CCRT evaluation was carried out by an experienced evaluator. In order to check for reliability and to avoid rater drift, during the evaluation process, one session out of the 11 evaluated blocks was selected at random to be evaluated by a second evaluator. In this we followed the approach of Luborsky and Diguer (1990). In the first step, agreement in the marking of the relationship episodes was checked, the criterion being an agreement within seven lines at the beginning and seven lines at the end of an episode. The percentage of agreement was 72% for the beginning of an episode and 69% for the end of an episode. In the relationship episodes in which marking was in agreement, agreement regarding the object of the episode reached 99%.

In the second step the relationship episodes were known, and agreement in the marking of the components was checked based on the criterion of seven words at the beginning and at the end of a component. The agreement at the beginning and the end of the component came to 76% for wishes, 96% and 95% for reactions of the object, and 94% and 96% for reactions of the subject. In the third step, the components were already given and the agreement regarding assignment to the standard categories and evaluation of the valence of the reactions was checked. Agreement regarding the valence of the reactions was a kappa coefficient of .78. For assignment to the standard categories (on the cluster level), the mean kappa coefficient was .68 (W .58, RO .60, RS .70).

Results of the CCRT Evaluation

In the 92 hours, altogether 579 relationship episodes were found, containing 806 wishes, 986 reactions of the object and 1103 reactions of the subject. The positivity index (number of positive reactions in relation to the sum of positive and negative reactions) came to 15.1% for reactions of the object and 23.9% for reactions of the subject.

Table 5.7 gives an overview of the frequency distribution of the categories on the cluster level.

Cluster		**WO** n=518	**WS** n=288	**RO** n=986	**RS** n=1103
A	Attending to	46.3	12.5	4.2	3.3
B	Supporting	26.6	4.9	5.1	2.4
C	Loving / Feeling well	14.3	19.8	4.4	6.0
D	Being self-determined	10.0	27.1	6.9	7.2
E	Being depressed	0	0	.3	6.4
F	Being dissatisfied / scared	0	0	1.7	24.2
G	Being determined by others	0	.3	5.3	15.3
H	Being angry / unlikable	0	0	4.7	15.5
I	Being unreliable	0	.3	19.3	.1
J	Rejecting	0	8.7	19.2	6.1
K	Subjugating	.2	6.2	13.6	1.4
L	Annoying / Attacking	0	2.8	7.3	1.4
M	Withdrawing	2.5	17.4	8.2	10.7

Table 5.7 Frequency distribution of CCRT variables: object-related wishes (WO), subject-related wishes (WS), reactions of the object (RO) and reactions of the subject (RS) (relative frequencies in %, n=579 relationship episodes)

The Core Relationship Conflictual Theme (CCRT, most frequent categories of all) for the entire therapy is as follows:

WO: Others should be attentive to me (WO Cl A),

WS: I want to be self-determined (WS Cl D),

RO: Others are unreliable (RO Cl I),

RS: I am dissatisfied, scared (RS Cl F).

Table 5.8 presents the typical categories for each phase of therapy.

ighest-frequency categories	uent-than-expected categories*
ase I, sessions 1-30, n = 30	
"Others should be attentive" (112/ 55)	"Others should be attentive" (112/ 55)
"I want to be self-determined" (42/ 37)	"I want to be self-determined" (42/ 37)
"Others reject me" (82/ 24)	"Others reject me" (82/ 24)
	"Others are weak" (24/ 7)
"I am dissatisfied, scared" (116/ 27)	"I am dissatisfied, scared"(116/ 27)
	"I am determined by others" (77/ 18)
	S 335/ 82
ase III, sessions 50-55, n=5	
"Others should be attentive" (9/ 41)	
"I feel like withdrawing" (4/ 21)	
"Others reject me" (10/ 20)	"Others are dissatisfied, scared" (4/ 8)
"I am dissatisfied, scared" (11/ 26)	"I feel good" (7/ 16)
ase V, sessions 100-104, n=5	
"Others should support me" (12/ 44)	"Others should support me" (12/ 44)
"I would like to love and feel good" (5/ 36)	
"Others are unreliable" (12/ 23)	"Others withdraw" (9/ 18)
"I am dissatisfied, scared" (25/ 42)	"I am dissatisfied, scared" (25/ 42)
ase VII, sessions 151-157, n=7	
"Others should be attentive" (7/ 78)	
"I want to reject others" (3/ 43)	"I want to reject others" (3/ 43)
"Others are unreliable" (6/ 27)	
"I am dissatisfied, scared"(6/ 37)	**O** 22/ 100
ase IX, sessions 202-206, n=5	
"Others should be attentive" (8/ 33)	"Others should be self-determined" (6/ 25)
"I feel like withdrawing" (4/ 31)	
"Others are unreliable" (11/ 26)	"Others are self-determined" (7/ 16)
"I am dissatisfied, scared" (11/ 22)	
ase XI, sessions 251-255, n=5	
"Others should be attentive" (7/ 33)	
"I want to be attentive to others" (4/ 67)	"I want to be attentive to others"(4/ 67)
"Others are unreliable" (7/ 27)	
"I am dissatisfied, scared"(10/ 32)	
ase XIII, sessions 300-304, n=5	
"Others should be attentive" (6/ 40)	
"I feel like withdrawing" (3/ 43)	
"Others reject me" (6/ 23)	
"I am dissatisfied, scared"(9/ 36)	
ase XV, sessions 351-355, n=5	
"Others should be attentive" (19/ 54)	
"I feel like withdrawing" (5/ 36)	"I want to subjugate others" (3/ 21)
"Others are unreliable" (14/ 25)	
"I am angry, disagreeable" (17/ 28)	"I am angry, disagreeable" (17/ 28)

ase XVII, sessions 401-404, 406, n=5	
"Others should love me" (7 30) "I want to reject others" (2/ 50) "Others reject me" (12/ 27) "I am determined by others"(9/ 25)	"Others should love me" (7/ 30)
ase XIX, sessions 445-449, n=5	
"Others should support me" (17/ 33) "I would like to love and feel good" (11/ 37) "Others are unreliable" (25/ 23) "I am dissatisfied, scared" (28/ 23)	"Others should love me" (13/ 25) "I would like to love and feel good" (11/ 37) "Others withdraw" (18/ 17) "I withdraw" (25/ 20) **S** 42/ 91
ase XXI and XXII, sessions 501-517, n=17	
"Others should be attentive" (40/ 45) "I want to be self-determined" (20/ 33) "Others are unreliable" (46/ 21) "I am angry, disagreeable" (45/ 19)	"I want to annoy, attack others" (5/ 8) "I am angry, disagreeable" (45/ 19) "I am self-determined" (37/ 16) "I reject others" (23/ 10) **S** 87/ 37

* Fisher Test, two-tailed, p .05, W: n=806, RO: n=986, RS: n=1103

Table 5.8 Core Conflictual Relationship Theme (CCRT) in the course of therapy (absolute/relative frequencies in % in relation to the given phase of therapy)

In order to connect the CCRT findings to the clinical description we used French's distinction between "nuclear conflicts" and "focal conflicts". We were able to determine that across all phases of the treatment one basic theme becomes clear in each of the most frequent categories of the CCRT procedure:

Amalia's wish for attention (WO C1 A) and support (WO C1 B) from others; her experience of the others as rejecting (RO C1 J) and unreliable (RO C1 I); and her dissatisfaction and anxiety (RS C1 F). In each of the phases of therapy, the subject-related wishes are distinct.

The more-frequent-than-expected categories are characterized by the themes that distinguish the particular therapy phase from the other phases.

Initial therapy phase I (sessions 1-30) is characterized chiefly by Amalia's wish for kindly attention from others (WO C1 A). She speaks of her colleagues, by whom she feels "used" as a "dustbin" (RO C1 J) but with whom she cannot speak about her problems. Amalia envies her female colleagues for their relationships. She feels insecure in relation to her students (RS C1 G), thinking they regard her as an old maid (RO C1 J), and there are

conflicts in which she does not feel properly supported by her director (RO C1 G). She describes her father as a sensitive, fearful and inaccessible person (RO C1 J, RO C1 G) and is disappointed at their distant and irritable relations (WO C1 A). A relationship episode with her father follows:

> *P: ...for example, when I come home, by car now, he won't even come out. I know from my colleagues that they have fathers much older, and they pick them up and carry their bags in and so on, and he doesn't even come. So when I get home, and maybe my mother opens the door, then I might go to the bathroom or something, or I'm taking off my coat and standing in the entryway, he doesn't come, he doesn't move. Or I go into the living room, and he'll be sitting in the other room, you see he somehow can't take a step towards a person...*[14]

In relation to her brothers she feels inferior and not taken seriously, either by them or by the family as a whole. She makes a theme of her dependence on the norms of the church, the opinions of others and on her mother though her mother is the one she talks to. On the other hand, Amalia has the feeling she needs to be available for her mother and has feelings of guilt when she distances herself from her.

> *P: ...sometimes I really need my Sunday to just, well, and then there'll be something I have to do again, and then you see, my parents, they come around often, you know, my mother will call up and then she'll say, then, she'll just say: 'Come' and I've simp- never managed yet to say, 'Please don't. I don't want you to.' Or 'It won't work out' or…*

Her wish for change is expressed in her wish for autonomy (WS C1 D), which results from her experience of herself as dependent and weak, unable to set limits and dissatisfied. For this phase of the therapy, the high proportion of negative reactions on the part of the patient herself is particularly characteristic.

In the ninth session, Amalia reports the first relationship episode with the analyst (out of a total of only four episodes in the initial phase):

> *P: ...(pause). You know, anyway today I was awfully, I am so dreadfully tired, I've said that before and then today I really didn't have time to catch my breath from yesterday. The whole evening I was — well, I had a girl student visiting, who wanted something and so I didn't get to give it any thought, but just the same I started realizing some things yesterday and in that…Sure in a certain sense it was finished too, and what I'm left with as a question is always the same thing. Fine, I see it now, but what I am supposed to do and how is it supposed to go on and, and, and what, I really didn't mean to say that, right.*
>
> *A: With the students and the grading problem, you mean, if that is supposed to go on?*

[14] Transcript of the Ulmer Textbank.

P: No, I mean here, how is this supposed to go on, when I lie here and tell you something and I try to understand it and you summarize it, then of course some things become clear, and nevertheless then I tell myself, what am I supposed to do with that, that's what was going through my head, and that's what I didn't want to say, because somehow it, because, I keep asking myself, if you recognize it, to what extent can you guide your actions by it.

A: How it will go on?

P: And how it will go on, right, that was really the question. Somehow at the moment I experienced that as an insult to you, and therefore I couldn't say it.

This episode illustrates the description of the clinical transference configuration of these therapy phases: the analyst as father confessor and examiner, in front of whom Amalia is careful, reserved and uncertain but also beginning to come to terms with "authority." What is striking is that Amalia reports a great many relationship episodes in the initial sessions (on average 11 episodes per session), which makes sense from the clinical perspective: in the initial phase, the therapeutic relationship is being established and biographical material occupies a greater space.

In **therapy phase III** (sessions 50-55), Amalia describes episodes chiefly reflecting her wish to withdraw (WS C1 M), which she in fact succeeds in doing in relation to her mother and younger brother. The following episode with her mother gives a picture of the clinical description of this phase of the therapy as "the bad mother," but also shows that Amalia is exploring alternative types of behavior:

P: No, otherwise on the weekend I actually have uh; well yes of course my mother called up again and wants, and would very much like me, uh, to come next weekend, or rather she would like to come, but I told her I wasn't sure yet what my plans were, and asked her to please wait, I mean, two or three weeks ago I would really have just, said, or let's say four weeks ago, uh please come and I have often said, yes please come, even when it wouldn't be convenient at all for me, and I just see that it, that it, uh would be perfectly ok alone, that I, um, I really don't need to get so, so worked up all the time because now, now I'm sitting here all alone and so forth, and of course it would be nice, not to be sitting all alone that way all the time well it's not always but a great deal of the time for sure but, um, I could make a lot more of it, not that I didn't used to read before or didn't do this or that too, but I just feel better about it, um, I can honestly say.

Amalia is feeling better and experiencing moments of self-confirmation (she is driving alone again taking walks, painting again; RS C1 C), although there are confrontations with the parents of her students.

Her relationship to the analyst is also becoming a more frequent topic (in 17% of the episodes). She demands answers instead of silence from the professional authority (RO C1 J) and would like to give her own interpretations as well.

Therapy Phase V (sessions 100-104) is marked especially by Amalia's wish for support (WO C1 B). She feels that her director is judging her and discriminating against her because of her therapy (RO C1 J). She also is expressing her wish that the analyst should give her clear answers and be open and honest with her. She experiences the analyst as the "most important person" (38% of all episodes deal with the analyst), but feels rejected by him. She is unsure who he is and what he thinks of her and complains of his changing the subject and of his keeping the rules secret (RO C1 M).

P: You know, just this business with my boss, really went to show how difficult it is, uh, what with the self-assessment that you make of yourself, and the assessment others make of you, which you can always somehow sense or see, to hold the balance there, when the two of them clash. And that's where I feel you are someone I can assume, um — right, I just feel — it's simply something like trust, and, and nevertheless, after all that's why I went running to the well, I didn't actually run to the bookstore, but I, I wanted to read it, because you see I keep wanting to know who you are, and uh, you, you can't help asking yourself the whole time, 'So who is this person that you are putting your trust in, and, and what kind of picture is he forming of you' — and, I mean, all those things that we've already spoken about,

A: um-hmm.

P: ...came back to me really powerfully — because — naturally I want to know: what kind of man is this, who has a profession like that, and a wife who also has a similar profession, uh, all that, that is somehow important. And then when you, if I can put it that way, to me it seems you change the subject, then I can't help asking myself: 'Why, why is he changing the subject — is he embarrassed – well, why is he embarrassed by that?' — or is it that he wants me to be independent, ok, right. It, of course it has to do with that. But, I just think it's kind of going down different

tracks. I mean, if I trust a person, of course I am dependent in a way — thank God, I would say and, and yet again at the same time I have to…

A: um-hmm.

P: I just need — at least here — to feel I have the right to sound you out, who you are and who I am — or rather I didn't put that quite right — who you are — it strikes me as very important, that, uh, why does he listen to me, right, it's another one of those questions. Why does he do that? What is interest in a person?

A: um-hmm.

P: What's behind it?

According to the assessment by the CCRT method, the patient's "search for norms of her own," which was identified as a theme in the clinical description, appears to take place in two ways: on the one hand in coming to terms with her disappointed wishes for support, but also in her confrontation and identification with the analyst.

Amalia's wish to reject others herself (WS C1 J) becomes important only in **therapy phase VII** (sessions 151-157). Amalia is dissatisfied (RS C1 F) and is considering entering a convent. Alongside of her relationship to her father (who is the object of interaction in four of fourteen episodes of this phase), the focus of these sessions is the therapeutic relationship (the therapist is the object in six of the fourteen episodes of this phase). On the one hand she is afraid she is asking too much of the analyst; on the other hand she criticizes his interpretations and finds, for example, that he does not laugh enough. During a visit by her parents she is disappointed that her younger brother is favored (WO C1 A), bringing back memories of her lifelong envy of her brother. In no other phase does Amalia portray the reactions of others so negatively as in this phase.

The wish that others should be self-directing (WO C1 D), characteristic of **therapy phase IX** (sessions 202-206), is aimed largely at her director, who lets himself be manipulated (RO C1 I) by a female colleague with whom Amalia is in rivalry and to whom she feels inferior (RO C1 D). From her analyst, Amalia wishes a direct answer to her concern that she might have caused herself damage in masturbation. She receives it (with some delay), in which process the therapist (by father transference) becomes a seducer and moral judge, as the clinical description emphasizes.

In **therapy phase XI** (sessions 251- 255), Amalia succeeds for the first time in initiating a date with a male colleague (WS C1 A). She wishes she were able to speak openly

about sexuality with her mother (WO C1 A), recalling her cautious attempts to question her mother, and wonders about her mother's sex life. Amalia wants to understand what happens in analysis — she attends lectures by psychotherapists and reads publications by her analyst, but finds no answers, is unable to understand many things and feels inferior to the analyst (RS C1 F). The clinical description of therapy phase XI, "Even father cannot make a son out of a girl," strongly reflects the therapeutic conception of the analyst, who focused on the patient's penis envy. The evaluation by the CCRT method, on the other hand, reveals above all Amalia's (new) openness ("I want to be attentive to others") in this therapy phase — both in the way she forms her relationships and in the way she confronts her own sexuality and femininity as she takes steps towards her mother.

During a three-week break in **therapy phase XIII** (sessions 300-304), Amalia decides to place a personal ad in a newspaper and receives several answers to which she in turn responds. She is afraid of how the analyst will react to this (WO C1 A), fearing his reproaches (RO C1 J):

> *P: ...In the weeks that you were away or unavailable, eh, I suddenly had the feeling I could 'swim on my own' now. And then came my resolution that I will definitely not go on vacation with my parents this summer; that I'd do something on my own. I had answered this personal ad and made the decision to place one myself. And that was actually what I didn't want to tell you, because I was afraid you would interrogate me up and down and then you'd get angry and say, and then I was awfully afraid of what would come next and of course I've transferred that fear, but still it is sitting down there like an elemental force, that you will make an awful angry face and though you won't in fact forbid it, you'll say, 'So all has been for naught, you've understood nothing, and this treatment here just gets in the way of your doing what you want,' that was it I think.*

The fact that her younger brother recognized her ad in the paper strengthens her wish to protect herself from her brothers' and parents' interference and judgments (WS C1 M), also intensifying her dissatisfaction and feelings of inferiority, as comes out clearly in the image of the "poor maiden" given in the clinical description.

In **therapy phase XV** (sessions 351-355), Amalia is disturbed (RS C1 H) by outward alterations (her analyst's department has moved, there is a new therapy room, noise from

building site). She feels unprotected by the analyst (WO C1 A) and jealous of his own children (RS C1 H):

P: ...that you only moved up here to make it easier for you to take your children to school.

T: What do you mean easier?

P: Because I keep imagining your children will be going to school now in the, on Hochsträß and uh, and at first that made me, I mean, really furious.

She feels put under pressure both by her analyst and her father and thinks that there are expectations she has to fulfill. In her school, Amalia has confrontations with the janitor and her director (WS C1 K), in which she is able to adopt a more active posture and defend herself (RS C1 H). Her (unfulfilled) longing for her analyst's attention and her rage in its disappointment are also expressed in the clinical description: "helpless love for the powerful father and envy of his wife."

In **therapy phase XVII** (sessions 401-404), the analyst receives a bouquet of flowers which holds manifold symbolism. The bouquet was actually intended for a correspondent who had answered Amalia's next ad. At the same time it is an apology for the negative judgment of the analyst by Amalia's nephew, who knows the analyst from lectures and with whose criticisms of the analyst Amalia in part identifies (as also becomes clear in the clinical description). Amalia also identifies with her flowers, fearing that the analyst will not take good care of them (WO C1 C).

P: I always really find it wonderful when someone knows how to take care of flowers. Most people take them and ram them in like a post in the earth, and let them sit in the vase till they hang their heads. No, you know, these ones especially began to droop last time, and I thought uh-oh…

T: I didn't understand, you were saying?

P: They were beginning to droop last time.

T: They?

P: They, the flowers began to droop.

T: The flowers right.

P: Right and so I thought, oh he's doing something wrong, that shouldn't be happening. And so naturally I was very glad today that you, that you did understand after all, how to give them the right amount of water and food.

Through her correspondence with various men, Amalia explores her relationship to men and recalls her brothers' air of superiority and the lack of validation she experienced through her father (RO C1 J):

P: It was never a climate of affirmation; it was always, how it all comes back to me, oh God. It was always, if I wanted to be a girl, I was stopped, and if I wanted, I remember once, I put on ski pants and my father said then 'I don't happen to have three sons, I should like to request, not at the table, go get changed.' So I wanted to be a boy or to pretend it wasn't so important. It was always such an exclusive thing, the boys, I always had the feeling that my brothers, in spite of the connection I have to my younger brother, they did a better job of affirming each other and, and stayed together. Somehow behind my back they stuck together. After all they were the men and they were ok, and they were in the majority. Predestined from eternity to eternity. I don't know; it was just that way. A troublemaker and a liar, that's what I was, right and, ok yes. I have the feeling they were always watching to see what would come of it. They wanted to know just exactly what was different and what was going to come of it. And at the same time they always knew it in advance, what came of it. They just always knew everything better.

Therapy phase XIX (sessions 445-449) reflects Amalia's ambivalent experiences in her first relationship with a man. She wishes for a close, intense and also sexually satisfying relationship (WO C1 C, WS C1 C), but she is not sure of the affection of her partner (who still is attached to his ex-wife and also has other relationships) and is disappointed by his distance (RO C1 M, RO C1 I, RS C1 M).

P: ...and then he said, 'Listen, when it comes down to it, you know, our relationship doesn't justify such a thing, you basically have no right, uh, hmm, to keep me away from other relationships. It would be a different thing if we wanted to start a family and have children, then it is bad to go around with other women,' that's more or less what he said, and in retrospect it really shocked me terribly. And then when he

called up on Monday, I had thought I wouldn't call again till Thursday, if he wants anything, let him do it, and then when he called on Monday, just as I had imagined,

T: First he wanted to put an end to it on Monday…

P: Monday was absolute rock bottom.

T: Hmm

P: I thought I really have to put an end to this. And on the telephone I was absolutely icy and didn't say an extra word but then of course he called again about the pills. So then we talked. And that's when he probably got the impression that I was, about putting an end to it, he probably sensed something, I don't know. I don't know. I never actually said 'I'm through.' And I never said 'Don't touch me again' or anything like that. Yes, indeed, we sure, oh we had such, talked so much on the telephone.

Insecurity, doubts about her physical attractiveness and guilt that she fails to live up to her mother's ideas of morality are the main traits of Amalia's feeling life, as becomes clear in high proportion of negative reactions in this phase. Here again, the clinical description and the CCRT evaluation contrast: While the clinical description chiefly emphasizes Amalia's ambivalent relationship to her analyst ("Hate directed at the bountifully giving analyst, and an incipient turning away from this expectation"), the CCRT focuses on her new relationship experiences outside of the therapeutic relationship.

In the **concluding phase XXI and XXII** (sessions 501-517) of her therapy, Amalia is chiefly occupied with coming to terms with the experiences of her last relationship and of a new one that is in the offing, though emotionally she still feels very strongly attached to her previous partner (WO C1 A). Set off by an invitation from her arch-enemy to a class gathering, intense feelings of hate awaken in Amalia, but she is able to come to terms with them (WS C1 L). In the professional sphere, despite a particular challenge from two teacher trainees whom she experiences as very pushy, she is able to assert her will (WS C1 D) and is proud of that (RS C1 D, RS C1 J, RS C1 H). The conclusion of the analysis and parting from the analyst are chief themes in this phase

T: …I mean is there an idea, one that you have, as to what my way, my idea of coming to an end is?

P: That one's easy for me. Mine is quite bold. I just thought you would adapt yourself to me.

T: Um-hmm.

P: And it was just in these last sessions that I got that feeling. It was really a feeling that, yes of course, he'll do what I want. Whereas before, there was this kind of tugging, I felt like I was being tugged on a leash and I had the feeling, he doesn't understand a thing, he has some kind of peculiar idea of his own of how to finish. He won't tell it to me of course, so I don't know it. And it was like a real tugging. And now, for about three or four sessions I think, I haven't been counting, my mind is the way I was just telling you. It'll simply work that way. I'll be sitting in my tortoise shell, and the harvest will come in. Like I told you.

T: Um-hmm.

P: I'll just get up and go, and I liked that so much that I thought, there's nothing he'll be able to do but go along. That fact that it isn't quite his idea of things, and if he finds something more thematically, that is his problem. Because there will always be something to find…

What is striking is the great number of positive reactions by Amalia in the concluding phase. The clinical description speaks of a "farewell symphony: the return of many fears and the discovery of many changes;" and this is powerfully evident in the CCRT evaluation of the concluding phase, which illustrates Amalia's newly acquired freedom of action.

Discussion

Within the framework of our study, it has become possible for the first time to examine a long-term psychoanalytic therapy with the CCRT method during its course. Thus, compared to previous studies of single cases using the CCRT method, it offers the most comprehensive sample to date.

The relatively great number of reactions of the subject compared with other CCRT studies may be due to the fact that this was a psychoanalytic therapy and the patient was particularly encouraged to reflect on her feelings and thoughts. The results of the evaluation by the CCRT method underscore the clinical assessment of the success of the therapy and support the results of previous studies done on this material. Though the negative reactions of the objects and of the patient still predominate in the final phase of the therapy, a significant increase in positive reactions of the patient becomes apparent. The patient also described the

reactions of the objects as more positive at the end of the therapy, but these changes could not be statistically established. The component "subject-related wishes and reactions of the subject" reveals that in the course of the therapy, the patient was able to expand her freedom of action and acquire new competencies, and that her depressive symptoms decreased.

The increase determined by Neudert et al. (1987a; see chapter 5) in positive feelings of self-worth and the decrease in negative feelings of self-worth in the course of the therapy match the content changes of the subject's reactions in the present study. Moreover, the distinct increase in positive reactions of the patient herself further supports this finding. Starting in therapy phase VII Amalia is in a position to perceive and express aggressive wishes, and starting in therapy phase XV these gain relevance in action. Particularly when this is contrasted with the dominant feelings of dissatisfaction and fearfulness at the inception of the therapy, the change in Amalia becomes apparent.

Alongside of a basic theme manifested in each of the absolute highest-frequency categories ("nuclear conflict"), each of the therapy phases also showed typical categories that characterize thematic foci in the sense of French's "focal conflicts" and which can be operationalized by the CCRT method. Thus the CCRT method makes it possible to structure material by content.

Being confined to narrative material, the CCRT method manifests a limitation when compared with the clinical description, particularly in the initial phases: while the clinical description of the first two phases focuses on the meaning of the treatment ("Analysis as Confession," "Analysis as a Test"), the CCRT method can access such aspects only through relationship episodes with the analyst. Such episodes in particular however are rarely reported by Amalia at the beginning of the therapy.

In contrast to the clinical description, which uses metaphorical language to highlight a theme according to the subjective assessment of the judges, investigation of the therapy phases by the CCRT method makes possible a more differentiated (and less subjective) analysis of the themes, as is seen in therapy phase III. In the clinical description, the "bad mother" takes center stage, while in the CCRT evaluation other aspects emerge: "I feel good" (regarding the patient's newly gained/regained freedom of action). While the clinical description is limited to the transference configuration, the CCRT method makes it possible to access interpersonal aspects inside and outside of the therapeutic relationship.

Both the strengths as well as the limits of the CCRT method stem from its confinement to reports on relationship experiences by the patient herself. In other words, the investigation remains limited to those relationship experiences that the patient has perceived and verbalized. The method provides no way of including unconscious material (apart from the repetitive schemas that patients — often unconsciously — follow in describing the course of relationships) or of assessing defense mechanisms. Hence the evaluation remains very close to the clinical material, though it does reflect intrapsychic processes in the narratives of interactions.

Parallels between the patient's descriptions of her relationship with the therapist and other objects can be examined by means of the CCRT method. Thus the method makes it possible to capture structural aspects of the clinical transference concept. Nevertheless, the interactive transference currently in progress will not enter into the evaluation.

Although the method is called the "Core *Conflictual* Relationship Theme," Luborsky leaves the concept of conflict unclarified. Conflicts in the analytic sense between wish and defense, between different systems or levels or between drives (Laplanche and Pontalis, 1972) are not captured by the method. The wish component makes it possible to describe conflicts between two wishes that occur simultaneously and are mutually exclusive. It might be most accurate to say that the CCRT captures the theme of the most frequent wish without immediately revealing the associated conflict itself. Therefore the CCRT should rather be understood as an indicator for capturing the patient's conflict. On the other hand, interpersonal conflicts are registered with great clarity and differentiation in the form of wish-reaction schemas. The ongoing interaction however is not captured; nor are the communicative and interactive functions of the narrative investigated within the therapeutic interaction.

With the CCRT method itself it is not possible to clarify how therapeutic changes have come about. In their studies, Crits-Christoph et al. (1998) showed a connection between the "accuracy" of the therapist's interpretations of the CCRT and the success of therapy.

It is now an uncontested fact that the quality of the therapeutic relationship is of critical importance for the success of therapy. On the whole, the relationship of the patient to her therapist seems to have been satisfying and positive for her — no other relationship is described with such a high rate of positive reactions of towards the object of interaction.

The present study shows that the CCRT method makes it possible to capture clinically relevant interpersonal aspects of the psychoanalytic process, from the patient's point of view, which support the Ulm Process Model. The analyst's contribution however is reflected only in the patient's narratives regarding her relationship to the therapist. Use of the CCRT method provides for structuring of clinical material, development of clinical hypotheses and checking on therapeutic focus during the course of therapy. The method is easily learned for clinical application and the time required in formulating the psychodynamic connections for clinical use is minimal, so that the method can accompany treatment throughout.

AMALIA'S UNCONSCIOUS PLAN[15]

Introduction

The long-term systematic work of Joseph Weiss, Harald Sampson and the San Francisco Psychotherapy Research Group (SFPRG) is a sensible response to Merton Gill (1994) observation: "While it is true that systematic research in psychoanalysis presents major obstacles, pitiful small percentage of work in our field is devoted to the development of methods that will allow for informed selection among our competing claims" (p.157). The empirically based theory of the psychotherapeutic process developed by Weiss (1993) has become known as Control-Mastery Theory. This cognitive-affectively oriented psychoanalytic theory represents an important contribution to recent developments in psychoanalytic treatment theory and the research inspired by it.

The Control-Mastery Theory

The Control-Mastery Theory is based on Freud's late ego psychology (1923b; 1926d; 1937c), but also includes concepts drawn from object relation psychology (Winnicott, 1965, Fairbairn, 1952) and interpersonal theory (Sullivan, 1940), attachment theory (Bowlby, 1969, 1973, 1980), as well as from recent infant research (e.g. Stern, 1985).

Weiss views the striving for security and the avoidance of danger as fundamental principles regulating the unconscious mental life. In order to maintain a sense of security, according to Weiss defense processes last as long as there is an unconscious assumption that the perception and experience of the resisted contents represent a threat. This reveals the central significance accorded by Weiss to unconscious, planful and adaptive processes — conceptualized as unconscious ego functions in Freud's structural theory — for the regulation of defense strategies. The goal of therapy is to acquire a higher degree of control over these unconscious defense strategies and increasingly place them in the service of the patient's goals ("control-mastery"). Weiss attributes to the patient a strong unconscious wish to collaborate with the therapist in solving her problems and believes that reenacting

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[15]Cornelia Albani, Reto Volkart, Judith Humble, Gerd Blaser, Michael Geyer & Horst Kächele. Adapted from Albani et al. (2000).

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biographically acquired conflictual relationship patterns in the transference relationship serves as a way of testing their validity and finding alternative means of overcoming — i.e. mastering — them. Weiss sees this mastery motivation as central to an understanding of the neurotic repetition compulsion and the therapeutic process.

Central to the theory is the existence of unconscious pathogenic beliefs, which are typically acquired in childhood or arise as a result of unconscious attempts to cope with traumatic experiences. Pathogenic beliefs make it possible to maintain relationships with important reference persons and aid in coping with traumatic experiences by diminishing feelings of helplessness (cf. Volkart, 1993).

Guilt feelings assume particular importance in Weiss' approach. Various forms of guilt are distinguished. Guilt at personal success or happiness that is felt to have been gained at the cost of other family members is referred to as "survivor guilt," a concept also found in Modell (1965) and Niederland (1961, 1981). Guilt at having injured others by one's own striving towards autonomy Weiss designates as "separation guilt."

In order to disconfirm pathogenic beliefs, the patient tests them in the relationship with the therapist. From this point of view, transference is not a pathological phenomenon to be seen as resistance to treatment, but an active unconscious strategy on the part of the patient to make use of the sheltered therapeutic relationship in order to come to terms with previous experiences and to have new relationship experiences. If the "test" is passed, the patient reacts with relief, introduces new material, works more intensively or initiates a new test that exposes him to greater danger. In agreement with Alexander and French's concept of corrective emotional experience (1946), Weiss emphasizes the active role of the therapist, which provides the patient with a positive experience of relationship in the ongoing therapeutic relationship, so that therapeutic change can take place even without bringing resisted contents to consciousness.

The purpose of interpretations, according to Weiss, is to allow the patient to feel safe, to become aware of his pathogenic beliefs and to understand his development and psychopathology. In this sense interpretations can also be evaluated empirically according to

whether or not they serve the patient's unconscious plan. (For a critical discussion see Eagle 1984, p 95ff).

The Plan Formulation Method

With a view toward formulating their case conceptions and testing their concepts empirically, Weiss, Sampson and members of the San Francisco Psychotherapy Research Group developed the Plan Formulation Method (Caston, 1977, Curtis and Silberschatz, 1986, Curtis et al., 1988 and 1994). A first version, called Plan Diagnosis, included only 4 categories (goals, obstructions, tests and insights). Later the method was supplemented to include a 5th area (traumas).

1. Goals: These are the therapeutic goals of the patient, i.e., modes of behavior and experience, affects, and abilities that the patient would like to attain. They may be quite specific and concrete (e.g. to marry) or general and abstract (e.g. to gain the ability to withstand feelings of guilt). Goals can be conscious to varying degrees or unconscious.
2. Pathogenic beliefs (obstructions): These include irrational pathogenic beliefs and associated fears, anxieties and guilt feelings, which are for the most part unconscious at the onset of therapy and prevent the patient from reaching his true goals.
3. Tests: This category lists tests by which the patient in therapy can attempt to disconfirm her pathogenic beliefs by testing the therapist and observing the latter's reactions.
4. Insights: This category comprises knowledge and experiences that can help the patient reach her goals. In particular, this includes insights about the genesis of the pathogenic beliefs in connection with traumatic experiences.
5. Traumas: Here all traumatic experiences are noted. These may be single traumatizing experiences or enduring negative relationship experiences from childhood.

Using the transcripts of the intake interview and the first therapy sessions, the judges independently determine items for the 5 categories. Typically the transcripts of three sessions are used for this purpose. The number of items is not limited. Items formulated include both especially typical ones as well as those that are possible but appear less relevant. All items of the individual judges are then gathered into a master list in random order. In a second step, the

judges use this master list to rate, on a 5-step scale, how relevant each of the items appears to them for this case. Using these ratings, the reliability is determined for each category.

For the final plan formulation, the mean values are determined per item and for one category across all judges. All items of one category of which the relevance rating falls beneath the median are dropped. The remaining items are checked for redundancy and edited for content by other judges. The plan formulation consists of a description of the patient, her current life situation and complaints, as well as the goals, obstructions, tests, insights and traumas that have been ascertained.

Results on the Reliability of the Method

The SFPRG studies employed 3 to 5 judges. The reported intra-class coefficients (ICC) for the 5 categories fall between .14 and .97 for the single rater pairs, but the mean comes to between .78 and .9 (.78 for tests, .9 for goals, .86 for obstructions and .9 for insights, Rosenberg et al., 1986). The ICCs across all raters come to between .91 and .93 (Curtis et al., 1988; Person et al., 1991). (For a detailed discussion of reliability, see Rosenberg et al., 1986).

To date there has been only a single reliability study of another working group using the Plan Formulation Method (Collins and Messer, 1991), and here too the ICCs for the various categories fall between .86 and .93.

Results of Empirical Research Using the Plan Formulation Method

In recent years Weiss, Sampson and the members of the San Francisco Psychotherapy Research Group have conducted extensive empirical studies of their theoretical concepts. The following selection is intended merely to provide an overview. For detailed information, the reader is referred to the original literature.

Studying the psychoanalysis of Mrs. C., Weiss and collaborators (Curtis et al., 1986) confirmed the hypothesis that even without interpretation, the patient was able to become conscious of previously repressed contents when she felt sufficiently sure of herself and did not react to these contents with heightened anxiety. This contradicts the classical

psychoanalytic view that patients in all cases display a resistance to becoming conscious of repressed contents, which can be overcome only by interpretation, and that the elimination of repression is associated with anxiety.

The study of Silberschatz et al. (1986) examined three short-term therapies to investigate whether certain case-specific interpretations lead to immediate progress. The Plan Formulation Method makes it possible to adequately evaluate aspects of plans on a scale (Plan Compatibility Scale of Bush, 1986) if an interpretation is helpful ("pro-plan") or unhelpful ("anti-plan") to the patient. Statements made by the patient immediately before and after the interpretation were rated on the Experiencing Scale (Klein et al., 1970), which contains (among others) scales for evaluating the degree of insight, resistance and associative freedom. The higher an interpretation is rated as "pro-plan," the greater and more positive the change on the Experiencing Scale.

Another study, based on seven 16-session short-term therapies (Norville et al., 1996), demonstrated positive correlations between the mean value of the plan compatibility of all interpretations and the total result of the therapy at termination and in a follow-up after 6 months.

Using three 16-session short-term therapies, Silberschatz et al. (1986) investigated whether and in what way the plan compatibility and type of interpretation was predictive of the immediate changes in the patient's behavior after the interpretation. All interpretations were classified according to the typology devised by Malan (1963), which distinguishes between transference interpretations and non-transference interpretations. In determining the immediate change, 3-minute segments preceding and following the interpretation were rated on the Experiencing Scale (Klein et al., 1970). The results failed to show either immediate effects of transference interpretations or connections between the number of transference interpretations per session and the mean experiencing score for that session. However, plan-compatible interpretations did lead to higher experiencing scores. When only those transference interpretations are considered that are rated as "pro-plan," no higher experiencing scores are found than after interpretations that were rated simply as "pro-plan" but not as transference interpretations.

Silberschatz and Curtis (1993) studied two short-term therapies and one psychoanalysis (Mrs. C. - Silberschatz, 1986) to investigate how the therapist's behavior in the session

influences the patient's therapeutic progress. They identified tests in the course of therapy and evaluated the appropriateness of the therapist's reactions and the immediate reactions of the patient to these using various scales (Relaxation Scale, Curtis et al., 1986, p.200; Boldness Scale, Caston et al. 1986, p. 289; Experiencing Scale, Klein, 1970). In the two short-term therapies, 69 and 45 tests were ascertained, and in the first 100 sessions of the psychoanalysis, 46 Tests. Positive changes were found on all three scales when the therapist passed the test.

Weiss' theory gives particular significance to interpersonal guilt. O'Connor, Berry and Weiss developed a questionnaire based on the Control-Mastery Theory in order to measure interpersonal guilt: the Interpersonal Guilt Questionnaire or IGQ (O'Connor et al., in press), whose 67 items form 4 scales: "survivor guilt," "separation guilt," "omnipotence responsibility guilt" and "self-hate." The connection between interpersonal guilt and psychopathology has been examined in numerous studies (e.g. B. Menaker, 1995; O'Connor et al., 1994). We are presently working on the development of a German version of this instrument.

5.7.5 Plan Formulation of Amalia X

To date there have been few German-language studies employing the Plan Formulation Method. Volkart (1995) uses the Weiss concept and the Plan Formulation Method for a detailed interpretation of a transcript. In the single case study of Volkart and Heri (1998), the FACS method was used to study emotional processes relating to the affects shame, guilt, rage, disgust and joy and to interpret them in connection with case-specific pathogenic beliefs.

Volkart and Walser (2000), again in a single case study using the Facial Action Coding System (FACS, Ekman and Friesen, 1978) for coding of mimic reactions, demonstrated that a female patient reacted with various nonverbal signals to a passed test and a failed test. These mimic signals were given almost immediately, i.e. within seconds.

Overcoming a wide geographical distribution, our group came into being out of a common interest in the Control-Mastery Theory, with which the various members have been familiar for some years. Visits to San Francisco had given us (RV and CA) an opportunity to familiarize ourselves with the method and discuss cases with SFPRG members. We began with a training phase on a transcribed case, which was made more difficult because the three raters (CA, RV and JH) were able to come together as a group only once for a thorough

clinical discussion. This meeting took place after the rating of the sample case, its purpose being to discuss the ratings and to arrive at as unified a case conception as possible.

For the final reliability study of the present research project, we chose the well-documented single case of Amalia X. Since for technical reasons the first interviews were not available, 5 therapy sessions from the initial phase of the therapy served as the data foundation, as well as several "stories about relationships" ("relationship episodes" in the Core Conflictual Relationship Theme (CCRT) method, Luborsky, 1992) taken from later sessions. We also had access to a compilation of case history data.

Results of the Reliability Test

The three judges first determine items for the 5 categories independently of one another. These are then combined into a master list and rated by each judge on a 5-point scale (0= not relevant, to 4 = very highly relevant). In all 252 items were rated by the three judges.

Table 1 gives an overview of the results of the reliability test, which correspond to the results of the SFPRG and can be considered quite good given the minimal common training of the judges.

Table 1

Interrater Reliability for the Five Categories in the Plan Formulation of Amalia

Category	ICC	n	M	n,>M
Goals	0.93	65	2.61	39
Pathogenic Beliefs	0.82	57	2.36	31
Traumas	0.90	56	2.32	37
Insights	0.89	46	1.94	31
Tests	0.94	28	2.67	20

ICC Intraclass correlation, two way random effects model, average measure reliability (Shrout and Fleiss, 1979)
n Number of items in total
M Mean value across all items and judges
n,>M Number of items above the mean value

1 Structuring of the Items by Content

Using the ATLAS/ti text interpretation program (Thomas Muhr, available from Scolari, Sage Publications, London), items of similar content were assigned by consensus to certain categories on a similar level of abstraction. Only those items were used whose relevance rating (mean value of three judges) exceeded the mean value of all items per category. This procedure corresponds to the content analysis technique of "content structuring" described by Mayring (1993). In tables 2 through 5 these categories are presented, each with one highly rated sample item. The categories are arranged according to the height of the mean value of the relevance rating of the items belonging to them.

Table 2: Traumatic Experiences, Content Categories and Sample Items

Content Category*	**M**	**n**	**Sample Item**	**M**
Functioning as substitute partner	3.67	4	*The children were "substitute partners" for their mother (due to her unsatisfying marriage and the absence of her husband).*	4.00
Mother's serious and protracted illness	3.67	1	*Her mother was affected by protracted life-threatening illness during Amalia's childhood.*	3.67
No contact with peers	3.67	1	*Her close relationship with her mother and her role as substitute husband hindered contact to her peers.*	3.67
Close relationship with mother	3.56	3	*She always had to be there for her sick mother and assume the role of her passive father in caring for her.*	3.67
Sent to live with aunt at age 5	3.56	3	*Because of her mother's tuberculosis, at the age of 5 she was the first of the siblings to be sent away, living in the care of her grandmother and aunt for ten years.*	3.67
Wartime absence of father	3.46	5	*During her first 5 years her father was absent because of the war.*	3.33
Puritanical, dogmatic religious upbringing	3.33	7	*She grew up in a strict, conservative, religiously fanatic environment, where any sensuality was prohibited.*	3.67
Father cool, distant, compulsive and rigid	3.13	5	*Her father is cool, distant, and emotionally unexpressive and has a compulsive, rigid attitude that makes it impossible to have a discussion with him.*	3.67

Hirsutism	2.83	2	*She has had abnormal body hair since childhood.*	3.33
Aloneness within family	2.80	5	*She felt like a complete outsider in her family, alone and not understood.*	3.00
"Reasonable" and restrained behavior expected of her	2.75	4	*The aunt requires Amalia to be "reasonable," because as a girl she "should understand."*	3.00
TB at age 3	2.67	2	*In her 3rd year of life she contracted TB and was bedridden for 6 months.*	2.67
Experiences criticism and undervaluation in the family	2.67	2	*She was often criticized or devalued.*	3.00
Domination by brothers	2.67	1	*She suffered greatly under her brothers' domination, unable to stand up to them or assert her own will.*	2.67

* Items may be assigned to multiple categories.

Table 3: Pathogenic Beliefs, Content Categories and Sample Items

Content Category*	**M**	**n**	**Sample Item**	**M**
No right to a life of her own	3.67	2	*She believes she has no right to impose her concerns on the family and therefore holds herself back.*	4.00
A burden to others	3.48	7	*She believes that she is a burden to others and must therefore make all decisions by herself, be perfect and never make mistakes.*	4.00
Responsibility for mother	3.45	6	*She believes that she is responsible for the well-being of others, particularly for her mother, and therefore finds it hard to dissociate herself from them.*	4.00
Deserves isolation	3.39	6	*She believes that she deserves being left alone and hence she thinks she has to do everything herself.*	3.67
Wish for closeness is bad	3.34	3	*She believes she should be ashamed of her longing for closeness and understanding and restrains herself in her wishes and needs.*	3.67
Sexuality is bad	3.34	2	*She believes that to enjoy sexual pleasure or long for a man makes her guilty and therefore she resists all sexual impulses.*	3.67
Autonomy on her part harmful to others	3.11	3	*She believes that that it is painful and hurtful to others if she sets limits from them, and therefore takes exaggerated care to do the opposite.*	3.33
Her personal wishes endanger others	3.00	4	*She believes that her wishes, needs and concerns pose a danger to others and therefore leads a socially isolated existence.*	3.33
Competition endangers others	3.00	4	*She believes she has to play the role of the "failure" (e.g. not earning an academic degree, remaining without male companionship) in order not to offer competition to others, and sabotages herself in both her private and professional life.*	3.33
Sees self as ugly and bad	2.89	3	*She believes that the sight of her ugliness must be unbearable to others, and therefore has to keep herself covered.*	3.33

* Items may be assigned to multiple categories.

Table 4: Goals, Content Categories and Sample Items

Content Category*	**M**	**n**	**Sample Item**	**M**
To experience satisfying sexuality	4.00	6	*She would like to be able to enter into a sexual relationship with a man without feeling guilty.*	4.00
To accept her own body	4.00	2	*She would like to change her attitude towards her body and her virile body hair in a positive direction.*	4.00
To perceive and realize her own wishes and needs	3.89	6	*She would like to be able to articulate her wishes and stand up for her needs.*	4.00
Self-determination, self-reliance and independence from norms and persons	3.78	9	*She would like to be able to define her own sphere of freedom and be able to move within it independently of the standards of the church, the doctrinaire views of the educated or conventional norms.*	4.00
To be able to express rage, annoyance and other feelings openly	3.67	2	*She would like to be able to communicate her annoyance without having to suffer feelings of guilt afterwards.*	3.67
To feel less responsible for others	3.67	2	*She would like not to feel responsible for others any more.*	3.67
To trust herself, find security in herself, be self-accepting	3.50	2	*She would like to develop greater security and confidence in herself.*	3.33
To be able to compete with other women	3.33	2	*She would like to be able to enter into competition with other women more openly.*	3.33
To have relationships and social contacts on an equal footing	3.29	7	*She would like to enjoy friendships on an equal footing, in which mutual interest and mutual support can be taken for granted.*	3.67
To enjoy professional success	2.67	1	*She would like to be professionally successful and also enjoy her success.*	2.67

Items assigned to only one category.

Table 5: Helpful Insights, Content Categories and Sample Items

Content Category*	**M**	**N**	**Sample Item: To become aware that...**	**M**
Assuming the role of her father	3.50	2	*... she feels responsible for the well-being of her mother, has assumed the role of her father and is identified with a masculine self-image.*	3.67
Wish for father	3.33	5	*... she had a bad conscience towards her mother because she imagines that by her intense wish for her father she made her mother ill and drove her away.*	3.67
Church as a substitute for father	3.33	2	*... she had a great longing for a strong father and transferred this longing to the authority of the church.*	3.33
Negative body- and self-image	3.27	5	*... she experiences herself as unbearable, ugly, and unworthy of love, and therefore avoids social contact and does not express her wishes and needs.*	3.67
Assumes guilt for absence of parents, aloneness as punishment	3.17	4	*... she experienced the absence of her mother and father in her childhood as very bad and felt it was her fault and took her aloneness as her deserved punishment.*	4.00
Avoidance of relationships out of guilt and shame	3.17	4	*... she experiences herself as unbearable, ugly and unworthy of love, and therefore avoids social contact and does not express her wishes and needs.*	3.67
Guilt feelings, responsibility, identification with mother	3.09	7	*... due to guilt feelings she feels intensely responsible for her mother and believes she has no right to dissociate herself from her.*	4.00
Problematic identity as a woman	3.07	5	*... she wished she had a masculine father who was involved in her life and was not afraid of her feelings or her femininity.*	3.67
Avoidance of competition	3.00	1	*... on top of her father's problematic personality she herself actively contributed to the lack of relationship to him because she was afraid this might be a threat to her mother.*	3.00
Others unable to tolerate autonomy on her part	2.53	5	*... she continues to maintain such a close relationship to her mother and avoids entering into friendships or a relationship with a partner because she is afraid her mother would not be able to bear a greater*	3.00

			degree of independence on her part and would feel abandoned.	
Subservience	2.33	5	*... she continually puts herself into the role of an outsider or Cinderella in order to fulfill other people's needs for superiority.*	2.33
Compulsive actions out of guilt feelings	2.00	1	*... her compulsive ideas and actions were an attempt to assuage her tormenting feelings of guilt.*	2.00

* Items may be assigned to multiple categories.

Table 6: Tests, Content Categories and Sample Items

Content Category*	**M**	**n**	**Sample Item**	**M**
Thematizing sexuality	3.67	2	*She will speak to the therapist of her sexual desires in order to test if he will condemn, punish, or pillory her for them morally as the church did.*	3.67
Speaking more openly and directly	3.67	2	*She will give herself more leeway in the course of therapy, speaking more openly and freely in order to test if the therapist tries to limit her and put her in her place.*	3.67
Showing annoyance	3.67	1	*She will explicitly express her annoyance (at a thing or person) in order to test if the therapist tolerates this or puts her in her place.*	3.67
Showing curiosity, interest and desire	3.67	1	*She will ask the analyst about the reason for the setting (no eye contact) in order to test if she is permitted to be curious and eager.*	3.67
A self-restrained and careful opening	3.62	7	*She will cautiously open up to the therapist in order to test if he remains benevolent and does not condemn her.*	4.00
Thematizing hirsutism	3.50	2	*She will return repeatedly to the subject of her virile body hair as a symbol of her ugliness, in order to test if the therapist can still tolerate her in spite of it.*	4.00
Expressing concerns and problems	3.33	1	*She will confront the therapist with her worries and concerns in order to test if he shows as little interest as her father.*	3.33
Checking the clock	3.17	2	*She will look at the clock in order to test if the analyst is not getting tired of her and if she should take over the responsibility herself and do everything herself.*	3.33
Emphasizing personal faults and weaknesses	3.00	1	*She will continually bring up her faults and weaknesses in order to test if the therapist confirms her badness.*	3.00
Challenging and provoking the therapist	3.00	1	*She will challenge and provoke him in order to test if he is just as passive as her father, or if he is capable of taking an active stand.*	3.00

* Items assigned to one category only.

Plan Formulation for Amalia

Amelie is a 35-year-old, single, employed woman who has sought treatment for worsening depressive complaints. She is socially isolated and maintains close contact with her family, particularly with her mother. Amalia has been unable to enter into sexual relationships up to this point.

Biography (see Traumatic Experiences, table 2): In the sibling order, Amalia is between 2 brothers, to whom she has always felt inferior. Her father was absent throughout her childhood — first due to the war, later for occupational reasons. At an early age, Amalia takes on the role of father, attempting to act as a substitute for her mother's missing partner. At the age of 3, Amalia contracts tuberculosis and remains bedridden for 6 months. When her mother's life is endangered by a serious case of tuberculosis, Amalia, aged 5, is the first of the siblings to be put in the care of an aunt, with whom she remains for about 10 years. Here she is subjected to a strictly religious, austere and puritanical upbringing at the hands of her aunt and grandmother. Since puberty Amalia has experienced great subjective suffering from an idiopathic hirsutism (pronounced body hair), though it is scarcely remarkable from an objective point of view.

The Pathogenic Beliefs (table 3) reveal a markedly negative self-image. Amelie sees herself as ugly, bad, and burdensome to those around her. This is aggravated by keenly experienced autonomy issues: she hardly permits herself to dissociate herself from others and feels especially responsible for the well-being of her mother. Amelie experiences her own wishes as dangerous and morally reprehensible, particularly her sexual needs.

Important Goals of therapy (table 4) are the perception and realization of personal wishes, particularly the need for a sexual relationship with a man, but also other social contacts. Amalia would like to be able to set her own course independently of outer norms and to maintain a sense of separateness from others. In particular, she would no longer like to feel so responsible for others. Amalia wishes to find greater acceptance of herself and her body and become surer of herself.

Among the Helpful Insights (table 5) are interpretations, which clarify for Amelia the problematic situation she entered into when she took on the role of her absent father in her mother's house. Alongside of this masculine identification, longing for her father is an important theme. A central focus is processing feelings of guilt and shame, by which Amalia experienced her aloneness as a deserved punishment and which continue to prevent her from forming close relationships. Also connected with the female identity problem stemming from identification with her father is Amalia's negative body- and self-image. With it Amalia attempted to explain to herself why she had been left alone by her parents and why she would be repulsive to any possible partner. Also important are insights that make Amalia aware that she withdrew from and subordinated herself to others because she always feared that independence on her part could become intolerable or dangerous to others.

In the Tests (table 6), on the one hand Amalia displays defensive modes of behavior in therapy, expressing her pathogenic beliefs affirmatively. She acts quite reserved towards the therapist and presents herself as ugly and weak. On the other hand she risks offensive behaviors in which she directly casts her pathogenic beliefs into doubt, e.g., speaking with increasing directness about sexuality, showing curiosity, challenging the therapist and introducing her own concerns.

Comparison with a Different, Psychoanalytic Case Conception

By way of comparison let us turn to the case conception of Amalia presented by Thomä and Kächele (1994b): "Our clinical experiences justify the following assumptions: a virile stigmatization strengthens the penis wish or penis envy, reactivating oedipal conflicts. If the wish to be a man were fulfilled, the patient's hermaphroditic body schema would be free of contradiction. The question "Am I a man or a woman?" would then be answered and the identity issue, which is continually exacerbated by the stigmatization, would be eliminated. Self image and body identity would then be in harmony. However, the unconscious fantasy cannot be maintained in the face of the bodily reality: a virile stigmatization still does not make a woman into a man. Regressive solutions of attaining inner security in spite of the masculine stigmatization, through identification with the mother, reawaken old mother-daughter conflicts and lead to a panoply of defense processes (p. 79ff)

Discussion

Comparison of these two case conceptions shows that Thomä and Kächele oriented themselves on the model of penis envy and diagnosed the conflict on an oedipal plane. The plan formulation based on Control-Mastery includes oedipal themes but prefers to diagnose a disturbance of "early triangulation" (Abelin, 1971), in which the existing dependence of the patient on her mother is understood not as a regression but as an inhibited development of autonomy caused by specific pathogenic beliefs. Clinically the two case conceptions would have different consequences for the interpretative work and possibly also for therapeutic interventions. From a Weissian viewpoint, chiefly one would have to thematize Amalia's feeling of responsibility for her reference partners and the resulting feelings of guilt, which ultimately serve to maintain the attachment to her mother and her resisted wish and longing for her father.

A comparison exploring which of the two conceptions is capable of clarifying which aspects of the therapeutic process must be left to future studies.

Even if our study is limited to a single case, we have been able to show that the Plan Formulation Method can be reliably applied outside of the group around Weiss and Sampson and the English-speaking world, which represents a contribution to establishing the method.

In contrast to the San Francisco Psychotherapy Research Group, in order to reduce the content of items lying above the mean value of the raters we chose a structured content analysis procedure enabling categorization on selected levels of abstraction for the final plan formulation. For future studies, as a further methodological refinement one might consider empirical verification of the assignment of the items to the categories. A disadvantage of this procedure is that the very specifically formulated items are lumped together in categories that seem rather general.

An explanation for the high reliabilities obtained is, first of all, that complex formulations are reduced to simple, clearly structured categories, with the judges rating only single items, not complete formulations, and secondly that the judges share the same theoretical orientation (Curtis et al., 1988).

Unlike other methods of recognizing interpersonal patterns using standardized categories, the Plan Formulation Method does not allow for interpersonal comparability. It

does, however, offer the advantage of an individual, case-specific formulation that keeps very close to the text while also making possible inferences and clinical conclusions.

A particular strength of the method is the high clinical relevance of the different categories (Silberschatz and Curtis, 1986; Curtis and Silberschatz, 1986). The items gathered for the categories of traumas, pathogenic beliefs, and insights represent the essential foundation for the interpretive work. The predicted tests can help the therapist become conscious of possible transference-countertransference enactments and develop helpful, patient-specific therapeutic interventions.

The goals ascertained in the plan formulation make possible course control, facilitating goal attainment in the course of psychotherapeutic treatment, and can serve as a guidepost for the therapist in the practical therapeutic work.

In addition, the method offers the possibility not only of ascertaining therapeutic success by the symptoms and by general procedures such as questionnaires, but of investigating the underlying psychological processes that lead to lasting changes using case-specific instruments. The Plan Attainment scale developed by Silberschatz et al. (1989) makes it possible to judge the extent to which the patient has reached her specific goals and overcome her pathogenic beliefs, and if she has succeeded in acquiring essential insights.

The plan formulation determined by this method can be understood in terms of a changing focus and serves as a way of structuring a case and generating hypotheses, which will require continual review and supplementation in the course of treatment (cf. Thomä and Kächele, 1985). Much as in Caspar's Plan Analysis (1995), in which a hierarchy of plans is determined, the relevance of the items ascertained with the Plan Formulation Method changes with the phases of therapy and of life.

Beyond the five categories covered in the plan formulation — traumas, goals, tests, pathogenic beliefs, and insights — other areas are conceivable that are not yet systematically captured by this method (e.g. resources of the patient).

Weiss sees patients as active collaborators in the therapeutic process — as interested in a solution to their problems, wishing to gain insights, seeking corrective emotional experiences by way of tests in the therapeutic process and unconsciously but "planfully" working to disconfirm their pathogenic beliefs. His general theory of psychotherapy is based on clinical observation and is supported by extensive empirical findings. Admittedly, Weiss' claim regarding the general validity of his theory of the therapeutic process still awaits

empirical validation in the clinical material of other forms of therapy (Eagle 1984, p.105). Nevertheless, the studies of the SFPRG are an impressive example of how theorization can be grounded and enriched by empirical research.

EVOLUTION OF THE REACTION TO BREAKS IN THE PSYCHOANALYTICAL PROCESS AS AN INDICATOR OF CHANGE[16]

Loss-Separation Model

Through its own peculiar method, psychoanalysis has generated a great number of hypotheses related to the different fields of the psychoanalytic theory. The important heuristic value of psychoanalytic methods contrasts greatly with the weakness of its external validation. Both inside and outside psychoanalysis, we observe a growing interest in the validation of hypotheses by using methodologies unrelated to the psychoanalytic method borrowed from the social sciences. Lately we have been working on validation with empirical methodology of some hypotheses of the loss-separation model in the theory of psychoanalytic therapy.

The assumption on which this study is based is that the analyst, in his therapeutic work and interpretative actions with the individual patient, builds and deploys "working models" in which the most varied and disparate levels of psychoanalytic theory and technique crystallize (Greenson 1960; Bowlby 1969; Peterfreund 1975). The patient too has working models, which have gradually become structured during the course of his or her life and in accordance with which he or she *interprets* his or her relationship with the analyst and develops expectations in regard to him (Bowlby 1973). Within these working models, for patient and analyst alike, the *loss-separation* model occupies a position of paramount importance.

The theme of loss and separation is to be found at all levels of psychoanalytic theory and technique and goes beyond differences between schools. It may be said to have become a clinical commonplace. As such it is found: 1) In the explanatory theory of the genesis of psychic and psychosomatic diseases — in the hypothesis of the pathogenic potential of the early separation traumas; 2) In the theory of psycho-sexual development — in the conceptions of M. Klein and M. Mahler; 3) In the theory of transference — in the idea of the repetition in the analytic situation of the early processes of separation from and loss of primary objects; 4)

[16]Juan Pablo Jiménez, Dan Pokorny & Horst Kächele. This study was part of J.P. Jimenez doctorial dissertation at the Ulm University Faculty of Medicine.

In the theory of personality when maturity and trait differentiation become dependent on the inner "separation" level of self and object representations, and 5) In the theory of therapy — in the association between working through and work of mourning.

The loss-separation model is also a psychoanalytic process model. This view was formulated explicitly by J. Rickman as long ago as 1949, as follows: "The week-end break, because it is an event repeated throughout the analysis, which is also punctuated by the longer holiday breaks, can be used by the analyst [...] in order to assess the development of the patient" (1950, p. 201). He adds: "the week-end and holiday interruptions of the [analytical] work force up transference fantasies; as the [analytical] work continues these change in character in correspondence with the internal pattern of forces and object relations within the patient" (p. 201).

Notwithstanding its central position in the theory of technique as a psychoanalytic process model, the evolution of the reaction to breaks has not hitherto formed the subject of a systematic empirical study. Every process model always has two aspects (Thomä and Kächele 1994a, Chapter 9): a *descriptive* one — i.e., it serves to describe the course and development of the treatment — and a *prescriptive* one, which guides the analyst in his interventions in the process and enables him to devise interpretative strategies.

This investigation is limited to the *description* by empirical means of the evolution of the reaction to breaks in an individual female patient's therapeutic process. The central hypothesis of the study may be formulated as follows:

The evolution of the reaction to breaks during the course of a psychoanalytic treatment is an indicator of the structural change being achieved by the patient through the therapeutic process.

This general hypothesis breaks down into two particular ones: 1) The working model of loss-separation can be detected in chronological correlation with breaks in the analytical treatment, in the material of the sessions (strictly speaking, in the verbal interaction between patient and analyst). 2) In a successful analysis, this model must evolve as envisaged for psychoanalytic theory.

An individual case is considered here because only a study of this kind allows a detailed examination of the evolution of the reaction to breaks during the analysis.

Amalia's psychoanalysis comprised 531 sessions extending over nearly five years. Of the 531 actual sessions, only 517 were recorded on tape, and of these, 212 had been (at the

time of this study) transcribed according to the transcription rules of the ULM TEXTBANK (Mergenthaler et al. 1988). The study was based on the 212 transcribed sessions fairly evenly distributed over the treatment.

Material and Method

The method of an empirical study should be consistent with what it is desired to find — i.e., with the hypotheses made and also with the available material — in this case, a sample of 212 verbatim transcripts of sessions in Amalia's psychoanalysis.

The *first hypothesis* of our study is that the transcripts of the sessions which relate to breaks in the treatment should contain the theme of loss-separation. Hence the first requirement is to define formally what we mean by a break. Secondly, we have to test whether the loss-separation model appears predominantly in the transcripts of the sessions related in time to a break, and not arbitrarily in any session within the sample. Once this relationship has been demonstrated, we shall turn to the *second hypothesis* and analyse the content of the sessions, which we shall from this point on call *separation sessions,* and consider whether the transference fantasies appearing in the material of these sessions evolve during the course of the process and if so; how?

From the foregoing, three stages of this research can be identified, each of which will require a different method appropriate to its particular aims. The aim of the first stage is to formally define a break in treatment. The second sets out to determine the correlation between a *break session,* defined operationally, and an appearance in the material of the theme of loss and separation. The third stage of the research seeks to demonstrate an evolution in the patient's transference reactions which is reflected in the content of the material of the *separation sessions*.

For an initial definition of a break in the treatment, we adopt operational empirical criteria. On the basis of the attendance card, we draw up a histogram of the treatment, which we shall analyse below.

At a second stage we try to establish the correlation between *break sessions* and *separation sessions,* because not all *break sessions* necessarily show a significant increase in the incidence of the loss-separation theme. If a correlation is found, we shall check what kind of *break session* may also be regarded as a *separation session*.

For a substantial description of the *break sessions,* we use the *Ulm Anxiety Topic Dictionary* (ATD, Speidel 1979), which is a computer-assisted instrument for content analysis. The ATD comprises four thematic categories, *guilt*, *shame*, *castration* and *separation*, operationalized as lists of individual words each presumed to represent one of these categories. A computer program is used to analyse the verbal content of the analyst's and the patient's texts, taken separately for each session in the analysis; the result being values reflecting the relative frequency of text words belonging to each of the thematic categories. This procedure yields values for the categories of guilt, shame, castration and separation, for the patient and the analyst respectively; a comparison of which from session to session gives an approximate idea of the extent to which these themes were touched upon in each session. The dictionary was used in this study only as a crude instrument for the detection of themes and not to detect specific affects or anxieties.

To understand our point we should consider that 90% of the values found in the sessions with this instrument range, in the case of our patient, between 0.1% and 1.2% for the different categories. For example, if in a given session ATD yields a value of 0,75% for the category *separation-patient,* it means that 0.75% of the words used by the patient in that session — an average of *22* words in 2933 — belongs to the semantic field of separation. It is therefore clear that values are mere indicators of spoken themes.

From this stage we hope to identify the sessions relevant from the point of view of the reaction to breaks — i.e., sessions which show the impact of the session-free intervals on the analyst-patient dyad, as reflected in the four themes defined by the dictionary.

The sessions so identified — or rather a sample of these sessions where there are many — can be analysed at a third stage by a method closer to the clinical method, with a view to examining in detail the evolution of the reaction to breaks throughout the treatment. In this part of the study we use the method devised by Luborsky et al. to evaluate the transference (CCRT).

The CCRT *(Core Conflictual Relationship Theme)* method of evaluation of the transference and aspects of this method's reliability and validity have been described in various publications (Luborsky and Crits-Christoph 1998; see chapt. 5.6). Being oriented towards description of the content of the transference, this method is highly suitable for

evaluating the evolution of the transference fantasies appearing in the patient in relation to breaks during the treatment.

The first step of this method is identification by independent judges of *relationship episodes (RE)* in the session transcripts. These relationship episodes are nothing other than small narrative units in which an interaction with another person is described. The second step is for the CCRT judges to evaluate the *relationship episodes,* identifying the following three components in each:

1) The patient's principal wish, need or intention in relation to the other person *(W, wish)*.

2) The actual or expected response from the other person *(RO, response from other)*.

3) The subject's (patient's) reaction to this response *(RS, response from self)*.

The *Core Conflictual Relationship Theme* (CCRT) is the representation, summarized in a few sentences, which make complete sense of the types of components appearing with the highest frequency throughout the sample of relationship episodes.

Results

Stage 1: Formal definition of a break

We define a break in the treatment by operational empirical criteria. The histogram reproduced in figure 5.10 shows the following: between the 531 actual sessions (of which 517 were recorded) there were 530 session-free intervals, of which we measure the duration in days (for instance, there is an interval of 1 day between a Monday session and the next Tuesday session). The histogram revealed five blocks of session-free intervals. Block 1 represents the shortest intervals and reflects the "ideal" timing (in this case, three times a week). These shortest intervals were defined as *non-breaks*. Block 2 contains the weekend breaks. Block 3 comprises short breaks due to illness on the part of the patient or absences of the analyst for attendance at congresses or other reasons. Block 4 comprises breaks for Christmas and Easter holidays. Finally, Block 5 represents three summer holidays taken by the patient and the analyst at the same time, two breaks due to non-simultaneous summer holidays, and two prolonged absences by the analyst for trips abroad.

{Figure 5.10 about here}

Figure 5.10 Stage 1: Histogram of Amalia´s sessions free intervals

On the basis of these blocks of breaks, it was possible to define which sessions correlated with which break and the type of correlation with the relevant break (whether before or after, and at what distance).

Stage 2: Identification of separation sessions

According to our hypothesis, the loss-separation model should appear in sessions correlated in time with the breaks *(break session)*.[17]

To investigate the correlation between *break sessions* and *separation sessions,* we divide the sessions of the sample into groups in accordance with their correlation with the breaks: according to the duration of the break, whether they preceded or followed the break and the number of sessions between the relevant session and the break. We compare the different groups formed in this way with a group of *non-break* sessions (N = 86). This group of 86 *non-break* sessions proved to be evenly distributed throughout the treatment.

The comparisons made between the different groups of *break sessions* and the group of *non-break sessions* reveal significant differences (t-test: $p < 0.05$) only in the group of sessions immediately before the longest breaks. In this group we find significantly higher values for the variable *separation-patient* and significantly lower values for the variable *shame-therapist*.[18]

These results enabled us to define operationally a *separation session* as one with a high value for *separation-patient* and a low value for *shame-therapist*. This operational definition specifies our construct *separation session*. The importance of these two variables was confirmed by additional statistical techniques such as discrimination analysis.

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[17]The relationship between the loss-separation model in the verbal records and the *break sessions* is not necessarily absolute and automatic. Theoretically it is also possible for the separation theme to occur in sessions which are not associated with real external break, such as those which are centered on an internal separation or on a certain distancing from the analyst during a particular session. On the other hand, breaks can occur that do not provoke in the patient a verbal reaction of separation that shows in records: there may be a non-verbal reaction that will obviously not appear in the verbal records. However, it is most likely that if the separation theme does appear in the verbal content of the session, it would do so in sessions associated with breaks.

[18] This does not mean that *separation sessions* do not occur in association with shorter breaks such as weekends for example; it simply means that *as a whole* the group of sessions immediately before a long break are clearly different from *non-verbal sessions*.

The question, which naturally then arose, was whether this construct might not also be detected in some individual sessions not associated with the longest breaks — e.g., in sessions before or after breaks that were not so long, or in weekend sessions or, finally, in *non-break sessions.* To answer this question, an artificial variable, called technically a *canonical variable*, was formed on the basis of the construct *separation session* (high *separation-patient,* low *shame-therapist*). Using the computer, this canonical variable was required to perform the classification function of rearranging all the sessions in the sample (N = 212) in a series from plus to minus — i.e., from the sessions that most resembled the construct *separation session* to those that were least like it.

The next step was to compare the extreme groups of the sessions thus rearranged with the actual dates on which they took place. The result of this comparison again confirmed the hypothesis that the separation sessions tended to be grouped around the breaks: of the first 20 sessions arranged in accordance with the canonical variable — i.e., the sessions most similar to the separation construct — 19 corresponded to sessions directly correlated with a break or to the period of termination of the analysis, while only one was a *non-break session.* The majority of these 19 break sessions preceded a prolonged break. Examination of the group of 20 sessions at the opposite extreme — i.e., those at the non-separation end — showed that the majority of these were non-break sessions and the remainder weekend sessions.

On the basis of these results it can be asserted that the separation construct is *unstable* but *consistent*. This means that it does not always appear in the case of a real separation between analyst and patient — i.e., a break in the continuity of the treatment — but that, when it does appear, its probability of appearance is greatest when the relevant session immediately precedes a prolonged break.

The separation construct so far suggests that *in this treatment — i.e., with this analyst-patient dyad — the reaction to breaks appears to be correlated with themes of separation and shame.* More precisely, the analyst mentions the theme of shame less in the *separation sessions* than in the treatment in general.[19] If we consider only the 20 *separation sessions* in

[19] It is highly likely that the separation content may lead to a general working model and that the shame aspect points to a dyadic-specific content. If so, this is merely a trivial fact, namely that Amalia experiences separations within the framework of her personal neurosis where shame plays a special psychopathological and psychodynamic role (given her hirsutism and erythrophobia). We can think of many possible combinations. For example, the separation anxiety can be defeated by sexual shame anxiety; or the patient may feel depressive shame vis a vis her analyst because of her painful feelings of isolation and abandonment; on the other hand, separation from the analyst by a break can be experienced by the patient as humiliation and as a sign of shameful dependence, etc., and all this can develop in the course of analysis in different ways.

the last third of the analysis — specifically, from session 356 onwards — the analyst ceases to speak about shame and the variable *shame-therapist* is practically zero. This might mean that towards the end of the treatment the analyst stopped relating the themes of separation and shame or the analyst felt that shame was no longer a concern of the patient.

The rearrangement based on the canonical variable described above enabled us to select a sample of 20 sessions of which the material we knew to contain allusions to separation and which could be analysed by the CCRT method in the third part of the study. These 20 sessions extend over a long period within the overall process (from session 14 to session 531, the latter being the final session of the treatment).

Stage 3: Evolution of the separation sessions.

Of the 20 *separation sessions* obtained during the course of the first part of the study, we selected a smaller group for the application of the CCRT method to evaluate the content of the transference, using the following criteria: 1) We disregarded sessions containing reports of dreams, as the application of the CCRT to reports of dreams was shown to be problematical (Luborsky 1988b). 2) We chose a set of sessions that spread roughly over the entire process.

On the basis of these criteria, we selected from the beginning of the analysis two sessions immediately preceding the first prolonged break (recorded sessions 21 and 22) and from the end the last three sessions of the analysis (recorded sessions 515 to 517). We also selected two in the second third (recorded sessions 221 and 277) and two in the last third of the treatment (recorded session 356 and 433).

The CCRT allows a quantitative analysis of the relative frequency of its different components. However, our sample of six observations is too small for conclusions of statistical value to be drawn. None of the differences found, in fact, reached the level of significance, although it was possible to detect very clear trends.

It is clear from a direct reading of the selected sessions that a break as such was accepted by Amalia as a fact, although at first she may not have shown awareness of a transference reaction to this. With regard to this external factor — weekends, holidays, or the analyst's trip abroad — the patient reacts by expressing wishes and expecting from the object, or actually receiving from him, the fulfillment or the rejection of the wish. With regard to her wishes or demands, and in view of the object’s responses, Amalia reacts with different emotions and fantasies which also range from positive to negative. The evolutions of the

CCRT components in the course of the analysis reflect the development of Amalia's reaction to breaks.

The various components of the CCRT evolved as follows:

1) Relationship episodes (RE) in which the interaction partner was some person extraneous to the treatment, declined as the treatment progressed; while those in which the analyst was the partner and in which the patient herself was the subject and object of the interaction (i.e., self-reflective episodes) increased. This means that the transference and self-reflection became increasingly intense or, in other words, that the patient was increasingly on his way in recognizing the character of the transference relationship in parallel with an intensification of the processes of internalization and self-analysis.

2) With regard to the actual or expected response of the object (RO) to the patient's wish, positive responses increased slightly, while negative ones fell. This means that in general the object to which the demand or wish was addressed was seen as possessing increasingly benevolent and decreasingly frustrating features. In the patient's reaction (RS) to the object's response, the changes were much more intense: the subject's negative reactions clearly decreased as the analysis progressed, while the positive reactions increased. This means that Amalia was reacting to the breaks with less and less of a fall in her self-esteem and confronting them with increasingly positive expectations.

3) The patient's principal wish (W) activated by the break, in general and at a high level of abstraction, fell within the conflict between autonomy and dependence. However, this conflict evolved during the course of the therapeutic process.

In relation to the first break (sessions 21-22), the wish for harmony, to be accepted and respected by others and by herself, predominated in Amalia during the last session before the first summer holidays. The wish to be cured and to be independent also appeared, although to a much less important extent. The object's response was predominantly negative, and the patient perceived rejection, lack of respect, devaluation, utilization and avoidance. Amalia reacted to this response with separation anxiety, helplessness, disillusionment, resignation, shame, avoidance, withdrawal and insecurity. All this was experienced by the patient in direct relation to her parents and family; there was hardly any allusion to the therapist. Her separation-verbalizations may have referred to feelings focused on her family rather than on her analyst.

In the second break (session 221), before an extendedweekend, a change in the balance of forces in the conflict between autonomy and dependence was noted. Although the principal wish was still for closeness, harmony and recognition, the wish for greater autonomy appeared more frequently, expressed in a desire to dominate the interpersonal situations that overwhelmed her and caused her anxiety. The object responded negatively, with remoteness, rejection and lack of consideration, leaving the patient in the lurch. The patient reacted to this response with feelings of helplessness, panic anxiety, revulsion and withdrawal; i.e., with intense separation anxiety and shame. This session marked the beginning of the appearance of transference allusions and also positive reactions by the patient to the negative response of the object; for instance, she acknowledged herself to be internally divided and full of jealousy, and asked for help. With effect from this session, Amalia openly recognized the transference dimension of her wishes and reactions; i.e., she began to experience the breaks in terms of her relationship with the analyst.

In the third break (session 277), immediately before an another long weekend, the conflict between autonomy and dependence continued to evolve. The poles of the conflict came closer together and began to merge; now constituting a single desire for reciprocity, which could be formulated as a wish for closeness, in a relationship of mutual belongingness and equality of rights. This was accompanied by an explicit wish to talk to the therapist about traumatic separation: the patient spoke directly about death and the fear of a premature termination of the analysis. The object's response to these wishes was predominantly positive; the patient perceived interest on the part of others and of the analyst and felt herself to be understood and engaged in a process of interchange. At the same time however, she felt that the analyst was resisting entering into a relationship of mutuality with her. Amalia reacted to this response with anxiety due to loneliness; she felt very isolated and abandoned, but began to show signs of rage, mourning and also hopes of permanence beyond loss.

The fourth break examined in our study corresponded to the last session (356) before a 40-day trip abroad by the analyst. In the second part of the study, the *Ulm Anxiety Topic Dictionary* (ATD) showed that the analyst stopped relating the themes of separation and shame. The CCRT shows that in this session other people disappeared as interaction partners; the majority of the relationship episodes had the analyst as partner and some of them the patient herself. It was therefore an intensely "transferential" session. The patient had a single desire, representing the overcoming of the conflict between autonomy and dependence:

Amalia wanted actively to place her needs and wishes in the framework of a relationship of mutuality. The object (analyst) responded to this wish without ambivalence, positively only, with acceptance and "giving permission" to Amalia to satisfy her wishes. The patient reacted with guilt feelings and loss anxiety, which gave rise to dissatisfaction and helpless rage. The positive reaction was represented by the hope of permanence in spite of the loss, and by fantasies of struggle to assert herself in reality. This constellation suggests that the patient was undergoing a depressive reaction in this session. The object, being idealized, was not affected by projections and the patient recognized that she herself was solely responsible for her difficulties and dissatisfactions. The analyst´s references to her shame disappeared; as a reaction formation, this had performed a defensive function against anxiety and the pain of separation. Starting with this session, the process entered upon the phase of resolution; other people, outside the analytical situation, again began to appear; this time as the possible objects of wishes and demands.

The fifth break corresponded to the session (433) immediately before the last summer holidays. In this session, the wish for a relationship of equality took on a new dimension. Amalia saw this relationship in a man/woman context: what she wanted was a sexual partner with whom to establish a mutually satisfactory human relationship. The object's response to this new wish was unequivocally negative and Amalia was rejected. In terms of the transference, this rejection represented an implicit recognition of the impossibility of forming a sexual relationship with the analyst. However, she reacted positively to this rejection and, beyond her angry renunciation of the wish and her feelings of disillusionment and insecurity, Amalia was thinking hard about suitable alternatives for the satisfaction of her wishes and needs.

At the end of the analysis (sessions 515-517), what was unequivocally predominant was the wish to assert a vital identity as a woman, in a real relationship of mutuality with a man. A wish related directly to the termination also appeared: Amalia wanted to be able to continue the internal dialogue (self-analysis) she had achieved in the treatment, beyond the termination. The object's response was ambivalent: on the one hand, the object showed itself to be rejecting, incapable, unworthy of trust and inconsiderate; at the same time however, it appeared as a model that offered support, with self-confidence, vitality and generosity. Amalia's reaction was predominantly positive; she felt more realistic, more confident and independent; she felt that she had changed positively, was not afraid of the separation, had

something enriching inside her, and was ready to seek new experiences and to achieve self-realization. However, Amalia also showed negative emotions, such as pain at renouncing the relationship with the analyst, and felt that she still had a tendency towards masochism and an antagonistic passivity.

Discussion

Our study successfully demonstrates the evolution of Amalia's reaction to breaks although early in the analysis they were focused on her family and later in the analysis on her analyst.. This evolution refers only to the transference fantasies that were verbalized. The method used, of analysis of verbal content, does not allow us to take account of non-verbal reactions. However, Amalia was a neurotic patient with a good capacity for symbolization, and it is therefore justifiable to suppose that her verbal behavior was a good expression of her internal world.

We must consider all components of the CCRT as the patient's reaction. That is to say, the wish, the object's response and the patient's reaction together constituted Amalia's reaction to breaks. The CCRT in the form applied does not distinguish between the actual and expected response of the object, so that the question remains open as to the extent to which the object's response corresponded to perception of the analyst's actual behavior or that of others towards Amalia and how far it is to be attributed to projections by the patient. In any case, the relative increase in relationship episodes in which the patient herself was an interaction partner showed a general tendency towards introjection, which ought to have been accompanied by an improvement in the reality sense. The evolution described conforms to analytical theory in its different versions. For instance, according to the Kleinian conception, Amalia attained "the threshold of the depressive position" (Meltzer 1967) around the session 356, the rest of the process being a working through of that position. On the basis of attachment theory (Bowlby 1973), Amalia may be said to have reacted to the loss by the following sequence: firstly, with protest, in which separation anxiety predominated; then, with despair, in which she began to accept the loss and embarked on the work of mourning; finally, with detachment, the phase in which Amalia decided to renounce the transference satisfaction of her wishes and needs and turned towards external reality. In terms of ego psychology, the fact that Amalia showed less object-loss anxiety towards the end of the analysis than at the beginning suggests that the mental representations of the object had

achieved greater independence of the instinctual wish and need for it (Blanck and Blanck 1988).

Blatt and Behrends (1987) study the nature of the therapeutic action with regard to the processes of separation and individuation proposed by Mahler, and with regard to the internalization phenomena. They point out that "progress in analysis appears to occur through the same mechanism and in a way similar to normal psychological development. Therapeutic change in analysis occurs as a developmental sequence which can be characterized as a constantly evolving process of separation-individuation including gratifying involvement, experienced incompatibility, and internalization. Patients gradually come to experience the analyst and themselves as separate objects, increasingly free of distortion by narcissistic needs and/or projections from the past relationships" (p. 293). Incompatibility experiences refer not only to real separations (breaks), but to all interaction in analysis, which fails to gratify a patient's wish or need. Basing themselves on this concept, Blatt and Behrends propose the hypothesis that "important changes in the analytic process frequently occur shortly before or subsequent to a separation (break). Early in treatment, changes in psychological organization and representational structures will occur after a separation or a major interpretation. Later in analysis changes may also occur in anticipation of separation rather than only as a reaction to it" (p. 291). In Amalia's case the reaction was always in anticipation. In terms of this hypothesis, it must be concluded that Amalia's psychic structure is basically neurotic, and in which the "separation" on the representation of the object and the representation of the self is clearly established. For this reason the emotions evoked by separation have the characteristics of an "affect-signal."

However, the results of our study have no prescriptive value. We mean by this that it cannot be deduced from this study that Amalia improved *because* the analyst interpreted the emotions aroused by separation. Authors such as Meltzer (1967) postulate that analysis of the anxieties and defences concerned with separation are the "motor of analysis." On the other hand, Etchegoyen states that "the task of the analyst consists, to a large extent, in detecting, analysing, and solving the separation anxiety. ... Interpretations which tend to solve these conflicts are *crucial* to the progress of the analysis..." (Etchegoyen 1986, p. 474; our italics). But our study shows something different: in the material investigated, although the analyst interpreted the reaction to breaks, he did so cautiously, infrequently and unsystematically; rather, he seemed not to set great store by the loss-separation model in the choice of his

interventions. Indeed, the variable *separation-therapist* in the ATD proved irrelevant to the detection of *separation sessions*. If we study the separation-therapist variable throughout the 20 *separation sessions* selected, it can be seen that in actual practice in the first and in the final third of the analysis, the analyst dealt with the separation theme more than the patient did; in the middle third, on the other hand, the analyst practically ignores the theme. Since the value of the variable is an average value, this value was never significantly higher than the average of the *non-break* sessions. Naturally, this can lead to the hypothesis of a countertransference reaction on the part of the analyst because of unconscious feeling of guilt since at that time he interrupted the treatment to make two long trips abroad. Nevertheless, the reaction to breaks evolved in accordance with the psychoanalytic theory of therapy.

This seems to agree with Blatt and Behrends (1987) who state that, together with interpretation, incompatibility experiences — and breaks are only one instance of this — have an independent therapeutic action which motivates interiorization processes. "Experienced incompatibility can take many forms in analysis besides interpretation, such as interruption of the cadence of hours because of the absence of the therapist or patient, failures in communication and empathy, or the patient's own increasing dissatisfaction with his or her level of functioning. It is important to stress that experienced incompatibility is not only externally imposed by the analyst through interpretations or by events such as the therapist's absence, but it can also originate with the analysand who may become increasingly dissatisfied with a particular level of gratifying involvement" (p.290).

From the idea that analysis consists fundamentally in interpreting anxieties and defences with regard to separations (breaks), the notion emerges that "the frequency [...] of the sessions is an *absolute* constant [...]. Five [sessions per week] seems to be the most suitable number since it establishes a substantial contact time with a clean break at the weekend. It is very difficult for me to establish a real psychoanalytic process with a rhythm of three times per week, although I know that many analysts are able to do so. Such an inconsistent an irregular rhythm as an every-other-day analysis *does not allow the conflict of contact and separation to emerge strongly enough"* (Etchegoyen, 1986, p. 474; our italics). Apart from the above contradiction (if "many analysts are able to do so," frequency cannot be an absolute constant). Our research shows that in Amalia's psychoanalysis, with a frequency of three times a week, the contact-separation conflict not only emerged, as it did in the long breaks and in a percentage of the weekend sessions, but developed as predicted in theory of

the therapy. This empirical fact deprives frequency of its absolute quality, and supports Thomä and Kächele (1994a, pp. 254) in the sense that a frequency should be established, which allows for evolution of the analytic process and that varies specifically with each analyst-patient dyad.

The final conclusion is that the evolution of the loss-separation phenomena as a reaction to breaks cannot continue to be considered as a direct result of specific interpretation, nor as a primary or independent cause of change in the patient. Our results suggest that the reaction to breaks evolves as an *indicator of change,* i.e., as a *result* of highly complex analytical work.

Finally, a few words on the technical consequences of this study: the existence of schools in psychoanalysis presupposes a unilateral emphasis on certain aspects of analytical theory. For example, the Kleinian school stresses the importance of working through of primary mourning, which would almost naturally become activated by the different breaks occurring in the framework of the analysis. Consequently, the technical importance of immediately interpreting fantasies, anxieties and defences related to breaks between sessions, at weekends, and others, is overemphasized. The danger of these interpretations becoming stereotype is maximized. Rosenfeld (1987, chapter 3) describes in detail how the interpretation of separation anxiety can be used by the analyst as a defence to ignore destructive fantasies, which emerge in the patient when in session with the analyst. Etchegoyen (1986, p. 528) points out that "patients frequently tell us that interpretations of this kind sound routine and conventional; and they are often right..." In the light of the results of this study, it is possible to claim that one of the reasons for this stereotyping lies in the confusion between *indicator* of change and *cause* of change.

AMALIA X'S PSYCHOANALYTIC THERAPY IN LIGHT OF JONES' PSYCHOTHERAPY-PROCESS Q-SORT[20]

Introduction

From early on in psychoanalytic research methods were sought after that would allow the description of different therapeutic processes without being too heavily oriented in favor of a specific theoretical orientation, but without being too general and able to identify the specifics of a concrete therapeutic operations. The first risk was illustrated by intervention catalogues as theb one created by Isaacs (1939) that was used by Thomä and Houben (1967); the second risk was typical of many studies using the Bales Interaction Catalogue (1950) from small group research. A first example for a transtheoretical instrument was provided by Strupp (1957) who performed a series of even experimental studies on the technical behavior of therapists (Strupp 1960). Later Benjamin (1974) conceived the Structural Analysis of Social Behavior (SASB) that found its way into many studies on process (Benjamin 1985).

Another major step was the development of Jones Q-Sort methodology sorting patient and therapists typical and untypical contributions in a session that first was used in the landmark psychoanalytic case study titled „Toward a method for systematic inquiry" (Jones and Windholz 1990). Meanwhile the Berkely Psychotherapy Research Group has assembled an impressive array of comparative studies (f.e. Jones and Pulos 1993; Jones and Price 1998; Ablon and Jones 1998). The most recent description of the achievements of the Psychotherapy Process Q-Sort has been delivered by Ablon and Jones (2005).

Fonagy (2005) speaks of a debt of gratitude we owe to Ablon and Jones for the humility they bring to our work:

> They bring reality to the psychological therapy we practice and believe in. The achievement of the paper is.....its very simplicity: the approach expounded by Ablon and Jones makes the complexities of psychoanalytic thought and technique understandable and accessible to all. They have mastered that most difficult dialectic

[20] Cornelia Albani, Gerd Blaser, Uwe Jacobs, Michael Geyer and Horst Kächele

> between the Scylla of an illusory of understanding generated by reductionism and simplification and the Charybdis of creating mystique and religion, where the innocent questions can no longer be asked and the truth is buried under layers of false sophistication. (p. 587).

Blatt (2005) in his commentary point to the method´s contribution to large scale research comparing different groups as well as to the analysis of a single case; he raises a number of critical points regarding te construction of a psychoanalytic prototype:

> It is important to keep in mind that the prototypes of the various treatments defined...appear to focus primarily on the activities of the therapist,....Yet the definition of any treatment is also contingent on the activities of the patient.....The style and nature of therapeutic interventions may vary not only among analysts but even within a particular analyst with different patients, or with the same patient at different phases of the therapeutic process. (p. 574)

This last point is illustrated by our findings on Amalia X.

Data and Methodology

In the present study, we applied the German version of the "Psychotherapy Process Q-Sort," PQS (Jones, 2000). Jones' method attempts to create a uniform language with a clinically relevant terminology that can describe the psychotherapeutic process in a manner independent from various theoretical models and thus allows a systematic and comparable evaluation of therapeutic interactions across different therapy methods. The PQS consists of 100 items that are applied according to a rating system of nine categories (1 = extremely uncharacteristic, 9 = extremely characteristic) following the thorough study of a transcript or videotape of an entire therapy hour. The distribution of items according to the nine categories is fixed in order to approximate a normal distribution.

The database for the study was the first and last five hours of the psychoanalytic treatment of Amalia, which was conducted by an experienced analyst. The analysis according to the PQS serves to describe the characteristic elements of this treatment and to allow a comparison of the two phases in order to illustrate the relevant differences. The evaluation of the sessions was performed by two raters in randomised order and resulted in a mean inter-rater agreement of r = .64 (.54 – .78).

Results

Characteristic and uncharacteristic items for all 10 hours

First, we will describe which items were rated as particularly characteristic and uncharacteristic for all 10 hours. A rank order of means was calculated. A further criterion for inclusion was that these items showed little or no difference in their means between the beginning and termination phases (p □ .10, Wilcoxon-Test). These items thus provide a general description of the behavior of the patient, the therapist, and their interaction in the beginning and termination phase of the analysis.

The attitude of the therapist is described as empathic (Q 6), neutral (Q 93), conveying acceptance (Q 18), tactful (Q 77), not condescending (Q 51) and emotionally involved (Q 9). Therapist's own emotional conflicts do not intrude into the relationship (Q 24) and, the therapist does not emphasise patient feelings (Q 81). Patient has no difficulties beginning the hour (Q 25); she is active (Q 15) and brings up significant issues and material (Q 88). Patient talks of wanting to be separate (Q 29), she accepts therapist's comments and observations (Q 42) and she feels understood by the therapist (Q 14). The interaction is characterised by a specific focus (Q 23), e.g., the self-image of the patient (Q 35), her interpersonal relationships (Q 63) and cognitive themes (Q 30).

These findings correspond partially to what the ideal psychoanalytic prototype of Ablon and Jones (2005) puts at the top of its list. There the key features are item 90: P´s dreams or fantasies are discussed, followed by item 93: A is neutral, followed by item 36: A points out P´s use of defensive maneuvers, followed by item 100: A draws connections between the therapeutic relationship and other relationships. The fifth item is No 6: A is sensitive to the P´s feelings, attuned to the P; empathic (p. 552).

Characteristic und uncharacteristic items separating the beginning and termination phases

In order to describe the differences between the beginning and termination phases of the therapy, the first and last five hours were pooled into separate blocks and the means of the ratings of the most characteristic and uncharacteristic items for both raters were calculated (tables 1 and 2).

Jones established the practice of identifying the respective ten highest and lowest ratings. Subsequently, the means were tested for statistical differences (Wilcoxon-Test, table 3).

Table 1

Rank order for the most characteristic and uncharacteristic PQS items for the beginning phase (Means across five therapy hours and two raters)

ems	M
characteristic items	
Dialogue has a specific focus.	7.9
Self-image is a focus of discussion.	7.9
Patient talks of wanting to be separate or distant.	7.8
Patient brings up significant issues and material.	7.8
Discussion centers on cognitive themes, i.e., about ideas or beliefs.	7.6
Patient's interpersonal relationships are a major theme.	7.6
Therapist clarifies, restates, or rephrases patient's communications.	7.6
Patient is clear and organized in self-expression.	7.4
Therapist's remarks are aimed at facilitating patient speech.	7.2
Therapist conveys a sense of non-judgmental acceptance.	7.2
characteristic items	
Patient does not initiate topics; is passive.	1.4
Therapist is tactless.	1.7
Therapist condescends to, or patronizes the patient.	2.2
Therapist is distant, aloof.	2.5
Patient does not feel understood by therapist.	2.8
Patient has difficulty beginning the hour.	2.9
Therapist's own emotional conflicts intrude into the relationship.	3.1
There is discussion of specific activities or tasks for the patient to attempt outside of session.	3.1
Patient rejects therapist's comments and observations.	3.1
Therapist encourages patient to try new ways of behaving with others.	3.4

Description of the beginning phase using the PQS

In the beginning phase of the therapy, the patient has no difficulty beginning the hour (Q 25), initiates themes, is organized, clear and structured (Q 54) and brings up significant issues (Q 88). She accepts the therapist's comments and observations (Q 42) and feels understood by him (Q 14). Patient predominantly talks about her wish for independence (Q 29). Therapist's attitude conveys a sense of non-judgmental acceptance (Q 18) and emotional involvement (Q 9) and is characterised by tact (Q 77). Therapist's remarks are aimed at facilitating patient speech (Q 3) and, he does not condescend to her (Q 51). Counter-

transference reactions do not intrude into the relationship (Q 24). Therapist clarifies (Q 65), but he does not encourage patient to try new ways of behaving with others or give her tasks (Q 85, Q 38). Dialogue has a specific focus (Q 23), the self-image of the patient (Q 35), her interpersonal relationships (Q63) and ideas or beliefs (Q 30) are central themes.

Table 2

Rank order of the most and least characteristic PQS-items in the termination phase (Means across five therapy hours and two raters)

ems	M
characteristic items	
Patient is controlling.	8.8
Termination of therapy is discussed.	7.8
Patient brings up significant issues and material.	7.6
Therapist is sensitive to the patient's feelings, attuned to the patient, empathic.	7.5
Self-image is a focus of discussion.	7.4
Therapist is neutral.	7.3
Love or romantic relationships are topic of discussion.	7.2
Patient's dreams or fantasies are discussed.	7.2
Therapist conveys a sense of non-judgemental acceptance.	7.1
Patient is animated or excited.	7.0
characteristic items	
Patient achieves a new understanding or insight.	1.8
Therapist is tactless.	1.9
Therapist condescends to, or patronizes the patient.	2.0
Patient does not initiate topics; is passive.	2.1
Therapist points out patient's use of defensive manoeuvres.	2.4
The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously.	2.4
Therapist actively exerts control over the interaction.	2.5
Patient relies upon therapist to solve her problems.	2.5
Patient does not feel understood by therapist.	2.6
Therapist clarifies, restates, or rephrases patient's communication.	2.9

Description of the termination phase using the PQS

Several characteristics of the therapy remain the same in the termination phase. Patient brings up relevant issues (Q 88), is active (Q 15) and feels understood by the therapist (Q 14). Ttherapist conveys a sense of non-judgmental acceptance (Q 18), he is tactful (Q 77) and does not patronise the patient (Q 51). The self-image is still a focus (Q 35). There are differences from the beginning phase: in the termination phase the patient is animated (Q 13) and

controlling (Q 87) and, the therapist does not actively exert control over the interaction (Q 17) and is neutral (Q 93) and empathic (Q 6). Patient does not achieve new insight (Q 32), but she also does not rely upon therapist to solve her problems (Q 52). In the last sessions termination of therapy is discussed (Q 75), love relationship is topic of discussion (Q 64) and the dreams of the patient (Q 90). Therapist does not clarify (Q 65), does not interpret defence manoeuvres (Q 36) and patient's behavior during the hour (Q 82).

Items that distinguish the phases of the therapy

Table 3 lists the items that distinguish the two therapy phases.

Table 3

Comparison of the initial and termination phase of the therapy (Mean across five sessions for each time period and two raters, Wilcoxon-Test, sorted by size of differences)

	Session 1-5	Session 513-517
items for the beginning phase		
Therapist clarifies, restates, or rephrases patient's communication.	7.6	2.9***
The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously.	5.9	2.4**
Therapist identifies a recurrent theme in the patient's experience or conduct.	7.1	3.8**
Patient achieves a new understanding or insight.	4.5	1.8***
Patient is self-accusatory, expresses shame or guilt.	6.7	4.3**
Patient is introspective, readily explores inner thought and feelings.	6.6	4.4**
Therapist actively exerts control over the interaction.	4.5	2.5**
Patient feels shy and embarrassed.	6.0	4.1**
Patient relies upon therapist to solve her problems.	4.2	2.5**
Therapist asks for more information or elaboration.	7.1	5.5**
Discussion centers on cognitive themes.	7.6	6.1*
Patient feels inadequate and inferior.	6.3	5.0*
Therapist's remarks are aimed at facilitating patients speech.	7.2	6.3*
Patient is clear and organized in self-expression.	7.4	6.7**
Therapist focuses on patient's feelings of guilt.	4.2	3.6*
items for the termination phase		
Patient is controlling.	4.3	8.8**
Patient's dreams or fantasies are discussed.	3.5	7.2***
There is an erotic quality to the therapy relationship.	4.2	5.2**
Love or romantic relationships are topic of discussion.	4.3	7.2**
Termination of therapy is discussed.	5.0	7.8*
Patient expresses angry or aggressive feelings.	4.4	6.4*
There is a competitive quality to the relationship.	3.6	5.0**

Patient resists examining thoughts, reactions or motivations related to problems.	3.4	5.9**
Patient is provocative, tests limits of the therapy relationship.	3.8	5.6**
Humor is used.	5.8	6.7*

*p □ .05, **p □ .01, ***p □ .001

Typical of the beginning phase is that the therapist asks for information (Q 31), clarifies (Q 65), facilitates patient's speech (Q 3) and identifies a recurrent theme in patient's experience (Q 62). It is more characteristic of the termination phase that the therapist does less reformulation on the actual behavior of the patient in the hour (Q 82), and reduced focus on patient's feelings of guilt (Q 22). He is less active in exerting control over the interaction (Q 17). In the beginning phase of the therapy, the patient has a clearer and more organized expression (Q 54), feels shyer (Q 61) and inadequate (Q 59), and expresses shame or guilt (Q 71). In the beginning phase she relies more upon the therapist to solve her problems (Q 52), but is more introspective (Q 97) and achieves more new understanding (Q 32). In the termination phase the patient is controlling (Q 87), provocative (Q 20), and resists examining thoughts, reactions or motivations related to problems (Q 58). She is more able to express angry or aggressive feelings (Q 84).

In the beginning phase the discussion was more centered on cognitive themes (Q 30). In the termination phase, the termination of therapy (Q 75), the love relationship (Q 64) and the dreams of the patient (Q 90) were discussed, and more humor was used (Q 74). The beginning phase was different in that it was especially typical that there was a less erotic (Q 19), and a less competitive quality (Q 39) to the therapy relationship.

Discussion

The items that were identified as characteristic for both phases of the therapy are not items one might call "typically psychoanalytic." This can be accounted for by the fact that the selected hours are from the beginning and termination phases of the therapy, where the analytic work is only begun or coming to a close. The patient appears to be constructively engaged in the work and the behavior of the analyst aims at establishing or maintaining a working alliance. Relevant themes are worked through; in particular the patient's self image and interpersonal relationships, as well as her wish for independence. The high rating of PQS item 23, "The dialogue has a specific focus" is consistent with the assumption that the

treatment was conducted according to the Ulm process model (Thomä and Kächele, 1994a). This model considers psychoanalytic therapy to be an interpersonally orientated non-time-limited focal therapy in which the thematic focus changes over time. The description using the PQS items conveys the impression of intensive therapeutic, albeit not (yet) genuinely psychoanalytic, work.

Using the PQS items in comparing the beginning and termination phase yields a vivid description of the differences between these treatment phases. In the beginning phase, the therapist interacts very directly and supportively with the patient. One can surmise an interactive influence between the patient's self-accusations, her embarrassment and feelings of inadequacy and the behavior of the therapist, who inquires and facilitates her communication. The therapeutic technique contains clarifications but also confrontations that are aimed at labelling repetitive themes and interpreting current behavior. This corresponds to the patient's willingness to express herself clearly and to reflect on thoughts and feelings. The description of the beginning phase with the aid of the PQS supports the assumption that this treatment was successful in establishing a stable working alliance, which was most likely a decisive factor in its success.

In the termination phase, the patient is able to express angry feelings and appears less burdened by guilt, which can be considered a positive treatment result. The fact that the patient was able to engage in a love relationship during the course of treatment is another indicator for success, even though the relationship ultimately failed. Thus, in the final hours the theme of separation becomes important in the working through of that relationship and the termination of the therapy. The patient discusses dreams during the final sessions and talks about her ability to interpret them, which can be seen as an identification with the analyst's functions.

While seven items that were rated as typical for the beginning phase described the behavior of the therapist and patient, the items rated as typical for the termination phase were exclusively items that describe the patient and the interaction. The therapist leaves the control of the hour mostly to the patient and keeps a low profile.

The description with the PQS illustrates the differences between the two treatment phases and the way in which patient and therapist influence each other's behavior in a close interaction. The findings illustrate that – as Blatt (2005, p. 574) points out - Ablon and Jones

idea of a psychoanalytic prototype might not be easy to stablizes given the diversity of analysts´ techniques of of phases in treatment.

The PQS does not provide complete information about the content of the therapeutic discourse. Therefore, a PQS rating does not allow the investigation of competitive treatment formulations. The description of a case by means of the PQS items has to reduce the richness of the clinical material, but provides a framework for working models concerning the patient and the therapeutic interaction. The PQS does allow the testing of hypotheses concerning therapeutic processes and their relationship to treatment success.

Jones himself discusses the PQS method as follows (Jones and Windholz, 1990): “As a descriptive language, the Q-technique provides a set of categories shared across observers, guiding observers attention to aspects of the clinical material that might have otherwise gone un-noted, and allowing them to emerge from the background” (p. 1012).