The Emotional Insight Rating Scale*

Roderich Hohage and J. Christopher Kübler

1. Introduction

The mechanism of therapeutic change in psychoanalysis is still a matter of discussion. 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. Monadic and dyadic points of view are mixed up even in theories of transference and of the therapeutic relationship, as Thomä and Kächele (1987) pointed out. Self-perception and interactive behavior are related to each other in a complex way that cannot be simply reduced to dependent and independent variables.

Psychoanalytic process research too deals partly with intrapsychic changes and partly with changes of the therapeutic relationship. There are differences in research methods and designs, but not necessarily differences in the theory of therapy. It is useful to study intrapsychic changes and interactive behavior by different approaches and then to compare the results in the course of treatment (see Horowitz 1979). The CCRT-method of Luborsky (this volume) as well as the PERT-method, as provided by Hoffman and Gill (this volume) deal with relationship phenomena in the psychoanalytic process. In this presentation we report on a content analysis scale dealing with the intrapsychic aspects of emotional insight.

Insight is regarded as one of the central concepts of psychoanalytic treatment: therapeutic change should result from gaining insight and not

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from behavioral training or from suggestions of the analyst. It has been difficult, however, to define and operationalize the concept of insight for empirical studies (Roback 1974; Fisher and Greenberg 1977). 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 (Hobbs 1962).

Nonetheless there is some agreement among psychoanalytically oriented scientists that a kind of integrative activity of mind is a predominant feature of insight (Kris 1956; Pressman 1969; Hatcher 1973). Scharfman (see Blacker 1981) presented a very short definition: "Insight is bridging different levels of mind." 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 (Reid and Finesinger 1952; Richfield 1954; Valenstein 1962).

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 (Zajonc 1980). 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 1985). As Kafka (1971) pointed out, tolerance of ambiguity in self-perception and in social interaction is a prerequisite of emotional growth.

2. 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" (Meissner 1979), i.e., to his thoughts, feelings, fantasies, wishes, etc. 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 like: "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:

1. The intensity and vividness of the experienced feelings.
2. The extent of imaginative plasticity of the experiences.
3. 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:

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

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

3. 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 1.

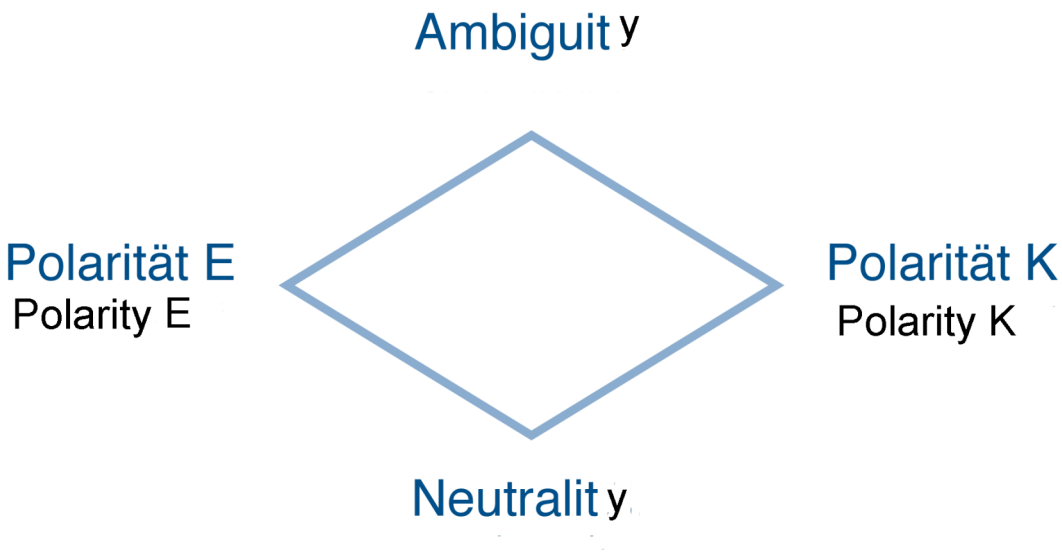

Figure 1 Extreme Positions Obtained by the Combination of Sub-Scales E and C

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.

3. Empirical Investigations

We now report on changes of emotional insight in the course of a psychoanalysis. The patient in this study (Ms X, a research case; see also Grünzig, this volume, and Neudert and Hohage, this volume) is an unmarried woman, 34 years old, suffering from depression, attacks of erythrophobia, and sexual inhibitions. She has been treated by psychoanalysis for 517 sessions. The sessions were tape-recorded and samples were transcribed. We compared the initial phase of the treatment, that is the first eight sessions, to the eight sessions just before termination. This treatment was successful according to clinical judgment as well as psychodiagnostic test results. We thus 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. 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.

Table 1 Reliability of Statement Scores

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

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.

Table 2 Average of Eight Mean Scores of the Initial Phase and of Eight Mean Scores of the Termination Phase (Pat. X)

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
Session510 - 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 2 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 too 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.

Finally we report on a micro-analysis of three sessions (1, 2, 7) from the initial phase of this treatment. In these sessions the analyst and his patient referred directly to the "here-and-now," focusing attention on the therapeutic relationship. If we compare the scores of each statement to the manifest content obtained by systematic description, and to the statements of the analyst, we have the opportunity to study how the interaction influences the patient's access to her experiences.

Figure 2 Course of Session No. 1 (Pat. X)

Figure 2 demonstrates the course of the first analytic session recorded.[1] The graph demonstrates high scores of emotional access that decrease slightly towards the end of the session. There are 4 peaks of manifest ambiguity at statement 4, 10, 13, 18.

If we examine the manifest content of these statements, there are two predominant themes: the patient complains that she feels lonesome (statements 5, 6, 7, 12, 13) and she criticizes herself for being too dependent (statements 5, 10, 18, 19, 20, 21). These two themes relate to each other. When describing her loneliness the patient refers to her feelings; at these statements the scores of emotional access tend to be higher than the scores of cognitive access. When the patient describes being dependent, she evaluates this experience self-critically; at these statements the scores of cognitive access exceed the E-Scores. Where both themes converge (statements 10, 13, 18) we observe peaks of insight.

The analyst in this session confines himself mainly to clarifications and encouragement. Following statement 18 however he verbalizes his observation that the patient looks at her watch. He suggests that she is afraid of staying too long and that she does not want him to close this session by himself. The patient in statement 19 agrees: she is a little bit haughty and does not want to be boring. She then says that she has problems regarding her relation to the analyst. In statements 20 and 21 the patient reinforces self-critically her dependency on other persons, especially her mother. In these statements the cognitive access to experiencing is high.

The course of this session mainly reflects a free and comfortable exchange between patient and analyst, including emotional insight and emotional involvement. This somewhat easy attitude has been described as typical for the initial phase of psychoanalytic treatment (Gitelson 1962). When the analyst confronts the patient for looking at her watch he focuses her attention on the "here-and-now." The patient's look at her watch might be a reaction to the fear of becoming dependent on the analyst. The confrontation seems to strengthen the conflictual aspects of this dependency and it is interesting that the patient reacts with agreement, but at the same time strengthens the cognitive and self-critical aspects of her feelings.

[1]Preceding this session there had been several initial contacts including some therapeutic interventions.

Figure 3 demonstrates the course of the second session. In the first half of this session there are high ratings of emotional access, experiencing and insight. In the second half emotionality decreases (except for the final statement, 18) and no insight is rated. The cognitive aspects of experiencing increase, however, with a peak at statement 14.

Figure 3 Course of Session No. 2 (Pat. X)

According to the manifest content of this session the patient reports that friends visited her and that she did not dare to end their visit at an appropriate time. She complains that she feels painful in such situations because she does not want to be like a bouncer and that she often is too self-conscious and anxious (statements 1 to 4). The analyst in his first interventions makes clarifications and encourages her to express her feelings. Following statements 4 and 5 he emphasizes that she had suppressed her anger at her friends. In statement 6 the patient describes her anger towards herself and her self-criticism which is in contrast to the view other people have of her. This description is plaintive and emotional. Statement 7 was not rated because the patient only describes an interaction with her chief without reference to her experiencing. She then describes herself as being inferior to her brothers, falls silent, and

in statement 8 she asks the analyst for his opinion. The analyst does not answer directly, but just repeats her description.

Following this incident the patient emphasizes her tendency to feel like an underdog, doing so first more emotionally, and later on more insightfully and self-critically. The analyst asks for details and the patient offers them in statements 11, 12 and 13. During statement 13 she again looks at her watch. The analyst now gives an interpretation connecting her tendency to be concerned about somebody else with her fear of being angry. Following this interpretation the patient complains at length about her self-consciousness, her obsessive thoughts and her inhibitions. This is reflected by a peak in the cognitive ratings when she begins to wonder about the meaning of the analytic setting. She later accepts that it might be of use if the analyst does not influence her thoughts. The analyst finally connects her concern about her friends to the concern about him.

There are two important incidents in the manifest interaction of this session: (1) the question about the analyst's opinion and, (2) the renewed confrontation with her looking at her watch. The evasive answer of the analyst might have been disappointing to the patient but again – just as in the session before – she reacts with a self-critical attitude. The renewed confrontation with her looking at her watch must have been irritating too, but here again the patient is very compliant; for instance, in fantasizing about the analyst's possible reactions she does so by strengthening her self-criticism and the cognitive access to her experience. This pattern seems typical of the way the patient copes with conflicts in the therapeutic relationship.

Session 7 also reveals some important interactions referring to the here-and-now. Its course is shown in Figure 4.

According to the manifest content the patient opens this session describing business problems. In statements 5 to 7 she reports a dream that deals manifestly with a defloration scene. She wonders about this sexual content and asks repeatedly if other people have dreams like this (statements 4, 7, 8). Later on she explains that she is much afraid of being abnormal (statement 9). The analyst asks questions of his own, and makes connections to her recent experiences with sanitary tampons and finally offers an interpretation of the dream content without answering her question. In the following sequence the patient deals with problems of using tampons and thereafter with feelings of guilt about sexual excitation. In these statements (10 to 13) she strengthens the cognitive access

Figure 4 Course of Session No. 7 (Pat. X)

while the emotional access is low. In statement 14 the patient gives up asking questions ("I have known that you would not answer me"). She accepts the dream interpretation (statement 16), begins to ruminate about her wishes for therapeutic support, and the complains about her conscience and her dependency on other people, etc. (statements 15 to 20). This sequence is accompanied by very high scores for cognitive experiences and low scores for emotionality. Following statement 21 the patient stops talking. She resists reporting another dream that came to her mind and she argues that this dream would be depressing and indiscreet (statement 22). The analyst points out that she had momentarily tried to look at him and she replies that she feels embarrassed and surprised because he observed her impulse. In statement 23 she assures the analyst that she is accepting the treatment and then explains at greater length why she resists reporting this dream.

This session has a similar pattern to session 2: the patient asks questions and seems to be disappointed that the therapist does not answer, but she tries to be compliant and accept the dream interpretation and the analytic setting. Both analyst and patient are dealing manifestly with the here-and-now, but not directly with her disappointment and anger. Our

rating scores reveal that this patient at this phase of treatment repeatedly reacts to conflicts in the therapeutic relationship by strengthening self-critical and obsessive-compulsive patterns. She withdraws from emotional experiences despite many allusions to unconscious affect. The emotional access therefore is low, and the discussion does not lead to emotional insight.

4. 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 three early sessions taken from a 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).

The evaluation of the rating procedure includes three different levels:

1. By comparing sequences of several hours we can examine the structural affective-cognitive patterns of the patient. If a long sequence

of hours is investigated the probability is low that the findings are based only on situational factors. So the differences between the initial phase and the termination phase of this patient are found in a total of 249 statements, most of them indicating a more insightful emotional attitude in the patient at termination. This supports the interpretation that in this respect a significant change took place.

2. Within segments of treatment we can describe and follow the mean scores for each session. In this way it is possible to study the influence of situational factors on the insight variables and to correlate insight with other variables such as anxiety level, level of suffering, etc. The results of this evaluation will be reported elsewhere.

3. If the statements within a single session are compared, as demonstrated in this paper, it is possible to study the influence of the therapist's actions and interpretations on the patient's insight. In these initial sessions the analyst confronts the patient with her looking at her watch, and he does not answer her questions. Thomä, Schrenk and Kächele (1985), referring to such clinical observations, urge a more liberal technique of answering questions to promote a good therapeutic relationship. In this case our findings seem to support their view, at least with respect to the emotional insight ratings.

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.