Phases of the Referential Process; A Strategy for Psychoanalytic Process Research

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The referential cycle as it operates in the treatment process includes three major phases:

1) the subsymbolic phase, characterized by activation of a dominant problematic emotion schema;

2) the symbolic narrative phase, which involves retrieval and telling of an image, fantasy, episode, memory or dream, whose meaning the patient may not recognize. The narrative that is told represents the schema in prototypic symbolic form; connects to objects within the patient and connects to the therapist;

3) a phase of reflection on the meaning of the narrative that has been told, which may involve recovery of old meanings and reconstruction of new ones. Links are made within verbal systems; links are made as well between analyst and patient and between present and past. New emotion schemas may be opened up, leading to recursion of the cycle on a deeper level.

The following major hypotheses, based on the theory of the referential cycle, provide a general strategy for treatment process research. The outline of hypotheses and directions for research that will be proposed here assumes a knowledge of the multiple code theory and the theory of the referential process, as formulated by Bucci (1997) as well as acquaintance with several widely used psychotherapy process measures, including measures of the Core Conflictual Relationship Theme (Luborsky & Crits-Cristoph (1990); Fundamental Repetitive and Maladaptive Emotion Structures or FRAMES (Dahl, 1988); Referential Activity (RA) (Bucci, et al., 1992); and computer assisted language measures, including measures of referential activity or CRA (Mergenthaler and Bucci, In press) and Abstraction (AB) and Emotion Tone (ET) (Mergenthaler, 1996) . We will present seven major hypotheses; the first has many sub-parts.

H1. Therapeutic work is qualitatively different in the three phases of the cycle, along the lines predicted by the model of the referential process.

This hypothesis has a number of sub-parts, addressing each of the phases of the cycle:

A - *Subsymbolic processing, the Arousal phase*.

1. Patient (and Analyst) expression will be dominated by nonverbal, subsymbolic channels in this phase. Indicators will include:

a) *Using transcripts*: Measures of somatizing or emotional expression as expressed in language.

b) *Using audio-tape recordings*: Paralinguistic cues, e.g. speech rhythms, pausing, vocal tone, pitch and amplitude.

c) *Using video recordings*: Expressive behavior including gesture, movement and facial expression.

d) *Using physiological assessment:* Somatic reactions such as GSR, blood pressure and heart rate.

2. The nature of the therapeutic process in this phase will be marked by particular forms of attunement and interaction (or failures of these) between analyst and patient in the nonverbal, subsymbolic indicators.

3. Analyst will be relatively silent; verbal interventions that do occur will tend to be neutral or supportive; with the goal of moving the patient to a symbolizing mode.

4. RA and CRA will be relatively low. Using RA scales, Concreteness will be relatively high, other three scales low.

5. Contents will be dominated by FRAMES or CCRTs involving the analyst, partially enacted, not represented fully in narrative form.

B - Symbolizing; the narrative mode.

1. CRA will be high in this phase; all 4 RA scales up.

2. CCRTs (and FRAMES), representing the patient's emotion schemas, are likely to be expressed in the narratives of the CRA or RA peaks. The narratives will incorporate the analyst in derivative rather than direct form.

3. The analyst will be silent and listening during the narrative of the CRA peak.

4. The analyst is most likely to intervene verbally following the CRA peak. In contrast to the neutral or supportive verbal interventions of the subsymbolic phase, interventions following the CRA peak are likely to be focal probes and interpretations of the meaning of the narrative material.

5. Subsymbolic expression and communication continue in the narrative phase; can be studied using indicators outlined in Phase One.

6. Symptoms or enactments (momentary forgetting, yawns, other somatic signs, interactions with analyst) may take the place of narrative in the referential process - may be seen as a type of symbolizing. If such events occur, how do they play out in the referential cycle: prevent - facilitate - movement to next phase?

C - Phase of verbal reflection.

1. CRA may decline from peak; patient moves in and out of narrative mode.

2. The analyst will be most consistently verbally active and interactive in this phase.

3. Contents are dominated by new understanding of the emotional meaning of the narrative material; this may include self-observation and new connections to other objects and events, including events of the transference. New generalizations, new categories, new distinctions are made. Possible verbal indicators include:

    a) Increased expression of concomitant emotion and abstract understanding, captured, for example, by Mergenthaler's concomitant high ET/AB pattern.

    b) Fonagy's measure of reflective self-functioning, adapted for application to therapeutic interaction.

    c) Measures of emotional insight (to be found or developed).

H2. Structural change refers to changes in maladaptive emotion schemas, including symbolizing (or resymbolizing) of a schema that has been dissociated, reflected in changes in verbal contents and subsymbolic indicators of the affective core.

H3. Changes in emotion schemas will lead to changes in symptoms, love, work (maxi-outcome measures). Conversely, maxi-outcome changes are less likely to occur without changes in emotion schemas.

H4. The referential process is a cognitive-linguistic universal, which applies in different forms, with different manifestations, across differing cultural groups, diagnostic groups and treatment orientations.

a) The CRA measure applies across languages; can be translated.

b) The basic process as identified in psychoanalysis or psychodynamic therapy may be seen in other approaches including behavioral treatments and child, group or family therapy; constitutes a common core of therapeutic process applying across orientation.

c) The process applies and may be adapted to develop psychodynamic treatments of populations that have been seen as difficult to reach, including violent youth and psychotic patients.

H5. Mathematical features of the CRA function need to be identified, including nature of cyclical fluctuation; variation for different individuals and different periods in treatment; sequential relationship to other measures including ET and AB.

H6. The process can be captured reliably using detailed process notes in place of transcripts.

H7. The cyclical fluctuation operates recursively, within sessions and across treatments.

Some of these hypotheses have already been investigated and supported; some are now being addressed; others remain to be studied. We expect that each investigation will in turn open up new questions and directions, and that this strategy will keep us quite busy, well into the next millennium.

References

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