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THE PSYCHOTHERAPY-PROCESS Q-SORT[1]

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 the 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; Jones 1993). Meanwhile the Berkely Psychotherapy Research Group has assembled an impressive array of comparative studies (f.e. Jones et al. 1991; Jones and Pulos 1993; Jones and Price 1998; Ablon and Jones 1998; Ablon and Jones 1999). 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

[1] Cornelia Albani, Gerd Blaser, Uwe Jacobs, Michael Geyer and Horst Kächele; adapted from Albani et al. (2002)

> 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 the 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

<u>Characteristic and uncharacteristic items for all 10 hours</u>

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 5.15 and 5.16).

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).

ms	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

Table 5.15 Rank order for the most characteristic and uncharacteristic PQS items for the beginning phase (Means across five therapy hours and two raters)

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.

PQS-Items		M
10 most characteristic items		
Q 87	Patient is controlling.	8.8
Q 75	Termination of therapy is discussed.	7.8
Q 88	Patient brings up significant issues and material.	7.6

Q 6	Therapist is sensitive to the patient's feelings, attuned to the patient, empathic.	7.5
Q 35	Self-image is a focus of discussion.	7.4
Q 93	Therapist is neutral.	7.3
Q 64	Love or romantic relationships are topic of discussion.	7.2
Q 90	Patient's dreams or fantasies are discussed.	7.2
Q 18	Therapist conveys a sense of non-judgemental acceptance.	7.1
Q 13	Patient is animated or excited.	7.0
10 least characteristic items		
Q 32	Patient achieves a new understanding or insight.	1.8
Q 77	Therapist is tactless.	1.9
Q 51	Therapist condescends to, or patronizes the patient.	2.0
Q 15	Patient does not initiate topics; is passive.	2.1
Q 36	Therapist points out patient's use of defensive manoeuvres.	2.4
Q 82	The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously.	2.4
Q 17	Therapist actively exerts control over the interaction.	2.5
Q 52	Patient relies upon therapist to solve her problems.	2.5
Q 14	Patient does not feel understood by therapist.	2.6
Q 65	Therapist clarifies, restates, or rephrases patient's communication.	2.9

Table 5.16 Rank order of the most and least characteristic PQS-items in the termination phase (Means across five therapy hours and two raters)

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 5.17 lists the items that distinguish the two therapy phases.

		Session 1-5	Session 513-517
Typical items for the beginning phase			
Q 65	Therapist clarifies, restates, or rephrases patient's communication.	7.6	2.9***
Q 82	The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously.	5.9	2.4**
Q 62	Therapist identifies a recurrent theme in the patient's experience or conduct.	7.1	3.8**
Q 32	Patient achieves a new understanding or insight.	4.5	1.8***
Q 71	Patient is self-accusatory, expresses shame or guilt.	6.7	4.3**
Q 97	Patient is introspective, readily explores inner thought and feelings.	6.6	4.4**
Q 17	Therapist actively exerts control over the interaction.	4.5	2.5**
Q 61	Patient feels shy and embarrassed.	6.0	4.1**
Q 52	Patient relies upon therapist to solve her problems.	4.2	2.5**
Q 31	Therapist asks for more information or elaboration.	7.1	5.5**
Q 30	Discussion centers on cognitive themes.	7.6	6.1*
Q 59	Patient feels inadequate and inferior.	6.3	5.0*
Q 3	Therapist's remarks are aimed at facilitating patients speech.	7.2	6.3*
Q 54	Patient is clear and organized in self-expression.	7.4	6.7**
Q 22	Therapist focuses on patient's feelings of guilt.	4.2	3.6*
Typical items for the termination phase			
Q 87	Patient is controlling.	4.3	8.8**
Q 90	Patient's dreams or fantasies are discussed.	3.5	7.2***
Q 19	There is an erotic quality to the therapy relationship.	4.2	5.2**
Q 64	Love or romantic relationships are topic of discussion.	4.3	7.2**
Q 75	Termination of therapy is discussed.	5.0	7.8*
Q 84	Patient expresses angry or aggressive feelings.	4.4	6.4*
Q 39	There is a competitive quality to the relationship.	3.6	5.0**
Q 58	Patient resists examining thoughts, reactions or motivations related to problems.	3.4	5.9**
Q 20	Patient is provocative, tests limits of the therapy relationship.	3.8	5.6**
Q 74	Humor is used.	5.8	6.7*

*p £ .05, **p £ .01, ***p £ .001

Table 5.17 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)

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) prototypical 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. It is clear that to generate a systematic time sample along the course of the treatment as high priority as a next step.

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 "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" (Jones and Windholz 1990, p. 1012).

Formal research in psychoanalysis started with the investigation of technique (Glover and Brierley, 1940) trying to identifdy the operations that create the psychoanalytic situation; it may be no surprise that the PQS brings the field closer to that aim.

References see the complete volume